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 _____	05/09/2018

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 The standard Medicare/Medicaid recertification started on 05/06/18 and concluded on 05/09/18.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident and family interviews, the facility failed to provide reasonable accommodation of needs regarding call lights for 2 of 2 sampled residents (Resident #30 and #39) observed requiring toileting assistance. Failure to answer call lights in a timely manner may result in discomfort, incontinence, and skin breakdown. Findings include: Review of the facility's procedure entitled "Call Light" occurred on 05/08/18. This procedure, dated September 2012, stated, ". . . When resident's call light is observed/heard, go to resident's room promptly. 2. Respond to request as soon as possible. . . ." - On 05/06/18 at 2:15 p.m., a family interview (A) identified the following: * At 1:40 p.m. Resident #30's call light had been activated. The resident had verbally communicated her need to be checked and	F 558	Preparation and execution of this response and plan of correction does not constitute an 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 7305 of the State Operations Manual. F558 1. For residents #30 and #39 nursing staff will be educated to remain with resident and use walkie-talkie to call for assistance if extra help is needed. Staff will also be	6/13/18

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

Electronically Signed | 05/31/2018

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F 558	Continued From page 1 changed to a family member * At 1:45 p.m. a staff member came into the room, turned off the call light, and stated staff would be back when a second staff member was found to utilize a mechanical lift transfer for Resident #30 Observation on 05/06/18 at 2:20 p.m. showed Resident #30 still sitting in Rock-n-Go wheelchair waiting for staff assistance, and at 2:30 p.m. observation showed staff entering Resident #30's room to assist with toileting, approximately 50 minutes after the resident's initial request. Review of Resident #30's medical record occurred on all days of survey. The quarterly Minimum Data Set (MDS), dated 04/07/18, identified moderately impaired cognition, clear speech, usually makes self understood, frequently incontinent, and total dependence of 2 assist for toileting. - During an interview on 05/06/18 at 11:30 a.m., Resident #39 indicated a staff nurse (#6) had answered her call light a few minutes earlier, turned the call light off, and stated when staff returned from lunch they would take the resident to the bathroom. At 11:45 a.m. the resident activated her call light again. The call light was answered by a staff nurse (#6) who turned the call light off, and stated she would find staff to help the resident to the bathroom. The resident stated she frequently waited for staff assistance for toileting. At 12:15 p.m. a certified nursing assistant (CNA) (#3) assisted the resident to the bathroom, approximately 45 minutes after the resident's initial request.	F 558	educated to leave call light on until adequate help has arrived to provide resident needed cares. For staff who do not carry a walkie-talkie they will be educated to leave the call light on and go find help and return to the resident within five minutes. All staff will be educated on 6/7/18. 2.All residents have the potential to be affected by this practice. 3.New call light system has been installed and walkie talkies are in use to enhance communication for front line staff. In addition we will make sure to have a staff member on the floor during meal times to assist residents while other staff are assisting in the dining room. All staff will be educated on 6/7/18. 4. DNS or Designee will audit Call light response times daily for two weeks. If no issues identified then we will audit call light response times every two weeks for 6 months. In addition we will conduct resident and family interviews monthly for 6 months to be sure residents are receiving care as soon as possible. QA will receive the weekly audits and review and monitor at QA meetings monthly.	

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F 558	Continued From page 2 Review of Resident #39's medical record occurred on all days of survey. The significant change MDS, dated 02/23/18, identified cognitively intact, clear speech, makes self understood, occasionally incontinent, and an extensive assist of one for toileting. The facility failed to ensure call lights were answered timely and residents' requests for toileting assistance were completed in a timely manner.	F 558		
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that	F 604		6/13/18

