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 _____	03/28/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEYENNE CROSSINGS CARE CENTER/TCU	125 13TH AVENUE WEST WEST FARGO, ND 58078

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F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey started on 03/26/12 and completed on 03/28/12, the sample included 4 residents for complete review, 9 residents for focused review, and 2 closed records for review.	F 000	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiency herein. To remain in compliance with all federal and state regulations we have taken actions set forth in the following plan of correction. The following plan of correction constitutes the allegation of compliance. The alleged deficiency cited has been corrected by the date indicated.	
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to review and revise the care plan to address current problems and specific interventions for 3 of 3 sampled residents (Resident #4, #5 and #9) on a scheduled hypnotic	F 280	F280 Resident #4, #5 and #9 care plans were reviewed and revised to address current problems and interventions. These care plans were updated to reflect use of hypnotics.	5/1/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Cheri Rekamoto — TITLE: Administrator — (X6) DATE: 4/10/12

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

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F 280	Continued From page 1 medication and 1 of 1 sampled resident (Resident #10) with a swallowing problem in a reclining wheelchair. Failure to revise the care plan as the residents' status changes has the potential to affect the care provided to the resident and limit the staff's ability to ensure continuity of care. Findings include: Review of Resident #4's, #5's, and #9's care plans did not address the use of the Ambien or include approaches to attempt to lessen the use of the medication, and what side effects to monitor for. - Review of Resident #5's medical record occurred on all days of survey. Record review identified the resident on Ambien 5 milligrams (mg) since 01/18/12. Review of Resident #5's Care Area Assessment (CAA), dated 01/27/12, for "Psychotropic Drug Use" stated, ". . . alert and oriented to person and time, disoriented to place, with STM [short term memory] . . . Needs assist of one for transfers, toileting, dressing, grooming, bathing, and ambulation in room . . ." The CAA did not address the use of Ambien or the resident's sleep pattern. - Review of Resident #4's medical record occurred on all days of survey. Record review identified the resident on Ambien (a hypnotic medication - sleeping pill) 5 mg since 01/25/12 and prior to that 10 mg every night and prn, since 10/03/11. Review of Resident #4's Care Area Assessment (CAA), dated 03/26/12, for "Psychotropic Drug	F 280	Residents #10 care plan was reviewed and revised to address current problems and interventions especially as it relates to the HTR chair. The HTR chair will be as upright as possible when being fed to facilitate swallowing and to be directly observed by staff when not reclined. Speech therapy evaluation conducted on 4/3/12. The Care plans on all other residents were reviewed for accuracy and to assure they are up to date. Nursing Staff and Clinical Coordinators were educated on importance of having the care plan revised and updated when changes occur. Education was also conducted on the care plan process. Education was held on 4/24/12.	

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F 280	Continued From page 2 Use" stated, ". . . Requires assist of one for transfers, toileting, bathing, personal cares . . . Taken [sic] Ambien for sleep at night. States she sleeps well. . . ." An Activities of Daily Living (ADL) CAA, dated 03/26/12, stated, ". . . Resident is alert and orientated x [times] 3 with occasional confusion to time especially at night. Resident pleasant and cooperative. Does sleep a lot . . . Taken [sic] Ambien for sleep at night. . . ." - Review of Resident #9's medical record occurred on all days of survey. Record review identified the resident on Ambien 5 mg since 08/12/11. A pharmacy drug regimen review regarding the use of the Ambien signed by a health care practitioner on 01/26/12 addressed the use of the Ambien (the practitioner responded with "Needs for sleep otherwise has chronic insomnia.") During interview on 03/28/12 at 2:25 p.m., an administrative staff member (#4) stated she would expect staff to address the resident's use of a hypnotic medication on the care plan. - Observation during the noon meal on 03/27/12, and during the noon meal on 03/28/12 showed Resident #10 seated in a reclining tilt wheelchair positioned at a 45 degree angle while nursing staff fed the resident. Review of Resident #10's medical record occurred on March 27-28, 2012. The resident's diagnoses included dysphagia, cerebral vascular disease, and esophageal reflux. The resident's quarterly Minimum Data Set (MDS), dated 12/17/11, indicated he required extensive assistance with eating.	F 280	This will be monitored by conducting four random chart audits weekly x 4 then monthly x2 and random audits thereafter for accuracy of care plans. The audits will be conducted by DON and Clinical Coordinators. Audit information will be reported to the QA team quarterly. DON responsible for compliance.	

