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 _____	04/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEYENNE CROSSINGS CARE CENTER/TCU	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 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey started on 04/18/11 and completed on 04/20/11 the sample included 4 residents for complete review, 9 residents for focused review, and 2 closed records review. The sample included 3 additional residents to verify specific concerns during the survey.	F 000	The statements made on this plan of correction are not an admission to and do not constitute and agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the center has taken the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. An alleged deficiencies cited have been corrected by the date or dates indicated.	
F 156 SS=C	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	F 156 – NOTICE OF RIGHTS, RULES, SERVICES, CHARGES Residents #3, 8 and 18 were provided with the option of having a demand bill submitted. This option had been provided to all other residents but was not documented on the written notice.	5/23/11

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

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 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	Staff person #12, social service staff, nursing clinical coordinators and the Director of Nursing were all provided education on the current policy and process and documentation of denial notices and offering opportunity for demand bills. This education was provided on 4/26/11. All current residents in the facility who are receiving Medicare services were explained the option of having a demand bill submitted during the discharge conference. This process will be monitored by random chart checks to be completed weekly x 4, monthly x3 and then quarterly thereafter. This audit will be completed by the facility Business office manager. Auditing began on 5/25/11. These audits will be submitted to the facility QA committee for evaluation of any trends and to ensure ongoing compliance.	

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F 156	Continued From page 2 The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. 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: Based on record review and staff interview, the facility failed to provide the option of a demand bill related to services determined by the facility as no longer covered by Medicare for 2 of 2 sampled residents (Resident #3 and #8) and 1 supplemental resident (Resident #18) whose Medicare coverage ended. Failure to provide the option of a demand bill to residents is an infringement of the residents' rights.	F 156		

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F 156	Continued From page 3 Findings include: Review of the Medicare billing records occurred on the afternoon of 04/19/11 and showed the Medicare Part A coverage ended for the following residents on: Resident #3 - 12/02/10 Resident #8 - 04/08/11 Resident #18 - 02/23/11 All of the above situations required the facility to send a denial notice (including the right to request a demand bill) to the resident or their representative. Although the facility did provide the denial notices, the notice failed to indicate whether the resident or their representative requested a demand bill. During an interview on the morning of 04/20/11, a facility staff member (#12) agreed, the denial notice did not indicate whether the resident or their representative requested a demand bill.	F 156		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, staff interview, and family interview,	F 246	F- 246 ACCOMODATION OF NEEDS Resident #2 has adaptive call light placed within reach. A facility wide review was conducted and the call lights were placed within reach of residents.	5/23/11

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F 246	Continued From page 4 the facility failed to provide services with reasonable accommodations of individual needs and preferences for 1 of 1 sampled bedfast resident (Resident #2) regarding an adaptive call light. Failure to place the adaptive call light in Resident #2's reach limited the resident's ability to call staff for assistance when necessary. Findings include: Review of the facility policy titled "Nurse Call System" occurred on 04/20/11. This policy, revised 02/23/10, stated, "Policy: . . . Call lights must be kept within resident's reach at all times. . . .Procedure: . . . 7. When providing care to a resident, staff should monitor for call light . . . placement so that it is conveniently located for resident use. . . . " Review of Resident #2's care plan occurred on April 19-20, 2011. The resident's current care plan, dated 08/02/10, identified the following: "Focus - Self care deficit related to pt [patient] being quadraplegic [sic]. . . . Goals . . . Resident's needs will be met with total assist from staff. . . . Focus - Resident is alert and oriented to person, place, and situation. . . . Goals - Will be able to communicate needs. . . ." On 04/18/11, at 5:15 p.m., Resident #2 returned from a medical appointment, accompanied by his family member (#10). During interview, on 04/18/11 at 5:30 p.m., the family member (#10) stated the certified nurse assistants (CNAs) (#6 and #9) had not positioned Resident #2's call light within reach on the resident's chest after transferring the resident from his wheelchair to his bed. The family member stated this is a	F 246	Facility nursing staff, dietary, housekeeping and activity staff have been educated on the call light placement procedure. This education was provided on 5/16/11, 5/18/11, 5/19/11, 5/20/11 and 5/23/11. This will be monitored through nursing rounds every two weeks x 2 by the unit clinical coordinators and DON and then quarterly. This will also be monitored on weekly guardian angel room rounds by the Interdisciplinary team (social services, nursing, dietary). This QA was started on 5/24/11. These audits will be submitted to the facility QA committee for identification of any trends and ensuring continued compliance or need for any additional interventions.	5/23/11