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F 604	Continued From page 3 are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to determine the affect a position change alarm device had on 1 of 1 sampled resident (Resident #21) observed with a wheelchair position change alarm device attached to their clothing and a wander/elopement alarm attached to their wheelchair. Failure to assess the need for and the impact the devices had on the resident has the potential to act as a restraint by limiting the resident's movement. Findings include: Review of the facility policy titled "Alarms: Bed, Chair and Door" occurred on 05/08/18. This policy, revised January 2014, stated, ". . . Review of the resident's condition will determine if the resident will benefit from the use of an alarm . . . The use of alarms will be reviewed on a regular basis but no less than quarterly by the interdisciplinary team. . . ." - Observations occurred on 05/06/18 at 10:00 a.m. as well as times throughout the survey of Resident #21 sitting in a wheelchair. The back of the wheelchair showed a position change alarm, with the string from the device attached to the resident's clothing. If the resident attempted to stand, the string would pull and an alarm would	F 604	1. For resident #21 tabs alarm was removed from her wheelchair. Her wanderguard remains on the wheelchair and restraint assessment completed. Family also signed a restraint consent form for the use of a wanderguard. The wanderguard will be reviewed quarterly for continued need. All staff will be re educated on restraint policy and procedure during staff meeting on 6/7/18. 2. All residents have the potential to be affected by this practice. 3.Any alarm or wander guard considered will be reviewed initially by the interdisciplinary team and then quarterly to ensure proper placement is adequate to the resident needs. Family will be informed about reason for use of an alarm or wander guard prior to them being initiated. The use of any alarm will be reviewed quarterly in resident care plan meeting. 4. MDS Coordinator or designee will audit restraints weekly while completing resident MDS, the care plan team will monitor during weekly care plan meeting for three months to ensure all resident are	

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F 604	Continued From page 4 sound. Also attached to the wheelchair was a wander/elopement alarm. If the resident came near an outside door the alarm would sound. Review of Resident #21's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease and dementia. A quarterly Minimum Data Set (MDS), dated 02/19/18, identified short and long term memory problems, moderately impaired cognition, and a chair alarm and wander/elopement alarm used daily. Resident #21's current care plan stated, ". . . Wander Guard to wheelchair used to alert staff to resident's movement and to assist staff in monitoring movement . . . wheelchair alarm used to alert staff to resident's movement and to assist staff in monitoring movement. . . ." The record lacked an assessment for the position change alarm device and the wander/elopement alarm. During an interview on 05/09/18 at 9:15 a.m., an administrative nurse (#1) stated the following: * The resident's wanderguard had been placed on 9/18/17 after the resident tried to elope into the assisted living area. The resident has not eloped since that time. * The resident's chair alarm had been started sometime in 2016. * No assessments had been completed on either alarm since first utilized The facility failed to ensure the position change alarm and wander/elopement alarm were assessed as appropriate for Resident #21.	F 604	reviewed. Once all resident have been reviewed audits MDS Coordinator or Designee will audit one MDS a week for three months.QA will receive the weekly audits and review and monitor at QA meetings monthly.	
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g)	F 641		6/13/18

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F 641	Continued From page 5 §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. 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 (Version 1.15), and staff interview, the facility failed to ensure the Minimum Data Set (MDS) accurately reflected the resident's status for 4 of 12 sampled residents (Resident #21, #30, #35, and #39). Failure to accurately complete Section J0100 (Pain Management) of the MDS does not allow each residents' assessment to reflect their current status/needs, and has the potential to affect the accurate development 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 2017, page J-3 stated, ". . . Coding Instructions for J-100C, Received Non-medication Intervention for Pain * Code 1, yes: if the medical record contains documentation that a non-medication pain intervention was scheduled as part of the care plan and it is documented that the intervention was actually received and assessed for efficacy. . . ." - Review of Resident #21's medical record occurred on all days of survey. The quarterly Minimum Data Set (MDS), dated 02/19/18, identified J-100C coded "1" or yes as receiving a	F 641	F641 1. For residents #21, #30, #35, and #39 MDS will be corrected and resubmitted. 2. All residents have the potential to be affected by this practice. 3. Education for nurses and CMA's will be provided on policy and procedure "Pain Management, Data Collection and Assessment and Non-Pharmacological Pain Interventions" on 6/7/18 regarding the use and documentation of non-pharmacological interventions for any PRN pain medication. 4. Audits will be conducted by DNS or designee weekly for four weeks on the medical record to determine if non-pharmacological interventions were attempted and documented before a PRN pain medication is administered. If no problems are identified then audits will be completed monthly for six months. MDS coordinator or designee will audit MDS weekly on all residents as MDS comes due for one quarter on J100C to be sure coding is accurate. If no issues are noted then audits will be completed monthly for a total of 6 months. Findings will be reviewed by the QA committee and	

