STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355033	A. BUILDING _____ B. WING _____	06/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CATHERINES LIVING CENTER	1307 N 7TH ST WAHPETON, ND 58075

(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 06/01/15 and completed on 06/03/15, the sample included four (4) residents for complete review, 10 residents for focused review, and three (3) closed records for review. The sample included eight (8) additional residents to verify specific concerns during the survey.	F 000		
F 156 SS=B	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.	F 156		7/8/15

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

Electronically Signed | 06/26/2015

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F 156	Continued From page 1 The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.	F 156		

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F 156	Continued From page 2 The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 06/16/14. Based on review of the facility's Medicare billing notices, Medicare billing records, and staff interview, the facility failed to confirm whether a resident or their responsible party requested a demand bill for 1 of 3 residents (Resident #25) issued a notice of non-coverage of Medicare services. Failure to confirm a resident or their responsible party requested a demand bill is a violation of resident rights. Findings include: Review of the facility's Medicare billing records occurred on 06/02/15 and showed the facility mailed Resident #25's responsible party the notice of non-coverage of Medicare services and the request for a demand bill for services ending on 02/25/15. The resident's responsible party signed the notice and returned it to the facility but failed to identify, by checking a box, whether they	F 156	1. The Notice of Medicare non-covered days and the SNF Determination of Continued Stay was issued to a resident¿s #25 family member (POA) after resident presented to the hospital and chose to hold their SNF bed. Residents POA signed the form but forgot to check whether or not they were going to accept the decision or deny. The SNF Determination of Continued Stay will be re-issued to the POA for `completion¿ of the form and will be verified that it is correct once returned to facility. 2. Every resident that is transferred from the facility and chooses to hold their bed, will be issued the necessary forms in order to stay in compliance; Notice of Medicare Non-Covered Days and the SNF Determination of Continued Stay. All forms will be returned and the Business Office will assure they are completed in their entirety. 3. The current policy for Medicare	

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F 156	Continued From page 3 requested a demand bill. During an interview on the afternoon of 06/02/15, an office manager (#11) stated the facility should have confirmed whether the responsible party wanted Resident #25's bill for services submitted for review.	F 156	Beneficiary Notices reviewed by the Business Office Manager. All business office staff will be educated regarding the policy on Medicare Beneficiary Notices. Procedure will be implemented immediately to ensure that all required notices are issued to the resident and/or resident family member and that all forms are returned and filled out in their entirety. 4. July 8, 2015 5. Audits will be completed initially by the Business Office Manager and/or delegate to assure all residents and/or representatives who have Medicare Part A services ended and remain in the facility will receive a SNF Determination on Continued Stay form (Medicare denial notice including the option to request a demand bill) and all required notices are returned and filled out in their entirety. Audits will then be completed weekly for the first month and then monthly for one year. Results of monitoring will be reported to the QA Committee at each scheduled meeting (at least quarterly). The Business Office Manager will follow up on further education/training on an as needed basis.	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property;	F 225		7/8/15

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F 225	Continued From page 4 and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 06/16/14. Based on observation, record review, review of facility policy, and staff interview, the facility failed to implement policies regarding abuse/neglect for 2 of 2 sampled residents (Resident #1 and #5)	F 225	1. The licensed nurses will complete an event to include the investigation of injuries of unknown origin for Resident #1 (occurrence 3/16/15) and Resident #5 (occurrence 6/02/15). 2. The licensed nurses will initiate an event on all injuries of unknown origin	

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F 225	Continued From page 5 identified with bruises of unknown origin. Failure to implement the facility's written abuse prevention policies and procedures and ensure a thorough investigation of injuries of unknown origin placed these residents and all other residents at risk for abuse and mistreatment. Findings include: Review of the facility policy titled "ABUSE PREVENTION PLAN" occurred on 06/03/15. This undated policy stated, "Definitions . . . "Injuries of unknown source": An injury should be classified as an "injury of unknown source" when both of the following conditions are met: (1) The source of the injury was not observed by any person or the source of the injury could not be explained; and (2) The injury is suspicious because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidence of injuries over time. . . ." Review of the facility policy titled "ACCIDENT/INCIDENT OCCURRENCE" occurred on 07/03/15. This policy, dated 2002, stated, "STANDARD: Appropriate interventions are initiated and an Event [incident report] is completed for: 1. All unexplained bruises or abrasions . . . POLICY: 1. Licensed nursing personnel are responsible for: . . . D. Initiation/completion of an Event, and follow-up investigation as appropriate for each resident involved. . . . 3. All Events will be reviewed for any involvement of medical device which might be a contributing factor of the incident. . . . 4. Events will be tracked and trends analyzed through	F 225	upon occurrence of injury to assure an investigation can be completed in a timely manner to prevent abuse and mistreatment to all residents. Nursing Administration will investigate all incidents of unknown origin to follow up with possible suspected abuse allegation and reporting process. 3. The current Abuse Prevention Policy and the Abuse and Neglect Clinical Protocol Policy will be reviewed by the Director of Nursing to assure a thorough investigation of all injuries of unknown origin in a timely manner. All licensed nursing staff will be trained on the Abuse and Neglect Clinical Protocol Policy to thoroughly investigate all injuries as a potential incident of abuse allegation per Abuse Prevention Policy. All residents who have an injury of unknown origin will have an event completed at the time of occurrence or being noted by staff. The event will trigger message to nursing administration to assure completed investigation in a timely manner to prevent abuse and mistreatment to all residents. This training will be included in new nurse orientation. 4. July 8, 2015 5. Audits will be completed initially by nursing administration to ensure all licensed nurses complete an event and investigate all injuries of unknown origin thoroughly and timely to prevent abuse and mistreatment of all residents. Audits will then be completed weekly for one month, then monthly for one year. Results of monitoring will be reported to the QA Committee at each scheduled meeting (at	

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F 225	Continued From page 6 Quality Council to enhance and improve resident safety and abuse prevention programs. . . ." - Review of Resident #1's medical record occurred on all days of survey. Diagnoses included dementia. A progress note, dated 03/16/15 at 11:06 a.m., stated, "Noted lump and bruise to resident's head on left side. Resident has not had a recent fall. . . . Will continue to monitor." The record showed no further documentation regarding Resident #1's lump and bruise. During an interview on 06/03/15 at 3:45 p.m., an administrative nurse (#12) stated she would have expected the nurse to create an "Event Report" when she discovered the lump/bruise on Resident #1's head. An "Event Report" would have led to an investigation into the possible cause of the lump/bruise. - Review of Resident #5's medical record occurred on all days of survey. Diagnoses included dementia. The resident's quarterly MDS, dated 03/18/15, identified long and short term memory problems, extensive assistance of two or more staff members for bed mobility and transfers and total assist of 2 or more staff for toilet use and personal hygiene. Observation on 06/02/15 at 1:45 p.m., showed two CNAs (#14 and #7) provided perineal care for Resident #5. Observation showed light purple brownish marks on the resident's right and left inner lower extremities. The CNA (#7) stated the marks could be hand marks from pulling her legs apart to provide care. Observation on 06/02/15 at 2:45 p.m. showed two CNAs repositioned Resident #5. The CNA (#16)	F 225	least quarterly). Administrative nursing staff will follow up on further education/training on an as needed basis.	

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F 225	Continued From page 7 stated Resident #5's marks on her legs have been there for a while, and that her legs are difficult to get apart when providing care. During an interview on 06/02/15 at 3:00 p.m., a licensed nurse (#15) stated she was not aware of the marks/bruises on Resident #5's lower legs. During an interview 06/02/15 at 3:30 p.m. a nurse manager (#5) stated there is a event report for Resident #5's bruises. A skin integrity "Event Report" created on 06/02/2015 at 3:20 p.m., (10 minutes before the interview) stated,". . . There are four separate bruises noted to left lower extremity; left ankle: light purple, measuring 1 1/2 X 1 1/2cm; most distal to knee on shin measuring 4x8, just above that bruise 2 1/2cm, just above that a bruise measuring 2cm x 3cm and to left knee measuring 1 1/2 x 1cm. Bruises are light green in color. . . .Bruising may be related to having been wheeled around in facility on 5/31 per sister . . ." Resident #5's medical record lack documentation of the bruises. The facility staff failed to report the bruises therefore an "Event Report" and an investigation was not completed in a timely manner.	F 225		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced	F 241		7/8/15

