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 _____	03/16/2017

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 recertification survey, started on 03/13/17 and completed on 03/16/17, the sample included 3 residents for complete review, 9 residents for focused review, and 1 closed record for review. The sample included 4 additional residents to verify specific concerns during the survey.	F 000		
F 160 SS=D	483.10(f)(10)(v) CONVEYANCE OF PERSONAL FUNDS UPON DEATH (v) Conveyance upon discharge, eviction, or death. Upon the discharge, eviction, or death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the resident, or in the case of death, the individual or probate jurisdiction administering the resident's estate, in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure personal funds deposited with the facility were conveyed to the residents' responsible parties/designees within 30 days for 2 of 4 supplemental residents (Resident #16 and #17) reviewed. Findings include: Review of conveyance of funds following discharge occurred on 03/15/17 at 3:15 p.m. with a business office staff member (#11). The resident trust account information identified the following: * Resident #16 discharged on 06/17/16. The	F 160	Preparation and execution of this response and plan of correction does not constituent and admission of agreement by the provider of the truth of the facts alleged or conclusions set forth in the 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 purpose of any allegations 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	4/20/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 04/04/2017

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F 160	Continued From page 1 facility issued a check for the remaining balance of $120.02 on 07/27/16, 40 days later. * Resident #17 discharged on 03/26/16. The facility issued a check for the remaining balance of $95.15 on 05/19/16, 54 days later. During an interview on the afternoon of 03/15/17, an administrative staff member (#3) agreed the facility failed to refund the residents' funds within 30 days of discharge.	F 160	7305 of the State Operations Manual. 1. Resident #16 and #17 funds were sent to responsible party and it was resolved. 2. All residents that have RTA account have the potential of being affected. 3.Business office manager or designee will be monitoring weekly if any resident is D/C from facility. If a resident is D/C BO staff or designee will be marking down on calendar when 30 days are due and will be making sure we stay within compliance. System Change: 4. Business office manager will have to complete re-training on policy and procedure on how to handle RTA accounts properly. When a resident is D/C Business office manager will need to bring a list to QA monthly to ensure compliance with proper conveyance of resident money. An audit will be developed to ensure compliance with proper conveyance of resident RTA money. Business office manager or designee will be responsible for the completion of the audit. BO staff or designee will start audits on the week of 4/10/17. An audit report will be provided monthly for one year to the QA committee to ensure compliance and if there is any further recommendations. The QA committee meets on 4/26/17 which the first report will be submitted.	
F 225 SS=D	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 483.12(a) The facility must-	F 225		4/20/17

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F 225	Continued From page 2 (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities 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. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily	F 225		

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F 225	Continued From page 3 injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey 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 policies, and staff interview, the facility failed to identify and immediately report 1 of 1 potential incident of neglect (Resident #5) to the State Survey Agency and report the results of the investigation within five working days. Failure to identify, report, and thoroughly investigate all potential violations of neglect places all residents at risk of neglect and subsequent injury. Findings include: Review of the facility policy titled "ABUSE DEFINITIONS" occurred on 03/16/17. This policy, revised November 2016, stated, ". . .	F 225	1. Incident involving resident #5 was reported on 3/17/17 with final review received form the Department of Health on 3/24/17. 2. All residents has the potential to be affected by this practice. 3. Education will be provided to all nursing staff on the proper use of a mechanical lift for transfers. Staff will also be educated regarding abuse and neglect policy and procedure. Investigation team (LSW, DNS and Administrator) will meet daily Monday through Friday to review	

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F 225	Continued From page 4 NEGLECT: Failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. . . ." Review of the facility policy titled "ABUSE AND NEGLECT" occurred on 03/16/17. This policy, revised November 2016, stated, ". . . If there is an allegation that does not involve abuse and there is no serious bodily injury, then it will be reported not later than 24 hours after the allegation is made to the administrator, and to other officials (including the state survey agency . . .) . . . The investigation team will determine whether further investigation is needed. . . . The investigation may include interviewing employees, residents or other witnesses to the incident. . . . The social worker or designated employee will report the results of all investigations to the state survey and certification agency and other officials within five working days of the incident . . ." Review of Resident #5's medical record occurred on all days of survey. Diagnoses included dementia and a history of falls. The significant change Minimum Data Set (MDS), dated 12/16/16, identified short and long-term memory problems, extensive assistance of two people required for transfers, and a history of falls. The current care plan stated, "Focus: The resident has an ADL [activities of daily living] self care performance deficit R/T [related to] Musculoskeletel impairment e/b [evidenced by] legs give out using wheelchair Interventions . . . Resident requires assist of two staff with a total lift and a medium high back sling. . . ."	F 225	falls to assure any potential abuse and neglect is reported in a timely manner. 4. LSW or designee will begin audits the week of 4/10/17. Audit will look for allegations on any form abuse or neglect and if abuse or neglect is suspected it will assure the incident was reported in a timely manner. Audits will be completed weekly for one month and then monthly for eleven months. An audit report will be provided to the QA committee starting 4/26/17 for further recommendations on monitoring and achieving compliance.	

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F 225	Continued From page 5 An incident report, dated 01/20/17 at 3:45 p.m. stated, "Incident Description . . . two cnas [certified nursing assistant] were getting resident up in the hoyer lift, when they moved the lift away from the bed, the resident slid out of the hoyer lift, cna grabbed and held resident's head, resident fell to the floor onto her buttocks with bumping her back on the legs of the lift, sling was checked, no tears noted, education was done with the cnas, about checking to see if the slings were tight when being [sic] to move the resident Immediate Action Taken . . . resident was assessed for injury, has a small abrasion noted to mid back on the spine area, resident is alert, oriented to self as per usual, laughing and making jokes, able to move all extremities without distress, nurse remained with resident as she was gotten off the floor and put into her wheelchair, with lift . . ." A progress note, dated 01/20/17 at 4:29 p.m., stated, "v/s [vital signs] [temperature] 97.2 - [pulse] 89 - [respirations] 16 - [blood pressure] 188/95, resident slid out of the hoyer lift [full body mechanical lift], see risk management for more info [information], resident assessed for injury, small abrasion noted to upper mid back on the spine, did not hit her head, resident was laughing and making jokes, able to move all extremities, pain med [medication] given for comfort. . . . np [nurse practitioner] was phoned and dtr [daughter] was phoned, made aware of fall" During an interview on 03/15/17 at 3:15 p.m., an administrative nurse (#2) reported staff failed to call a 'timeout' where staff double check the mechanical lift sling straps and positioning. This	F 225		

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F 225	Continued From page 6 nurse further stated, based on a staff interview, one strap between the resident's legs was loose and the resident slid out of the sling. During an interview on 03/16/17 at 9:53 a.m., a social worker (#3) confirmed the facility should have reported Resident #5's fall to the state agency as potential neglect. By failing to identify the potential of neglect involved in Resident #5's fall, the facility subsequently failed to immediately report the incident to the State Survey Agency, failed to conduct a thorough investigation, and failed to report the results of their investigation within five working days.	F 225		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE (b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, and staff interview, the facility failed to complete significant	F 274	1) For resident 6, a significant change assessment was completed with an ARD of 4/4/17. For resident 9, a significant change	4/20/17