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F 246	Continued From page 5 concern she has previously voiced to staff. Observation of personal cares and suctioning for Resident #2 occurred at 12:30 p.m. on 04/19/11. As the CNA (#11) left Resident #2's room, she asked the staff nurse (#7) present to give Resident #2 his call light when she completed cares. At the completion of cares, the staff nurse (#7) prepared to leave Resident #2's room without positioning the call light within reach for Resident #2. When the surveyor asked the nurse (#7) if she forgot anything, the nurse stated "the call light." On 04/19/11 at 4:30 p.m., Resident #2 returned from a medical appointment. Three CNAs (#6, #8, and #9) transferred Resident #2 to his bed and left the room. During an interview with the family member (#10) in the resident's room at 5:20 p.m., she identified the three CNAs (#6, #8, and #9) failed to position Resident #2's call light on his chest prior to leaving the room. Observation identified the call light on the floor. The surveyor asked the CNA (#6) to return to Resident #2's room and the CNA (#6) confirmed they forgot to position the call light within reach prior to leaving the room. The family member (#10) stated she requested staff put up a sign to remind them to position the call light within reach and the facility advised her they prefer not to have signs on the wall. During interview, on 04/20/11 at 10:10 a.m., a nursing management staff member (#12) stated she was aware of Resident #2's family member's concerns regarding the call light accessibility and stated the facility has educated and disciplined staff.	F 246		

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F 280 SS=B	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, review of facility policies and procedures, and staff interview, the facility failed to ensure the care plans were reviewed and revised to include current treatment and specific interventions for 2 of 13 sampled residents (Resident #1 and #10). Failure to review and revise the care plans limited the staff's ability to communicate treatment approaches and limited the facility staff's ability to ensure the continuity of care. Findings include:	F 280	F280 – REVISION OF CARE PLANS Residents #1 and #10 care plans were revised to reflect their current status and new interventions for the behaviors were implemented. The care plans of the residents who had MDS coded for behaviors were reviewed and revised to reflect their current status. The care plans of the residents whose MDS was coded for behaviors were reviewed and revised to reflect their current status. Nursing staff, unit clinical coordinators and social service staff were educated on the current policy and care planning process on 5/16/11, 5/18/11, 5/19/11, 5/20/11 and 5/23/11. This will be monitored by conducting four random chart audits weekly x 4 then monthly x 2 by the Interdisciplinary team (unit clinical coordinators and social worker) through the QA process. These audits started on 5/24/11.	5/23/11

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F 280	Continued From page 7 -Review of Resident #1's medical record occurred on April 18-20, 2011. The resident's diagnoses included osteoporosis, anxiety, dementia, and macular degeneration. The resident's current quarterly Minimum Data Set (MDS), dated 02/17/11, identified this resident as severely cognitively impaired and requiring extensive assistance of one to two persons for transferring, locomotion on and off the unit, dressing, toileting, and bathing. Observation on 04/18/11 at 12:55 a.m., during initial tour, showed Resident #1 self propelling himself in the lounge area and at times, yelling out. Review of Resident #1's interdisciplinary notes identified the following: *01/02/11, 3:30 p.m. stated, ". . . family spoke with this writer on concern. Worried about how to address his dad when he is confused . . ." *01/07/11, 2:00 p.m., ". . . he was very confused. . . . attempted to redirect resident, but with no success. . ." *01/09/11, no time., ". . . Res. [resident] stated he wanted to 'put a shot gun to his head and end it' . . ." *01/12/11, 4:00 p.m., "Resident very agitated this afternoon . . . would go into the entry way of res. room . . . went into another room et [and] hollered . . ." *01/12/11, 11:30 p.m., "Res very agitated @ [at] hs [hour of sleep] . . . yelling at staff . . . attempt to redirect with no success." *01/15/11 at 10:00 p.m., "Res became very agitated after supper . . . He grabbed another resident's w/c [wheelchair] and refused to let go.	F 280	The audits will be submitted to the facility QA committee who will evaluate them to identify any trends. They will develop any new interventions to address any areas of concern.	

