| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 355124 | A. BUILDING _____ B. WING _____ | 08/09/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| EVENTIDE AT SHEYENNE CROSSINGS | 125 13TH AVENUE WEST WEST FARGO, ND 58078 |

| (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 |
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| F 000 | INITIAL COMMENTS<br><br>The standard Medicare/Medicaid recertification started on 08/06/18 and concluded on 08/09/18. | F 000 | | |
| F 657 SS=D | Care Plan Timing and Revision<br>CFR(s): 483.21(b)(2)(i)-(iii)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(2) A comprehensive care plan must be-<br>(i) Developed within 7 days after completion of the comprehensive assessment.<br>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--<br>(A) The attending physician.<br>(B) A registered nurse with responsibility for the resident.<br>(C) A nurse aide with responsibility for the resident.<br>(D) A member of food and nutrition services staff.<br>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.<br>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.<br>(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.<br>This REQUIREMENT is not met as evidenced by:<br>THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 07/19/17. | F 657 | F657<br>1. Resident #47's care plan was updated to accurately reflect the | 9/13/18 |

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

Electronically Signed | 08/28/2018

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| F 657 | Continued From page 1<br>Based on observation, record review, review of facility policy, and staff and resident interviews, the facility failed to review and revise care plans to reflect residents' current needs for 2 of 16 sampled residents (Resident #47 and #50). Failure to update care plans limited staff's ability to ensure continuity of care and may result in unmet resident needs.<br><br>Findings include:<br><br>Review of the facility policy titled "Care Plans" occurred on 08/09/18. This policy, revised September 2017, stated, ". . . Purpose: To develop a person-centered care plan in conjunction with the Interdisciplinary team and resident/resident representative that reflects the actual care, condition, and preferences of each resident. . . . Baseline Care Plan . . . must include the minimum healthcare information necessary to properly care for the resident including, but not limited to: . . . Dietary orders . . . Bladder and Bowel Function . . . Comprehensive Care Plan . . . in addition to the items in the baseline care plan, must include the following: . . . Dialysis . . . Documentation . . . Care plans will be updated and changes will be made as they occur to ensure the most current care plan for the resident. . . ."<br><br>- Review of Resident #47's medical record occurred on August 7-9, 2018. Diagnoses included chronic kidney disease. The resident's current care plan stated, ". . . [Resident #47] needs dialysis r/t [related to] renal failure . . . Interventions . . . Encourage [Resident #47] to go for the scheduled dialysis appointments. Resident receives dialysis three times per week | F 657 | individualized dialysis schedule & treatment facility.<br>Resident #50's care plan was updated to accurately reflect the current diet and toileting needs.<br>2. All resident's care plans will be reviewed for accuracy in regard to diet orders, toileting plans, and dialysis schedule & treatment facility.<br>3. Care plans are initiated upon admission using an interdisciplinary approach. These are reviewed and revised as needed for each resident with every change of condition and MDS by a nurse or nurse leader. Nursing will ensure that the care plan accurately reflects the resident's current condition through assessment and by communicating all changes in condition to staff providing care. Education will be provided to all staff completing care plans on August 30, 2018.<br>4. QA monitoring will be implemented following mandatory staff education. QA will be initiated on August 31, 2018.<br>The DON or designee will be responsible to monitor the care plan process to accurately reflect individualized, person-centered care.<br>The DON or designee will monitor 10 care plans weekly for one month, 10 care plans monthly for 3 months, and then audits will be completed at least quarterly for one year with additional audits as recommended by the QA committee. Results will be reported to the Executive Director. If concerns are identified, immediate corrective action will be | |

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| F 657 | Continued From page 2<br>at [dialysis facility A]. . . ."<br><br>Record review and interview with Resident #47 identified the resident receives dialysis on Tuesdays, Thursdays, and Saturdays at dialysis facility B.<br><br>The care plan failed to include individualized information regarding Resident #47's dialysis schedule/treatment facility.<br><br>- Review of Resident #50's medical record occurred on all days of the survey. The current care plan identified an intervention, initiated on 07/17/18, which stated, ". . . NPO [nothing by mouth] with only ice chips. . . ." An intervention, dated 08/01/18, stated, ". . . Providing regular diet with thin liquids. . . ."<br><br>Resident #50's progress notes showed an order signed for "dysphagia advance diet with thin liquids" on 07/25/18. Further review of the progress notes identified on 08/01/18 the resident changed to a "regular diet with thin liquids."<br><br>During an interview on the morning of 08/09/18, Resident #50 stated she is presently eating some meals and drinking some thin liquids and is no longer NPO.<br><br>Resident #50's current care plan also stated, ". . . Toileting: assist of two to bedside commode every 2 hours and prn [as needed] while awake . . . Transfer using a Hoyer [full body mechanical lift] and toilet sling to bed side commode. . . ."<br><br>During an interview on the morning of 08/08/18, | F 657 | implemented.<br>The DON will submit a report of the monitoring results to the QA committee at each scheduled meeting.<br>5. Date of correction: September 13, 2018 | |