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F 274	Continued From page 7 change in status assessments (SCSA) for 2 of 12 sampled residents (Resident #6 and #9) reviewed. Failure to determine the need for and complete a SCSA in response to a resident's improvement or decline limited the facility's ability to accurately assess each resident's status, and identity and implement appropriate care approaches. Findings include: The Long-Term Care Facility RAI 3.0 User's Manual (Version 1.14), dated October 2016, page 2-22 stated, ". . . A "significant change" is a decline or improvement in a resident's status that: 1. Will not normally resolve itself without staff intervention . . . 2. Impacts more than one area of the resident's health status; and 3. Requires interdisciplinary review and/or revision of the care plan. . . ." and page 2-25 stated, "A SCSA is appropriate if there are either two or more areas of decline or two or more areas of improvement. . . ." - Review of Resident #6's medical record occurred on all days of survey. The quarterly Minimum Data Set (MDS), dated 10/07/16, identified: * rejection of cares occurred on 1-3 days * wandering occurred on 1-3 days * supervision with locomotion off the unit * independent with eating The quarterly MDS, dated 01/07/17, identified the following changes: * no rejection of care or wandering (an improvement in both behaviors) * extensive assistance with locomotion off the unit and eating (a decline in both Activities of	F 274	assessment was completed with an ARD of 4/4/17. 2) All residents are at risk to be affected by this practice. 3)The interdisciplinary team reviewed the Care Planning and MDS training(June 2013) from AANAC to educate on Significant Change Assessments. The Interdisciplinary care team will review the validation section on the MDS prior to MDS completion to determine if there are 2 or more areas of change. If 2 or more areas are identified to have changed, a Significant Change Assessment will be initiated, unless it is found that it is not a significant change for the resident. If it is found that it was not a significant change, documentation will be entered into the resident's medical record to support the decision. 4) MDS Coordinator or designee complete weekly audits starting the week of 4/10/17 for one month and then monthly for five months, to determine if there was a possible significant change to insure that the significant change assessment was completed or that there was documentation as to why there was not an assessment completed. An audit report will be provided to the QAPI committee starting 4/26/17 for further recommendations on monitoring and achieving compliance.	

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F 274	Continued From page 8 Daily Living [ADLs]) * a non-physician prescribed significant weight loss The facility failed to complete a SCSA following Resident #6's improvement in two behavioral areas, decline in two ADLs, and a new significant weight loss. - Review of Resident #9's medical record occurred on March 15-16, 2017. The admission MDS, dated 09/07/16, identified: * extensive assistance in six ADLS: bed mobility, transfers, locomotion on the unit, locomotion off the unit, dressing, and toilet use * activity did not occur in two ADLs: walk in the room and walk in the corridor * frequent urinary incontinence The quarterly MDS, dated 02/23/17, identified the following improvements: * supervision with bed mobility, transfers, and toilet use * independent with walk in room and corridor, and locomotion on and off the unit * limited assistance with dressing * occasional urinary incontinence The facility failed to complete a SCSA following Resident #9's improvement in eight ADLs and in urinary incontinence. During an interview on 03/16/17 at 9:50 a.m., an administrative nurse (#1) stated she does not determine whether changes on the MDS constitute a significant change, but "is usually something discussed with the team." This nurse also stated the changes in Resident #6 and #9's MDSs "could be significant changes."	F 274		

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F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review, review of the	F 278	1) MDS for resident #5 and resident #3	4/20/17

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F 278	Continued From page 10 Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual (Version 1.14), and staff interview, the facility failed to ensure accurate coding of Minimum Data Sets (MDSs) for 2 of 12 sampled residents (Resident #3 and #5). Failure to accurately complete Section E (behaviors) of the MDS does not allow each resident's assessment to reflect their current status/needs, and has the potential to affect the accuarate developement of a comprehensive care plan and the care provided to the residents. Findings include: The Long-Term Care Facility RAI User's Manual, revised October 2016, Chapter 3 pages E-4, E-5, E-8, and E-10, stated, "E0200: Behavioral Symptom - Presence and Frequency . . . A. Physical behavioral symptoms directed toward others (e.g., hitting, kicking, pushing. scratching, grabbing. abusing others sexually). B. Verbal behavioral symptoms directed toward others (e.g. threatening others, screaming at others cursing at others) . . . Coding Instructions: *Code 0, behavior not exhibited: if the behavior symptoms were not present in the last 7 days. Use this code if the symptom has never been exhibited or if it previously has been exhibited but has been absent in the last 7 days. . . . E0500: Impact on Resident . . . Coding Instructions for E0500B. Did Any of the Identified Symptom(s) Significantly Interfere with the Resident's Care? *Code 0, no: if none of the identified behavioral symptom(s) significantly interfered with the resident's care. . . . E0600: Impact on Others . . . Coding Instructions for E0600A. Did Any of the Identified Symptom(s) Put Others at Significant Risk for Physical Injury? * Code 0, no: if none of the	F 278	were modified and corrected on 3/28/17. 2) All residents have the potential to be affected by this practice. 3) LSW will review RAI manual for education on Section E. LSW will also attend a training session on 6/6/17 sponsored by the ND Department of Health in regards to Coding Section E-Behavior. 4) MDS coordinator or designee will complete Audits for MDS the week of 4/10/17. As they are completed to determine that behaviors are accurately assessed. Audits will be completed on MDS behavior coding weekly for one month and then monthly for five months. An audit report will be provided to the QAPI committee on 4/26/17 for further recommendations on monitoring and achieving compliance.	

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F 278	Continued From page 11 identified behavioral symptom(s) placed staff, visitors, or other residents at significant risk for physical injury. . . ." - Review of Resident #5's medical record occurred on all days of survey. The significant change Minimum Data Set (MDS), dated 12/16/16, identified physical and verbal behaviors occurred one to three days, the behaviors impacted the resident's care and placed others at risk for physical injury. The medical record lacked evidence of Resident #5's behaviors during the look-back period. - Review of Resident #3's medical record occurred on all days of survey. The quarterly Minimum Data Set (MDS), dated 10/31/16, identified verbal behaviors occurred one to three days. The medical record lacked evidence of Resident #3's behaviors during the look-back period. During an interview on the morning of 03/15/17 the social worker (#3) confirmed the medical record lacked evidence of behaviors during the look-back period Resident #3 and Resident #5.	F 278		
F 280 SS=E	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request	F 280		4/20/17

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F 280	Continued From page 12 revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that	F 280		

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F 280	Continued From page 13 includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to review and revise the comprehensive care plan to reflect the residents' status for 10 of 12 sampled residents (Resident #1, #2, #3, #4, #5, #6, #7, #8, #10, and #12). Failure to review and revise the care plan limited staff's ability to communicate care needs and ensure continuity	F 280	1. Resident #4 care plan was updated under the risk for falls focus the RA intervention was resolved. Resident #4 care plan was reviewed and updated in regards to her weight gain. Resident #5 care plan was updated to resolve the RA program for Rt. Wrist and the use of brace was resolved.	