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F 280	Continued From page 8 He shook the w/c that the res was sitting in . . ." *01//17/11 at 1:00 p.m., "Res became agitated and combative . . . He was going into female residents rooms . . . " *01/17/11 at 11:30 p.m., "res was yelling out and hitting at staff when trying to check . . . " *01/18/11 at 12:30 p.m., "Res was holding onto back of another resident's w/c. 'Don't take her away that's my wife' This resident was not his wife . . . Res . . . attempted to enter another resident room after the res and her husband. Grabbing the back of her w/c and pulled husband, attempted to get Resident #1 to let go. Resident #1 started hitting his hand and arguing with him . . ." *01/22/11 at 1:00 p.m., "Res really angry . . . called an aid some inappropriate names . . ." *01/23/11, no time, "Res found several times throughout day going into people's rooms . . ." *01/26/11, "week 4, . . . Behaviors noted daily . . ." *01/27/11, "Behaviors. Res was going into res rooms after supper . . ." Review of Resident #1's weekly "Behavior Summary Report" from 01/14/11 thru 04/20/11 identified ten instances the resident demonstrated inappropriate behaviors including abusive language, kicking/hitting, pinching, scratching, yelling, and resistive to cares. Resident #1's care plan, dated 09/30/10, stated "FOCUS, History of saying negative statements and unsatisfied with placement, GOALS: Resident's negativity will decrease to one incident a week, INTERVENTIONS: *Staff offer reassurance as needed. *Offer resident choices in cares. *Activities of resident's choice offered." The care plan failed to identify behavior	F 280		

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F 280	Continued From page 9 problems, interventions, or goals for the resident's wandering, physical and verbal abuse, and yelling/screaming. During interview, on 04/20/11 at 10:30 a.m., an administrative staff member (#22) agreed Resident #1's care plan did not address the resident's behaviors or interventions specific to his needs. Failure to develop a care plan related to Resident #1's behaviors does not provide an accurate reflection of the resident's current status or provide staff the information necessary to carry out individualized interventions for this resident. - Review of Resident #10's medical record occurred on April 19-20, 2011. Medical diagnoses included persistent mental disorder, depression, and anxiety. The resident's current medications included Zoloft (for depression) daily and Alprazolam (for anxiety) as needed. Resident #10's MDS, dated 03/15/11, identified a Brief Interview for Mental Status (BIMS) score of two, indicating severe cognitive impairment. The current care plan stated, "Focus: Diagnosis of anxiety &[and] depression. Hx [history] of wandering . . . Interventions: . . . Follow resident's preferred, consistent routine as able . . . Medications as ordered . . . Mood and behavior monitoring . . . Offer emotional support and reassurance as needed when resident appears/verbalizes being frustrated . . . RTLS tag [wanderguard] . . ." Resident #10's interdisciplinary notes stated the following:	F 280		