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| F 657 | Continued From page 3<br>an unidentified certified nurse aide (CNA) indicated staff transfer the resident utilizing a Hoyer with two assist to a toilet, not to a bedside commode.<br><br>The care plan failed to reflect Resident #50's current diet and toileting needs. | F 657 | | |
| F 658 SS=D | Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)<br><br>§483.21(b)(3) Comprehensive Care Plans<br>The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br>(i) Meet professional standards of quality.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, review of professional reference, and staff interview, the facility failed to follow professional standards regarding medication administration during 1 of 3 observations of medication pass (morning of 08/08/18). Failure to follow infection control standards may result in contamination of oral medications.<br><br>Findings include:<br><br>Saxton and Clark's "Geriatric Medication Handbook," 7th edition, American Society of Consultant Pharmacists, page 145-146, stated, ". . . Infection Control . . . Other infection control procedures should include . . . Tablets and capsules should not be poured into the nurse's hand or touched during the medication pass. The nurse should wear gloves when cutting tablets in half or touching them for any other reason. . . ." | F 658 | F658<br>1. All medication carts are stocked with gloves and medication cups to allow staff to follow appropriate infection control processes during medication pass.<br>2. All residents who receive medications have the potential to be affected.<br>3. The facility will ensure that no medications will be poured into the nurse's hand or touched during the medication pass. Education will be provided for all staff that pass medications on August 30, 2018.<br>4. QA monitoring will be implemented following completion of mandatory staff education. QA will be initiated on August 31, 2018.<br>The DON or designee will be responsible to monitor the medication pass for appropriate infection control standards for 10 residents per week for one month, 10 | 9/13/18 |

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| F 658 | Continued From page 4<br>Observation of medication pass occurred on the morning of 08/08/18 at 8:33 a.m. with a nurse (#1). The nurse prepared vitamin D3 for a resident by pouring the pill from the bottle into her bare hand and then placing it in a medication cup. The nurse then prepared vitamin D3 and vitamin B12 for another resident by pouring the pills from the bottles into her bare hand and then placing them in a medication cup.<br><br>During an interview on the morning of 08/09/18, an administrative nurse (#2) identified staff should not touch medications with their bare hands. | F 658 | residents per month for 3 months, and then audits will be completed at least quarterly for 1 year with additional audits as recommended by the QA committee. Results will be reported to the Executive Director. If concerns are identified, immediate corrective action will be implemented.<br>The DON will submit a report of the monitoring results to the QA committee at each scheduled meeting.<br>5. Date of correction: September 13, 2018 | |
| F 676 SS=D | Activities Daily Living (ADLs)/Mntn Abilities<br>CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii)<br><br>§483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that:<br><br>§483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ...<br><br>§483.24(b) Activities of daily living.<br>The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: | F 676 | | 9/13/18 |

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| F 676 | Continued From page 5<br>§483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care,<br><br>§483.24(b)(2) Mobility-transfer and ambulation, including walking,<br><br>§483.24(b)(3) Elimination-toileting,<br><br>§483.24(b)(4) Dining-eating, including meals and snacks,<br><br>§483.24(b)(5) Communication, including<br>(i) Speech,<br>(ii) Language,<br>(iii) Other functional communication systems.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, and resident interview, the facility failed to provide the necessary care and services to maintain abilities in activities of daily living (ADL) for 1 of 1 sampled resident (Resident #50) who experienced incontinence. Failure to answer call lights in a timely manner resulted in a resident's incontinence.<br><br>Findings include:<br><br>Review of Resident #50's medical record occurred on all days of the survey. An admission Minimum Data Set (MDS), dated 07/11/18, identified intact cognition and extensive assist of two for toileting. Resident #50's current care plan stated, ". . . Toileting: assist of two to bedside commode every 2 hours and prn [as needed] while awake . . . Transfer using a Hoyer [full body mechanical lift] and toilet-sling to bed side commode. . . ." | F 676 | F676<br>1. Resident #50□s care plan was updated to accurately reflect her current toileting needs. Nursing staff will be educated on the expectation that call lights are to be answered in a timely manner and the resident□s needs met. Staff who were working on the unit at the time of incident were educated regarding meeting resident's needs in a timely manner on 8/10, 8/13, and 8/14.<br>2. All residents that use their call light to request assistance with toileting have the potential to be affected.<br>3. The facility will educate all staff to leave the call light on until the resident□s needs have been met. Staff will answer call lights and communicate with residents so they know what they can expect from their nursing staff and when the staff will be back to meet their needs. | |