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F 280	Continued From page 14 of care for each resident. Findings include: The facility policy titled "Comprehensive Care Plan and Care Conferences" occurred 03/16/17. This policy, revised November 2016, stated, ". . . The care plan is driven by identified resident issues/conditions and their unique characteristics, strengths and needs. . . . If a resident has a specific behavioral interventions, they need to be reflected on the care plan. . . . The interdisciplinary team will ensure that the care plan is comprehensive by incorporating the following: All triggered Care Area Assessments (CAAs) employees have decided to proceed on. . . . Care plans are to be reviewed with each MDS [Minimum Data Set] completed. . . . In addition to updates during a care plan review, care plans must be revised as the resident's needs/status changes. . . ." - Review of Resident #4's medical record occurred on all days of survey. The current care plan stated, "Focus: The resident has Diabetes Mellitus. Interventions . . . Scheduled resident snack/food intervention . . . offer 1/2 sandwich and carton milk at HS [hour of sleep] . . . Focus: The resident is at risk for falls R/T [related to] History of falls e/b [evidenced by] pelvic fracture. Interventions: RESTORATIVE: Provide restorative nursing program to maintain improved strength and balance. . . ." Progress notes identified the following: * 12/05/16 at 9:30 a.m.: ". . . Has had gradual weight increase for past year . . ." * 03/06/17 at 12:26 p.m.: ". . . Has had weight	F 280	Resident #6 care plan was updated regarding the residents glasses, non pharmacological interventions for Ambien and Seroquel for hallucinations, we added fall mat, pummel cushion, bed in low position, and we resolved resident having enhanced cereal and added enhanced juice and health shakes. Resident #7 care plan was reviewed and updated. It stated that resident required hand over hand guidance that was resolved and updated to show residents current eating capabilities. Resident care plan was updated to show a unplanned weight loss focus and interventions. Resident #8 care plan was updated to show resident takes Seroquel for hallucinations and added non pharmacological interventions to the care plan. The care plan was also updated to show the resident wears glasses and dentures. Resident #10 care plan was updated with a diabetes focus with interventions. Resident #1 Care plan was updated with a unplanned weight loss Focus and interventions. Resident #2 care plan was reviewed and updated to show an elopement focus with new interventions. Resident also had a depression focus added with interventions to show the mirtazapine on the care plan. Resident #3 care plan was updated to show accurate bed mobility and transfers. Care plan was also updated to show a focus that addressed Zoloft to include non-pharmacological interventions. Resident #12 care plan was reviewed and	

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F 280	Continued From page 15 gain since admit, is stable at this time. . . ." The care plan lacked a nutritional focus to address Resident #4's eighteen pound weight gain. During an interview on 03/16/17 at 10:45 a.m. a restorative aide (#5) stated Resident #4 has not been on a restorative program for two years. Facility staff failed to update the care plan to reflect Resident #4's weight gain and restorative therapy. - Review of Resident #5's medical record occurred on all days of survey. The current care plan stated, "Focus: The resident has a need for restorative intervention due to limited physical mobility R/T fracture of wrist E/B wears brace to support wrist. no longer wearing brace Interventions: NURSING REHAB #1: Active range of motion wrist brace to be removed to complete wrist flexion and wrist extension times ten reps [repetitions] each. NURSING REHAB #2: Active range of motion wrist brace to be removed to complete ulnar deviation times ten reps. NURSING REHAB #3: Active range of motion wrist brace to be removed to complete radial deviation times ten reps. NURSING REHAB #4: Active range of motion remove wrist brace to complete supination and pronation times ten reps each. NURSING REHAB #5: Active range of motion remove wrist brace to complete wrist circles times ten reps. . . ." A physician progress note, dated 03/16/16, stated, "PLAN . . . She does not need to use a brace as it is stable and well healed. . . ."	F 280	updated to show a focus and interventions in regards to the residents Lorazepam. 2.All residents have the potential of being affected. 3. Care plan interdisciplinary team will be re trained by completing the care planning and the MDS 3.0 AANAC (June 2013 version). All nursing staff will also be re educated on the importance of making sure all resident care plans are individualized and up to date at all times. All resident care plans have been reviewed and updated to meet their needs. All nursing staff will have to review each resident Kardex to ensure staff understand the care plan changes. 4. The care plan interdisciplinary team will be responsible to monitor and assure accuracy of care plans. Care plans will be monitored weekly starting 4/10/17. We will continue to monitor care plans weekly for a total of six months. If concerns are identified, action will be taken and implemented. The Care plan team will submit a report of the monitoring results to the QA committee at each scheduled meeting starting 4/26/17.	

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F 280	Continued From page 16 Facility staff failed to update the care plan to reflect Resident #5 no longer used the wrist brace. - Observation throughout the survey showed Resident #6 wore glasses at all times when out of bed, had her bed in a low position with a fall mat beside it when in bed, had a pummel cushion in her wheelchair, and received eggs and toast for breakfast. During an interview on 03/14/17 at 8:58 a.m., an unidentified cook stated Resident #6 usually refused cereal, as she doesn't like it, so she is served enhanced juice instead. During an interview on the afternoon of 03/15/17, a social services staff member (#3) stated the facility trialed Resident #6 not wearing her glasses due to misplacing them, but discontinued this intervention and failed to remove it from the care plan. Review of Resident #6's medical record occurred on all days of survey. Physician orders included Seroquel (antipsychotic medication) daily for "hallucinations" and Ambien (hypnotic medication) as needed for "insomnia," ordered 09/28/16 and 10/26/16 respectively. The Falls CAA, dated 07/26/16, stated, ". . . no falls . . . tends to slide down in her wheelchair. . . ." The current care plan listed the following problems: * ". . . She is frequently misplacing her glasses. . . . Interventions: . . . Do NOT put eyeglasses on resident, as she frequently removes them. . . ."	F 280		

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F 280	Continued From page 17 The facility failed to update the care plan as the resident wore glasses. * "The resident has a behavior symptom R/T Parkinson's E/B wanders throughout the center. . . . Interventions: . . . Attempt non-pharmacological interventions . . ." The facility failed to care plan the problem of hallucinations and the use of Seroquel. * "The resident is at risk for falls R/T unable to ambulate . . . does scoot self on floor . . ." The facility failed to include the interventions of a low bed, fall mat, and pummel cushion. * "The resident has potential nutritional problem . . . Interventions: . . . Scheduled resident specific snack/food intervention #1 enhanced cereal at breakfast. Enhanced juice with lunch and supper . . . " The facility failed to discontinue the enhanced cereal from the care plan and add enhanced juice at breakfast. The facility failed to care plan the problem of insomnia and use of Ambien. During an interview on 03/15/17 at 5:35 p.m., an administrative nurse (#2) agreed the facility failed to update the care plan to reflect the resident's current condition. - Review of Resident #7's medical record occurred on all days of survey. The current care plan stated, "Focus: The resident has an ADL [activity of daily living] self care performance deficit R/T Dementia e/b needs assist Interventions . . . EATING: Resident requires Hand over hand guidance . . . Focus: The resident has nutritional problem or potential nutritional problem R/T dementia Interventions: Scheduled resident specific snack/food	F 280		

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intervention offer snack between meals if res [resident] eats less than 50% of breakfast lunch or supper. Scheduled resident specific snack/food intervention . . . fortified foods with meals. . . ."

Observations during meals throughout the survey showed Resident #7 fed herself. During an interview on 03/15/17 at 3:15 p.m., an administrative staff member (#6) stated Resident #7 would not tolerate hand over hand assistance with eating. The care plan failed to reflect the resident's current eating capability.

A progress note dated 02/27/17 at 12:27 p.m. stated "Significant change note: [Resident #7] has had a significant weight loss in past quarter. . . ." The care plan failed to identify Resident #7's weight loss.