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F 241	Continued From page 8 by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 06/16/14. Based on observation, facility policy review, resident interview and staff interview, the facility failed to provide care for 2 of 14 sampled residents (Resident #1, and #3) and for 3 supplemental residents (Resident #20, #22, and #26) in a manner and environment that maintained, enhanced, and respected each resident's dignity and individuality. Failure to ensure care and services provided in a respectful manner for Resident #3 and failure to ensure dignity during meal time assistance for Resident #22 and #26, and failure to ensure privacy during medication administration for Resident #1 and #20, did not recognize the residents' individuality or provide care in a dignified manner. Findings include: Review of facility policy "Assistance with Meals" occurred on 06/03/15. The policy, dated 09/2013, stated: "Residents shall receive assistance with meals in a manner that meets the individual needs of each resident. . . . Facility Staff will . . . help residents who require assistance with eating. c. Residents who cannot feed themselves will be fed with attention to safety, comfort and dignity, for example: . . . (2) Keeping interactions with other staff to a minimum while assisting residents with meals . . ." Review of facility policy "Quality of Life-Dignity" occurred on 06/03/15. The policy, dated 08/2009, stated, "Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality. . . .	F 241	1. All staff will provide care in a manner and environment that maintains, enhances, and respects each resident¿s dignity and individuality. Care and services will be provided in a respectful manner for Resident #3, with meal time assistance for Resident #22 and #26, and privacy during administration of nursing treatment for Resident #1 and #20. 2. All staff will provide care in a manner and environment that maintains, enhances, and respects each resident¿s dignity and individuality. All residents will receive care and services in a respectful manner, and with meal time assistance and no medical treatments will be completed in any common areas; privacy of the resident will be promoted and maintained. 3. Meal/Fluid Assistance Policy and Quality of Life-Dignity Policy will be reviewed by the Director of Nursing. All staff will be trained on the Meal/Fluid Assistance Policy and the Quality of Life-Dignity Policy and Communication Techniques (this training will be included in new employee orientation). The Meal/Fluid Assistance Policy and the Quality of Life-Dignity Policy will be followed by all staff to ensure all residents received care and services in a manner and environment that maintains, enhances, and respects each resident¿s dignity and individuality with interactions, meal time assistance, and privacy during any medical treatment. 4. July 8, 2015 5. Audits will be completed initially by	

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F 241	Continued From page 9 1. Residents shall be treated with dignity and respect at all times. 2. 'Treated with dignity' means the resident will be assisted in maintaining and enhancing his or her self-esteem and self-worth. . . . 7. Staff shall speak respectfully to residents at all times . . . 10. Staff shall promote, maintain and protect resident privacy . . . 11. Demeaning practices and standards of care that compromise dignity are prohibited. Staff shall promote dignity and assist residents as needed . . ." - During observation of meal service for the breakfast meal on the morning of 06/02/15, starting at 8:05 a.m., observation showed three to four staff members seated at a table with five residents to provide assistance or cues and prompts. The following occurred: * A certified nursing assistant (#20) provided feeding assistance for Resident #22. The CNA, using a spoon, scraped food off the resident's face over 10 times and re-fed it to the resident. At times, rather than wiping just the mouth area, the CNA used a hand towel and wiped the entire face of Resident #22 after each spoonful of food. In addition, observation showed the CNA (#20) wiped over the resident's face with a napkin five times after a spoonful of food. The CNA fed Resident #22 on her right side while also assisting Resident #26 on her left side. While feeding Resident #26, the CNA presented some of the (cut) food items into the resident's mouth with the fork tines backwards from normal presentation. * Three CNAs (#18, #19, and #20) talked amongst themselves about eating steak and how they personally liked their steak prepared.	F 241	departmental managers and online staff (culinary staff, Pastoral Care, Activity Staff, licensed social workers, and licensed nurses) as designated to ensure staff provides care in a manner that maintains, enhances, and respects each resident¿s dignity and individuality with interactions, meal time assistance, and privacy during any medical treatment. Audits will then be completed weekly for one month, then monthly for one year. Results of monitoring will be reported to the QA Committee at each scheduled meeting (at least quarterly). The Departmental Supervisor will follow up on further education/training on an as needed basis.	

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F 241	Continued From page 10 Observation and record review showed Resident #3 on a mechanical soft/ground textured diet. One of the CNAs (#19), while facing and directing the conversation toward Resident #3, asked the resident how she liked her steak and before awaiting a response from the resident stated "that's right you don't eat steak." Resident #3 stared forward, nodded her head, and did not make any comment. * Two CNAs (#19 and #20), in the presence of the residents, talked about other resident's personal cares. - Observation on 06/02/15 at 9:10 a.m. showed Resident #1 seated at the dining room table with two other residents. The nurse (#13) obtained Resident #1's eye drops and administered them in the dining room. The nurse failed to offer privacy during the administration. - Observation on the morning of 06/02/15, showed a licensed nurse (#2) administered Resident #20's inhaler at the dining room table. Two other residents were present at the table.	F 241		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of	F 278		7/8/15

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F 278	Continued From page 11 that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly 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 an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 06/16/14. Based on record review and review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual (Version 3.0), the facility failed to ensure the Minimum Data Set (MDS) accurately reflected the resident status for 2 of 2 sampled residents (Resident #6 and #8) coded incorrectly on the MDS. Failure to code the MDS correctly does not provide an accurate assessment of the resident's current status and needs and may prevent staff from developing an effective comprehensive care plan that meets their needs. Findings include: The Long-Term Care Facility RAI User's Manual Version 3.0, October 2014, stated the following:	F 278	1. The MDS nurses and licensed social workers will complete Minimum Data Set (MDS) assessments accurately to reflect the resident¿s status regarding the coding of delusions for Resident #6 and #8. 2. The MDS nurses and licensed social workers will complete MDS assessments accurately to reflect the resident¿s status regarding coding of delusions for all residents. 3. The Long-Term Care Facility RAI User¿s Manual (Version 3.0), October 2013 and the ND Department of Health, Division of Health Facilities-MDS 3.0 Answers to Questions update regarding Hallucinations and Delusions (06/26/2014) will be followed by all facility staff completing the coding of delusions on the MDS. All MDS staff completing the coding of delusions will be trained on the	

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F 278	Continued From page 12 * Page E-2 and E-3, "E0100: Potential Indicators of Psychosis . . . Coding Instructions . . . Code based on behaviors observed and/or thoughts expressed in the last 7 days rather than the presence of a medical diagnosis. Check all that apply. . . . Check E0100B, delusions: if delusions were present in the last 7 days. A delusion is a fixed, false belief not shared by others that the resident holds true even in the face of evidence to the contrary. . . . Coding Tips and Special Populations . . . If a belief cannot be objectively shown to be false, or it is not possible to determine whether it is false, do not code it as a delusion. . . . If a resident expresses a false belief but easily accepts a reasonable alternative explanation, do not code it as a delusion. If the resident continues to insist that the belief is correct despite an explanation or direct evidence to the contrary, code as a delusion." Review of Resident #8's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease and dementia. The quarterly MDS, dated 05/09/15, identified long and short term memory problems and delusions during the seven day assessment period. Resident #8's progress notes, dated 05/08/15, stated the following: *Nursing at 1:36 p.m. - "MOOD: Resident a little teary eyed . . . She was delusional during conversation as she stated that her father and brother had died and on the same day but she wasn't sure what happened to them. She then stated her father and mother died and she saw them in their caskets. When asked how old they were she said they died at about her age, which is old. She was able to tell me she was ninety something, she is 91 . . ."	F 278	updated state guidelines of 06/26/14 regarding Hallucinations and Delusions and to follow the LTC Facility RAI User¿s Manual. 4. July 8, 2015 5. Audits will be completed initially by the social workers to ensure that all of the MDS assessments are coded accurately regarding delusions. Audits will be then completed weekly for one month and then monthly for one year. Results of monitoring will be reported to the QA Committee at each scheduled meeting (at least quarterly). The MDS Nurse and/or social worker will follow up on further education/training on an as needed basis.	

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F 278	Continued From page 13 *Social Services at 3:16 p.m. - ". . . She became tearful when she make delusional statements about her parents recently being killed but they have been deceased for awhile now . . ." * Pastoral Care at 5:02 p.m. - ". . . Resident began by saying 'My Dad died.' Encouraged resident to talk about resident's Dad; . . ." The above progress notes failed to show a behavior of delusions including staff trying to clarify a false belief. - Review of Resident #6's medical record occurred on all days of survey. Diagnoses included dementia. The resident's annual MDS, dated 12/20/14, identified severely impaired cognitive skills and delusions during the seven day assessment period. Resident #6's nursing progress notes stated, 12/17/14 - 3:53 p.m. "[Resident's name] is alert, she is often confused and looks for her husband or thinks her daughters are young and need her attention. . . . Her behaviors are resisting cares and her wandering looking for family. . ." The above progress note failed to show a behavior of delusions including staff trying to clarify a false belief.	F 278		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable	F 279		7/8/15

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F 279	Continued From page 14 objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review, and staff interview, the facility failed to develop a comprehensive care plan for 3 of 14 sampled residents (Resident #1, #3 and #13) that included measurable objectives and interventions to meet the resident's medical and nursing needs related to moods (Resident #3), behaviors (Resident #1) and smoking (Resident #13). Failure to develop a comprehensive care plan based on resident specific needs does not allow staff to communicate care needs and ensure continuity of care for each resident. Findings include: - Review of Resident #3's record occurred on all days of survey. Diagnoses included dementia, cerebrovascular accident (CVA) with left sided paralysis, depressive disorder, anxiety state, and psychosis not otherwise specified (NOS).	F 279	1.The licensed social worker and/or licensed nurse will develop a comprehensive care plan for Resident #1, #3, and #13 that includes measurable objectives and interventions to meet the resident¿s medical and nursing needs related to moods (Resident #3), behaviors (Resident #1), urinary problems (Resident #1), and smoking (Resident #13). 2. The licensed social worker and/or licensed nurse will develop a comprehensive care plan for all residents that includes measurable objectives and interventions to meet the resident¿s medical and nursing needs related to moods, behaviors, urinary problems, and smoking as applies per resident. 3. The Comprehensive Care Plan Policy will be reviewed by the Director of Nursing. All staff responsible for completing the resident¿s individualized	