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| F 676 | Continued From page 6<br><br>Observation on 08/07/18 at 10:07 a.m. showed Resident #50's call light on. At 10:15 a.m., the resident's spouse left the room looking for staff assistance and was told by a staff nurse, "We only have two girls." At 10:18 a.m., the spouse took the resident to therapy. The spouse then returned to the resident's room to retrieve a sling, and at 10:29 a.m., the surveyor overheard the spouse tell a staff nurse, "She [Resident #50] had to go to the bathroom twice this morning. It took so long and no one came. Now the feeling [resident's urge to void] went away, so we decided to just go to therapy." The spouse then came over to the surveyor and reported the same.<br><br>Further observation at 11:29 a.m. showed Resident #50 returned from therapy and informed a certified nurse aide (CNA) about the two previous episodes [on the morning of 08/07/18] of needing the bathroom and not receiving timely staff assistance after she turned on her call light, resulting in an incontinent episode. The CNA responded, "Hopefully we can get here quicker next time."<br><br>During an interview before the noon meal on 08/07/18 and on the morning of 08/08/18, Resident #50 stated the following:<br>* Waited for call light to be answered twice this morning (08/07/18) for at least 30 minutes each time and became incontinent one time<br>* Often waits a "long time" for her call light to be answered and "one time had to wait an hour"<br>* Staff often turn off the call light, tell her they will be back, and do not return<br>* "Now that I am better, I can hold my urine if | F 676 | Education will be provided on August 30, 2018.<br>4. QA monitoring will be implemented following completion of mandatory education. QA will be initiated on August 31, 2018.<br>The DON or designee will monitor call light response for 10 residents weekly for 1 month, 10 residents monthly for 3 months, then audits will be completed at least quarterly for one year with additional audits as recommended by the QA committee.<br>Results will be reported to the Executive Director. If concerns are identified, immediate corrective action will be implemented.<br>The DON will submit a report of the monitoring results to the QA committee at each scheduled meeting.<br>5. Date of correction: September 13, 2018 | |

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| F 676 | Continued From page 7<br>they would get here."<br>* Believes she is incontinent at least once daily due to staff not answering her call light promptly<br><br>Failure to ensure staff promptly answered a resident's call light resulted in a resident's incontinence and the inability to maintain/improve current ADL status. | F 676 | | |
| F 689 SS=D | Free of Accident Hazards/Supervision/Devices<br>CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, review of facility policy and procedure, and resident interview, the facility failed to provide adequate supervision and assistive devices to prevent accidents for 1 of 3 sampled residents (Resident #38) observed during transfers with a gait belt. Failure to properly utilize a gait belt during the transfers placed the resident at risk for pain and/or injury.<br><br>Findings include:<br><br>Review of the facility policy and procedure titled "Standards of Care" occurred on 08/09/18. This policy, dated October 2016, stated, ". . . A gait belt will be used for assisted transfers and ambulation. . . ." | F 689 | F689<br>1. Staff will be educated on the appropriate placement of a gait belt for Resident #38. Education was provided to staff who were working at the time of the incident on 8/10, 8/13, and 8/14.<br>2. All residents who require assistance with transfers that utilize a gait belt have the potential to be affected. All nursing staff will be checked for competency.<br>3. Nursing education will include appropriate use and positioning of gait belts. The facility will ensure gait belts are positioned and utilized appropriately for residents that use them during transfers. Staff education will be provided on August 30, 2018. | 9/13/18 |