- Observation throughout the survey showed Resident #8 wore glasses, used a wheelchair for mobility, and transferred with a sit-to-stand mechanical lift.

Review of Resident #8's medical record occurred on March 13-15, 2017. Physician orders included Seroquel daily for "agitation related to Parkinson's Disease; Dementia with Lewy Bodies." A physician's response to a gradual dose reduction form, dated 03/14/17, stated, ". . . continue Seroquel as is, due to decreased hallucinations."

The current care plan listed the following problems:
* "The resident has depression . . . She needs encouragement to continue to participate in

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ADLs, such as walking. . . . Interventions: . . . Tell her 'It's time to, [sic] lets go for a walk.' Remind her she can sit and rest if she gets tired." The facility failed to update the care plan to reflect the resident was no longer going for walks.
* "The resident has Parkinson's Disease. takes [sic] quetiapine fumarate [Seroquel]." The facility failed to care plan the symptoms of agitation or hallucinations requiring treatment with Seroquel, or develop interventions to utilize when the resident displayed those symptoms.

The facility failed to include Resident #8's use of glasses on the care plan.

During an interview on 03/15/17 at 5:30 p.m., a social services staff member (#3) stated Resident #8 took Seroquel before admission to the facility for "seeing worms in the carpet" and agreed the facility should have care planned hallucinations. An administrative nurse (#2) stated Resident #8 does not walk. This nurse further stated the facility should care plan resident items such as dentures, glasses, and hearing aides if used.

- Review of Resident #10's medical record occurred on 03/16/17. Diagnoses included diabetes mellitus. The physician's orders included HumaLog 4 units before meals and Lantus 10 units at bedtime. The current care plan failed to address Resident #10's diabetes.

- Review of Resident #1's medical record occurred on all days of survey. Diagnoses included nutritional deficiency, dehydration, diabetes mellitus, and constipation. The current care plan stated, "Focus: The resident has potential nutritional problem R/T decline in health

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F 280	Continued From page 20 status E/B not eating or drinking well . . . Interventions . . . weigh weekly . . . Schedule resident specific snack/food intervention #1 offer snack in between meals if res [resident] eats less than 50% of breakfast lunch or supper . . . Scheduled resident specific snack/food intervention, 1/2 sandwich and juice at HS . . . Monitor and record intake at each meal. . . ." Resident #1's progress notes showed the following weights: * 04/05/16: 179 pounds [lbs] * 03/13/17: 134 lbs The care plan failed to address Resident #1's continued weight loss. During an interview in the morning of 03/16/17 a dietary manager (#9) confirmed Resident #1's care plan lacked an actual weight loss problem and interventions. - Review of Resident #2's medical record occurred on all days of survey. Diagnoses include depression, anxiety, and elopement history. The current care plan stated, "Focus . . . The resident has potential for elopement R/T. Dementia M/B [manifested by] Exhibits wandering behavior, Exit seeking behavior [resident's name] exited the building unattended on 4/9/14. ATTEMPTS TO REMOVE WANDERGAURD . . . Interventions . . . Offer to take resident for walk outdoors. . . . Provide diversionary activity : resident likes to help with projects such as cleaning and sorting. . . . PERSONAL ALARM: Wander Guard used to alert staff to resident's movement and to assist staff in monitoring movement. . . . Focus: The resident	F 280		

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F 280	Continued From page 21 has a behavior symptom R/T dementia E/B rummaging, swearing at others. . . ." The quarterly Minimum Data Set (MDS), dated 01/24/17, identified minimal depression with behaviors. Resident #2's CAA, dated 10/25/16, stated, "Psychotropic Drug Use . . . antidepressant medication administered to resident . . . Adverse consequences of Antidepressants exhibited by this resident . . . Anxiety . . . Will Psychotropic Drug Use - Functional Status be addressed in the care plan? Yes . . ." Review of Resident #2's investigation report showed the following: * 01/30/17: ". . . on 01/27/17 regarding an elopement. The resident . . . exited the care center through a door in the dining room that leads to a connecting hallways which joins Souris Valley Care Center and Valley View Manor. When [resident's name] approached the door her Wander guard alarm bracelet set off the alarm and alerted staff of a possible elopement. She went through the door and 20 seconds later staff responded and redirected her back to the skilled care side where she resides. . . ." * 02/02/17: ". . . on 02/1/17 regarding an elopement . . . [name of resident] wears a wander guard alarm bracelet on her right wrist because she does wander about the facility. . . . On 02/1/17 she exited through doors in the dining room into a connecting corridor between SVCC [Souris Valley Care Center] and VVM [Valley View Manor]. She went to a door used for deliveries and opened the door. Staff responded to the alarm from the wander guard in less than a minute and before she could exit the building	F 280		

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staff redirected her back to SVCC. We are going to try a couple changes to try and deter her from exiting that door. First when kitchen staff leave in the evening we are going to lock the door to the dining room. There is a key hanging beside the door so staff can still gain access to the dining room if necessary. Dietary staff will unlock the door in the morning an leave the door open so that the alarm will not be muffled by the closed doors. Second, we placed a sign that states Do Not Enter on the door leading to the connecting door to hopefully deter from opening that door. All staff have also been reminded to be mindful of where she is and to intervene as necessary if she is trying to exit the building unattended. . . ."

Review of Resident #2's physician orders stated, ". . . wandergaurd check nightly . . . wandergaurd to right wrist change every 90 days . . . Mirtazapine (anti-depressant) 15 milligram (mg) half a tablet at bedtime. . . ."

During an interview on 03/15/17 at 4:37 p.m., an administrative staff (#2) confirmed the facility failed to update the careplan for Resident #2's depression, recent elopements and interventions.

- Review of Resident #3's medical record occurred on all days of survey. Diagnoses include abnormal gait and mobility, dementia, and depression. The significant change MDS, dated 01/31/17, identified a severely impaired cognitive level, verbal behaviors, mild depression, and extensive assist of two people with bed mobility and transfers. Medications included Zoloft (antidepressant) 50 mg once daily. Resident #3's CAA, dated 02/01/17, stated, "Psychotropic Drug Use . . . antidepressant

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F 280	Continued From page 23 medication administered to resident . . . Will Psychotropic Drug Use - Functional Status be addressed in the care plan? Yes . . ." The current care plan stated, ". . . Focus: The resident has a mood problem R/T change in medical status E/B is easily irritated by others, feels down and has difficulty concentrating daily, feels fidgety and has little energy less than daily. Believes people are 'Out to get her.' . . . Interventions . . . Resident is able to express feelings. . . . Attempt non-pharmacological interventions. . . . Focus . . . The resident has a behavior symptom E/B tends to sit in the middle of the hall, has difficulty being still, has called others names, has hit and threatened staff. She becomes defensive and believes she is being picked on if she is asked not to talk to others that way. . . . Interventions . . . Provide opportunity for positive interaction, attention. Minimize potential of resident behavior problems by modifying environmental factors and daily routine: . . . If she resists cares, tell her you will come back later. . . . Focus . . . The resident has an ADL self care performance deficit R/T spinal stenosis and degenerative disc disease E/B impaired balance, activity intolerance and limited mobility. . . . Interventions . . . Bed Mobility - Position Up in Bed: weight bearing assist of two with use of positioning bar. . . . Bed Mobility - Turn from Side to Side: total dependent with assist of two as is rigid or difficult to turn. use total lift with repositioning sling. . . . Bed Mobility - Lying to Sitting: Resident is independent, uses positioning bar, cueing from staff. . . . Bed Mobility - Sitting to Lying: weight bearing assist of one with cueing . . . Transfer - Transfer Between Surfaces an CAN pull self to stand: Resident is independent	F 280		