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F 279	Continued From page 15 A care conference progress note, dated 03/18/15, stated ". . . Resident is obsessed with trying to get a hold of her husband and will try and call him numerous times throughout the day even if she knows he is probably working. . . ." During interview on the afternoon of 06/03/15, an administrative staff member (#10) stated Resident #3 has a cell phone which is disconnected so she cannot call her husband on a frequent basis. The facility failed to complete a comprehensive plan of care to assess, develop appropriate interventions and evaluate the effective of interventions attempted. - Review of Resident #13's medical record occurred on 06/03/15. Diagnosis included CVA with left sided hemiparesis and use of tobacco disorder. An annual Minimum Data Set (MDS), dated 03/29/15, and a quarterly MDS, dated 06/27/14, identified the resident as cognitively intact. The "Mood State" care area assessment (CAA) dated 03/29/15 stated, ". . . triggered due to resident's mood score being greater then [sic] his previous assessment. Resident struggles with moods at times, particularly when approached about following smoking regulations in the facility. Resident can also be anxious, verbally abusive and demendning [sic] of staff at times. Staff will encourage resident to follow smoking rules and redirect inappropriate behaviors as needed. Staff will also allow time for resident to calm down when needed. . . ." The current care plan addressed the following problem, revised on 03/27/15, *"MOOD AND BEHAVIOR: . . . is seldom verbally	F 279	plan of care will be educated on the policy to ensure the care plans have measurable objectives and interventions to meet the medical and nursing needs of every resident as it applies related to moods, behaviors, urinary problems, and smoking. CAAs will be used as a guide of potential triggered areas for resident, plus specific individualized needs (such as smoking). All staff responsible for implementing the comprehensive care plan for all residents will be provided education by the Director of Nursing on the documentation of results of interventions for mood and/or behaviors and toileting plans in the resident¿s medical record. These interventions will include appropriate interactions with residents to minimize resident outbursts and behaviors. Revisions to all residents¿ plan of care will be communicated to the CNAs by updating the CNA group sheets and behavior/mood monitoring tracking tools. 4. July 8, 2015 5. Audits will be completed initially by the licensed social workers and/or licensed nurses to ensure all residents have a comprehensive care plan that includes measurable objectives and interventions to meet the resident¿s medical and nursing needs related to mood, behaviors, urinary problems, and smoking as applies per resident. Audits will be then completed monthly for one year. Results of monitoring will be reported to the QA Committee at each scheduled meeting (at least quarterly). The Administrator and/or Director of Nursing will follow up on	

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F 279	Continued From page 16 abusive. He is occasionally anxious and demanding of staff. He will yell at them to leave him alone . . . is a smoker and will at times smoke to [too] close to the outside doors." with an approach regarding the smoking as ". . . Give resident smoking policy and read it with him if he does not follow policy." The facility failed to develop interventions to address Resident #13's behaviors related to the smoking rules and develop, review and revise Resident #13's comprehensive plan of care. - Review of Resident #1's medical record occurred on all days of survey. Diagnoses included dementia, nonorganic psychosis, and persistent mental disorder. Medications included Zyprexa (antipsychotic) as needed for behavioral problems. Resident #1's admission MDS, dated 08/29/14, identified severely impaired cognition, behaviors impacting the resident and others one to three days during the assessment period, rejection of cares and wandering four to six days during the assessment period, occasionally incontinent of urine, and required extensive assistance for toilet use. Resident #1's care plan stated, "Problem: PSYCHOTROPIC: Resident receives psychotropic medications r/t [related to] dx [diagnosis] of Dementia, Depressive disorder . . . Approach: . . . Refer to behavior plan of care . . . Problem: ADL [Activities of Daily Living] FUNCTION: . . . Toileting: See urinary plan of care . . ." Resident #1's care plan failed to include a plan for behaviors and urinary problems until the afternoon of 06/02/15.	F 279	further education/training on an as needed basis.	

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F 279	Continued From page 17 During an interview on 06/03/15 at 3:45 p.m., an administrative nurse (#12) stated the behavior and urinary plan of care must have been overlooked.	F 279		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to provide care in accordance with facility policy for 2 of 6 sampled residents (Resident #10 and #11) who experienced a fall with head injury. Failure to complete neurological assessments following a fall has the potential for a head injury to go undetected. Findings include: Review of the facility policy titled "Neurological Checkpoint Assessment Guidelines" occurred on 06/02/15. This policy, dated 08/13/13, stated, "Purpose: Monitoring neurological checkpoints will aid in recognizing changes in level of consciousness. . . . Procedure For Neurological Assessment Form . . . 2. Record the result in the Neurological Observation in Matrix. Attach vital signs to observation. 3. Record the details of the assessment in the Nurses Notes. . . . Frequency as listed below, unless physician directs otherwise: Initial Neurological Assessment and 3 additional sets every 15 minutes for a total of 4	F 281	1. Resident #10 and #11 will have neurological assessments completed following a fall that has the potential for a head injury to go undetected. 2. All residents will have neurological assessments completed following a fall that has the potential for a head injury to go undetected. 3. The Director of Nursing will review the Neurological Assessment Guidelines Policy. All licensed nursing staff will be educated on the facility policy on Neurological Assessment Guidelines. The licensed nursing staff will assure all residents who experience a fall with a potential for head injury will have neurological assessments completed per the policy. 4. July 8, 2015 5. Audits will be completed initially by nursing administration to ensure all licensed nurses complete neurological assessments on all residents following a fall that has the potential for a head injury.	7/8/15

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F 281	Continued From page 18 sets. Then every hour times 4. Then every 4 hours times 4. . . ." - Review of Resident #10's medical record occurred June 1-3, 2015. The progress notes for Resident #10 identified the following: * 01/20/15 at 3:30 p.m., "Fall: . . . resident is on floor . . . Staff state that he did not hit his head . . ." * 01/20/15 at 4:30 p.m., "Staff came to notify nurse that there is a red slightly blue, raised, and tender to touch area to right upper temple that was not present post fall. Neuro [neurological] checks implemented. . . ." * 01/20/15 at 8:43 p.m., "Neerological [sic] checks done per facility policy. WNL [within normal limits] for resident. pupils 2 mm [millimeter], brisk, generalized weakness, but equal to both sides. Resident received tylenol 650 mg [milligrams] at 1430 [2:30 p.m.] and 1830 [6:30 p.m.] for pain. Resident is lethargic, did fall asleep during supper. Will continue to monitor." * 01/21/15 at 5:29 a.m., "Neuro checks done as ordered, WNL, acting per usual self." * 01/21/15 at 11:02 a.m., "[Medical Practitioner] here on rounds . . . Verbal order to discontinue Neuro checks. This writer evaluated bruise to forehead; noted 5 cm [centimeter] [by] 5 cm to right forehead near hairline; light purple in color. . . ." Review of the flow sheet "Other Clinical Assessments -- Neurological Checks," For Resident #10 showed a nurse completed a neurological assessment on 01/21/15 at 9:30 a.m., 17 hours after the staff noted the head injury. Staff failed to complete and document 11 of 12 neurological assessments as per facility policy once staff identified the head injury	F 281	Audits will then be completed monthly for one year. Results of monitoring will be reported to the QA Committee at each scheduled meeting (at least quarterly). Administrative nursing staff will follow up on further education/training on an as needed basis.	

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F 281	Continued From page 19 experienced by Resident #10. - Review of Resident #11's medical record occurred 06/03/15. The progress notes for Resident #11 identified the following: * 04/26/15 at 5:33 a.m., "Found on floor sitting up on her buttocks against the side of her bed with her back against the bed. Stated that she had slipped while trying to get up from the bed to her W/C [wheelchair], . . . stated did not hit her head initial neuro check WNL, . . ." * 04/26/15 at 5:38 a.m., "Scheduled neuro checks done per policy WNL." * 04/28/15 at 7:14 a.m., "Neuro checks within normal limits." Review of the flow sheets "Other Clinical Assessments -- Neurological Checks," showed a nurse completed neurological checks as follows: * 04/26/15 at 7:37 a.m., two hours after the fall. * 04/26/15 at 1:24 p.m., almost eight hours after the fall. * 04/26/15 at 3:31 p.m., almost 10 hours after the fall. A nurse also completed another set but failed to identify the date and time completed. * 04/27/15 at 7:29 a.m., almost 24 hours after the fall. Staff failed to complete and document 11 of 12 neurological assessments as per facility policy following an unwitnessed fall experienced by Resident #11. During an interview on 06/03/15 at 2:10 p.m., an administrative staff member (#5) confirmed nursing staff failed to perform neuro checks as per facility policy.	F 281		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309		7/8/15

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F 309	Continued From page 20 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, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: DEMENTIA WITH BEHAVIORS 1. Based on record review, review of facility policy, and staff interview, the facility failed to provide the necessary care and services to manage behavioral and psychological symptoms of dementia (BPSD) for 3 of 9 sampled residents (Residents #1, #3, and #4) identified with behaviors and receiving scheduled or as needed (PRN) medications. Failure to thoroughly assess the residents' behaviors, implement individualized interventions, including non-pharmacological interventions, and establish on-going monitoring of the behaviors may result in decreased physical, mental, and psychosocial well-being and may negatively impact the residents' quality of life. Findings include: Review of information provided by the facility addressed "Evidenced Based Behavior Symptoms of Dementia" occurred on 06/03/15. The information, undated, stated/included an algorithm to define behaviors as "Is behavior a danger to self or others? Is behavior disturbing?" and if not, to "Optimize environmental, behavioral	F 309	1.Residents #1, #3 and #4 will have a thorough assessment completed for behaviors, implement individualized interventions, including non-pharmacological interventions, and establish on-going monitoring of the behaviors by the licensed social worker. Resident #10 will be proper positioned prior to providing liquids to prevent aspiration. 2.All residents who have dementia with behaviors will have a thorough assessment completed for behaviors, implement individualized interventions, including non-pharmacological interventions, and establish on-going monitoring of the behaviors by the licensed social worker. All residents will be properly positioned prior to providing liquids to prevent aspiration. 3.The Director of Nursing will educate the social services department and licensed nurses on the Algorithm for Treating Behavioral and Psychological Symptoms of Dementia. The licensed social workers and licensed nurses will utilize the Algorithm for Treating Behavioral and	