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F 280	Continued From page 10 * 10/04/10 - ". . . Staff has been redirecting the last week as resident states 'I'm trying to get home.' Redirection to another activity or walking to her room and identifying personal belongings helps re-orient her to present time." * 12/05/10 - "Resident went to front door area. Told receptionist she was leaving. Going to walk home. Redirected . . . wanted to speak to daughter . . . left message. Gave PRN [as needed] ativan [antianxiety medication] . . ." * 01/27/11 - [Resident name] has been declining activities more often to sleep. She was becoming disruptive during Bible study as she was unable to stay on task. We have not taken her since. When she participates she needs one step commands and constant reminders. She remains happy and loves to color." * 04/19/11 at 1:00 p.m. - "[Resident name] was confused this afternoon, looking for her friend . . . Reorientated resident, staff offered to get her coloring book. [Resident name] says she will do that after taking her dog for a walk (referring to her stuffed animal dog)." * 04/19/11 at 4:30 p.m. - "Resident voicing concerns over friend she could not find, her deceased husband. Res [resident] making repetitive statements of concerns. Res. ambulating on unit [with] worried expression. Unable to calm Resident's concerns. PRN . . . [antianxiety medication] given . . . which was effective. Observations on 04/19/11 at 1:30 p.m. and 4:00 p.m. showed facility staff redirected Resident #10 out of another resident's room. At 4:00 p.m., a licensed nurse (#7) stated the resident can never find her room and staff members redirect her often. She stated staff offer her a coloring book	F 280		

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F 280	Continued From page 11 and crayons and a stuffed dog which keep her occupied for a while. During a interview on 04/20/11 at 11:25 a.m., an administrative nurse (#15) agreed Resident #10's care plan lacked interventions related to the resident's wandering behavior. Failure to develop/review/revise Resident #10's care plan related to her wandering behavior does not provide staff with the information necessary to carry out individualized interventions for this resident.	F 280		
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 observation, record review, professional reference review, resident interview, and staff interview, the facility failed to follow professional standards for 1 of 1 sampled resident (Resident #7) whose scheduled Lortab pain medication was not identified on the current physician orders and 1 of 1 sampled resident (Resident #10) whose medication administration record (MAR) and "as needed" (PRN) record showed an inconsistency in documentation. Failure to ensure physician orders are reconciled and followed accurately and failure to document PRN medications consistency in the medial record has the potential for medication errors to occur and residents to experience adverse consequences.	F 281	F 281 – PROFESSIONAL STANDARDS Resident #7 physician orders were reviewed and all medications and treatments have current orders. Resident #10 physician orders were reviewed. All medications have current physician orders. A chart audit of all current residents' orders. All orders were verified for accuracy. Nursing staff were educated on the current policy regarding documentation of PRN (as needed) medications and transcribing physician orders for residents who are newly admitted and residents returning from the hospital. This education was done on 5/16/11, 5/18/11, 5/19/11, 5/20/11 and 5/23/11.	5/23/11

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	355124	A. BUILDING _____ B. WING _____	04/20/2011

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 281	Continued From page 12 Findings include: Kozier & Erb's "Fundamentals of Nursing Concepts, Process and Practice," 8th Edition, dated 2008, page 850, stated, "Process of Administering Medications . . . 5. Record the drug administered . . . The record should also include the exact time of administration . . . Often, medications that are given regularly are corded on a special flow record. PRN (as needed) or stat (at once) medications are recorded separately." - Review of Resident #10's medical record occurred on April 20-21, 2011. Medical diagnoses included persistent mental disorder, anxiety, and depression. Medications included Zoloft (an antidepressant) 50 mg daily and Alprazolam (an antianxiety) 0.25 mg twice a day PRN. Review of the MAR and the "PRN/Withheld/Refused Explanation" sheet (explains the reason a medication was given) from December 2010 through April 19, 2011 showed Resident #10 received Alprazolam on the following days: * December MAR: 4th, 9th, 11th, 17th, 20th, 22nd, 23rd, 29th, 31st * December PRN/Explanation sheet: 4th, 9th, 11th, 23rd, 29th * January MAR: twice on the 1st, 6th, 15th 19th, 26th, 29th, 30th * January PRN/Explanation sheet: twice on the 1st, 3rd, 15th, 19th, 21st, 26th, 31st * February MAR: 3rd, 17th, 18th, 21st * February PRN/Explanation sheet: 3rd, 7th * March MAR: 6th, 7th, 9th, 14th, 17th, 25th, 29th * March PRN/Explanation sheet: 2nd, 6th 17th,	F 281	Physician orders for residents who are newly admitted or return from the hospital will have orders verified by two nurses. Audits started 5/22/11. (current policy is) This will be monitored through our QA process with random chart checks completed weekly x8 and then monthly x2 therafter by unit clinical coordinators and the DON. The audits will be submitted to the facility QA committee who will evaluate them to identify any trends. They will develop any new interventions to address any areas of concern. per T.C. with Penny Weston, Adm. 10:15 6/6/11 P. Swenson	