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F 280	Continued From page 24 sometimes need cueing from staff. if unable use sit to stand. . . ." Observations showed the following: * 03/14/17 at 9:57 a.m.: Resident #3 was laying in her bed and sat herself up to sit on the edge of the bed using a positioning bar. Facility staff failed to update the care plan to reflect Resident #3's current transfer and bed mobility and the resident's depression. - Review of Resident #12's medical record occurred on March 15-16, 2017. Diagnoses included anxiety. Medications included lorazepam (antianxiety) 0.5 mg two times a day. The care plan lacked a focus, interventions, and non pharmalogical interventions for anxiety. During an interview on 03/15/17 at 4:37 p.m., an administrative staff (#2) confirmed the facility failed to update the careplan to address Resident #12's for the diagnosis of anxiety.	F 280		
F 281 SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: INSULIN ADMINISTRATION 1. Based on record review and staff interview, the	F 281	1. For Resident #1 her Novolg insulin was discontinued on 3/1/17, medical provider was contacted to get parameters	4/20/17

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F 281	Continued From page 25 facility failed to follow the medical provider's orders regarding insulin administration for 2 of 4 sampled residents (Resident #1, and #4) dependent on insulin. Failure to obtain a physician order to hold insulin may result in poorly controlled diabetes and does not allow the resident to maintain the highest practicable level of physical well-being. Findings include: - Review of Resident #4's medical record occurred on all days of survey. Diagnoses included diabetes mellitus. Previous and current physician's orders included the following: * HumaLog (a fast-acting insulin) 17 units twice a day administered January through February * Novolog (a short-acting insulin) 15 units daily administered February through March * Blood sugar check in the morning and one random time during the day. Notify physician if results are less than 55 or greater than 400. The progress notes identified the following: * 01/02/17 at 9:57 a.m.: "HumaLog . . . 17 units . . . held" * 02/02/17 at 8:43 a.m.: "HumaLog . . . 17 units . . . held due to low am blood sugar" * 03/07/17 at 5:33 p.m.: "NovoLOG . . . 15 units . . . blood sugar was 65, insulin held, given orange juice and taken to supper" * 03/10/17 at 5:57 p.m.: "NovoLOG . . . 15 units . . . Resident has not eaten very much and states she does not want to eat much of supper" The facility staff failed to notify the physician after	F 281	for holding insulin due to hypoglycemia. For resident #4 Also contacted the medical provider for parameters needed to hold insulin due to hypoglycemia. Nurses have been educated on the need for a doctors order to hold insulin. 2. All residents who receive insulin have the potential to be affected by this practice. 3. Nurse will be provided with online education on insulin administration and diabetes management. 4. Facility DNS or designee will audit insulin administration to look for proper procedure on insulin administration and holding insulin. If a concern is identified immediate corrective action will be taken. Audits will be completed weekly starting on 4/10/17 for one month and then monthly for five months. An audit report will be provided to the QA committee for further recommendations and monitoring to achieve compliance. Report will be given to QA committee on 4/26/17. 1. For resident #11 antibiotics were ordered and completed at the time of the infection. 2. All residents who have cultures pending have the potential to be affected by this practice. 3. Since the provider receives the results of labs we will place a reminder on the	

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F 281	Continued From page 26 holding Resident #4's insulin. - Review of Resident #1's medical record occurred on all days of survey. Diagnoses included diabetes mellitus. Previous and current physician's orders included the following: * Lantus (a long-acting insulin) 10 units once a day administered January through March 2017 * NovoLog (a short-acting insulin) 3 units administered before meal January and February 2017 * Blood sugar check in the morning and one random time during the day. The January through March 2017 medication administration records (MARs) showed the following: * January 2017: Lantus 10 units held nine times and NovoLOG 3 units held thirty times. * February 2017: Lantus 10 units held nine times and NovoLOG 3 units held fourteen times. * March 2017: Lantus 10 units held four times. The facility staff failed to notify the physician prior to holding Resident #1's insulin. During an interview on 03/15/17 at 3:15 p.m., administrative nurse (#2) stated he would expect facility staff to notify the physician and obtain a physician's order to hold resident's insulin. URINARY TRACT INFECTION TREATMENT 2. Based on record review and policy review, the facility failed to ensure 1 of 7 sampled residents (Resident #11) with a urinary tract infection (UTI)	F 281	calendar to call the provider and ask for results three days after the collection of specimen for culture and document in the residents chart the result of the call. Licensed nurses will be re-educated on proper follow up procedure regarding cultures results. A nurses meeting is going to be held on 4/13/17 for all licensed nurses to ensure compliance. 4. DNS or designee will start audits on 4/10/17. The Audits will be created to determine if culture reports are being addressed in a timely manner to prevent the delay of treatment for residents with infections. Audits will be completed weekly for one month and than monthly for five months. Audit reports will be provided to the QA committee for further recommendations and monitoring to achieve compliance.1. For resident #6, she was treated with an antibiotic and has no signs of infection at this time. 2. All residents have the potential to be affected by this practice. 3. All nurses will be provided education on the importance of documenting assessment findings before, during and after treatment of cellulitis or other infections requiring antibiotic therapy. 4. Staff development or designee will complete Audits weekly starting the week of 4/10/17 for one month and monthly for five months to assure that documentation of infections is completed accurately	

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F 281	Continued From page 27 in the past year was treated in a timely manner. Failure to treat a UTI in a timely manner may lead to delayed healing and increased discomfort. Findings include: Review of the facility policy titled "Laboratory Services" occurred on 03/16/17. This policy, revised November 2016, stated, ". . . Policy: . . . Findings will be reported to the medical provider who ordered the test (or their representative) in a timely fashion . . ." Review of Resident #11's medical record occurred on March 15-16, 2017. Diagnoses included history of UTIs, retention of urine (indwelling catheter), and dementia. Resident #11's progress notes stated the following: * 12/19/16 at 3:00 a.m., "Unable to flush current catheter; brief is wet. Deflated balloon and removed catheter. Inserted [new] catheter . . . Immediate return of 150 cc [cubic centimeters] of dark amber urine. . . ." * 12/19/16 at 9:59 a.m., "orders received and observed for to [sic] collect u/a [urinalysis] and send to [name of clinic] due to foul odor, cloudy with lots of sentiment . . ." * 12/19/16 at 11:49 a.m., "u/a was sent to [name of clinic]" * 12/27/16 at 1:45 p.m., "[Name of physician] returned fax sent with orders for Ceftin [antibiotic] 250 mg [milligrams] bid [twice daily] x [times] 7 days" The urine culture final report, dated 12/24/16, identified a UTI caused by the bacteria Proteus	F 281	before, during and after the use of an antibiotic. Audit reports will be provided to the QA committee on 4/26/17 for further recommendations and monitoring to achieve compliance.	

