STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355109	A. BUILDING _____ B. WING _____	03/27/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOURIS VALLEY CARE CENTER	300 MAIN ST S VELVA, ND 58790

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS For the standard Medicare/Medicaid survey started on 03/25/13 and completed on 03/27/13, the sample included three (3) residents for complete review, nine (9) residents for focused review, and one (1) closed record for review. The sample included four (4) additional residents to verify specific concerns during the survey.	F 000	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and state law. For the purposes of any allegation that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the State Operations Manual.	
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON MARCH 29, 2012. Based on observation, medical record review, review of facility policy, and staff interview, the facility failed to properly assess the use of and continued need for a one-piece undergarment and jump suit for 1 of 1 sampled resident (Resident #6) observed with physical restraints. Failure to assess, monitor, and re-evaluate the necessity of these devices limited the resident's freedom of movement and access to her body and placed her at risk for skin breakdown and a loss of dignity. Findings include: Review of the facility policy titled "Restraints: Physical" occurred on 03/27/13. This policy,	F 221	1. For resident #6, the GSS 248 & 248A will be completed by 4/26/13. Care plan updated. 2. Any resident who is disrobing in public areas is at risk. No residents are identified at this time. 3. Education to all staff was given on 4-29-13 over Physical Restraint procedure. Risk Management Committee will monitor and review restraint use. 4. QA Nurse or designee will audit adaptive clothing use monthly for 3 months. If no issues are noted, The audited will be completed quarterly for the next three quarters. Survey issue will be managed, and addressed during Quality meetings.	5-7-2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kaylene Kitzinger — TITLE: Administrator — (X6) DATE: 4-30-13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 221	Continued From page 1 revised August 2008, stated, ". . . Definitions . . . Physical Restraints - any manual method of physical or mechanical device, material or equipment attached to or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's own body. . . . Removes easily - the manual method, device, material, or equipment that can be removed intentionally by the resident in the same manner as it was applied by the staff . . . Procedure: Anytime a device, material, or equipment is attached or placed adjacent to the resident's body, a determination will be made by a licensed nurse as to whether it is or could be a restraint for the individual resident. . . . The registered nurse will complete the designated portions of the Physical Restraint Assessment . . . The interdisciplinary care team or the reduction committee will complete the designated portion of the [Physical Restraint Assessment] . . . Contact the physician . . . Obtain the physician order . . . Obtain informed consent . . . Update the resident care plan . . ." Review of Resident #6's medical record occurred on all days of survey. Diagnoses included dementia. The current Minimum Data Set (MDS), dated 01/12/13, identified short and long term memory problems, severely impaired daily decision-making skills, no behavioral symptoms, total dependence on one person for dressing, and a chair-prevents-rising type restraint used daily (observations during the survey showed Resident #6 used a lap buddy while in the wheelchair). The current care plan, dated 01/17/13, stated, ". . . [Resident name] is restless at times. . . . I do remove my upper clothing in public . . . Plans and	F 221		

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F 221	Continued From page 2 Approaches . . . Adaptive clothing to prevent disrobing including one piece outfits. . . ." A previous care plan, dated 04/19/12, also identified: "Adaptive Clothing to Prevent Disrobing." The current MDS, as well as previous MDSs dated 10/12/12 and 06/25/12, failed to identify Resident #6's one piece garments as restraints. A physician's progress note, dated 09/26/12, stated, ". . . They have solved the problem of her undressing herself by getting her into sort of a jump suit. That seems to be working quite nicely for now, they state. . . ." Resident #6's medical record lacked physician's orders and assessments for the one-piece garments, as well as consent from Resident #6's family related to the use of the garments. Observation on 03/25/13 at 5:29 p.m. showed two certified nursing assistants (CNAs) (#2 and #3) assisted Resident #6 to the bathroom. Resident #6 wore a one-piece jump suit that zipped halfway down the front and also across her bottom. Under the jump suit, Resident #6 wore a one-piece undergarment that snapped between the legs. The CNA (#2) identified Resident #6 wore these to prevent her from removing her clothing in public. Observation on 03/26/13 and 03/27/13 showed Resident #6 did not wear the one-piece jump suit or undergarment. Observations during the survey showed no attempts by Resident #6 to undress. During an interview on 03/27/13 at 8:12 a.m., a CNA (#4) stated Resident #6 wears the jump suit with a one-piece undergarment underneath to	F 221		

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F 221	Continued From page 3 prevent disrobing. She stated one type has a half zipper in front, and the other has a zipper up the back, but it does not seem to be as comfortable for Resident #6 as it "bunches up." The CNA stated Resident #6 has worn this type of clothing for "probably a year," and that the resident's undressing has gotten better. The CNA stated the staff do not really have a protocol as to when Resident #6 wears the adaptive clothing, and it "depends on the day," because Resident #6's mood and behavior can change. Failure to assess the one-piece garments as possible restraints, monitor their use, and periodically re-evaluate the need for the garments may result in Resident #6 being unnecessarily restrained.	F 221		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and	F 225		

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F 225	Continued From page 4 to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to thoroughly investigate an injury of unknown origin for 1 of 1 sampled resident (Resident #12) found with bilateral bruising on her lower forearms. Failure to report and investigate an injury of unknown origin placed Resident #12 and other residents at risk for mistreatment and/or abuse, and did not allow the facility to determine causative factors for the injury and implement corrective action. Findings include: Review of the facility policy titled "Abuse and Neglect" occurred on 03/27/13. This policy, revised June 2012, stated, ". . . Policy . . . Alleged or suspected violations involving any	F 225		