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F 641	Continued From page 6 non-medication pain intervention. The medical record lacked documentation the intervention was actually received and assessed for efficacy during the 5-day look-back period. - Review of Resident #30's medical record occurred on all days of survey. The quarterly MDS, dated 04/07/18, identified J-100C coded "1" or yes as receiving a non-medication pain intervention. The medical record lacked documentation the intervention was actually received and assessed for efficacy during the 5-day look-back period. - Review of Resident #35's medical record occurred on all days of survey. The annual MDS, dated 01/31/18, identified J-100C coded "1" or yes as receiving a non-medication pain intervention. The medical record lacked documentation the intervention was actually received and assessed for efficacy during the 5-day look-back period. - Review of Resident #39's medical record occurred on all days of survey. The significant change MDS, dated 02/23/18, identified J-100C coded "1" or yes as receiving a non-medication pain intervention. The medical record lacked documentation the intervention was actually received and assessed for efficacy during the 5-day look-back period. During an interview on 05/08/18 at 2:45 p.m., a MDS Coordinator (#7) stated she coded J-100C as yes if the care plan identified pain interventions and failed to determine if an intervention was implemented and assessed for efficacy by staff during the look-back period.	F 641	changes made as needed.	

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F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(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 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: THIS IS A REPEAT DEFICIENCY FROM THE STANDARD SURVEY CONDUCTED ON 03/16/17 Based on observation, record review, review of the facility policy, resident and staff interview, the facility failed to review and revise the	F 657	1. Resident # 10 care plan has been updated to reflect residents special diet orders. Resident #11 care plan has been updated to reflect that the resident is receiving physical therapy and the use of a CPAP machine. Resident #18 careplan has been updated to reflect current	6/13/18

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F 657	Continued From page 8 comprehensive care plan to reflect the current status for 5 of 12 sampled residents (Resident #10, #11, #18, #27, #39). Failure to review and revise the care plan limits the ability of staff to communicate care needs and ensure continuity of care for each resident. Findings include: Review of the facility policy titled "Care Plan" occurred on 5/7/18. This policy, dated November 2016, stated, ". . . Residents will receive and be provided the necessary care and services to attain or maintain the highest practicable well-being in accordance with the comprehensive assessment. . . . " - Review of Resident #10's medical record occurred on all days of survey. Diagnoses included cerebral infarct [stroke] and dysphagia. The physician order stated: "Cautious Oral Feeding to be done by staff. Family may offer small amounts when awake and alert. May use pureed pudding texture foods such as applesauce, yogurt, cream of wheat with minimal milk, oatmeal, or thick soup with no texture. . . . Special diet, Level 1-Puree texture, Regular fluid consistency. The current care plan stated, "The resident has an ADL [Activities of Daily Living] self care performance deficit R/T [related to] stroke e/b [evidenced by] weakness and fatigue. . . . Eating: Resident requires total assist with eating and drinking. . . ." Resident #10's care plan failed to reflect the special diet ordered. - Review of Resident #11's medical record	F 657	mobility status. Resident #27 careplan has been updated to reflect goals and interventions for current diet order. Resident #39 careplan has been updated to reflect current ambulation and transfer status, Hot beverage care plan was updated to meet the residents needs, and doctors order's were reviewed and added to care plan for foot cellulitis. 2. All resident have the potential to be affected by this practice 3. Staff will be re educated on 6/7/18 at staff meeting to address the residents needs are getting updated on care plan in a timely manner. System Change: Night Nurse or designee will review new orders daily to make sure care plan is updated to address change. 4. HIM or designee will audit weekly for three months to make sure all new order have been addressed on the resident care plan. If no issues audit will be done bi weekly for three months after. QA will receive the weekly audits and review and monitor at QA meetings monthly.	

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F 657	Continued From page 9	F 657		

occurred on all days of survey. Diagnoses included chronic respiratory failure, asthma, obstructive sleep apnea, morbid obesity and cerebral infarct. The current care plan stated, " . . . The resident has an ADL self care performance deficit R/T stroke affecting the right side e/b weakness. . . ."