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F 309	Continued From page 21 & non-pharmacologic interventions." The information described conditions including "Delirium: . . . is common among elderly persons. . . . is characterized by fluctuating periods of confusion vs [verses] continual confusion. Whenever an elderly person with dementia has behavioral and/or mental status changes, it is important to assess for delirium superimposed on the dementia. This [is] due to various causes ie. [what is], medication, exacerbation of chronic illiness [sic], urinary tract infection, pain, fall. . . . it is important to differentiate delirium from the dementia, determine the precipitating factor or factors and then to institute proper treatment. . . ." and defined: "Validation Therapy . . . The key is to acknowledge the importance or reality of what the person is saying to them, without disagreeing, arguing, or presenting a reality that . . . cannot grasp. . . . This type of response can be calming and allows the person to talk about feelings and their reality. . . ." - Review of Resident #3's record occurred on all days of survey. Diagnoses included dementia, cerebrovascular accident (CVA) with left sided paralysis, depressive disorder, anxiety state, and psychosis not otherwise specified (NOS). Review of Minimum Data Sets (MDSs), an annual dated 03/11/15 and quarterly dated, 12/11/14 and 06/11/14, identified Resident #3 with no behavioral symptoms, and no rejection of care. The 12/11/14 and 03/11/15 MDSs identified the resident with moderately impaired cognitively, and the 06/11/14 MDS identified the resident as cognitively intact. Review of the annual/comprehensive MDS,dated 03/11/15, showed behaviors did not trigger,	F 309	Psychological Symptoms of Dementia Resource on all residents with dementia that have behaviors to identify, assess and treat contributing factors of behaviors (antecedents), select and apply non-pharmacological interventions, and monitor outcomes and adjust course of interventions as needed. Director of Nursing will educate all licensed nurses and certified nursing assistance on Meal/Fluid Assistance Policy for residents to be properly positioned prior to assisting with fluids to prevent aspiration. 4.July 8, 2015 5.Audits will be completed initially by the social service department to ensure all residents who have dementia and behaviors have a thorough assessment completed for behaviors, implement individualized interventions, including non-pharmacological interventions, and establish on-going monitoring of the residents with behaviors. Audits will be completed initially by the licensed nurses to ensure all residents are properly positioned prior to provide liquids to prevent aspiration. Both audits will then be completed monthly for one year. Results of monitoring will be reported to the QA Committee at each scheduled meeting (at least quarterly). The licensed social worker and/or licensed nurses will follow up on further education/training on an as needed basis.	

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therefore no assessment occurred for behaviors. The "psychotropic medication use" care area assessment (CAA) stated to "Refer to diagnosis listing" for supporting documentation, and stated, "Res [resident] has had bizarre behavior to include increased confusion, accusing staff of stealing from her, asking staff for their belongings and making up lies and fabricating stories. She is receiving antipsychotic medication for this. . . . Res meds [medication] are appropriate at this time . . ." The "mood state" CAA stated ". . . triggered due to resident scoring in the 10-27 range on her Miood [sic] Assessment as she struggles with her moods. Staff will monitor resident's mood for safety and they will encourage resident to expfress [sic] her feeling in a [sic] an apporiate [sic] manner. . . ."

Review of "Behavior Analysis" documentation between 03/01/15 and 06/03/15 identified one rejection of care behavior and two "Other behaviors." The corresponding progress notes showed the "Other behavior" on 03/26/15 occurred during the night while the resident was having cold symptoms; and two entries on 05/20/15 lacked evidence of any behaviors.

Review of Resident #3's current care plan identified the following problems:
* "PSYCHOTROPIC: Resident receives psychotropic medications r/t [related to] dx [diagnosis] of CVA, depressive disorder, personality change, d/t [due to] CCE (psychosis - secondary to CVA), Anxiety, dementia and insomnia." with approaches including "Encourage resident to smile . . . Administer medications . . . AIMS [test for tardive dyskinesia) . . . Assess if the behavioral/mood symptoms present a danger to the resident and/or others. . . . Psychiatric

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services to follow as ordered/indicated. . . . Refer to behavior plan of care. . . ."
* "MOOD AND BEHAVIORAL SYMPTOMS: . . ." with approaches of "1) Resident will routinely evaluated per psychiatry and administer meds [medications] as ordered. 2) Assure basic needs are met, such as toileting, repositioning, hunger, etc. 3) Provide independent, in room supplies 4) refer to psych [psychiatric] care plan."
* "Resident experiences spasms, abnormal involuntary movements . . . risk for increased sx. [symptoms] tardive dyskinesia . . . secondary to use of antipsychotics and CVA." with an approach of "Administer medications as ordered. . . ."
* ". . . mood changes, cognitive deficits . . ." with approaches of "Administer medications as ordered . . . Provide the resident opportunities to make decisions . . . Respect resident's rights to make decision(s). . . ."
* "COGNITIVE STATUS . . . moderately impaired cognitive skills for daily decision making evidenced by her decisions regarding care, etc. being poor. . . ." with approaches of ". . . Respect resident's rights to make decision(s). 3) Encourage resident to self-evaluate decisions made. 4) Set expectations and limits . . . 7) Encourage resident to verbalize feeling and fears 8) Calm resident if signs of distress develops . . . 9) Structure daily programs around the physical aspects of the resident's life."

The care plan failed to identify specific non-pharmacological interventions other than encouraging the resident to smile and the utilization of antipsychotic medication and visits from the psychiatrist.

Review of Resident #3's the record showed current physician orders included Risperdal (an

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antipsychotic medication) one milligram (mg) once daily. The initial order for Risperdal occurred on 10/17/14 when the psychiatrist ordered Risperdal 0.125 mg at bedtime for a diagnosis of "atypical psychosis," major neuro cognitive disorder due to vascular disease with moderate behavioral disturbance. On 11/14/14, the psychiatrist documented the resident had chickenpox, delusions, confusion on the family member who died, and increased behaviors (not specified). The psychiatrist increased the dose of Risperdal on 11/14/14 to 0.25 mg, on 03/13/15 to 0.5 mg and on 04/17/15 increased the dose to one mg once daily.

Progress notes identified the following:
* 01/22/15: "BEHAVIORS: CNA [certified nursing assistant] staffing let RN [registered nurse] know that resident was placing inappropriate food items in drink glasses at lunch and making a mess. Then after lunch refused to have her pad changed and lay down. RN went to talk with [resident] and she called the staff 'liars'. She then wouldn't look at the RN and stated [derogatory comment] 'their [sic] are such liars.' RN stated that she would go and get the staff and we would confront the issues. CNA staff [two of them] me in [resident's room] where RN brought up [resident] placing inappropriate things in cup at lunch table and playing with food. [Resident] then stated, 'I wanted my grapes in my hot cocoa.' Then RN asked about her lying down. RN stated, that it is important to off load and change incontinent brief, because if she gets sores she will have to lay in bed longer. . . . [Resident] does have attention seeking behaviors even if they are negative behaviors. Her husband has not been visiting as often and she can't get a hold of him and when this happens her behaviors escalate. Will

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continue to monitor and when behaviors reported will have staff approach resident with charge nurse or RN and resolve issues."

* 03/13/15: ". . . Here for monthly psychiatric rounds. NEW ORDER: Increase Risperdal to 0.5 mg po [by mouth] daily. Resident states she is 'okay.' States her brother and sister just died (her brother didn't die and she did have a family member die before Christmas). She thinks the year is 1915 and when asked if she know who the President is she states, 'that black man that is a communist.' She says she doesn't sleep, however . . . resident does sleep and nap. Resident continues to have behaviors that consist of lying and or making up stories, asking other for belongings, accusing staff of stealing from her, spilling food. . . ." The record showed prior to the increase in the Risperdal on 03/13/15 the resident had symptoms of a urinary tract infection (UTI), including confusion, mumbled or slurred speech, difficulty of staff to understand her, strong urine odor, and frequency. On 03/16/15, the provider started Resident #3 an antibiotic for an UTI.

* 03/18/15: A care conference progress note stated ". . . Resident is obsessed with trying to get a hold of her husband and will try and call him numerous times throughout the day even if she knows he is probably working. She gets very upset and has negative behaviors when she is unable to talk to him. Resident is followed monthly by [psychiatrist] for mood/behaviors. . . ."