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F 281	Continued From page 13 and twice on the 25th * April MAR: 2nd, twice on the 10th, 15th, and twice on the 19th * April PRN Explanation sheet: twice on the 19th Review of the above information reveals discrepancies between Resident #10's MAR and the PRN/Explanation sheet. On many days the facility staff failed to give an explanation as to why the resident received the Alprazolam and on many days either the facility nurse recorded the Alprazolam on the MAR and not on the PRN/Explanation sheet or vise versa. During an interview on 04/20/11 at 11:25 a.m., and administrative nurse (#15) agreed there are discrepancies between Resident #10's MAR and PRN/Withheld/Refused Explanation sheet. - During interview, on 04/18/11 at 4:15 p.m., Resident #7, identified by the facility as interviewable, stated she received scheduled pain medication throughout the day and night. Review of Resident #7's medical record occurred on April 18-20, 2011. Review of Resident #7's MAR for April 2011 identified staff administered Lortab 7.5/500 mg orally every six hours. The April physician orders failed to identify the Lortab which staff currently administer.	F 281		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional	F 325	F 325 – NUTRITIONAL STATUS Resident #9 has been assessed by the LRD and nutritional interventions have been implemented. Resident's weight has stabilized. The resident is within the the ideal body weight.	5/23/1

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F 325	Continued From page 14 status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy and procedure review, resident interview, and staff interview, the facility failed to ensure acceptable parameters of nutritional status for 1 of 1 sampled resident (Resident #9) who experienced unplanned weight loss. Failure to implement additional interventions or evaluate the effectiveness of current interventions may have contributed to Resident #9's significant weight loss. Findings include: Review of the facility's policy titled "Nutrition Assessment" occurred on the afternoon of 04/20/11. The policy, revised November 2009, stated, ". . . Weights are taken weekly and monitored monthly by the dietitian. Any weight change of 5% in one month, or 7.5% in 3 months, or 10% in 6 months is considered a significant weight change. The dietitian will make recommendations for interventions on residents with significant weight changes." Review of Resident #9's medical record occurred on all days of survey. The resident's medical diagnoses included depressive disorder, anxiety,	F 325	Current resident's weights were reviewed to determine if there were any unplanned significant weight losses. None were identified. Education was provided to the nursing staff on the current policy and procedure on the measurement of weights. Dietary and nursing staff were educated on the policy for passing snacks . LRD and clinical coordinators were educated on weight monitoring. This education was presented on 5/16/11, 5/18/11, 5/19/11, 5/20/11 and 5/23/11. Resident weights will be monitored monthly x1 for all current residents and weekly x4 on all new admissions and hospital returns by the unit clinical coordinator, DON, and LRD through the QA process. This was started on 5/25/11. These audits will be submitted to the facility QA committee for identification of any trends and ensuring continued compliance or need for any additional interventions.	