Review of Resident #11's progress notes identified the following:
* 04/26/2018 at 10:41 p.m.: "Resident refuses to wear his CPAP [continuous positive airway pressure]; hit nurse's hand away, yelled "NO!", and turned his head away."
* 04/26/2018 at 11:39 a.m.: " . . . HIS ASSISTANCE DOES VARY AS IS SLEEPIER AT TIMES. HE WAS WEIGHT [sic] BEARING ASSIST OF TWO WITH TRANSFERS AND TOILETING. HE HAD WEIGHT BEARING ASSIST OF ONE WITH REMAINING ADL'S. . . . HE HAS RIGHT SIDED WEAKNESS RELATED TO STROKE IN THE PAST. HE TENDS TO HANG HIS RIGHT ARM OVER HIS WHEELCHAIR. . . . HE DOES USE CPAP AT NIGHT. . . ."

Observation on 05/08/18 at 11:00 a.m. showed Resident #11 ambulated with a Physical Therapist using a gait belt and a front wheeled walker.

Observation of Resident #11's room occurred on all days of survey and identified a CPAP machine on the bed side stand.

Resident #11's care plan failed to reflect the resident received physical therapy and use of a CPAP machine.

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F 657	Continued From page 10 - Review of Resident #18's medical record occurred on all days of survey. Diagnoses included convulsions, macular degeneration, rheumatoid arthritis, osteoporosis, pain, history of falling, vascular Parkinsonism, and dizziness. The current care plan stated,". . . resident has an ADL selfcare performance deficit . . . needing assist, is using wheelchair . . . She will transfer and/or ambulate on her own at times . . . Can ambulate with a walker and staff assist . . . ." Observation of Resident #18 on all days of survey identified mobility only in a wheelchair. Resident #18's care plan failed to reflect her current use of only the wheelchair for mobility status. - Review of Resident #27's medical record occurred on all days of survey. Diagnoses included Parkinson's disease, and dysphagia. The current physician orders stated regular diet with regular texture and nectar consistency. During an interview on 05/09/18 at 11:55 a.m., a kitchen staff member (#5) stated Resident #27's diet card reflected a regular diet with nectar thickened liquids. The current care plan failed to include a goal and interventions for Resident #27's current diet order. - Review of Resident #39's medical record occurred on all days of survey. Diagnoses included Parkinson's disease and glaucoma. The	F 657		

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F 657	Continued From page 11 current care plan stated, ". . . Resident is able to ambulate with wheeled walker without staff assist." Observation on 05/06/18 at 12:05 p.m. showed a certified nurse aide (CNA) (#3) propelled Resident #39 into the bathroom utilizing a wheelchair and transferred the resident to the toilet without a gait belt. Observation on 05/06/18 at 4:11 p.m. showed a CNA (#4) ambulated Resident #39 into the bathroom utilizing a walker and gait belt. The CNA (#4) stated the resident has a sore foot and now must use a wheelchair for long distances, but can use a walker to ambulate to the bathroom. Staff failed to update the care plan regarding the resident's current ambulation and transfer status. - Review of Resident #39's progress notes identified the following: * 11/19/17 - "Resident spilled coffee in her lap (left thigh area) . . . Nurse assessed. Resident denies any pain and no markings observed by nurse." * 04/28/17 - Physician's order of an oral antibiotic for 10 days due to right foot cellulitis During an interview on 05/06/18 at 11:30 a.m., Resident #39 stated her right foot hurt due to an infection. The care plan failed to address the previous hot coffee spill and the current cellulitis infection. During an interview on 05/07/18 at 3:30 p.m., a	F 657		

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F 657	Continued From page 12 nurse manager (#1) agreed the care plan failed to address Resident #39's current ambulation/transfer status, cellulitis, and history of a hot coffee spill.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(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: Based on observation and record review, the facility failed to obtain a physician order for 1 of 1 sampled resident (Resident #11) before applying a CPAP machine. Using a CPAP (continuous positive airway pressure) machine on a resident without obtaining a physician order may cause adverse consequences to the resident. Findings include: Observation of Resident #11's room occurred on all days of survey and identified a CPAP machine on the resident's bedside stand. Review of Resident #11's medical record occurred on all days of survey. Diagnoses included chronic respiratory failure and obstructive sleep apnea. An admission Minimum Data Set (MDS), dated 04/25/18, identified a CPAP used during the last 14 days. Review of Resident #11's progress notes identified the following: * 4/26/2018 22:41 Mood/Behavior Note Text:	F 658	1. Resident #11 physican orders have been reviewed and updated to show an order for the use of a CPAP machine. Order was recieved on 5/8/18. 2. all residents have the potential to be affected by this practice. 3. Systemic change: DNS and HIM or designees will review orders on all new admissions together to assure no orders are omitted or entered incorrectly in the residents chart. Education will be provided for nursing staff on 6/7/18 to double check orders for any procedure or device that is applied or removed and requires documentation of application and or removal. 4.DSN or designee will audit orders to ensure accuracy once nursing inputs orders into PCC. All new orders will be reviewed daily. Audits will be completed daily for two weeks, if no issues are noted	6/13/18