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F 225	Continued From page 5 mistreatment, neglect or abuse including injuries of unknown origin will be reported immediately to the center administrator and to other officials in accordance with state law . . . Purpose . . . To ensure that all identified incidents involving injuries of unknown origin are promptly investigated to determine probable cause of unknown origin injuries . . . Procedure . . . If a staff member receives an allegation . . . or witnesses suspected abuse, neglect or misappropriation of resident property, the staff member will immediately report this to a supervisor . . . The charge nurse or licensed nurse will be notified immediately, assess the situation to determine if any emergency treatment or action is required, and compete an initial investigation. . . ." Review of Resident #12's medical record occurred on 03/27/13. Diagnoses included senile dementia and anxiety. A nurse's note, dated 11/19/12, stated, ". . . Weekly skin assessment [with] bath. Bruising to lower forearm bil. [bilaterally]. Reported to proper management. . . ." Another note, dated 11/20/12, stated, ". . . Staff noted two large bruises to res. [resident] bil. forearms. Unknown how bruises occurred. They are resolving spontaneously. . . ." An incident report, dated 11/19/12 at 9:30 a.m., stated, ". . . While doing a skin assessment bruises were found on bilateral top lower arms. When I asked resident what happened she stated 'that big nurse did it.' This was not noticed Friday day shift. (11-16-12). . . ." The incident report lacked further investigation into the cause of the bruising.	F 225	1. for resident #12, skin assessment completed. No skin alteration is noted. Incident was re investigated and found that placement of residents arms on the side of her wheelchair could have been the cause. Residents wheelchair will be evaluated for safety. 2. All residents have the potential to be affected. 3. All staff was educated on 4-29-13 and Nursing staff was also educated on 4-10-13 regarding injury of unknown origin and reporting procedure. Education included definition of injury of unknown origin with the steps of internal reporting and how to report to external agencies. All injuries of unknown origin will be reported to State Health Department per Federal regulations. 4. DNS or designee will audit injury of unknown origin monthly for 3 months. If no issues are noted, audits will be completed every quarter for the next 3 quarters. Survey issue will be reviewed at Quality meetings.	5-7-2013

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F 225	Continued From page 6 During an interview on the morning of 03/27/13, an administrative staff member (#1) stated facility staff should have done an internal investigation regarding the above incident, but was unable to locate any further documentation.	F 225		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observation, record review, facility policy review, and resident and staff interviews, the facility failed to accommodate 1 of 1 sampled resident (Resident #11) who ate all his meals in his room. Failure to bring Resident #11's breakfast tray earlier in the morning did not recognize the resident's right to make choices that are significant to him. Findings include: Review of the facility policy titled "Frequency of Meals and Snacks" occurred on 03/27/13. This policy, dated August 2012, stated, ". . . Policy . . . The center will serve at least three meals each day at regular times comparable to normal meal times in the community and/or honoring individual choice. . . . Individuals who have specific requests for meal service outside these	F 242		

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F 242	Continued From page 7 guidelines will be accommodated. Resident preferences will be care planned accordingly . . ." Review of Resident #11's medical record occurred on 03/27/13. Current diagnoses included end stage chronic obstructive pulmonary disease, laryngeal cancer, failure to thrive, nausea, and pneumonia. The resident's admission Minimum Data Set (MDS) identified the resident with moderately impaired cognition, mild depression, and required limited assistance with eating. Review of the resident's communication Care Area Assessment (CAA), dated 01/29/13, stated Resident #11 is "able to make his needs known." The current comprehensive care plan, dated 02/05/13, stated, " . . . Problem . . . Alteration in nutrition r/t [related to] less than body requirements. Failure to thrive, poor appetite. . . . Plans and Approaches . . . Dining: Independent, encourage/cue . . . Problem . . . Potential for adjustment reaction/mood state r/t end stage COPD. . . . Approaches . . . Chooses to eat meals in his room . . ." Observation on 03/27/13 at 9:25 a.m. showed Resident #11 received a breakfast tray in his room. Meal times provided by the facility identified breakfast at 8:00 a.m. and lunch at 12:00 p.m. (noon). During a resident interview on 03/27/13 at 9:45 a.m., Resident #11 (identified by the facility as interviewable) stated there is no schedule for when he receives morning medications or breakfast. The resident stated at home he would eat breakfast at 6:00 a.m. and here breakfast is	F 242	1. For resident #11, the nurse giving him his morning medication will offer to get his tray while he is receiving morning medication. 2. Any resident who requests to receive meals outside of the dining room has potential to be affected. 3. All breakfast trays will be served by 9 am or per residents choice. Education to all staff over tray service was given on 4-29-13. 4. QA Nurse or designee will audit tray service monthly for 3 months. If no issues noted, audits will be completed quarterly for the next 3 quarters. Survey issue will be managed and addressed during Quality meetings.	5-7-2013

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F 242	Continued From page 8 usually served after 9:00 a.m. The resident stated breakfast has been as late as 10:30 a.m. The resident stated he informed staff members about wanting breakfast with his medications (which are scheduled at 8:00 a.m.) During an interview on 03/27/13 at 10:00 a.m., a nurse (#8) stated Resident #11 has been wanting his medications and breakfast earlier. The nurse reported in the past she waited to give his medications with his breakfast, but the resident informed her he wants the medications at the scheduled time (8:00 a.m.) even if breakfast is delivered to his room later. During an interview on 03/27/13 at 11:55 a.m., a CNA (#7) stated staff try to have all breakfast trays delivered by 9:00 a.m. and it is "out of the ordinary" for Resident #11 to receive his tray later than 9:00 a.m. During an interview on 03/27/13 at 12:00 p.m., a dietary staff member (#9) stated breakfast is usually served by 9:00 a.m., but at times it is later. This staff member stated kitchen staff can be accommodating to residents who would want breakfast trays earlier then the scheduled time, but dietary staff are not aware of any residents who want to eat earlier. The facility failed to accommodate Resident #11's request and develop a plan of care to include the resident's individual choice of wanting breakfast served with his medications (8:00 a.m.).	F 242		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must	F 309		

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F 309	Continued From page 9 provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of professional literature, and staff interview, the facility failed to ensure 1 of 1 sampled resident (Resident #1), identified as having dysphagia received the care and services necessary to attain the highest degree of safety possible when assisted with fluids while in bed. Failure to properly position the resident before providing beverages has the potential to affect the resident's overall swallow safety, and placed him at greater risk of aspiration. Findings include: Nancy B. Swigert, The Source for Dysphagia: Third Edition, LinguiSystems, Inc, 2007, pages 9, 15-16 and the educational handouts identified the following: * "Signs and Symptoms of Dysphagia: . . . Weight loss . . ." * "What good are postural changes?: Some postural changes [being as close to 90 degrees as possible] can provide increased airway protection . . . " * "Why is it important for patients to sit at 90 [degrees] when eating? Many patients with dysphagia have decreased back of tongue control. This condition allows food and liquid to	F 309		