* 04/17/15: ". . . monthly psychiatric rounds. Resident continues to have bizarre behaviors. Noted to be stealing other resident's silverware at table and asking for juice when she has four full glasses. She has needed more assistance at

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F 309	Continued From page 26 meals. . . ." The facility failed to assess Resident #3's behaviors, develop and implement individualized interventions, including non-pharmacological interventions, and monitor/reassess the effectiveness of the interventions. The record identified an increased dose of Risperdal at a time when the resident was displaying symptoms of a UTI. - Review of Resident #4's record occurred on all days of survey. Diagnoses included dementia, Alzheimer's disease, depressive disorder and agitation. Review of MDSs, an annual, dated 08/22/14 and quarterly dated 05/25/15, identified Resident #4 with no behavioral symptoms (of physical, verbal or other), and no rejection of care. Review of the annual/comprehensive MDS showed "Mood State" and "Behavioral Symptoms" did not trigger, therefore no assessment occurred for either. The annual MDS did trigger for "Psychotropic Medication Use," and the CAA, dated 08/22/14, stated, ". . . resident receiving antipsychotic, antidepressant meds r/t [related to] agitation, hitting, yelling out, swearing secondary to major depressive disorder and dementia with behaviors, Alzheimer's, Atypical Psychosis. Refer to dx. [diagnosis] list. . . ." Review of "Behavior Analysis" documentation flow sheet from 03/01/15 to 06/03/15 included monitoring for verbal and physical abuse toward others, other behaviors and rejection of care. The documentation lacked the specific details of the behavior including what may have triggered the	F 309		

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F 309	Continued From page 27 behavior (precipitating factors). Review of Resident #4's current care plan identified the following problems: * "MOOD/BEHAVIORS; . . . has behaviors of being physically and verbally abusive, and rejection of care. He worries about his family . . . (. . . has dementia)" with approaches of "approach calmly. 2. offer reassurance . . . 3. offer food 4. meds as ordered 5. He enjoys visiting . . . 6. assist him to room . . ." * "PSYCHOTROPIC: Resident recieves [sic] . . . r/t increased anxiety, confusion, restlessness secondary to dx. of dementia with behavioral disturbance, Alzheimer's Disease, depressive disorder and nonorganic psychosis" with approaches of monitoring labs, notifying the provider of changes, administering medications, psychiatric services, gradual dose reductions (GDR) and pharmacy consultant review monthly." Review of the record showed current physician's orders included Zyprexa (antipsychotic medication) 2.5 mg once a day, ordered on 11/12/13. Progress notes identified the following: * 05/15/15: ". . . Here for monthly psychiatric nursing home rounds. . . ." The progress note lacked any evidence of behavioral or mood related behavior. * 04/17/15: ". . . monthly psychiatric rounds. No changes. . . . Mood is fairly stable. A few episodes of hollering out on nights. . . ." * 03/13/15: ". . . monthly psychiatric rounds. No changes in medications. . . . Does occasionally holler out or make comments about someone killing him. . . ."	F 309		

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The progress notes between March 2, 2015 and June 2, 2015 showed isolated incidents of the resident hollering out during the night, and one incident of the resident combative with a CNA during cares.

Failure to assess the reason/causative factor(s) for behaviors including identifying precipitating factors, and implement appropriate non-pharmacological interventions and establish accurate on-going monitoring may have resulted in the inappropriate utilization of anti-psychotic medication. The facility failed to identify the harm to the resident and others by the specific behaviors and identified, at times, staff responded inappropriately to resident behaviors.

- Review of Resident #1's medical record occurred on all days of survey. Diagnoses included dementia, depression, and atypical psychosis. Medications included Remeron (antidepressant) once a day,Risperdal twice a day, and Zyprexa (antipsychotic) as needed.

Resident #1's quarterly MDS, dated 05/24/15, identified wandering one to three days during the seven day assessment period. The admission MDS, dated 08/29/14, identified behaviors impacting herself and others occurred one to three days during the assessment period, and rejection of cares and wandering four to six days during the assessment period.

Resident #1's care plan stated, "Problem: . . . Resident receives psychotropic medications r/t [related to] dx [diagnosis of Dementia, Depressive disorder . . . Approach: . . . Administer medications: scheduled and PRN as ordered.

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Evaluate/record/report effectiveness . . . Assess if the behavioral/mood symptoms present a danger to the resident and/or others. Intervene as needed . . . Refer to behavior plan of care . . ." Resident #1's record failed to include a behavior plan of care until the afternoon of 06/02/15.

Review of the MARs and progress notes from March 01 to May 31, 2015 identified Resident #1 received PRN Zyprexa 27 times for increased agitation, restlessness, pacing, increased anxiety, and crying.

Resident #1's progress notes included the following reasons facility staff administered PRN Zyprexa:
*"Resident very needy this shift, pacing restlessly before supper up and down the halls. PRN Zyprexa given . . ."
*"Resident was very agitated early PM shift. Was very needy and pacing back and forth from the dining room to her room. Could not get resident to settle. PRN Zyprexa was given . . ."
*"Resident was very anxious prior to breckfast [sic]. Resident was pacing back and forth from dining to her room. PRN Zyprexa given . . ."
*"PRN Zyprexa given to resident at 1:30 for up [increased] anxiety and agitation . . ."
*"Resident has been wandering halls, walking while eating and drinking supper, lots of redirection to sit back down. PRN Zyprexa given at 6pm to curve agitation . . ."
*"Resident took water pitcher off the table and carried it down the hall and put in a w/c [wheelchair]. . . . pull at the doors on activity closet . . . Resident was given a PRN Zyprexa to help calm her down . . ."
*"Resident very agitated, started wrapping blankets around herself and walking down

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hallway (fall risk) . . . PRN Zyprexa . . ."
*"Resident wandering up and down hallways this day shift. Resident very needy, needing to be next to staff . . . PRN Zyprexa . . ."
*"Resident had PRN zyprexa for increased agitation. Resident wandering in and out of room . . ."
*"Zyprexa given for agitation and anxiety . . ."
*"Resident was very anxious . . . in staff area sifting though the drawers . . .Hard to re-direct then. PRN Zyprexa . . ."
*". . . Per family request resident was given a Zyprexa . . ."
*"Resident very needy . . . kept following staff up and down hallways and into other resident's rooms. Resident seemed very anxious and agitated . . . Resident given PRN Zyprexa . . ."
*"Resident has started pacing up and down hallways w/o [without] her walker. Trying to get out of locked SCU [special care unit] doors . . . PRN Zyprexa . . ."
*"Resident was given PRN Zyprexa at 2:20pm for agitation, pacing the hallway . . ."
*". . . Resident was starting to get really anxious and wandering. PRN Zyprexa given at 1300 [1:00 p.m.] for increased agitation . . ."

During an interview on 06/03/15 at 3:45 p.m., an administrative nurse (#12) stated nursing staff are expected to attempt and document non-pharmacological interventions before administering Zyprexa to Resident #1.

The facility failed to assess Resident #1's behaviors, develop and implement individualized interventions, including non-pharmacological interventions, and monitor/reassess the effectiveness of the interventions.
POSITIONING FOR FLUID INTAKE

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F 309	Continued From page 31 2. Based on observation, record review, and staff interview, the facility staff failed to ensure 1 of 1 sampled resident (#10) observed with sign/symptoms of aspiration received the care and services necessary to attain the highest degree of safety possible during cares. Failure to ensure residents are positioned properly prior to providing liquids resulted in Resident #10 coughing and placed the resident at an increased risk of aspiration. Findings include: - Review of Resident #10's medical record occurred on June 01-03, 2015. Diagnoses included Lewy body dementia. The resident's quarterly Minimum Data Set, dated 04/08/15, identified severely impaired cognitive skills and extensive assist of one person for eating. Observation of care for Resident #10 occurred on 06/02/15 at 1:00 p.m. Two certified nurse aides (CNAs) (#7 and #8) transferred Resident #10 to bed, and positioned him on his right side, with the head of the bed elevated to less then 30 degrees. The CNA (#8) gave Resident #10 a drink of water, he held the liquid in his mouth, the CNA (#8) offered him another drink the resident did not take. Resident #10 then swallowed the water given and immediately began to cough. During an interview on 06/03/15 at 2:10 p.m., an administrative staff member (#5) agreed staff failed to position Resident #10 properly when given a drink of water.	F 309		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER	F 315		7/8/15

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F 315	Continued From page 32 Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to ensure appropriate treatment and services to maintain urinary continence for 1 of 1 sampled resident (Resident #6) not toileted according to the care plan. Failure to toilet Resident #6 may have resulted in avoidable incontinence and a loss of dignity. Findings include: Review of Resident #6's medical record occurred on all days of survey. Diagnoses included dementia, and history of urinary track infection (UTI). Medications included Macrobid 100 milligrams every other day prophylactic for UTI. The resident's quarterly Minimum Data Set (MDS), dated 03/22/15, identified severely impaired cognition, extensive assistance of one person for toilet use and personal hygiene and frequently incontinent of urine. The current care plan stated, ". . . Urinary: Resident is continent of bowel has occasional bladder incontinence. At risk for UTI r/t [related to] hx [history] of UTI . . .	F 315	1.Resident #6 will have a urinary plan of care developed and will be toileted according to plan of care to avoid incontinence and a loss of dignity. 2.All residents who exhibit urinary incontinence will have plan of care developed to avoid incontinence and a loss of dignity and will be toileted according to plan of care. 3.All residents will have a plan of care developed by licensed nursing staff that exhibit urinary incontinence and trigger on the MDS for a urinary CAA. The CNA group sheets will then be updated to reflect all residents¿ toileting plans by the Nurse Managers. All nursing staff will be educated by the Director of Nursing on importance of following the urinary plan of care for all residents who are incontinent to avoid incontinence and a loss of dignity and following the plan of care. The updates to all residents¿ plan of care for toileting and updates to the CNA group sheets will be continued per resident MDS	