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F 658	Continued From page 13 "Resident refuses to wear his CPAP; hit nurse's hand away, yelled "NO!", and turned his head away." * 4/26/2018 11:39 MDS Note Text: ADMISSION NOTE. ". . . HE WAS WEIGHR [sic] BEARING ASSIST OF TWO WITH TRANSFERS AND TOILETING. HE HAD WEIGHT BEARING ASSIST OF ONE WITH REMAINING ADL'S [activities of daily living]. HE HAD SOME ASSIST WITH EATING WITH CUEING. STAFF PROPEL HIS WHEELCHAIR AS HE HAS RIGHT SIDED WEAKNESS RELATED TO STROKE IN THE PAST. . . . HE DOES USE CPAP AT NIGHT. WILL COMPLETE CARE PLAN WITH COMPLETION OF CAA'S [care area assessment summary]." Review of Resident #11's physician's orders failed to show an order for use of a CPAP machine.	F 658	audits will be completed monthly for 6 months. Audits will be given to QA committee to help monitor accuracy and make changes as needed.	
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to provide adequate supervision and maintenance to prevent accidents for 2 of 2 sampled residents (Resident #35 and #39) observed requiring assist for	F 689	1. For resident #39 resident care plan was updated to include hot beverages, and transfers. For resident #35 a new chair was ordered to replace her current chair.	6/13/18

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F 689	Continued From page 14 activities of daily living (ADLs). Failure to ensure staff assessed and monitored a resident after a hot beverage spill (Resident #39), utilized a gait belt during transfer (Resident #39), and replaced a torn wheelchair armrest (Resident #35) may result in accidents with injury. Findings include: Review of the facility policy titled "Hot Beverage Safety" occurred on 05/07/18. This policy, revised December 2017, stated, ". . . When serving hot beverages to residents with behavior or medical conditions that put them at increased risk for spill: a. Evaluate the ability of the resident to manage hot beverages independently and provide assistance as needed. b. Encourage resident to consume cold beverages. c. allow hot beverage to cool to below 120 degrees Fahrenheit before serving to reduce the risk and/or severity of burns. d. Add ice to hot beverages before serving, if resident agrees. 4. Interventions are added to the care plan from the Hot Beverage Safety focus in the care plan library as indicated. . . ." Review of the facility policy titled "Burns" occurred on 05/07/18. This policy, revised May 2017, stated, ". . . Update the Care Plan with changes/new interventions. . . ." Review of the facility policy titled "Safe Resident Handling Program Overview" occurred on 05/07/18. This policy, revised August 2017, stated, ". . . assistive devices are to be used as an extension of the employee to complete resident mobilization tasks where employee assistance is needed. This includes transfers. . .	F 689	2. All residents have the potential to be affected by this practice. 3. All staff will be educated on 6/7/18 wheelchair repair, assessing a resident after a hot beverage spill and proper transfers with a gait belt per care plan. Maintenance or designee will audit wheelchairs for rips or tears and repair or replace as needed. Education will be provided for all staff to complete a work order on equipment that needs repair. Education will also be provided to nursing staff to complete 72 hours of follow up for any resident who spills a hot beverage. Nursing staff will also be educated to update the care plan for spills, falls, transfers with a gait belt, and any other resident changes to resident so that care plan accurately reflects the residents current condition. 4. A spreadsheet will be created to inventory and make sure all wheelchairs are inspected weekly for one month then on a quarterly basis. Maintenance or designee will conduct the inspections. DNS or Designee will be complete audits weekly for one month on falls, transfers with gait belt and hot beverage spills the audit will monitor staff is assessing resident for at least 72 hour follow up from the incident.If no issues are identified audits will be completed monthly for five months. Quality Coordinator or designee will Audit quarterly on care plans for the first full	