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F 309	Continued From page 10 fall over the back of the tongue with risk of it entering the airway." - Review of Resident #1's medical record occurred on March 25-27, 2013. A quarterly Minimum Data Set, dated 01/26/13, identified the resident with severely impaired cognition; dependent on two or more staff for bed mobility; and required extensive assistance of one staff member for eating. Diagnoses for Resident #1 included dysphagia and amyotrophic lateral sclerosis. Observation of care for Resident #1 occurred on 03/26/13 at 10:00 a.m. Two CNAs (#7 and #17) laid the resident in bed and provided water without attempting to elevate Resident #1 to a safe position. Observation on 03/26/13 at 10:35 a.m. showed a CNA (#7) provided Resident #1 a beverage while he was in bed. The CNA (#7) failed to elevate the resident to a safe position before providing the beverage. Observation on 03/27/13 at 8:10 a.m., showed a nurse (#8) visiting with a maintenance staff member (#18) about not being able to raise the head of Resident #1's bed. The nurse (#8) then demonstrated the head of the bed could not be raised using the electronic control. During an interview, on 03/27/13 at 11:55 a.m., administrative staff members (#1 and #5), identified staff should have elevated the head of the bed before they provided Resident #1 with fluids.	F 309	1. For resident #1, staff was educated regarding the importance of proper position while receiving fluids. Bed has repaired by maintenance. 2. All residents have potential to be affected by this process. 3. All staff was educated on 4-29-13 over the proper positioning of residents while in bed. 4. QA nurse or designee will completed monthly audits for the next 3 months and then quarterly for the next three quarters. Survey issue will me monitored and addressed at QA meetings.	5-7-2013
F 312	483.25(a)(3) ADL CARE PROVIDED FOR	F 312		

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F 312 SS=E	Continued From page 11 DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide the necessary assistance to carry out activities of daily living for 3 of 12 sampled residents (Residents #2, #9, and #10) and 1 supplemental resident (#16) observed during meals who required encouragement, cueing, and/or assistance with meal consumption. The facility also failed to provide necessary services for 1 of 8 sampled residents (Resident #1) and 1 supplemental resident (Resident #17) who required assistance to maintain personal hygiene. Failure to ensure residents received assistance at meals may affect residents' nutritional status and failure to ensure residents' personal hygiene needs are met increases the potential for the spread of infections and does not respect resident dignity. Findings include: Review of the facility policy titled "Nutritionally Dependent Resident Total Assistance in Feeding" occurred on 03/27/13. This policy, dated November 2009, stated, ". . . . If resident dislikes food/fluid offered or has poor intake, offer/try alternative and refer to director of dietary services	F 312	1. For resident #16, staff educated regarding timely assistance with meals. Staff educated regarding the need to offer alternatives and report to dietary and nurse regarding eating less than 50% of provided meals. For resident #2 & #9, Charge nurse or designee will observe and monitor during meal times to ensure residents are receiving cuing and utensils are accessible. They will also offer alternatives if the resident does not eat at least 50% of the meal. For resident #10, moved to an assist table to provide more cuing/ assistance. For resident #1, staff educated on proper procedure for pericare to prevent infection and maintain skin integrity. For resident #17, staff educated on infection control and hygiene to prevent food contamination.	5-7-2013

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 12 for evaluation of dining needs and preferences. . . . when resident is finished, remove napkin and tray . . . document amount of food/fluids/supplement consumed . . . report to charge nurse or director of dietary services if resident has eaten less than 50 percent . . ." - Review of Resident #16's record occurred on 03/27/13. Current diagnoses include dementia, blindness, chronic kidney disease, and depression. A quarterly Minimum Data Set (MDS), dated 03/04/13, identified the resident as severely impaired with decision making and needing total assistance with eating. The resident's current comprehensive care plan, dated 03/12/13, stated, " . . . Total assist in the dining room . . ." Review of the "Dining Report" on 03/27/13 identified Resident #16 ate 25% of her food and drank 440 cubic centimeters (cc) of fluids for breakfast. Observation of Resident #16 in the dining room on 03/27/13 showed the following: * 8:50 a.m.- hot cereal and breakfast delivered to Resident #16. * 9:04 a.m. (14 minutes after hot cereal delivered) - the CNA (#7) sat next to Resident #16, placed a clothing protector, and a minute later stood up from the table, assisted another resident, and retrieved straws for Resident #11's beverages. * 9:07 a.m. (17 minutes after being served breakfast)- the CNA (#7) again sat next to Resident #16 and assisted the resident to eat until 9:23 a.m. The CNA then rolled her chair over to a neighboring table and assisted another resident. * 9:30 a.m. - The CNA obtained a container of whole milk for Resident #16 and sat down next to	F 312	2. All residents who require cuing or assistance with dining, personal hygiene and /or pericare have potential to be affected. 3. Education to all staff was given on 4-29-13 regarding importance of residents receiving needed cuing and assist with dining, personal hygiene and pericare. Charge nurse or designee will monitor meals to ensure that residents are receiving cuing and needed assist if not eating, as well as alternatives are being offered. Dietary will notify Charge nurse if a resident eats less than 50% of meals and will provide a snack between meals. Charge nurse will document snack consumption or refusal. 4. QA Nurse or designee will audit dining room for cuing, assistance, utensil accessibility, alternatives, and personal hygiene in dining room. QA Nurse or designee will audit pericare. Audits will be completed monthly for three months then quarterly for the next three quarters. Survey issue will be monitored and addressed at the QA meetings.	

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F 312	Continued From page 13 the resident. The CNA fed the resident a spoonful of hot cereal (served 40 minutes earlier) and assisted her to drink some milk. * 9:32 a.m. - the CNA then assisted another resident to leave the dining room. * 9:40 a.m. - a second CNA (#11) walked over to Resident #16, removed the clothing protector, wheeled the resident out of the dining room, and met the first CNA (#7) in the hallway who then asked if the resident had finished her milk. The second CNA (#11) responded "yes" and continued to wheel the resident into the activity room. * 9:42 a.m. - the first CNA (#7) brought Resident #16's remaining 1/2 glass of milk to the activity room, which the resident then consumed. - Review of Resident #2's medical record occurred on all days of the survey. Medical diagnoses included, in part, diabetes, weakness, anemia, dementia, urine retention, chronic obstructive pulmonary disease, chronic ulcer, and history of weight loss. Resident #2's current quarterly Minimum Data Set (MDS), dated 03/16/2013, identified oversight, encouragement, or cueing for eating. Resident #2's Resident Care Area Assessment (CAA), dated 12/16/2012, stated, ". . . Resident #2 has been declining physically. He is needing more assistance with many Activities of Daily Living (ADL's) . . ." Observation on 03/26/13 from 8:20 a.m. until 9:25 a.m., showed Resident #2 sat in the dining room with two pieces of toast, fried eggs, 2% milk, apple juice, coffee, and a supplement. At 8:32 a.m., the resident removed his own clothing protector and tried to wheel away from the table. He continued to wheel back and forth during the	F 312		