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F 281	Continued From page 28 mirabilis, susceptible to Ceftin. Failure of the facility to ensure the physician received the urine culture results promptly upon completion of the culture report delayed Resident #11's treatment by three days. MONITORING CELLULITIS 3. Based on record review, professional reference, and staff interview, the facility failed to follow professional standards of practice related to assessment and documentation of a change in condition for 1 of 1 sampled resident (Resident #6) with cellulitis [bacterial skin infection]. Failure to assess the cellulitis and evaluate the response to treatment on a routine basis has the potential to limit continuity of care and may delay recognition of a worsening condition. Findings include: Berman, Snyder, Frandsen, "Kozier & Erb's Fundamentals of Nursing: Concepts, Process, and Practice, 10th ed., Pearson Education, Inc., New Jersey, 2016, "page 236, stated, "PRACTICE GUIDELINES: Documentation. Do: * Chart a change in a client's condition and show that follow-up actions were taken. . . . * Chart the client's response to interventions. . . . Review of Resident #6's medical record occurred on all days of survey. Diagnoses included cellulitis of left upper limb and unspecified pain. A progress note, dated 10/20/16 at 2:41 p.m., stated, "Resident seen by [name of nurse practitioner]. Orders received for Keflex	F 281		

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F 281	Continued From page 29 [antibiotic] 500 mg TID [three times daily] for ten days for left arm cellulitis." The record lacked evidence the facility nursing staff identified and assessed Resident #6's left arm when the cellulitis initially occurred, performed an ongoing assessment of the cellulitis, documented the resident's response to treatment, or when the cellulitis was healed. During an interview on 03/15/17 at 1:50 p.m., an administrative nurse (#2) stated staff should have documented what the resident's arm looked like and followed-up at least when it healed.	F 281		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management.	F 309		4/20/17

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F 309	Continued From page 30 The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE STANDARD SURVEY COMPLETED ON 04/13/16. Based on record review, review of standing orders, and staff interview, the staff failed to follow the facility policy/standing orders for 2 of 10 sampled residents (Resident #4 and #7) requiring interventions for constipation. Failure to monitor the residents' bowel status and follow the facility policy/standing orders to relieve constipation does not ensure regular bowel evacuation and may cause the resident unnecessary discomfort. Findings include: Review of the "SOCIETY GENERAL STANDING ORDERS", revised July 2015, occurred 03/16/17. The standing orders stated, ". . . Senna-S Tablet 8.6 - 50 MG [milligrams] Give 2 tablets by mouth as needed for constipation. Give up to twice daily as needed; hold for loose stool. Contact	F 309	1. Resident #4 and #7 do at times toilet themselves independently staff did ensure that the individual residents needs have been met.Nursing staff has completed a new bowel assessement for resident #4 and 7 and both care plans have been reviewed and updated. 2. All residents with the diagnosis of constipation has the potential of being affected. System Change 3.At the end of each shift the CNA's and the Licensed Nurses will meet to report/reveiw the BM list. All nursing staff have been re-educated on the Standing Orders for consipation. Licensed nurses will be involving the physician if the resident hasnt had a substantial bowel movement for at least three days. 4. An audit will start on 4/10/17 to be	

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F 309	Continued From page 31 provider/practitioner if there are three days without a significant BM [bowel movement]. Dulcolax Suppository 10 MG (Bisacodyl) Insert 10 mg rectally as needed for constipation. Give daily as needed. Contact provider/practitioner if there are three days without a significant BM. Milk of Magnesia Suspension 400 MG/5 ML [millimeter] Give 30 ml by mouth as needed for constipation. Give daily as needed. Contact provider/practitioner if there are three days without a significant BM. . . . Fleet Enema 7-19 GM [gram] / 118 ML Insert 1 application rectally as needed for constipation. One time daily as needed. Contact provider/practitioner if there are three days without a significant BM. . . ." - Review of Resident #4's medical record occurred on all days of survey. Diagnoses included constipation. Physician orders included Colace 100 mg as needed (PRN) and Milk of Magnesia 30 ml PRN for constipation. Review of Resident #4's February and March 2017 medication administration record (MAR) and bowel movement record showed the following: * 02/21/17 - 02/25/17: no bowel movement for four days, and Milk of Magnesia administered on 02/25/17 (fifth day of no BM). Facility staff failed to notify the physician. * 03/02/17 - 03/05/17: no bowel movement for four days, and no PRN medication administered. Facility staff failed to notify the physician. * 03/07/17 - 03/12/17: no bowel movement for six days, and no PRN medication administered. Facility staff failed to notify the physician. - Review of Resident #7's medical record	F 309	completed daily by Licensed nurses or designee. The audit will be completed daily for two months, weekly for two months,and then monthly for the remander of the year.If concerns are identified, immediate corrective action will be implemented. The DNS or designee will submit a report monthly for monitoring results of the QA committee. The first report will be submitted to QA on 4/26/17	

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F 309	Continued From page 32 occurred on all days of survey. Diagnoses included constipation. Physician orders included Dulcolax Suppository 10 mg PRN, MiraLax 17 gram daily PRN, and Senna Plus one tablet daily PRN for constipation. Review of Resident #7's February and March 2017 MAR and bowel movement record showed the following: * 02/18/17 - 02/22/17: no bowel movement for five days, and no PRN medication administered. Facility staff failed to notify the physician. * 03/08/17 - 03/11/17: no bowel movement for four days, and no PRN medication administered. Facility staff failed to notify the physician. During an interview on 03/15/17 at 3:15 p.m., an administrative nurse (#2) stated on day three of no bowel movement staff should perform a bowel assessment, or ask the resident if they have had a bowel movement, or administer a PRN bowel medication.	F 309		
F 314 SS=D	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives	F 314		4/20/17

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F 314	Continued From page 33 necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and review of facility policy, the facility failed to provide the necessary care and services to prevent the worsening of current pressure ulcers or the development of new pressure ulcers for 1 of 2 sampled residents (Resident #1) receiving treatment for pressure ulcers. Failure to assess and monitor Resident #1's left heel pressure ulcer as per facility policy may result in deterioration of an existing pressure ulcer. Findings include: Review of the facility policy titled "Pressure Ulcer Practice Guidelines" occurred on 03/16/17. This policy, revised September 2016, stated, ". . . Wound Assessments . . . At a minimum, weekly documentation is recommended to provide a review of the pressure ulcer/wound. . . ." Review of Resident #3's medical record occurred during all days of survey. Diagnoses included diabetes mellitus and left heel pressure ulcer. The physician order stated, ". . . aquacel ag [wound dressing] to left heel ulcer with bandage change every Monday, Wednesday, and Friday. The significant change Minimum Data Set (MDS), dated 04/19/16, identified a stage three pressure ulcer measuring 3.0 x 3.0 centimeters (cm). The quarterly MDS, dated 01/07/17, identified a stage three pressure ulcer measuring 5.0 x 5.0 cm.	F 314	1. Resident #1 Licensed nurses are doing dressing changes to the residents pressure ulcer on M, W, and F. The wound data collection is done daily with weekly measurement. The RN wound assessment is being done weekly per procedure. 2. Any resident with pressure ulcers has potential of being affected. System Change 3. All licensed nursing staff have been re-educated on "Pressure Ulcer Practices and Guidelines. A wound team has been developed to ensure that all wounds are measured weekly and consistently. Licensed nursing staff will completed an on line training over proper wound procedure. 4.An audit was developed to ensure that weekly measurement of wounds are being completed and documented. The audit will be completed weekly starting the week of 4/10/17 for two months and then monthly for four months. The DNS or designee will be responsible to monitor and ensure that the audit is completed. The DNS or designee will submit a report of the monitoring results to QA Committee at each scheduled meeting.	