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F 689	Continued From page 15 ." - Review of Resident #39's medical record occurred on all days of survey. Diagnoses included Parkinson's disease, anxiety, and dementia. Review of the resident's progress notes and an incident report, dated 11/19/17, identified "Resident spilled coffee in her lap at dinnertime . . . Resident taken out of dining room . . . No markings on left leg where coffee was spilled . . . Coffee temp [temperature] taken: 136 degrees farenheit [Fahrenheit]. . . ." The facility failed to assess the resident to determine the need for interventions to prevent further hot beverage spills and update the care plan. Observation on 05/06/18 at 12:15 p.m. showed a certified nurse aide (CNA) (#3) transferred Resident #39 from the wheelchair to the toilet and back to the wheelchair. The CNA held onto the resident's clothes and arm and failed to utilize a gait belt. - Observation on 05/06/18 at 10:00 a.m. showed Resident #35 sitting in her Rock-N-Go (wheelchair) located in the activity room. The wheelchair's left armrest was cracked and torn with part of the padding showing. Both wheelchair armrests were cracked creating the potential for skin tears. The facility failed to ensure staff maintained Resident #35's wheelchair armrests to decrease the potential for skin tears. During an interview on 05/07/18 at 3:30 p.m. an	F 689	quarter to be sure care plans are updated to reflect resident current transfer status. Audits will be reviewed by the QA committee and changes or additional audits will be completed as necessary.	

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F 689	Continued From page 16 administrative nurse (#1) verified the following: * Staff failed to assess Resident #39 after the hot coffee spill and implement interventions to prevent further spills * Staff are encouraged to use a gait belt when transferring residents * Resident #35's wheelchair armrests should have been replaced	F 689		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to ensure the appropriate care and services to	F 693	1. For resident #10 all nurses were required to review policy and procedure for administering enteral tube feeding to	6/13/18

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F 693	Continued From page 17 prevent complications for 1 of 1 sampled resident (Resident #10) observed receiving enteral tube feedings. Failure to ensure the head of the bed is elevated during and after feedings has the potential to result in adverse events, such as aspiration pneumonia. Findings include: Review of the facility policy titled "Tube (Enteral) Feeding" occurred on 05/09/18. This policy, revised October 2017, stated, " . . . Head of Bed (HOB): Elevate HOB 30-45 degrees at all times during feeding and for at least 30-40 minutes after the feeding is stopped. . . ." Review of Resident #10's medical record occurred on all days of survey. Diagnoses included cerebral infarct, dysphagia, cognitive impairment, and dementia. The quarterly Minimum Data Set (MDS), dated 03/28/18, identified moderately impaired cognitive skills, presence of a feeding tube, and required extensive assist for bed mobility. Physician's orders included: ". . . Enteral Feed four times a day FEEDING-GRAVITY/BOLUS: Osmolite 1.5 cal [calories] 175cc [cubic centimeter] via bolus/gravity per peg [percutaneous endoscopic gastrostomy] tube. Document the amount of formula provided every shift. Flush tube with 25cc water before and 100cc water after feeding. . . . HOB: Elevate HOB 30 degrees at all times during feeding and for one hour after bolus feeding. . . ." Resident #10's current care plan identified the following: "The resident requires tube feeding R/T [related to] Dysphagia . . . peg tube at risk for	F 693	assure head of bed is elevated to 30 - 45 degrees during feeding and for at least half an hour after the feeding by 6/13/18. 2. Any resident who receives enteral tube feedings would have potential to be affected by this practice. 3. Maintenance will place a piece of tape or other temporary marking on the wall next to residents bed as a reference for 30 degree angle for raising head of bed. Education will be provided to all nurses about the reference for raising head of bed on 6/7/18. 4. Staff development coordinator or designee will have all nurses demonstrate competency on proper procedure for performing feeding via enteral tube (G-Tube) by 6/13/18. Audits will then be completed via observation monthly for 6 months. QA committee will review audits and make changes as necessary.	