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F 312	Continued From page 14 observation with one wheel chair brake locked on the chair. The first time staff approached, at 9:07 a.m., a dietary staff member (#12) documented the resident's meal intake and stated, "you haven't ate much." At 9:21 a.m. a CNA (#13) sat next to the resident and encouraged him to eat. When the resident refused, the CNA encouraged him to drink. The resident picked up the supplement drink, finished it, and the CNA left. At 9:25 a.m., another CNA (#7) offered the resident a banana, which the resident declined. The CNA unlocked the wheelchair brake and Resident #2 self propelled out of the dining room. Staff failed to encourage/cue, assist, or offer alternatives to the resident for the first 45 minutes after breakfast had been served. Observation on 03/26/13 at 12:20 p.m. showed Resident #2 sat in the dining room with spaghetti, garlic toast, lettuce salad, fruit salad pieces, and a chocolate drink. At 12:40 p.m., the resident remained sitting at the dining room table. The resident drank six ounces of chocolate drink, ate 25% or less of the spaghetti and ate 100% of the fruit pieces. The resident did not eat salad or toast. Staff failed to encourage/cue,assist, or offer alternative choices to the resident at any time during this meal. Observation on 03/27/13 at 8:40 a.m. showed Resident #2's breakfast delivered to the table, and at 9:07 a.m., the resident wheeled himself out of the dining room. No staff approached Resident #2's table during this time. The resident ate 1/4 of a piece of toast, bites of cereal, and drank four ounces of grape juice, two ounces of coffee, and two ounces of whole milk mixed with a chocolate supplement. Staff failed to	F 312		

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F 312	Continued From page 15 encourage/cue the resident during the breakfast meal. Resident #2's meal intake records showed the following: *03/25/2013- noon meal- intake 25% *03/25/2013- evening meal- intake 25% *03/26/2013- breakfast- intake 0% *03/26/2013- noon meal- intake 25% *03/26/2013- evening meal- intake 25% *03/27/2013- breakfast- intake 25% - Review of Resident #9's medical record occurred March 27, 2013. A quarterly MDS, dated 03/09/13, identified the resident had severely impaired cognition; and as independent with eating after staff set up. Resident #9's care plan, dated 03/19/13, identified she had a vision deficit; she needs physical assistance with eating at times; and staff are to provide assistance with eating as the resident requires. Observation on 03/25/13 from 6:10 p.m. to 6:40 p.m., showed Resident #9 in the dining room with food in front of her while Resident #9's utensils remained wrapped in a napkin. At 6:40 p.m. (30 minutes later), an unidentified CNA came over to the table, unwrapped the utensils, fed the resident a bite of hotdish and left the table. After the CNA left, the resident continued to feed herself. Staff failed to encourage/cue or assist Resident #9 for thirty minutes. - Review of Resident #10's medical record occurred March 27, 2013. A quarterly MDS, dated 02/09/13, identified the resident had severely impaired cognition; and required limited assistance by one staff member for eating.	F 312		

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F 312	Continued From page 16 Resident #10's care plan, dated 02/19/13, stated, "I have diabetes mellitus. I receive insulin and oral meds [medications]. I have a good appetite. . . . Serve a consistent carbohydrate diet; weigh me weekly." The care plan failed to indicate the need for assistance while eating as identified by the MDS. Observation on 03/25/13 from 6:10 p.m. to 6:40 p.m., showed Resident #10 in the dining room with food in front of her. Resident #10 did not consume any of the meal during the 30 minute observation. Staff failed to encourage/cue or assist Resident #10 for 30 minutes. Observation on 03/26/13 from 8:20 a.m. to 8:50 a.m., showed a staff member brought cold cereal, toast, milk, water, and coffee to Resident #10 who sat in the dining room. The staff member poured half of the milk over the cereal and handed the resident a half slice of toast. At 8:35 a.m., a staff member came over to the resident and handed her the remaining milk and the resident drank approximately one fourth of the milk. The staff failed to offer further assistance to the resident who only consumed the half slice of toast and the milk during the 30 minute observation. During an interview, on 03/27/13 at 12:20 p.m., an administrative nurse (#5) identified the facility expects staff not to serve a resident's tray until staff members are available to assist the resident. - Review of Resident #1's medical record occurred March 25-27, 2013. A quarterly Minimum Data Set, dated 01/26/13, identified the resident had severely impaired cognition;	F 312		

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F 312	Continued From page 17 dependent on two or more staff for bed mobility and toilet use; dependent on one staff member for personal hygiene; at risk for the development of pressure ulcer; received skin treatments of application of ointments and/or medications other than to the feet. Diagnoses for Resident #1 included candidiasis of skin, specifically groin and nails, and amyotrophic lateral sclerosis. Observation, on 03/26/13 at 10:00 a.m., showed CNAs (#7 and #17) provided pericare, for urine incontinence, while Resident #1 lay in bed. The CNA (#17) provided rectal pericare as the resident laid on his side and then reached through to cleansed a portion of the resident's genitals. The CNAs (#7 and #17) failed to turn Resident #1 onto his back and cleanse the frontal groin and full genital area. - Review of Resident #17's medical record occurred on 03/27/13. An admission MDS completed on 02/11/13 identified Resident #17 had severely impaired cognition; required limited assistance of one staff member for eating; and extensive assistance of two or more staff members for personal hygiene. Meal observation for Resident #17 occurred on 03/26/13 at 12:00 p.m. A CNA (#16) sat at Resident #17's table assisting another resident, but also spoke to Resident #17. During this meal, nasal drainage began to drip from Resident #17's nose to his upper lip. The drainage fell into the resident's food, beverage, and onto his lap, until he wiped his nose when he had completed eating and drinking. The CNA (#16) failed to cue the resident to wipe his nose or assist the resident to wipe his nose.	F 312		

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F 312	Continued From page 18 During the breakfast and the noon meal on 03/27/13, observation showed Resident #17 developed nasal drainage while eating/drinking. Multiple staff members assisted the residents sitting to the left, right, and directly across from Resident #17 during both meals. These unidentified staff members failed to cue Resident #17 to wipe his nose or assist him to wipe his nose. The secretions fell into his beverages, food, and lap. During the noon meal, a CNA (#3) handed Resident #17 a tissue and stated, "Catch your nose." Resident #17 took the tissue, looked at it, and sat the tissue on the table next to his plate. During an interview, on 03/27/13 at 11:55 a.m., two administrative staff members (#1 and #5), identified staff members should have assisted Resident #17 with personal hygiene during the meal observations. These same staff members (#1 and #5) expected staff to complete pericare for Resident #1's full groin area following urine incontinence.	F 312		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.	F 315		