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F 315	Continued From page 33 Approach: Toileting: 1 assist every 1 hour and prn [as needed]; . . ." Observation on 06/02/15 showed the following: * 9:13 a.m. resident self toileted * 10:50 a.m. CNA toileted resident, resident continent * 12:35 p.m. resident refused toileting * 12:57 p.m. CNA toileted resident, resident incontinent * 3:15 p.m. CNA toileted resident, resident incontinent * 5: 00 p.m. CNA toileted resident The CNAs failed to toilet Resident #6 according to her care plan. During an interview on 06/03/15 at 3:45 p.m., a supervisory nurse (#5) stated she expected staff to toilet Resident #6 every 1 hour as per her care plan.	F 315	assessment schedule by the Nurse Managers. 4.July 8, 2015 5.Audits will be completed initially by the Nursing Managers to ensure all residents who trigger the MDS for a urinary CAA have a plan of care developed to avoid incontinence and a loss of dignity and the updates are then communicated to the CNAs via the CNA group sheets. Audits will also be completed initially by licensed nursing staff to ensure all residents who have a urinary plan of care are being assisted with toileting per their individualized plan of care. Both audits will then be completed monthly for the first quarter, then quarterly for one year. Results of monitoring will be reported to the QA Committee at each scheduled meeting (at least quarterly). The licensed nurses will follow up on further education/training on an as needed basis and report deviations to the Director of Nursing and/or Nurse Managers.	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 323		7/8/15

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F 323	Continued From page 34 FALLS 1. Based on record review, and review of facility policy, the facility failed to ensure adequate supervision to prevent accidents for 2 of 6 sampled residents (Resident #5, and #10) who experienced a fall from bed. Failure to clearly identify how staff are expected to provide bed mobility for a resident (Resident #10) and failure to monitor a resident as she sat on the edge of the bed (Resident #5), increased their risk for falls, pain, and potential injury. Findings include: - Review of Resident #10's medical record occurred on June 01-03, 2015. Diagnoses included Lewy body dementia. The resident's annual Minimum Data Set (MDS), dated 01/08/15, identified severely impaired cognition, total assistance of two persons for bed mobility, a height of 71 inches and a weight of 195 pounds. The facility "Daily Assignment Sheet," (used by certified nurse aides (CNAs) as a quick reference of the care plan), dated 01/20/15, identified the following regarding Resident #10: * "Toileting 1-2 assist Check and change q2h [every two hours] and PRN [as needed] purple brief" * "Transfers Hoyer w/ [with] two assist" * "Repositioning 1-2 assist Q2h [every two hours] The progress notes for Resident #10 identified the following: * 01/20/15 at 3:30 p.m., "FALL: Staff called to room by nurse aide, resident is on floor, staff was under his torso region. Staff state that they were	F 323	1.Resident #10 will have plan of care for safe bed mobility to prevent falls clearly identified on CNA group sheet by the Nurse Manager. Resident #10 will have plan of care for safety with bed mobility and supervision with transfers to prevent falls clearly identified on CNA group sheet by the Nurse Manager. Resident #13 will have an assessment completed and plan of care developed for smoking safely and per facility policy by the licensed social workers. 2.All residents who are at risk for fall from bed will have plan of care clearly identified on CNA group sheet to prevent accidents and falls from bed. All residents who smoke will have an assessment completed and plan of care developed for smoking safely and per facility policy by the licensed social workers. 3.The Nurse Managers will review and update all CNA group sheets to ensure all residents who are at risk for fall from bed will have plan of care clearly identified to prevent accidents and falls from bed. All licensed nurses will be responsible for updates to the CNA group sheets as changes occur for all residents. The CNA group sheets will be regularly reviewed and updated by the Nurse Managers monthly. All nursing departmental staff will be educated by the Director of Nursing on the importance of following all residents¿ plan of care and safety with bed mobility and positioning, transfers, and supervision needed to prevent falls and accidents. The administrator and social service department will review the Smoking Policy. The licensed social	

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F 323	Continued From page 35 doing his cares. When they rolled him to complete cares his upper body stiffened causing him to start to slide out of the bed. Aide was able to brace is body with her own as they lowered to floor, fall was cushioned by her body. Staff state that he did not hit his head, ROM [range of motion] intact, slight redness noted to his left elbow where he was lying on floor. Gotten up with four assist and Hoyer, placed back to bed, VS [vital signs] obtained. Will continue post fall monitoring." * 01/20/15 at 4:30 p.m., "Staff came to notify nurse that there is a red slightly blue, raised, and tender to touch area to right upper temple that was not present post fall. Neuro [neurological] checks implemented. . . ." Review of the facility investigation of Resident #10's fall showed one CNA assisted the resident at the time of the fall above. The MDS showed Resident #10 is tall, dependent for bed mobility and of significant weight for one person to move without assistance. Failure of the "Daily Assignment Sheet" to clearly define the amount of assistance Resident #10 required with bed mobility/toileting may have contributed to his fall from bed during cares that resulted in a head injury. - Review of Resident #5's medical record occurred on all days of survey. Diagnoses included dementia. The resident's quarterly MDS, dated 03/18/15, identified long and short term memory problems, extensive assistance of two or more persons for bed mobility and transfers and total assist of 2 or more persons for toilet use and personal hygiene.	F 323	workers will assess all residents who smoke for the ability to safely smoke without supervision and develop plan of care (referrals will be made as necessary). The licensed social workers will review assessments at least quarterly and prn to assure all residents who smoke have the ability to safely smoke without supervision and the plan of care remains updated to ensure the safety also of other residents and staff. 4.July 8, 2015 5.Audits will be completed initially by the licensed nurses to ensure adequate supervision to prevent accidents for all residents who are at risk for fall from bed with mobility, positioning in bed, and/or transfers. Random audits will then be completed on a minimum of ten residents who require assist with mobility, positioning in bed, and/or transfers monthly for the first two months, then quarterly for one year. The licensed nurses will follow up on further education/training on the safety of bed mobility, positioning residents in bed, and/or transfers on an as needed basis and report deviations to the Director of Nursing and/or Nurse Managers immediately. Audits will be completed initially by the licensed social worker to ensure all residents who smoke have an assessment completed and a plan of care developed to ensure the safety of the residents, other residents and staff per the smoking policy. Audits will then be completed monthly by the licensed social worker on residents who smoke to ensure safety measures continue to be followed	

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F 323	Continued From page 36 Resident #5's care plan stated, " . . . 11/13/2011 Problem: . . . Resident is limited to total dependence and 1-2 physical assist with ADL's [activities of daily living] . . . Bed mobility and Repositioning: 1-2 assist . . .transfer: Hoyer lift with assist of 2 . . ." Resident #5's nursing progress notes stated the following: * 12/21/14 11:18 a.m. "resident fell out of bed. She was sitting on side of bed and CNA walked away and resident fell. No noted injuries or bruising at this time. . . ." The facility investigation report stated, " . . . Occurrence Date/Time December 21, 2014 11:18 AM . . . Resident fell out of bed. Resident sat self up on edge of bed, CNA went to get help, and resident found on floor. No noted injuries or bruising at this time. . . .Employee counseled to use call light and not leave resident, or reposition resident first. . . ." RESIDENT SMOKING 2. Based on observation, review of facility policy, record review, and resident and staff interview, the facility failed to adequately assess 1 of 1 sampled resident (Resident #13) for the ability to safely smoke without supervision. This resulted in the failure to develop a plan consistent with an the assessment to ensure the facility and the resident followed with the facility policy. Findings include: Review of the "RESIDENT AND STAFF SMOKING POLICY" occurred on 06/03/15. The policy, dated 12/12, stated, "PURPOSE: To	F 323	per facility policy for one year. Results of all monitoring listed above will be reported to the QA Committee at each scheduled meeting (at least quarterly). The licensed social workers will follow up on further education/training/referrals on residents who smoke on an as needed basis and report deviations to the Administrator immediately.	

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ensure a safe and clean living/working environment for all residents and staff. . . . The current residents . . . effective December 6, 2012 will be . . . allowed to smoke in the central gazebo, which is the designated area which is 20 feet from the building. . . ."

On 06/02/15 at 9:15 a.m. observation showed Resident #13 propelling his wheelchair on a sidewalk in the courtyard and hollering profanity toward/within proximity of a staff member (#1).
On 06/02/15 at 9:20 a.m. a staff member (#1) stated:
* Resident #13 is "supposed" to smoke by the gazebo and lighted up a cigarette just outside the facility door. The staff member stated that when the resident doesn't smoke by the gazebo the cigarette smoke drifts into the building.
* Resident #13 is not allowed to go inside of the gazebo to smoke as other residents use the gazebo.
* Resident #13 will light the cigarette outside the facility door as he says he can't light it by the gazebo as it is too windy
* In the above incident she told the resident to smoke out by the gazebo.

Review of Resident #13's medical record occurred on 06/03/15. Diagnosis included cerbrovascular accident with left sided hemiparesis and use of tobacco disorder. An annual Minimum Data Set (MDS), dated 03/29/15, and a quarterly MDS, dated 06/27/14, identified the resident cognitively intact. The medical record lacked an assessment of Resident #13's capabilities to smoke safely without supervision.

The current care plan identified a problem of ". . .

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is a smoker and will at times smoke to [too] close to the outside doors" with an approach of ". . . Give resident smoking policy and read it with him if he does not follow policy" and regarding activities " . . . Smokes outdoors daily." with approaches including ". . . Assistance will be given as needed to/from areas of facility. . . ."