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F 693	Continued From page 18 aspiration. . . . Resident will remain free of side effects or complications related to tube feeding through review date. HOB: Elevate HOB 30 degrees during and after tube feeding is stopped. Monitor/report to Nurse s/s [signs and symptoms] of complications of tube feeding (coughing, choking)" Observation on 05/07/18 at 3:03 p.m. showed Resident #10 lying in bed with the head of the bed elevated approximately 15-20 degrees. A facility nurse (#6) completed the resident's bolus feeding without raising the HOB to 30 degrees. During an interview on 05/08/18 at 4:00 p.m., an administrative nurse (#1) stated Resident #10's head of the bed should be elevated at least 30 degrees during bolus feedings.	F 693		
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident	F 726		6/13/18

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F 726	Continued From page 19 assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, and record review, the facility failed to complete a performance evaluation and competency skills evaluation for 1 of 3 certified nurse assistants (CNAs) (#3) at least once every 12 months, based on review of the CNA employee record. Failure to monitor the skills/techniques of the CNA, then provide training based on weaknesses identified may result in physical or psychological harm to the residents, through improper care. Findings include: Review of CNA #3's individual employee record identified the following: * Hire date 07/07/16. * No yearly evaluation completed since hire date. * Competency verification last completed 07/25/16 During an interview on 05/09/18 at 11:26 a.m., an administrative nurse (#1) stated CNA competencies and evaluations should be	F 726	1. CNA #3 employee record has been updated to include a current evaluation and competency verification of duties. 2. All staff have the potential of being affected by this practice 3. All staff will be educated on 6/7/18 about employee evaluation and competency verification on the importance that everyone is current and up-to-date. Systemic change: Career links is being used for all staff evaluations. Managers must have all the staff evaluations completed by June 13th to ensure all staff are current and up to date. Department Managers are ensuring staff competencies are completed to ensure staff are competent with their assigned duties. 4. Staff Development or designee will ensure all staff competencies are current	

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F 726	Continued From page 20 completed yearly and verified that an evaluation and competency testing had not been completed on CNA #3 since her hire date.	F 726	and up to date. All staff evaluations are to be completed by 6/13/18. HR or Designee will monitor monthly for 6 months to ensure competencies are completed on all staff. QA committee will be given monthly audits to ensure compliance.	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, manufacturers' guidance, and staff	F 761	1.Resident #16 insulin; physician orders has been updated to reflect current	6/13/18

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F 761	Continued From page 21 interview, the facility failed to ensure accurate labeling and storage of medications for 2 of 6 residents (Resident #16 and #40) observed during medication pass. Failure to correctly label insulin (Resident #16) and store an insulin pen (Resident #40) may increase the risk of residents receiving an inaccurate dose of medication and/or reduced medication efficacy. Findings include: Review of the facility policy titled "Medication - Change of Direction Stickers" occurred on 05/08/18. This policy, dated December 2015, stated, ". . . If the prescriber's directions for use change, the nurse may place a direction change, change of order-check chart or similar sticker on the container indicating there is a change in directions for use . . . When the sticker is applied the new order must be sent to the pharmacy so that it is correctly logged and dispensed with the next official refill. . . ." Review of the facility policy titled "Acquisition, Receiving, Dispensing and Storage of Medications" occurred on 05/08/18. This policy, revised September 2016, stated, ". . . All medications will be stored in accordance with manufacturers' recommendations. . . ." A manufacturers' guidance/patient information for NovoLog FlexPen, revised April 2015, stated, ". . . Store the FlexPen you are currently using out of the refrigerator below 86 F [degrees Fahrenheit] (30 C [Celsius]) for up to 28 days. . . ." - Observation on 05/08/18 at 9:20 a.m. showed the label on Resident #16's Lantus insulin box	F 761	order's. Resident # 40 insulin pen was moved to nurses medication cart once the insulin was opened. Insulin pens will not be placed back into fridge once opened per manufractures guidelines. 2. All resident that recieve insulin have the potentional of being affected. 3. All nurses will be re-educated on 6/7/18 for proper storage and labeling of insulin. Nursing staff will be trained on ensuring proper medication administrator policy and procedure are being followed. Nurses will make sure they are following the 5 rights while giving medications (Right dose, right route, right patient, right time, and right drug). 4. DNS or designee will audit daily for 2 weeks if there is no issue we will continue to audit bi-weekly for 3 months to ensure proper storage and labeling of insulin. Audits will continue on a monthly bases for 3 months to ensure compliance. QA committee will monitor audits during QA meeting to ensure compliance.	