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F 315	Continued From page 19 This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident interview, staff interview, and review of facility policy, the facility failed to ensure 1 of 2 sampled residents (Resident #11) who had an indwelling catheter had a clinical condition that required catheterization. Failure to discontinue Resident 11's indwelling foley catheter when not clinically necessary increased the residents risk for pain, discomfort, and urinary tract infections (UTIs). Findings include: Review of the facility policy titled "Catheterization" occurred on 03/27/13. This policy dated November 2002, stated, " . . . A resident will not be catheterized unless the clinical condition demonstrates that catheterization is necessary . . . " Review of the facility policy titled "Catheter (Indwelling/Retention)" occurred on 03/27/13. This policy, dated July 2012, stated," . . . Purpose for Catheter Removal . . . Indication for usage has been resolved . . . To Prevent potential complications (such as urinary track [sic] infections and kidney stones) associated with the long-term use of indwelling catheters . . . Guidelines for Attempted Catheter Removal . . . The SOM (State Operations Manual) F-Tag 315 indicates that indwelling catheters must be medically necessary for the resident. The medical records must have documentation of attempts to remove indwelling catheters and the results of these attempts. . . . If there is no record of previous attempts to remove catheter: Discuss	F 315	1. For resident #11, we have received supportive documentation from the MD for catherter purpose and resident and family have been educated regarding the risks vs. benefits. 2. Any resident with a foley catheter has potential to be affects. 3. Nurses were educated on 4-10-13 about the documentation over the medical need of a foley catheter. All staff was educated on 4-29-13. Any resident who has a foley catheter needs medical documentation with supporting diagnosis. If no diagnosis is found, nurse will contact MD to determine if catheter use is appropriate. 4. QA Nurse or designee will audit all charts of residents who have a foley catheter to ensure there is supportive diagnosis. Survey issue will be monitored and addressed at QA meetings.	5-7-2013

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F 315	Continued From page 20 with physician a trial attempt at removal . . . If unable to void . . . determine if resident can be managed with intermittent catheterization schedule . . ." During a resident interview on 03/27/13 at 9:45 a.m., Resident #11 (identified by the facility as interviewable) reported pain around the sight where his indwelling catheter was inserted. The resident stated he did not have the catheter at home and he was not sure why he had the catheter here at the facility. Observation showed an indwelling catheter bag on the side of the bed during the interview. Review of Resident #11's medical record occurred on 03/27/13. Current diagnoses included end stage congestive obstructive pulmonary disease (COPD), laryngeal cancer, failure to thrive, pneumonia, hypoxia, and pain. Physician orders, dated 01/23/13, stated, "Foley Cath [catheter] change monthly " and the resident's current care plan, dated 02/05/13, stated, "Problem . . . Attempts to remove catheter, restlessness, trying to get out of bed, refusing to reposition . . ." The care plan failed to identify the reason for the catheter or approaches for catheter cares. Review of a "Bladder Assessment" dated 01/27/13 identified an external catheter and lacked a "diagnosis for use." Review of Resident #11's admission Minimum Data Set (MDS), dated 01/29/13, identified an indwelling catheter. Review of the resident's urinary incontinence and indwelling catheter Care Area Assessment (CAA), dated 01/29/13, stated, " . . . describe the relationship that these risk	F 315		

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F 315	Continued From page 21 factors/complications and confounding problems have on this residents Urinary Incontinence and Indwelling Catheter. . . . [resident's name] has end stage COPD. He has haad [sic] vocal cord cancer. He is on oxygen. He rarely gets out of bed. . . . 6. Proceed to care plan? No . . . 7. Why or why not? I will be continent . . ." During an interview on 03/27/13 at 10:50 a.m., an administrative nurse (#5) stated he was unaware that the resident's medical record lacked a diagnosis which would require an indwelling catheter. The medical record failed to identify a clinical condition that demonstrated that catheterization was necessary, failed to develop a plan of care to maintain and assess the use of the catheter, and failed to show the facility attempted to discontinue the catheter during the resident's two month stay at the facility.	F 315		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: 1. Based on observation, record review, review of facility policy and procedure, review of manufacturer's instructions, and staff interview,	F 323		

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F 323	Continued From page 22 the facility failed to ensure the appropriate use of transfer devices (a bath chair and a sit to stand mechanical lift) to prevent falls for 2 of 12 sampled residents (Resident #2 and #8) and failed to implement fall prevention measures (chair alarms) for 2 of 12 sampled residents (Resident #4 and #8) with a history of falls. Failure to use devices for transfer and safety appropriately placed the residents at risk for falls and injury. Findings include: Review of the manufacturer's pamphlet for the Cascade Patient Transfer Lift Systems (bath chair) "Safe Operation & Daily Maintenance Instructions" occurred on 03/27/13. The instructions stated, ". . .Therefore before each patient transfer, it is required that the nursing staff inspect for proper operation and missing or worn parts such as belts, cushions. . . . Belting Technique and Transfer Procedure with the Penner Transfer System. . . . 7. Route the belt through the belt loops of the chair frame prior to placing the resident into the chair. 8. Transfer the resident into the Penner Transfer using the proper nursing transfer techniques. Bring the seat belt around the resident, to the D-ring connector. . . . Warning . . . Failure to secure the resident properly with the seat belt could result in injury to the resident. . . . Adjust the belt to insure safety while transporting. . . . Daily Safety Checklist, . . . Perform the following safety checks for the Penner Transfer: 1. Seat Belt - Check the condition of the seat belt(s). . . ." - Review of Resident #2's medical record occurred on March 25-27, 2013. Diagnoses	F 323	1. When Resident #2 is being transferred with the bath chair set belt will be used at all times. 2. All residents have the potential to be affected. 3. All staff was educated on 4-29-13 per manufacturer's procedure that seat belt must be worn at all times while in the bath chair. 4. Staff Development Nurse or designee will do weekly audits for 3 months then quarterly for the next 3 quarters. Survey issue will be monitored and addressed at QA meetings.	5-7-2013

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F 323	Continued From page 23	F 323		

included urine retention, diabetes, hypertension, weakness, chronic ulcer, macular degeneration, dementia, and a history of falls. The current Minimum Data Set (MDS), dated 03/16/13, identified the resident required extensive assistance from staff for transfers, personal hygiene, and bathing.

A facility incident report, dated 10/18/12 at 3:00 p.m., stated, " . . . Contributing Factors: . . . Comments: was getting [Resident # 2] Ready [sic] for a bath and was wheeling him in the bath chair to the bath and the side of the bath chair caught on the bathroom door and proppeled [sic] [Resident #2] forward in which he landed on his left arm & knee . . . Incident Details . . . Certified Nursing Assistant [CNA] reminded to use lap belt to secure resident . . ."