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F 325	Continued From page 15 chronic renal failure, and dyspepsia (upset stomach). Resident #9's current care plan, initiated on 08/30/10, identified the following: Problem: "Altered nutrition and possible weight loss r/t [related to] times of edema [fluid retention], diuretic medication, abnormal labs . . . has dentures, food allergy to eggs, disease/conditions . . . impaired skin integrity, [short term memory] loss, times of pain, h/o [history of] significant weight gain. Goals: "[Resident name] will consume at least 75% of meals with assistance as needed without difficulties . . . [Resident name] will maintain her weight. . . ." Interventions: "Weigh as needed. Monitor for changes and notify MD/NP [medical doctor/nurse practitioner] as indicated of significant weight changes. . . . Provide a Regular diet and monitor during and between meals for food consumption. . . . Offer snacks throughout the day. . . ." During an interview on 04/19/11 at 8:30 a.m., Resident #9 stated she had not been eating in the past because she was nauseated and lost weight but she was better now and trying to eat. Observation of Resident #9's meals on 04/19/11 showed the resident received a regular diet with no additional high calorie or high protein foods. Observation of breakfast, showed the resident consumed two pancakes and 8 ounces (oz) orange juice. At the noon meal, Resident #9 consumed more than 50% and continued to eat 6 oz turkey tetrazinni, 4 oz tropical fruit, one dinner roll, 4 oz orange juice, and 8 oz coffee. Observation on 04/19/11 at 3:15 p.m., showed no	F 325		

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F 325	Continued From page 16 evidence of a snack provided to the resident. Interview of an evening shift certified nursing assistant (CNA) (#18) indicated an unidentified morning shift CNA passed a variety of snacks at 2:30 p.m. Review of Resident #9's meal intake records on the afternoon of 04/20/11, showed for the breakfast meal 76 - 100%, the noon meal 51-75%, and the evening meal 76-100%. Review of Resident #9's dietary card, on the afternoon of 04/19/11, showed facility staff did not provide additional high calorie or high protein foods to the resident. Review of Resident #9's Nutrition Assessments identified the following: *initial, 08/04/10 - weight 128 pounds and ideal body weight between 105 and 115 pounds with no usual body weight recorded. *quarterly, 10/29/10 - weight 133 pounds, within normal limits body mass index (BMI) of 24.3 and an albumin on 10/04/10 of 2.9 (below normal limits indicating possible malnutrition). *quarterly, 01/27/11 - weight 118.8 pounds, appetite 50 - 100 % range, and times of edema. Resident #9's physician's orders identified the physician last adjusted the resident's Lasix (a diuretic) from 20 milligrams (mg) at 8:00 a.m. and 10 mg at 12:00 p.m. to 30 mg at 8:00 a.m. and no dose at 12:00 p.m. on 11/08/10. Review of the MD/Nursing Communication notes revealed the facility last provided information regarding Resident #9's weight to the physician on 11/10/10. Review of the nurses' notes for January - April revealed no evidence of Resident #9 experiencing edema.	F 325		

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F 325	Continued From page 17 Review of the dietary progress notes identified the following: *01/31/11 - "Quarterly review: Diet: Regular Weight 118.8# (01/27/11). Resident has had weight fluctuations. Was 122# (12/28/10), [down] 2.6% in one month. Weight six months ago was 128#, a loss of 7% in six months. Currently eating 50-100% at most meals. . . Continue to monitor weights." The record lacked further dietary progress notes following this entry. Review of Resident #9's weight summary record showed an overall weight loss. Weekly weights obtained from the resident's daily weights included the following: *10/18/10 - 140.0 pounds *10/25/10 - 136.5 pounds *10/31/10 - 133.4 pounds *11/10/10 - 132.6 pounds *11/17/10 - 131.0 pounds *11/30/10 - 128.5 pounds *12/07/10 - 125.8 pounds *12/14/10 - 127.4 pounds *12/20/10 - 125.8 pounds *12/29/10 - 124.4 pounds *01/08/11 - 120.1 pounds *01/15/11 - 122.0 pounds *01/21/11 - 120.0 pounds *01/30/11 - 117.2 pounds *02/07/11 - 117.2 pounds *02/14/11 - 111.8 pounds *02/27/11 - 112.2 pounds *03/08/11 - 110.0 pounds *03/15/11 - 110.4 pounds *03/22/11 - 109.2 pounds *03/31/11 - 104.6 pounds *04/01/11 - 108.5 pounds	F 325		