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| F 689 | Continued From page 8<br><br>Review of Resident #38's medical record occurred on all days of the survey. The current care plan stated, ". . . Transfers: assist of two with walker. . . ."<br><br>During an interview on the afternoon of 08/06/18, Resident #38 reported the staff had been rough with her during a recent transfer into her wheelchair. When asked if she had pain related to the transfer, the resident pointed to her underarms.<br><br>Observation on 08/08/18 at 11:55 a.m. showed two unidentified certified nurse aides (CNA) transferred Resident #38 to and from the toilet with a gait belt placed around her upper chest and directly under her arms. When the CNAs assisted the resident to stand for the transfers, they firmly pulled up on the gait belt causing the resident's shoulders to raise and roll forward.<br><br>Failure of staff to properly place and utilize a gait belt during the resident's transfer caused the resident discomfort and pain. | F 689 | 4. QA monitoring will be implemented following completion of mandatory education. QA will be initiated on August 31, 2018.<br>The DON or designee will be responsible for monitoring proper gait belt use and positioning for 10 residents weekly for 1 month, 10 residents monthly for 3 months, and then audits will be completed at least quarterly for 1 year with additional audits as recommended by the QA committee.<br>Results will be reported to the Executive Director. If concerns are identified, immediate corrective action will be implemented.<br>The DON will submit a report of the monitoring results to the QA committee at each scheduled meeting.<br>5. Date of correction: September 13, 2018 | |
| F 698<br>SS=D | Dialysis<br>CFR(s): 483.25(l)<br><br>§483.25(l) Dialysis.<br>The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, and review of professional reference, the facility failed to | F 698 | F698<br>1. An assessment of Resident #47's AV | 9/13/18 |

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| F 698 | Continued From page 9<br>ensure adequate monitoring of a fistula site for 1 of 1 dialysis resident (Resident #47). Failure to assess/monitor hemodialysis vascular access sites (arterial-venous fistulas) after dialysis can result in complications with access function and possible loss of the access site.<br><br>Findings include:<br><br>The Centers for Medicare and Medicaid Services (CMS) has outlined standards of practice regarding dialysis which states, ". . . The nursing home staff must provide immediate monitoring and documentation of the status of the resident's access site(s) upon return from the dialysis treatment to observe for bleeding or other complications. . . ."<br><br>Review of Resident #47's medical record occurred on August 7-9, 2018. Diagnoses included chronic kidney disease. Record review identified the resident received dialysis at an outside facility three times per week.<br><br>Observations during the survey showed Resident #47 with a fistula site to his left arm.<br><br>The record lacked evidence staff monitored/assessed Resident #47's fistula site upon his return from dialysis appointments. | F 698 | fistula immediately upon return from dialysis has been implemented.<br>2. All residents who receive hemodialysis have the potential to be affected.<br>3. The facility will be implementing a new process for assessment/monitoring of AV fistulas immediately upon return from dialysis. Education will be provided to all nurses on August 30, 2018.<br>4. QA monitoring will be implemented following completion of mandatory education. QA will be initiated on August 31, 2018.<br>The DON or designee will be responsible for ensuring that assessments are completed upon return for all residents receiving dialysis for 2 months and then audits will be completed quarterly for 1 year with additional audits as recommended by the QA committee. Results will be reported to the Executive Director. If concerns are identified, immediate corrective action will be implemented.<br>The DON will submit a report of the monitoring results to the QA committee at each scheduled meeting.<br>5. Date of correction: September 13, 2018 | |
| F 804 SS=E | Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2)<br><br>§483.60(d) Food and drink<br>Each resident receives and the facility provides-<br><br>§483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; | F 804 | | 9/13/18 |

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| EVENTIDE AT SHEYENNE CROSSINGS | 125 13TH AVENUE WEST WEST FARGO, ND 58078 |