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F 280	Continued From page 3 The speech therapist's "Rehabilitation Screen," dated 11/19/10, stated, ". . . Observed at lunch - was initially at about 50 [degrees] staff reported this [secondary] head positioning. When more upright, head would tilt to [right], discussed [with] [occupational therapy] No difficulties [with] intake today. Recommend positioning as upright as possible. . . ." Review of Resident #10's current care plan lacked an approach for maintaining the resident in an upright position for meals. Interview of an administrative nursing staff member (#4) occurred on 03/28/12 at 2:25 p.m. The staff member indicated they look at the screen as a recommendation and expect it to be followed and care planned.	F 280		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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: Based on observation, record review, and staff interview, the facility failed to ensure proper positioning for 1 of 1 sampled resident (Resident #10) diagnosed with a swallowing disorder and observed being fed in a reclined position. Failure	F 309	F309 Resident #10 care plan has been reviewed and revised as needed to assure proper positioning during meals and anytime the resident is receiving any type of food or fluid intake. Speech Therapy evaluation was conducted on 4/3/12.	5/1/12

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F 309	Continued From page 4 to provide proper positioning at meals has the potential to affect the residents' overall swallowing safety. Findings include: Review of Resident #10's medical record occurred on March 27-28, 2012. The resident's diagnoses included dysphagia, cerebral vascular disease, and esophageal reflux. The resident's quarterly Minimum Data Set (MDS), dated 12/17/11, indicated he required extensive assistance with eating. - Observation during the noon meal on 03/27/12 showed Resident #10 seated in a reclining tilt wheelchair positioned at a 45 degree angle while a certified nursing aide (CNA) (# 5) fed the resident. The CNA fed the resident heaping teaspoons of a chicken salad mixture from the sandwich, soup, with occasional spoon fulls of soup between bites, followed by large pieces of bread. Observation showed Resident #10 lean forward with his head throughout the meal anticipating each bite through the meal. - Observation on 03/28/12 showed Resident #10 seated in a reclining tilt wheelchair positioned at a 45 degree angle. A CNA (#1) fed the resident his noon meal. Observation showed the resident coughing. The staff member then adjusted the resident's tilt wheelchair to an upright (90 degree) position. The speech therapist's "Rehabilitation Screen," dated 11/19/10, stated, ". . . Observed at lunch - was initially at about 50 [degrees] staff reported	F 309	All residents care plans were reviewed and revised to assure accuracy and that all residents are being properly positioned during meals and snacks. All staff educated on observation and expectation of assuring that residents are in the proper position while being fed with special emphasis on specialized chairs and equipment. Education was held on 4/24/12.	

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F 309	Continued From page 5 this [secondary] head positioning. When more upright, head would tilt to [right], discussed [with] [occupational therapy] No difficulties [with] intake today. Recommend positioning as upright as possible. . . ." When interviewed on 03/28/12 at 2:20 p.m., an administrative nursing staff member (#3) confirmed if coughing was a concern she would "get a speech evaluation." During interview on 03/28/12 at 12:33 p.m., a speech therapist (#2) stated, "If nursing reported coughing, I would pursue an evaluation as this indicates possible difficulty swallowing." Interview of an administrative nursing staff member (#4) occurred on 03/28/12 at 2:25 p.m. The staff member indicated they look at screen as a recommendation and expect it to be followed and care planned. The staff member further stated when staff start feeding the resident he should be at an upright position.	F 309	Random audits weekly x 4 then monthly x2 and random audits thereafter to assure proper positioning of residents while being fed, or eating as well and to ensure therapy's recommendations are followed up on and care planned accordingly. The audits will be conducted by Clinical Coordinators, Charge Nurses and Dietician. Audit information will be reported to the QA team quarterly. DON responsible for compliance.	