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F 314	Continued From page 34 The current care plan stated, ". . . The resident has one deep tissue injury pressure ulcer to left heel. Altered mental status . . . Interventions . . . Assist to turn/reposition at least every 2 hours while in bed. Put pillows under legs to keep heels off bed . . . Provide pressure relieving/reducing [word omitted] on bed and wheelchair . . . Explain and reinforce to resident the importance of adequate intake. receives healthy shot twice daily providing protein . . ." Review of the Wound Data Collection assessments from December 2016 through February 2017 showed the following wound measurements: * 12/23/16: 4 cm x 3 cm * 01/11/17: 3.5 cm x 3 cm - 19 days since last assessment (this conflicts with the quarterly MDS measurement of 5.0 x 5.0 cm on 01/07/17, four days later) * 01/21/17: 3 cm x 2.2 cm - 10 days since last assessment * 02/02/17: 1.5 cm x 1 cm - 12 days since last assessment The facility failed to assess and document Resident #1's left heel ulcer weekly. During an interview on the afternoon of 03/15/17, an administrative nurse (#2) stated staff should assess and document Resident #1's left heel pressure ulcer weekly.	F 314		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that -	F 323		4/20/17

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F 323	Continued From page 35 (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy review, and staff interview, the facility failed to ensure each resident received adequate supervision and the necessary assistance devices to prevent accidents for 2 of 3 sampled residents (Resident #3 and #6) observed transferred with a stand aid or sit-to-stand mechanical lift. Failure to ensure adequate supervision and utilize appropriate methods of transfer increased the risk of falls and injury for these residents. Findings include:	F 323	1. For resident #6 her care plan was updated to use a stand aid with assist of two for transfers. For resident #3 care plan was updated to state resident is independent with cueing from staff. If unwilling or unable, consult nurse for transfer needs. 2. All residents who need assist with transfers have the potential to be affected by this practice. 3. All nurses and CNA's will be educated	

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F 323	Continued From page 36 Review of the facility policy titled "Gait (Transfer) Belt" occurred on 03/16/17. This policy, revised March 2017, stated, ". . . Purpose: * To safely stabilize a transfer . . . * To aid residents in maintaining balance * To avoid injury to both resident and staff member Note: Gait belts used unless medically contraindicated. . . ." - Review of Resident #6's medical record occurred on all days of survey. Diagnoses included Parkinson's Disease. The current care plan stated, "Focus: The resident has an ADL [activity of daily living] self care performance deficit R/T [related to] Activity intolerance . . . Interventions: . . . TOILET USE: assist of two with stand aid [a frame with handles, a foot platform, and buttock supports to lean on] . . . TRANSFER: Transfer Between Surfaces resident May use a stand aid with assist of two for toileting. If unwilling or unable may use sit-to-stand [mechanical lift] with assist of 2. . . . Focus: The resident is at risk of falls R/T unable to ambulate . . . Gait/balance problems . . ." On 03/13/17 at 4:05 p.m. and on 03/14/17 at 3:54 p.m., observation showed staff transferred Resident #6 to the toilet using a stand aid and the assistance of two certified nurse aides (CNAs), as per the care plan. On 03/14/17 at 12:24 p.m., observation showed a CNA (#4) wheeled Resident #6 into the bathing room to use the toilet. The CNA positioned the resident's wheelchair perpendicular to a grab bar on the wall (not by the toilet), and cued her to hold the grab bar and stand. The resident pulled herself to a standing position. The CNA failed to	F 323	on proper use of lift and following the resident care plan. 4. Performance audits will be conducted by staff development or designee to assure staff are following resident care plans and operating lifts according to policy and procedure. Audits will be completed weekly starting the week of 4/10/17 for two months and monthly for one quarter. If any issues are noted immediate corrective action will be taken. Audit report will be provided to the QA committee for further recommendations and monitoring to achieve compliance.	

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apply a gait belt to Resident #6 prior to the transfer. The CNA lowered Resident #6's pants and brief, placed a portable commode behind the resident, and cued her to sit down. When the resident stated she finished on the commode, the CNA (#4) cued her to stand, provided perineal cares, and adjusted her clothing. The CNA then moved the commode out of the way, and pulled Resident #6's wheelchair behind her for the resident to sit. The CNA failed to use the stand aid and two staff to transfer Resident #6.

On 03/14/17 at 12:53 p.m., Resident #6 requested to lie down. The CNA (#4) wheeled the resident to her room and cued her to hold the positioning bar at the head of the bed to stand. The CNA failed to use a gait belt. The resident stood, pivoted, and sat on her bed. The CNA assisted Resident #6 to lie down. The CNA failed to use the stand aid and two staff to transfer Resident #6.

During an interview on 03/15/16 at 5:35 p.m., an administrative nurse (#2) stated staff are expected to use a gait belt for transfers if the resident stands and pivots, and the CNA (#4) should have followed Resident #6's care plan for her method of transfer (stand aid).

- Review of Resident #3's medical record occurred on all days of survey. Diagnoses include abnormal gait and mobility and dementia. The significant change Minimum Data Set (MDS), dated 01/31/17, identified a severely impaired cognitive level, and extensive assist of two people with bed mobility and transfers.

The current care plan stated, ". . . Focus . . . The

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resident has an ADL self care performance deficit R/T spinal stenosis and degenerative disc disease E/B [evidenced by] impaired balance, activity intolerance and limited mobility. . . . Interventions . . . Bed Mobility - Position Up in Bed: weight bearing assist of two with use of positioning bar. . . . Bed Mobility - Turn from Side to Side: total dependent with assist of two as is rigid or difficult to turn. use total lift with repositioning sling. . . . Bed Mobility - Lying to Sitting: Resident is independent, uses positioning bar, cueing from staff. . . . Bed Mobility - Sitting to Lying: weight bearing assist of one with cueing . . . Transfer - Transfer Between Surfaces and CAN pull self to stand: Resident is independent sometimes need cueing from staff. if unable use sit to stand. . . ."

Observation on 03/14/17 at 9:57 a.m. showed Resident #3 laying in her bed and then able to sit herself up to the edge of the bed using a positioning bar. The CNA (#10) secured the mechanical stand lift belt around the residents waist, hooked the belt to the mechanical stand lift, and left the resident's room to find another CNA for assistance. The CNAs (#10 and #11) then transferred Resident #3 from her bed to the wheelchair utilizing the mechanical stand lift. The CNA (#10) failed to confirm with a licensed nurse which transfer method she should use.

During an interview on 03/15/17 at 4:37 p.m., an administrative nurse (#2) stated he expected staff to remain with residents while they are hooked up to any mechanical stand lift or hoyer lift.