Progress notes stated the following:
* 01/06/15 at 2:39 p.m.; "Resident went out employee entrance door without a coat to smoke a cigarette . . ."
* 01/07/15 at 9:44 a.m.: "Resident has been told several times that he should not smoke . . . will not listen to staff" at 11:00 a.m.: "RN [registered nurse] stopped resident to tell him he can't smoke . . . He continued to argue . . . RN then also reminded him that he can't smoke out south service entry and needs to go to the North side to get out to gazebo. He mumbled something and wheeled away."
* 01/08/15 at 9:47 a.m.: "Resident found smoking right outside of employee entrance this a.m."
* 01/11/15 at 1:43 p.m.: "Resident has been outside smoking and has refused to put an coat on."
* 01/16/15 at 8:50 p.m.: "Resident continues to use the front doors to go out and smoke. . . ."
* 01/26/15 at 12:23 p.m.: ". . . He continues to smoke out front door, right outside the door. Does not always shut door after coming back in."
* 02/20/15 at 12:16 p.m.: "Due to resident being rude about cigarettes and demanding them from staff and not using please or thank you, staff and activities staff have decided that when cigarettes are bought he can have one pack at a time. When he runs out, he's out for the month. . . ."
* 03/27/15 at 9:22 a.m.: "SMOKING: Resident continues to not follow smoking rules per facility.

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He is often found smoking out side courtyard doors near venting system causing smoke to come back into RN office. He is told often that he needs to smoke in appropriate place near gazebo, but refuses to follow rules. . . ."
* 04/08/15 at 4:54 p.m. care conference; ". . . continuously doesn't follow smoking rules. . . ."
* 04/30/15 at 1:25 p.m.: "It was reported by activities staff that resident was outside of door smoking next to it, when he needs to be by gazebo as per smoking plan. When told resident needs to be by gazebo, became very verbally aggressive, swearing at activity staff and using very vulgar language. Called staff a [vulgar name]. Staff spoke to this resident and stated they were hurt by his words and didn't appreciate being talked to like this. Resident again became verbally aggressive basically stating the same thing as before and denying that he was even by the door. Will update SS [social services] as this behavior is not tolerated."
* 05/14/15 at 12:33 p.m.: "BEHAVIORS: Resident only has one cigarette left at this time. Given this cigarette and resident asked for two. Told resident that he does not have any left. Resident stated 'well can you call [name] and let her know.' Told resident I would do so when I got a minute. Resident rolled away and stated [foul words]. Told resident I will not tolerate language like that and he can not speak to me this way. Resident kept on eating."
* 05/18/15 at 8:56 a.m.: "Resident found smoking next to back door. Told resident he knows better than to smoke there. He moved away and stated, 'yeah, yeah yeah.'"
* 06/02/15 at 10:56 a.m.: "Resident became upset at activities person when she told him that he could not sit right outside the door and light his cigarette. Resident became very upset and

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F 323	Continued From page 40 started to swear and call activities person names. Resident is well aware that he can not do this and becomes upset when he is spoken to about this." On the afternoon of 06/03/15, an administrative staff member (#10) stated nursing staff cannot dictate when Resident #13 can have his cigarettes at "those are his cigarettes" and "it is his money." The staff member stated the facility did not complete a smoking assessment for Resident #13. The facility failed to complete a smoking assessment on Resident #13, develop a plan of care related to smoking based on the assessment, implement appropriate measures, and evaluate the effectiveness of those measures to ensure the safety of the resident, other residents and staff. The facility smoking policy stated smoking residents are "allowed to smoke in the central gazebo, which is the designated area which is 20 feet from the building. . . ." Facility staff have failed to follow the policy by not allowing Resident #13 to smoke in the gazebo.	F 323		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy review, review of professional reference, and staff interview, the facility failed to ensure residents were free of any significant medication errors during 1 of 1 observations of medications	F 333	1. Resident #13 will have injectable medication prepared by the licensed nurse following professional standards of care, including administering the proper dose, labeling of syringes and infection	7/8/15

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F 333	Continued From page 41 administration to Resident #13. Failure to prepare an injectable medication following professional standards of care, including administering the proper dose, and labeling each syringe may adversely affect a resident's quality of care and life. This resulted in the administration of the wrong dose of medication, and a potential break in sterility of the medication. Findings include: Review of the facility policy "Medication Administration" occurred on 06/03/15. The policy, dated 07/01/14, stated, "Purpose: 1. To assure [sic] that residents receive ordered medications . . . 7. Use a sanitizing solution to cleanse hands between residents. . . ." Kozier & Erbs, "Fundamentals of Nursing," 9th edition, Pearson Education Inc., New Jersey, page 878-880, provides a standard of practice for preparing medications from vials. During observation of medication pass on the afternoon of 06/01/15, a nursing staff member (#4) prepared two medications for Resident #23. The nurse obtained two tuberculin (TB) (one milliliter - ml) syringes without luer lock ends (screw lock mechanism that securely locks a needle or other device in place) from a supply room across from the nurses station, then went to the medication cart, and without performing hand hygiene, obtained a one ml vial of 2 milligrams (mg) per ml of Hydromorphone (Dilaudid) (a Schedule II narcotic pain medication used to treat moderate to severe pain). Physician's orders and the medication administration record stated to administer the entire vial or one ml. The nurse, uncapped the vial and utilizing a needle on the TB	F 333	control to prevent significant medication errors (including hand hygiene, proper equipment identification, sterile/clean fields, proper removal of air bubbles and prepping medication just outside of resident¿s room). 2.All licensed nurses will follow professional standards of care with all injectable medications, including administering the proper dose, labeling of syringes, and infection control to prevent significant medication errors. 3.The Director of Nursing and/or Hospice Coordinator will review and educate all licensed nurses on injectable medication administration per professional standards of care. Hospice Coordinator and/or Director of Nursing will demonstrate and have return demonstrations occur from all nurses on the proper procedure for administration of injectable medication per professional standards of care. 4.July 8, 2015 5.Audits will be completed initially by the Director of Nursing and/or Hospice Coordinator with return demonstrations by all licensed nurses to ensure injectable medications are prepared following professional standards of care, including administering the proper dose, labeling of syringes and infection control to prevent significant medication errors (including hand hygiene, proper equipment identification, sterile/clean fields, proper removal of air bubbles and prepping medication just outside of resident¿s room). Audits will then be completed monthly for the first quarter, then quarterly for one year by Director of Nursing and/or	

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F 333	Continued From page 42 syringe, entered the vial to aspirate the contents. The nurse failed to draw up into the syringe the amount of air equal to the volume of the medication to be withdrawn. The nurse (#4) commented on how difficult it was to aspirate the medication from the vial stating "it comes out in drops." On two occasions, the nurse noted air aspirated into the syringe and opened the lid covering the top of the waste receptacle on the the medication cart, and pointed the syringe downwards toward the waste receptacle. The nurse then entered the rubber stopper of the vial and attempted to aspirate more of the medication from the vial. Upon removal of the syringe, the nurse noted an air bubble in the syringe and with the syringe pointed upwards, tapped the syringe. Upon removal of that air bubble, the syringe contained 0.8 ml of the medication and an estimated 0.1 ml remained in the vial. The nurse then capped the needle on the syringe. The nurse then obtained a bottle of Haldol liquid for oral (by mouth) administration. The nurse, utilizing the second TB syringe, aspirated out the prescribed amount of 0.5 ml. The nurse reached for an alcohol wipe, dropped one on the floor, picked it up and placed it on the top of the medication cart, removed the cap off the TB syringe (with 0.8 ml) of Dilaudid, and without first labeling each syringe with the contents, carried both syringes down the hall to administer. During interview on the afternoon of 06/03/15, an administrative staff member (#10) stated the nurse failed to follow the medication pass procedure including proper hand hygiene, preparing the medications just outside of the resident's room, aiming the syringe downwards to remove air (on two occasions) instead of pointing	F 333	Nurse Managers. Results of monitoring will be reported to the QA Committee at each scheduled meeting (at least quarterly). The Director of Nursing will follow up on further education/training on an as needed basis.	

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F 333	Continued From page 43 the syringe upwards, and in addition, using a syringe which lacked a luer lock for the subcutaneous administration via a port.	F 333		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. 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. 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. 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.	F 431		7/8/15

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F 431	Continued From page 44 This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 06/16/14. Based on observation, record review, review of professional standards, and staff interview, the facility failed to ensure 1 of 1 insulin vial label matched the physician's order and the medication administration record (MAR). Failure to ensure the insulin vial label matched the physician order and the MAR has a potential to cause a medication error. Findings include: Kozier & Erb's "Fundamentals of Nursing, Concepts, Process and Practice," 9th Edition, dated 2012, page 863 stated, ". . . Compare the label of the medication against the MAR. Observation during medication pass on 06/02/15 at 8:00 a.m., showed Resident #24 received Levemir insulin. The label on the Levemir vial stated to inject 10 units every morning. Resident #24's MAR and physician's orders stated to inject 16 units every morning. Review of Resident #24's physician's orders identified the following: * 05/13/15 Levemir 10 units every morning * 05/20/15 Levemir 14 units every morning * 05/28/15 Levimer 16 units every morning During an interview on 06/02/15 at 08:05 a.m. a licensed nurse (#2) confirmed Resident #24's Levemir order had changed twice and the vial	F 431	1.Insulin vial label will match the physician¿s order and the medication administration record (MAR) to avoid potential medication error. 2.All insulin vial labels will match the physician¿s order and the medication administration record (MAR) to avoid potential medication error. 3.Pharmacy Consultant and Director of Nursing review and updating policy for Reordering Medication Supply. Director of Nursing will educate all licensed nurses on policy for Reordering Medication Supply-specific to directions changed by provider. All insulin vials will have labels inspected for accuracy and will be updated by pharmacy as required per policy. Any changes to prescription medications will be faxed to pharmacy by the licensed nurse for refill, label change, and notification. 4.July 8, 2015 5.Audits will be completed initially by the licensed nurses to ensure all insulin vial labels match the physician¿s order and the MAR. Audits will then be completed weekly for first month, then monthly for one year by the licensed nurses and also by pharmacy consultant monthly. Results of the monitoring will be reported to the QA Committee at each scheduled meeting (at least quarterly). The Director of Nursing will follow up on further education/training on an as needed basis.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 45 needed a new label.	F 431		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441		7/8/15