An Interdisciplinary Progress Note, dated 10/18/12 at 3:00 p.m., showed Resident #2 sustained skin tears to his left wrist & elbow, an abrasion to his left knee, and had difficulty bearing weight on his left leg.

During an interview on 03/27/13 at 1:30 p.m., an administrative staff member (#1) stated she expected facility staff to use the bath chair lap belt during transfers and baths.

- Review of the Manufacturer's Guidelines for the Steady-Aid Stand Lift, page 6, stated, "5 - Wrap the harness around the patient and attach in front by snapping the two part buckle together. Ensure the harness is square by pulling forward on the two loop sections so they extend out equally. The front safety strap should be below the sternum level. Tighten the safety strap by pulling on the

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F 323	Continued From page 24 free end so that the harness is adjusted to a point where it fits snugly around the chest." Review of Resident #8's medical record occurred on March 25-27, 2013. Diagnoses included advanced dementia of an Alzheimer's nature, osteoporosis, and a history of falls. A quarterly MDS, dated 03/04/13, identified extensive assistance of two or more staff for transfers. The care plan, dated 03/12/13 stated, ". . . Transfer and reposition with assist of 2 . . ." Observation of care on 03/25/13 at 10:22 a.m., showed two CNAs (#7 and #17) utilized the Steady-Aid Stand Lift and transferred Resident #8 from his wheelchair onto the toilet and back to his wheelchair. The CNAs (#7 and #17) failed to tighten the front safety strap as they raised the lift three times, twice for the transfer and once when the CNAs (#7 and #17) lowered the resident back onto the toilet. With each lift, the harness slid upward into his axilla, caused Resident #8's shoulders to shrug upward, causing his arms to extend outward so the elbows were parallel to the shoulders. Observation of care on 03/26/13 at 1:16 p.m., showed a CNA (#17) took Resident #8 to his room to lay down. The CNA (#17) unhooked the tab alarm to place a gait belt around the resident. The staff member left the room to get help for the transfer. Before leaving the room, the CNA (#17) failed to reattach the tab alarm. During an interview, on 03/27/13 at 11:55 a.m., with two administrative staff members (#1 and #5), these staff agreed the CNAs should have tightened the lift harness as the resident stood	F 323	1. Resident #8 will be re-assessed with lift assessment to ensure proper lift and sling are being used and will be re-evaluated for proper safety device. 2. All residents could potentially be affected. 1. Resident #4 will be re-evaluated to ensure personal alarms are appropriate for resident. 2. All residents with a personal alarm have potential to be affected. 3. All staff was educate on 4-29-13 and Nursing staff on 4-10-13 over proper sling size/placement and on alarm use/checking that alarms are functioning. 4. QA nurse or designee will audit every month for 3 months and quarterly for next 3 quarters. Survey issue will be monitored and addressed at QA meeting.	5-7-2013

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	355109	A. BUILDING _____ B. WING _____	03/27/2013

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F 323	Continued From page 25 and the CNA is to reattach the tab alarm until the resident is transferred. - Review of the facility policy titled "Alarms: Bed, Chair, and Door" occurred on 03/27/13. This policy, dated October 2008, stated, ". . . Procedure . . . Bracelets, bed, personal and motion alarms - Rehab or Nursing are to check daily to see if alarm sounds. . . . Each shift of nursing staff will be responsible for visually checking placement of alarms . . ." Review of Resident #4's medical record occurred March 25-27, 2013. Current diagnoses included generalized pain, history of femur fracture with surgery after a fall on 09/26/12, osteoporosis, muscle weakness, and dementia. A quarterly Minimum Data Set (MDS), dated 03/20/13, identified the resident required extensive assistance of one person for transfers and assistive devices included a wheelchair. The resident's plan of care for falls and impaired mobility, dated 12/28/12, included the following approaches, "I have bed/chair alarms," "Staff be aware of attempts to self transfer, "Continues to self transfer. Needs cueing reminders to ask for help," "Remind me to wait for staff assistance," and "Keep call light accessible & instruct Res [resident] to call for assist before transferring." Observation showed Resident #4 transferring from her wheelchair to the bed on 03/25/13 at 2:55 p.m. with the help of a nurse (#5), and from her bed to wheelchair at 5:30 p.m. with the help of a CNA (#6). During the observations, the resident's wheel chair alarm failed to sound when the resident stood up from the wheelchair. Observation showed the cord running from the	F 323		

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F 323	Continued From page 26 pad alarm to the alarm box was unplugged. The CNA failed to plug in the alarm cord after transferring the resident to the wheelchair. On 03/26/13 at 3:25 p.m., observation showed a CNA (#3) assisted Resident #4 to transfer from her bed into a wheelchair. When the resident sat at the edge of bed, the CNA noticed the alarm did not sound and plugged the cord from the alarm pad into the alarm box on the bed. The CNA then transferred the resident again from the wheelchair onto the toilet and the alarm failed to sound. The CNA noticed the cord on the wheelchair alarm was unplugged when the surveyor asked if the alarm was functioning. The CNA then stated the resident has a history of unplugging the alarms and self transferring. Facility staff failed to ensure bed and chair alarms functioned properly. 2. Based on observation, review of facility policies and procedures, review of warning labels on containers of chemicals, and staff interview, the facility staff failed to maintain an environment free of hazardous chemical supplies on 2 of 2 wings of the facility (Wing 100 and 200); and failed to store a mechanical standing lift in a safe location on 1 of 2 wings of the facility (Wing 100). Accessible hazardous chemicals places cognitively impaired and wandering residents at risk for accidents/injury; and a mechanical standing lift stored directly in front of a toilet used by residents has the potential to cause injury to residents attempting to gain access. Findings include:	F 323	1. Lock was fixed on the cabinet in the East wing. All staff were educated on the safety importance of locking this cabinet. 2. All residents have the potential to be affected if chemicals are not safely stored. 3. Copy of safety rules was given to all staff on 4-29-13. 4. Maintenance or designee will audit weekly for the next 3 months then quarterly for the next 3 quarters.	5-7-2013