The facility failed to remain with Resident #3 while connected to the mechanical stand lift and

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F 323	Continued From page 39 failed to seek the nurse's recommendation for mode of transfer.	F 323		
F 329 SS=D	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;	F 329		4/20/17

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F 329	Continued From page 40 (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 04/13/16. Based on record review, policy review, and staff interview, the facility failed to ensure a medication regimen free from unnecessary drugs for 2 of 3 sampled residents (Resident #6 and #11) who received as needed (PRN) psychotropic medications. Failure to attempt non-pharmacological interventions prior to administering a hypnotic or antianxiety medication placed residents at risk of receiving unnecessary medications and experiencing adverse consequences related to their use. Findings include: Review of the facility policy titled "Psychotropic Medications" occurred on 03/16/17. This policy, revised November 2016, stated, "Purpose: To evaluate behavior interventions and alternatives before using psychotropic medications. To eliminate unnecessary psychotropic medications. . . . Procedure: Non-Emergency Administration: . . . 7. . . . It is important to initiate other care plan interventions prior to the use of prn psychotropic medications. . . ." - Review of Resident #6's medical record occurred on all days of survey. Medication included Ambien 5 milligrams (mg) PRN at bedtime for "insomnia," ordered 10/26/16, and on	F 329	1. Resident #6 Ambien has been added to the care plan to insure non pharmacological interventions are tried prior to giving the PRN. Resident #11 Ativan has been added to the care plan to insure non pharmacological interventions are being tried prior to be given the PRN. 2. All residents that received PRN medication have the potential of being affected. 3. Licensed nursing staff and CMA's will be re-educated on policy and procedure over giving PRN medication. 4.An audit has been developed to ensure that non-pharmacological interventions are being done prior to giving a PRN medication. Licensed nursing staff or designee will complete an audit daily for two weeks starting on 4/10/17, weekly for four weeks, and then monthly for five months. If concerns are identified, immediate corrective action will be implemented. The DNS or designee will submit a report of the monitoring results to the QA committee at each scheduled meeting starting 4/26/17. QA will insure compliance and offer recommendations when needed.	

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F 329	Continued From page 41 01/09/17 revised "to be given between 8:00 pm and midnight when used for sleep." Resident #6's current care plan stated, "Focus: The resident has a behavior symptom . . . wanders throughout the center. She has entered others rooms. She rummages. . . ." The interventions included "Attempt non-pharmacological interventions" and listed multiple interventions to utilize. The facility failed to develop a care plan or interventions for insomnia, which could contribute to wandering. See F280. Resident #6's Medication Administration Records (MARs) from November 2016 through March 16, 2017 showed staff administered Ambien on seven occasions in November, 12 occasions in December, 11 occasions in January, three occasions in February, and three occasions in March, The record lacked evidence staff attempted non-pharmacological interventions prior to administering Ambien on 35 of the 36 occasions. During an interview on 03/15/17 at 3:45 p.m., an administrative nurse (#2) stated staff should offer food, drink, activity, or some other intervention before giving Ambien. - Review of Resident #11's medical record occurred on March 15-16, 2017. Medication included Ativan 0.5 mg twice daily PRN for "agitation, anxiety related to anxiety disorder," ordered 03/14/17, and revised from a prior order for Ativan 0.5 mg daily plus 0.5 mg once daily PRN.	F 329		

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F 329	Continued From page 42 Resident #11's current care plan stated, "Focus: The resident has a mood problem R/T [related to] dementia E/B [evidenced by] tearfulness, angry responses to interaction. Talks repetitively and/or calls out. Repetitive physical movements. . . . Interventions: * MOOD - NON-PHARMACOLOGICAL: Attempt non-pharmacological interventions: move to a quite [sic] area; enjoys soap operas and game shows on tv. . . ." Resident #11's MARs from December 2016 through March 16, 2017 showed staff administered PRN Ativan once in December and once in March. The record lacked evidence staff attempted non-pharmacological interventions prior to administering Ativan on both occasions.	F 329		
F 371 SS=F	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in	F 371		4/20/17

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F 371	Continued From page 43 accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, review of the manufacturer's instructions, review of dietary chemical sanitizer test logs, and staff interview, the facility failed to ensure appropriate sanitization in food preparation/service areas in 1 of 1 facility kitchen. Failure to ensure the correct sanitizer strips are used to measure the amount of sanitizer in two cleaning buckets and a three-compartment sink may result in improper sanitization and places residents at risk for food-borne illness. Findings include: Review of the facility policy titled "Sanitizing Solutions" occurred on 03/16/17. This policy, revised February 2016, stated, ". . . 1. Employees need to be properly trained in handling different cleaning agents. 2. . . . Refer to manufacturer's information for proper concentrations measured in parts per million (ppm). High concentrations can be unsafe and may leave an odor or bad taste on the objects and corrode metals. . . . 6. Check solution concentrations frequently with a test kit since they may become depleted when they kill microorganisms and bind with food. . . . 8. Staff members may use Dietary Chemical Sanitizing Log . . . to document the process as desired. . . ."	F 371	1. The Hydrion QT-40 test strips were received are on 3/15/17 2. All residents has the potential of being affected. System Change: 3. Dietary Staff was re-educated on the proper procedure for sanitation in food areas. On 3/15/17 the correct test strips was put into place to ensure proper sanitation procedure was being followed. 4. An audit was developed to ensure compliance with proper sanitation procedure. Dietary staff or designee will be responsible to ensure compliance with the use of correct test strips. The Audit will be completed weekly for six months starting the week of 4/10/17. An audit report will be provided monthly to QA starting on 4/26/17 to ensure compliance and if there is any further recommendations.	

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F 371	Continued From page 44 - Observation of the dietary department occurred on 03/13/17 at 11:00 a.m. with the dietary manager (#9) and showed a three compartment sink in the kitchen. The dietary manager (#9) stated the third sink contained sanitizer. When asked, the dietary aide tested the sanitizer in the sink with a test strip, compared it to a color chart on a test strip wheel (Hydrion QT-10), and found it measured at 100 ppm. Observation showed a chart provided by Ecolab (supplier of sanitizer) affixed to the wall above the three compartment sink. The chart stated, "Oasis 146 Multi Quat Sanitizer" (a type of sanitizer) and identified the Hydrion QT- 40 test strips (wheel) for use with the sanitizer. When asked what it should measure, the manager (#9) stated 200 to 400 ppm. The dietary staff failed to use the correct test strips (wheel) to measure the sanitizer. - Observation on 03/13/17 at 11:00 a.m. with a dietary manager (#9) showed a sanitizer ppm test log staff had documented the concentration solution of the three compartment sink inconsistently every one to two weeks for over a year. - Observation on 03/13/17 at 11:00 a.m. with a dietary manager (#9) showed a dietary aide (#7) filled a bucket with Oasis 146 sanitizer and water and proceeded to go into the dining room without testing the sanitizer solution. When asked, the dietary aide (#7) measured the concentration of the sanitizer with a test strip, compared it to the color wheel, and found it measured 100 ppm. - Observation on 03/13/17 at 11:11 a.m. with a dietary manager (#9) showed a dietary cook (#8)	F 371		

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F 371	Continued From page 45 filled a bucket with Oasis 146 sanitizer and water and wiped down the kitchen food prep table. When asked, the dietary manager (#9) measured the concentration of the sanitizer with a test strip, compared it to the color wheel, and found it measured 100 ppm. During an interview on 03/13/17 at 11:00 a.m., a dietary manager (#9) stated she was unaware the facility had been using the wrong test strips for the Oasis 146 sanitizer, and the facility had received the correct test strips on 03/15/17. The dietary manager (#9) also stated staff are expected to measure the concentration mixture of the three-compartment sink once a week.	F 371		