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	355033	A. BUILDING _____ B. WING _____	06/03/2015

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F 441	Continued From page 46 This REQUIREMENT is not met as evidenced by: Based on observation, review of policy and procedure, and staff interview, the facility failed to follow standard infection control practices for 3 of 7 sampled residents (Resident #5, #6, and #7) observed during personal cares and in the cleaning of 2 of 2 resident bathing areas observed. Failure to follow infection control practices during personal care and when cleaning resident care equipment has the potential to cause or spread infection within the facility. Findings include: Review of the facility policy titled "Handwashing" occurred on 06/02/15. This policy, dated 12/19/13, stated, ". . . 7. The facility must require staff to wash hands when indicated . . . k. Before and after assisting a resident with personal care . . . q. After removing gloves . . ." - Review of Resident #6's medical record occurred on all days of survey. Diagnoses included dementia. The resident's quarterly Minimum Data Set (MDS), dated 03/22/15, identified severely impaired cognition and extensive assistance of one person for toilet use and personal hygiene. Observation on 06/02/15 at 9:13 a.m., showed Resident #6 toileting herself in her bathroom. The certified nursing assistant (CNA) (#16) was alerted to this and entered the room as Resident #6 exited the bathroom. The CNA failed to offer Resident #6 hand hygiene after the resident used	F 441	1.The facility will ensure standard infection control practices are followed for all residents during personal cares; including hand washing protocol for resident and staff and correct completion of perineal care with or without application of barrier creams. The bathing systems (tub and/or shower) and nail equipment will be disinfected per facility policy to prevent the spread of infection. 2.The facility will ensure standard infection control practices are followed for all residents during personal cares; including hand washing protocol for resident and staff and correct completion of perineal care with or without application of barrier creams. The bathing systems (tub and/or shower) and nail equipment will be disinfected per facility policy to prevent the spread of infection. 3.The Director of Nursing and Infection Control Nurse will review and update the Hand Hygiene Policy, the Perineal Care Policy, and the Cleaning of Bathing Systems (tub and/or shower) and Cleaning of Nail Equipment Policies. The Director of Nursing and/or Infection Control Nurse will educate all nursing staff on the policy and procedure for following standard infection control practices during personal cares and cleaning of the tub and/or shower and nail equipment to prevent the spread of infection. 4.July 8, 2015	

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F 441	Continued From page 47 the bathroom. Observation on 06/02/15 at 10:40 a.m., showed the CNA (#16) assisted Resident #6 onto the toilet. Resident #6 voided and used toilet tissue to wipe herself. The CNA (#6) failed to offer Resident #6 hand hygiene after the resident used the bathroom. - Observation on 06/02/15 at 1:45 p.m., showed two CNAs (#14 and #7) provided perineal care for Resident #5. Both CNAs donned gloves and the CNA (#14) cleansed the rectal area with visible BM on the wipe. After completing perineal care, the CNA (#14) removed her gloves, positioned Resident #5 on her side, adjusted the resident's pillows, covered Resident #5 with a bed sheet, raised the head of bed, and then performed hand hygiene. The CNA (#14) failed to perform hand hygiene after completing perineal care, prior to performing other tasks. During an interview on 06/03/15 at 3:45 p.m., a nurse manager (#5) stated she expected staff to perform hand washing according to facility policy. - Observation on 06/02/15 at 10:05 a.m. showed two CNAs (#7 and #16) provided morning cares for Resident #7. A CNA (#16) wore gloves and applied barrier cream to the resident's skin folds and buttocks. The CNAs (#7 and #16) then assisted Resident #7 to turn onto her back and the CNA (#16) applied barrier cream to the resident's groin wearing the same pair of gloves. During an interview on 06/03/15 at 2:10 p.m., an administrative staff member (#5) agreed staff failed to apply barrier cream from front to back.	F 441	5.Audits will be completed initially by the licensed nurses to ensure standard infection control practices are followed for residents during personal cares; including hand washing, completion of perineal, application of barrier creams, disinfection bathing systems (tub and/or shower) and disinfecting nail equipment to prevent the spread of infection. The facility will conduct random audits on a minimum of five residents per week for one month. Audits will then be completed monthly for first quarter and then quarterly for one year by the licensed nurses. Results of the monitoring will be reported to the QA Committee at each scheduled meeting (at least quarterly). The Director of Nursing and/or Infection Control Nurse will follow up on further education/training on an as needed basis.	

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F 441	Continued From page 48	F 441		

Review of the facility policy titled "Disinfecting of Shower Chair and Bathtubs" occurred on 06/02/15. This policy, dated 2008, stated, " Objective: To prevent the spread of infection . . . Procedure: . . . 3. Spray all surfaces involved with disinfectant, including top and underside of tub/shower chair. 4. Allow appropriate disinfecting time, as per manufacture's direction."

Review of the manufacturer's guidelines for "Pleascent Clean" occurred on 06/02/15. These guidelines stated, " Pleascent Clean - non acid bathroom cleaner ready - to - use germicide/disinfectant . . . To clean and disinfect hard surfaces: Apply by mop, sponge, cloth or spray on hard nonporous surfaces. Allow to remain wet for 10 minutes. . . ."

- Observation on 06/02/15 at 10:45 a.m., showed a certified nursing assistant (CNA) (#3) cleaning the bathtub in the north bathing area. The CNA explained she had just finished a bath and started cleaning the tub before giving the next bath. The CNA (#3) sprayed the entire bathtub and bath chair with "Pleascent Clean." Using a long handled brush, the CNA (#3) scrubbed the entire tub and used the bathtub spray nozzle to rinse the tub. (contact time approximately two minutes) The CNA (#3) then used a wash cloth and wiped down the bath chair. During this observation, the CNA (#3) explained she used the nail clipper hanging in the bathroom to trim resident's finger/toe nails. The CNA (#3) said she cleans the nail clipper with alcohol wipes between each resident.

Observation on 06/02/15 at 1:20 p.m. showed a CNA (#6) cleaning the bathtub in the south bathing area. The CNA (#6) explained that

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F 441	Continued From page 49 between resident's, she sprays the bathtub with Pleascent Clean, scrubs the bathtub with a brush, and sprays it off with water. The CNA (#6) stated she has never used a cleaning wipe to clean the bathtub. During an interview on 06/02/15 at 1:12 p.m., a supervisory nurse (#9) stated she expected staff to clean the bathtubs with a cleaning wipe. After reviewing the manufacturer's guidelines for Pleascent Clean she agreed the contact time should be ten minutes. During an interview on 06/02/15 at 6:00 p.m., an administrative nurse (#10) stated she expected staff to use a disinfectant to clean the nail clipper when used on multiple residents.	F 441		
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the	F 520		7/8/15

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F 520	Continued From page 50 compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on review of the North Dakota Department of Health, Division of Health Facilities provider files and record review, the facility failed to maintain a Quality Assurance (QA) process which identified and addressed quality issues; and failed to develop and implement appropriate plans of action to correct deficient practice and ensure compliance with federal requirements. Findings include: Refer to F156, F225, F241, F278, and F431 for specific findings. These five citations are repeat deficiencies. Failure to effectively utilize QA resulted in the facility not maintaining compliance in the following: *F156 - the right to request a demand bill *F225 - reporting/investigating injuries of unknown origin *F241 - treating residents with dignity *F278 - MDS coding for delusions *F431 - incorrect dosage label on an insulin vial	F 520	2. The facility will maintain Quality Assurance (QA) process which will identify and address quality issues; and develop and implement appropriate plans of action to correct deficient practices to ensure compliance with federal requirements. 3. The Quality Assurance Committee will review the facility policy for audits that are required on a regularly reporting basis back to the Committee. The QA Committee will determine upon review of information received from audits the frequency to continue the audits and/or if additional items need to be added to ensure compliance with federal requirements. Audits to correct deficient practices will have audit frequency increased (refer to F156, F225, F241, F278, F431) other department/consultants will be assisting with specific audits (refer to F241, F431), and random audits will be completed instead of scheduled audits for specific deficient practices (refer to F241, F431). A checklist of audits will be reviewed and completed by the QA Coordinator and Administrator monthly to ensure defiance practices are in compliance with federal requirements.	

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F 520	Continued From page 51	F 520	4. July 8, 2014 5. Refer to plan of correction for F156, F225, F241, F278, and F431. Audits to correct deficient practices will have audit frequency increased (refer to F156, F225, F241, F278, F431) other department/consultants will be assisting with specific audits (refer to F241, F431), and random audits will be completed instead of scheduled audits for specific deficient practices (refer to F241, F431). A checklist of audits will be reviewed and completed by the QA Coordinator and Administrator monthly to ensure defiance practices are in compliance with federal requirements.	