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F 323	Continued From page 27 Review of the facility's policy and procedure (issued 04/2001; revised 12/2008 and 09/2012) titled "HOUSEKEEPING AND LAUNDRY DEPARTMENTS SAFETY RULES" occurred on 03/27/13. This policy/procedure stated, "Personnel in the housekeeping and laundry departments have an excellent opportunity to observe and report safety hazards because their work takes them to all areas of the center/campus/agency . . . Keep cleaning equipment properly stored and locked when not in use . . . Do not leave any chemicals unattended in resident rooms or in any area to which residents have access. Store chemicals in a locked area . . . General safety rules must be reviewed and understood." - Observations on 03/25/13 at 3:00 p.m. and 6:00 p.m., and on 03/26/13 at 8:25 a.m. showed the door to the entrance of the 100 wing restroom and bathing room/area to be open. Inside the room, an unlocked cabinet by the tub contained the following chemicals: Buckeye Sanicare TBX, Lysol Brand I.C. Foaming Disinfectant Cleaner, and Lysol Brand III I.C. Disinfectant Spray. Observation showed a side panel missing on the whirlpool tub exposing the following liquid chemical: CLASSIC Whirlpool Disinfectant Cleaner. Observations on 03/25/13 at 3:10 p.m. and 6:10 p.m., and on 03/26/13 at 8:35 a.m. showed the door to the entrance of the 200 wing restroom and bathing room/area to be open. Inside the room, an unlocked cabinet by the door and an unlocked cabinet by the tub contained the following chemicals: Lysol Brand I.C. Foaming Disinfectant Cleaner and Lysol Brand III I.C.	F 323		

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F 323	Continued From page 28 Disinfectant Spray. Review of the warning labels, on the above-stated chemicals, identified the following: * CLASSIC Whirlpool Disinfectant Cleaner - ". . . DANGER . . . Keep out of reach of children. Corrosive. Causes irreversible eye damage and skin burns. Do not get in eyes, on skin or on clothing . . . Harmful if absorbed through skin. Harmful if swallowed . . ." * Buckeye Sanicare TBX - ". . . PRECAUTIONARY STATEMENTS: Hazards to Humans and Domestic Animals . . . KEEP OUT OF REACH OF CHILDREN. Causes moderate eye irritation. Avoid contact with eyes or clothing . . . First Aid . . . If swallowed: Call a poison control center or doctor immediately for treatment advice . . ." * Lysol Brand III I.C. Disinfectant Spray - ". . . CAUTION: KEEP OUT OF REACH OF CHILDREN . . . PRECAUTIONARY STATEMENTS: Hazards to Humans and Domestic Animals . . . CAUTION: Causes moderate eye irritation. Do not spray in eyes, on skin or on clothing . . ." * Lysol Brand I.C. Foaming Disinfectant Cleaner - ". . . CAUTION: KEEP OUT OF REACH OF CHILDREN . . . PRECAUTIONARY STATEMENTS: Hazards to Humans and Domestic Animals . . . CAUTION: Causes moderate eye irritation. Avoid contact with eyes, skin or clothing . . ." - Observations on 03/25/13 at 3:00 p.m. and 6:00 p.m., and on 03/26/13 at 8:25 a.m. showed the door to the entrance of the 100 wing restroom and bathing room/area to be open. Inside the room, a mechanical standing lift was	F 323		

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F 323	Continued From page 29 located/stored directly in front of the toilet, not allowing access to the toilet. A sign located on the wall behind the toilet stated, "DO NOT leave the lifts in front of toilet safety hazards." During interview, on the morning of 03/04/12, an administrative maintenance staff member (#18) identified the expectation would be for chemicals to be stored in a locked area, and for mechanical lifts not to be stored in front of the toilets in the restroom and bathing room/area.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329		

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F 329	Continued From page 30 This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to ensure a medication regimen free from unnecessary medications for 3 of 5 sampled residents (Resident #6, #7, and #8) receiving antipsychotic medications and 1 of 5 sampled residents (Resident #7) who received an as needed (prn) antianxiety medication. Failure to periodically re-evaluate the necessity of antipsychotic medications and attempt gradual dose reductions (GDRs) (unless contraindicated); and failure to adequately assess Resident #7's behaviors and attempt non-pharmacological interventions prior to administering an antianxiety medication, placed residents at risk of receiving unnecessary psychotropic medications and experiencing adverse consequences related to their use. Findings include: Review of the facility policy titled "Psychopharmacological Medications and Sedative/Hypnotics" occurred on 03/27/13. This policy, revised January 2007, stated, ". . . Purpose . . . To eliminate unnecessary psychopharmacological medications and sedative/hypnotics . . . Policy . . . Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: a. in excessive dose including duplicate therapy or b. for excessive duration or c. without adequate monitoring or d. without adequate indications for its use . . . Based on a comprehensive assessment of a resident, the	F 329	1. For residents #6, #7, and #8, psychoactive medications will be reviewed with MD and pharmacist, and a gradual dose reduction will be attempted per MD order. All staff to be educated regarding non-pharmacological approaches. 2. Any resident has the potential to be affected. All nursing staff was educated 4-10-13 regarding the importance of documenting need for and outcome of PRN anti anxiety medication. 3. Education regarding psycho pharmacologial medications and sedative/hypnotics. Education regarding behavioral causes and interventions policy/procedure. 4.Risk committee will assess antipsychotic usage quarterly to ensure procedure is followed. Survey issue will be monitored and addressed at QA meetings.	5-7-2013

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F 329	Continued From page 31 center must ensure that: a. Residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record. . . . b. Residents who use antipsychotic drugs receive gradual dose reductions and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. . . ." Review of the facility policy titled "Documentation of Medication" occurred on 03/27/13. This policy, dated March 2011, stated, ". . . The following information will be documented in the medical record upon administration of medications: . . . 8. Reason for administration if PRN [as needed] drug given and resident response to medication. . . ." - Review of Resident #7's medical record occurred on all days of survey. Diagnoses included depression, dementia, Parkinson's disease, chronic pain, and agitation. Current physician orders included 25 milligrams (mg) of Seroquel (an antipsychotic) two times a day (BID) (initiated on admit to facility on 03/01/12), and 1 mg Ativan (an antianxiety medication) as needed for agitation and anxiety (initiated on 05/23/12). Review of the resident's Minimum Data Sets (MDSs), dated 03/08/12, 11/25/12, and 02/23/13, failed to identify behaviors except on the annual Minimum Data Set (MDS), dated 02/23/13, the resident exhibited rejection of care on one to three days. All the MDSs identified the resident received an antipsychotic medication and the resident received one dose of the antianxiety medication during the 02/23/13 MDS assessment	F 329		