| (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 804 | Continued From page 10<br><br>§483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, review of resident council minutes, review of temperature logs, resident interview, and group interview, the facility failed to serve foods at palatable temperatures for 2 of 2 meals observed (Lunch 08/06/18 and Lunch 08/07/18). Failure to serve foods at a temperature acceptable to residents may result in decreased intake, weight loss, and inadequate nutrition.<br><br>Findings include:<br><br>Review of the resident council meeting minutes on 08/07/18 identified multiple concerns related to food temperatures.<br><br>The surveyors received a lunch test tray on 08/06/18 at approximately 1:00 p.m. The test tray from the LTC unit consisted of a summer sausage sandwich, potato soup, and cucumber salad. The 4 surveyors confirmed the food did not maintain a palatable temperature.<br><br>During the group interview on the morning of 08/07/18, six of six residents stated the food is usually cold.<br><br>The surveyors received two lunch test tray on 08/07/18 at approximately 1:00 p.m. The test tray from the LTC unit consisted of casserole and vegetables, while the test tray from Transitional Care Unit (TCU) consisted of casserole, hash | F 804 | F804<br>1. Culinary staff will ensure that food is at a palatable temperature prior to being served.<br>2. All residents have the potential to be affected.<br>3. Culinary staff will be educated on proper cooking instructions for food, appropriate settings for steam tables, use of plate warmers, and accuracy of monitoring food temperatures to ensure that food is served at a palatable temperature. Nursing staff will be educated on timeliness of serving food to ensure food remains at appropriate temperature. Education will be provided on August 30, 2018.<br>4. QA monitoring will be implemented following completion of mandatory education. QA will be initiated on August 31, 2018.<br>The Dietitian or designee will be responsible for monitoring that food is served at an appropriate temperature 10 meals per week for 1 month, 20 meals per month for 3 months, and then audits will be completed at least quarterly for 1 year with additional audits as recommended by the QA committee.<br>The DON or designee will be responsible for monitoring that food is served in a timely manner 10 meals per week for 1 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 355124 | A. BUILDING _____ B. WING _____ | 08/09/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| F 804 | Continued From page 11<br>browns, and eggs. The 3 surveyors confirmed the food did not maintain a palatable temperature.<br><br>During a confidential interview on the afternoon of 08/07/18, Resident H stated the food is always cold.<br><br>Failure to serve foods at palatable temperatures may negatively impact residents' meal consumption. | F 804 | month, 20 meals per month for 3 months, and then audits will be completed at least quarterly for 1 year with additional audits as recommended by the QA committee. Results will be reported to the Executive Director. If concerns are identified, immediate corrective action will be implemented.<br>The dietitian and DON will submit reports of the monitoring results to the QA committee at each scheduled meeting.<br>5. Date of correction: September 13, 2018 | |
| F 809 SS=E | Frequency of Meals/Snacks at Bedtime<br>CFR(s): 483.60(f)(1)-(3)<br><br>§483.60(f) Frequency of Meals<br>§483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care.<br><br>§483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span.<br><br>§483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care.<br>This REQUIREMENT is not met as evidenced by: | F 809 | | 9/13/18 |

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| F 809 | Continued From page 12<br>Based on review of facility policy, resident interview and resident group interview, the facility failed to provide snacks for 6 of 6 residents attending the resident group interview (Resident A, B, C, D, E, and F) and 1 supplemental resident (Resident G). Failure to provide a bedtime snack (HS) has the potential to cause adverse reactions for residents receiving medications such as short acting insulin and decreases the quality of life for residents wanting a bedtime snack and not being offered a snack.<br><br>Findings include:<br><br>Review of the facility policy titled "Standards of Care," occurred on 08/09/18. This policy, dated October 2016, stated, ". . . An HS snack will be offered to each resident (unless directed otherwise - i.e. the resident has a tube feeding and doesn't eat) . . ."<br><br>During an interview on the morning of 08/06/18, Resident B stated the staff went room to room at night offering snacks to resident's, but no longer do this. She stated not all the residents go to bed early and she would like a snack before bed.<br><br>During an interview on the afternoon of 08/06/18, Resident G identified she did not know of an evening snack cart, and staff had not offered her a bedtime snack.<br><br>During the group interview on the morning of 08/07/18, six of six residents stated staff used to take a snack cart around at night and offer snacks, however the staff no longer does this. | F 809 | F809<br>1. All residents will be offered a snack at HS. The availability of snacks will be communicated to residents through the resident council.<br>2. All residents have the potential to be affected.<br>3. The facility will be implementing a new process for the HS snack pass. All nursing staff will be educated on this process on August 30, 2018.<br>4. QA monitoring will be implemented following completion of mandatory education. QA will be initiated on August 31, 2018.<br>The DON or designee will be responsible for monitoring that residents are offered a snack at HS 3 times/week for 1 month, 2 times/week for 1 month, and 1 times/week for 1 month and then at least quarterly for 1 year with additional audits as recommended by the QA committee. Results will be reported to the Executive Director. If concerns are identified, immediate corrective action will be implemented.<br>The DON will submit a report of the monitoring results to the QA committee at each scheduled meeting.<br>5. Date of correction: September 13, 2018 | |