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F 761	Continued From page 22 identified Lantus insulin 45 units every day. A staff nurse (#4) administered Lantus 42 units before breakfast. During the observation the staff nurse (#4) agreed the label did not match the current physician's order. Review of Resident #16's physician orders showed the physician changed the Lantus insulin dosage from 45 units to 42 units on 03/23/18, 47 days prior to the 05/08/18 observation. The facility failed to ensure the label on the box containing the Lantus insulin vial reflected the current physician's order. - Observation on 05/08/18 at 9:28 a.m. showed a staff nurse (#4) obtained an opened NovoLog insulin pen from the medication refrigerator and administered 7 units to Resident #40. The nurse (#4) returned the insulin pen to the refrigerator. The nurse (#4) verified the used insulin pen had been stored in the refrigerator. During an interview on the afternoon of 05/08/18 an administrative staff member (#2) verified used insulin pens were stored in the refrigerator.	F 761		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control	F 880		6/13/18

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F 880	Continued From page 23 program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable	F 880		

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 _____	05/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 24 disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation and review of facility policy, the facility failed to follow infection control practices for 2 of 4 observations of staff providing care and services to residents. Failure to practice infection control during meal service, and hand hygiene with resident cares (Resident #11) has the potential for transmission of communicable disease and infections to residents and staff. Findings include: Review of the facility policy titled "Hand Hygiene and Handwashing" occurred on 05/09/18. This policy, revised January 2018 stated, " . . . If hands are not visibly soiled or contaminated with blood or body fluids, use an alcohol-based hand rub for routinely cleaning hands: . . . After touching equipment or furniture near the	F 880	1. All staff will be educated on the infection control practices with a resident that has C-Diff to ensure they are being followed correctly. Dietary Staff was educated immediately over proper food handling to ensure proper serving utensils are being used. 2. All resident have the potential of being affected. 3. All staff will be educated on 6/7/18 over policy and procedure for contact precautions including C-Diff and infection control practices on food handling. 4.Infection Preventionist or designee Will audit twice a week for 3 months to ensure	

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F 880	Continued From page 25 resident/patient. . . . Food Service: The goal is to protect all residents from foodborne illness by never touching their food with bare hands or contaminated gloves. . . . Use a barrier such as deli paper, knife and fork, or tongs when ready-to-eat food needs setup . . . Do not wear gloves routinely during meal delivery or setup. . . ." Review of the facility policy titled "Contact Precautions" occurred on 05/09/18. This policy, revised January 2017, stated, ". . . Change gloves and wash hands after contact with material that could contain high concentrations of microorganisms. Avoid touching potentially contaminated surfaces or items after gloves are removed and hands are washed. . . ." Review of Resident #11's medical record occurred on all days of survey and identified a diagnosis of enterocolitis due to clostridium difficile (C-Diff). The current care plan stated, . . . The resident has C Difficile . . . Provide private room and use contact precautions. . . ." The Physician orders identified "Vancomycin HCl Capsule 125 MG [milligrams] , Give 1 capsule by mouth four times a day for C-Diff. for 10 Days until finished . . . " Dates of medication administration identified as 04/30/2018 through 5/10/2018. Observation on 05/07/18 at 1:19 p.m. showed Resident #11's room door with a sign for "Contact Precautions." Observation showed two certified nurse assistants (CNAs) (#8 and #9) entered the resident's room and donned gowns, masks, and gloves. The CNAs assisted the resident to the toilet, removed the soiled incontinent brief,	F 880	proper procedure for contact precautions are being followed. If no issues audit will be completed monthly for 3 months. Dietary or designee will audit weekly for three months to ensure proper utensils are being used while serving food. If no issue audit will continue monthly for 3 months. Audits will be given to QA committee. QA committee will monitor compliance.	

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F 880	Continued From page 26 provided perineal cares, and transferred the resident back to the wheelchair. The CNAs (#8 and #9) removed their gowns, masks, and gloves. One CNA (#9) applied Resident #11's foot rests to his wheelchair and failed to wash her hands before leaving the resident's room as per facility policy. - Observation on 05/06/18 12:15 pm. identified a facility cook (#10) dished up residents' dinner trays with gloves on. The cook (#10) touched multiple surfaces with the gloved hands, then using the same gloved hands, picked up buns and placed them on the resident trays.	F 880		