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F 329	Continued From page 32 period. Review of Resident #7's current plan of care, dated 03/05/13, stated, ". . . hx [history] of physical & verbal aggression. He is restless at times and will bump into other residents and things with his wheelchair. He will do this repetitively his restlessness does increase when his wife leaves . . . Plans and Approaches . . . move to a less congested area, to decrease his potential of bumping others . . . give him items to fidget with . . ." Review of Resident #7's prn Ativan use showed staff administered the medication for restlessness, wandering, "crawling out of bed-unable to redirect", "crawling out of bed-trying to stand", aggressive behavior, anxiousness, being uncooperative, and agitation. Review of Medication Administration Records (MARs) for the months of December, 2012 through March 24, 2013 showed prn Ativan administered eight times without the effectiveness documented by staff. In addition, staff failed to identify non-pharmacologic interventions attempted prior to administering prn Ativan on nine occasions. Review of Resident #7's "Mood & Behavior Report" showed the following behaviors documented: * two occurrences of "other behavioral symptoms not directed towards others" * seven occurrences of rejection of care * two "physical behavioral symptoms directed toward others" on 01/21/13 and 03/09/13 * one episode of wandering.	F 329		

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F 329	Continued From page 33 Review of providers' progress notes, since the resident's admission, failed to identify a GDR attempt of the Seroquel during the first year after the resident's admission. During an interview on 03/27/13 at 12:20 p.m., an administrative nurse (#5) stated the facility did not attempt a dose reduction for Resident #7. - Review of Resident #6's medical record occurred on all days of survey. Diagnoses included senile dementia with depressive features. Current physician's orders included Seroquel (an antipsychotic) 25 mg once a day (initiated 03/02/12). Previous physician's orders showed a GDR attempted 02/22/12; however the GDR was unsuccessful, and the physician increased the Seroquel back to 25 mg daily on 03/02/12. The current MDS, dated 01/12/13, identified no behaviors. Previous MDSs, dated 10/12/12 and 07/11/12, also identified no behaviors. Review of nurses' notes and certified nursing assistant (CNA) charting from 08/01/12 through 03/27/13 showed the following behaviors: *2 episodes of resisting cares *1 episode of pulling at her clothes During an interview on 03/27/13 at 8:12 a.m., CNA (#4) stated Resident #6 "seems more content now," and has not had any recent behaviors. Providers' progress notes since 03/02/12 failed to identify a GDR attempt of Seroquel within the past year.	F 329		

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F 329	Continued From page 34 - Review of Resident #8's medical record occurred March 25-27, 2013. Diagnoses included advanced dementia of an Alzheimer's nature, history of major depression, insomnia, and agitation. Current physician's orders included Seroquel (an antipsychotic) 25 mg at bedtime, for insomnia, (initiated 09/10/12). A quarterly MDS, dated 03/04/13, identified behaviors not affecting others on one to three days of the assessment period as the only behavior exhibited by the resident. The facility admitted Resident #8 in September 10, 2012. Review of Resident #8's plan of care, dated 03/12/13, stated, "[Problem] Altered thought process [related to] dementia/depression [manifested by] refusal of cares. Unable to recall time [and] place. Poor short term memory . . . [Goal] Will not hurt self others. . . .[Approaches] Return later if agitated/aggressive; Assess pain for [signs/symptoms] of pain . . ." Review of providers' progress notes since the resident's admission failed to identify a GDR attempt of the Seroquel during the first six months of the resident's stay.	F 329		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.	F 428		

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F 428	Continued From page 35 This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility's consultant pharmacist failed to identify medication regimen irregularities for 3 of 5 sampled residents (Resident #6, #7, and #8) receiving an antipsychotic medication. Failure to recognize and report irregularities may result in residents receiving unnecessary medications and experiencing adverse consequences related their use. Findings include: Review of the facility policy titled "Medication Regimen Review" occurred on 03/27/13. This policy, dated January 2007, stated, ". . . The drug regimen of each resident will be reviewed at least once a month by a licensed pharmacist. . . . The MRR [medication regimen review] will identify the following: . . . potential medication irregularities and response to these irregularities . . . Irregularities will be reported to the attending physician and the director of nursing services. . . . Regarding psychopharmacological medications . . . In addition those residents who DO USE these types of medications will receive gradual dose reductions or behavioral interventions, unless clinically contraindicated, in an effort to discontinue the drugs. . . ." - Review of Resident #6's medical record occurred on all days of survey. Diagnoses included senile dementia with depressive	F 428	1. For residents #6, #7, and #8, psychoactive medications will be reviewed with MD and pharmacist, and a gradual dose reduction will be attempted per MD order. All staff to be educated regarding non-pharmacological approaches. 2. Any resident has the potential to be affected. All nursing staff was educated 4-10-13 regarding the importance of documenting need for and outcome of PRN anti anxiety medication. 3. Education regarding psycho pharmacalogical medications and sedative/hypnotics. Education regarding behavioral causes and interventions policy/procedure. 4.Risk committee and pharmacist will assess anti psychotic usage quarterly to ensure procedure is followed. Survey issue will be monitored and addressed at QA meetings.	5-7-2013

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features. Current physician's orders included Seroquel (an antipsychotic) 25 mg once a day (initiated 03/02/12). Previous physician's orders showed a GDR attempted 02/22/12; however the GDR was unsuccessful, and the physician increased the Seroquel back to 25 mg daily on 03/02/12. The current MDS, dated 01/12/13, identified no behaviors. Previous MDSs, dated 10/12/12 and 07/11/12, also identified no behaviors.

- Review of Resident #8's medical record occurred March 25-27, 2013. Current diagnoses included advanced dementia of an Alzheimer's nature, history of major depression, insomnia, and agitation. The facility admitted the resident on 09/10/12. Since that time, Resident #8 received 25 milligrams of Seroquel daily.

- Review of Resident #7's medical record occurred on all days of survey. Current diagnoses included depression, dementia, Parkinsons disease, chronic pain, and agitation. The facility admitted the resident on 03/01/12 on 25 milligrams of Seroquel (an antipsychotic) two times a day. Physician orders showed the dose remained the same throughout the resident's stay.

During an interview on 03/26/13 at 10:05 a.m., the pharmacist stated nursing makes her aware of changes in resident's behaviors and she does not recommend a GDR if the resident is still having issues. This staff member could not recall the last time nursing staff discussed Resident #7's behavior with her. The staff member stated she doesn't "as a rule" make recommendations for a GDR for residents on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355109	A. BUILDING _____ B. WING _____	03/27/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOURIS VALLEY CARE CENTER	300 MAIN ST S VELVA, ND 58790

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 37 psychopharmacological medications. This staff member stated she would not recommend a GDR unless "deemed appropriate," and when asked if Resident #7 had been "deemed appropriate" the pharmacist reported she would have to discuss with nursing staff on why she had not recommended a GDR for the resident. Review of monthly MRRs from March 3, 2012 through March 25, 2013 lacked evidence to indicate the pharmacist recommended a GDR of Seroquel within the past year for Resident #6 and Resident #7, or within the last six months for Resident #8.	F 428		