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F 325	Continued From page 18 *04/07/11 - 103.8 pounds *04/14/11 - 105.8 pounds *04/19/11 - 106.4 pounds (24% weight loss in 6 months) Review of the "Evening Snack Check List," a record of residents' evening snack intake completed by dietary staff, for January - April identified the following: *February - 4 days with recorded refusals/sleeping and no record for 7 of 28 days. *March - 5 with recorded refusals/out and no record for 11 of 31 days. *April - 2 with recorded refusals and no record for 5 of 17 days. During an interview on the afternoon of 04/19/11, two CNAs (#13 and #14) stated the CNAs did not record the residents' intake of the afternoon snacks, as stated on the care plan. During an interview on the afternoon of 04/19/11, a nursing staff member (#16) stated nursing staff pass nutritional supplements to the residents with a required order from the physician. Resident #9's physicians' orders identified the resident did not have an order for a nutritional supplement. During interviews conducted on the morning and afternoon of 04/20/11, an administrative dietary staff member (#4) stated she completed a random review of the "Weights and Vitals Exception Report" for all residents in the facility the first week of April to determine if immediate nutrition interventions should be implemented. This staff member stated she reviewed the resident's weight for the one month of March and it had remained stable. This staff member confirmed facility staff should monitor the	F 325		

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F 325	Continued From page 19 residents' afternoon and evening snack intake to evaluate the effectiveness of the care planned intervention. This staff member agreed additional nutrition interventions should be implemented for Resident #9. Resident #9 did have weight fluctuations indicating edema, however an overall weight loss had occurred for the resident from January - April. Review of the resident's weight records showed it is the history of the resident for her weight to remain stable overall for one month then decline as a gradual weight loss. Failure to evaluate Resident #9's current dietary interventions and initiate new interventions may have contributed to her overall significant weight loss.	F 325		
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 record review, review of professional reference, family interview, and staff interview, the facility failed to ensure 1 of 1 sampled resident (Resident #2), who received an antipsychotic medication without a physician's order, remained free from significant medication errors. Failure to ensure medications are given accurately, with a physician's order, may jeopardize the health and safety of the residents. Findings include:	F 333	F 333 – FREE OF MED ERRORS Resident # 2 has had all physician orders verified including med orders. He is receiving medications as ordered. Refer to F 281 re: chart audits ~~This plan of correction is included in F 281. See F281.~~ Staff education on documentation of prn meds + transcribing ... Nursing staff were educated on the current policy regarding transcribing physician orders for new admissions and patients returning from the hospital. The education was provided on 5/16/11, 5/18/11, 5/19/11, 5/20/11 and 5/23/11.	5/23/1 per T.C. with Penny Weston, Adm. To P. Swenson 10:15 am 6/6/11

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F 333	Continued From page 20 Kozier & Erb's "Fundamentals of Nursing, Concepts, Process and Practice," 8th Edition, dated 2008, page 850, stated, ". . . Ten "Rights" of Medication Administration . . . Right Medication . . . The medication given was the medication ordered . . . ." During interview, on 04/19/11 at 2:10 p.m., Resident #2's family member (#10) stated after a hospitalization last November, the resident received two antipsychotic medications Risperdal and Seroquel from 11/19/10 to 11/30/10. The family member (#10) stated the "Seroquel should have been discontinued." Review of Resident #2's medical record occurred on April 19-20, 2011. The record identified the facility readmitted Resident #2 on 11/19/10. The record contained a hospital discharge list, dated 11/19/10, which identified Seroquel 25 mg (milligrams) as discontinued with a line drawn through the column. Review of Resident #2's medication administration record (MAR) for November, 2010 identified the facility administered Seroquel 25 mg orally at bedtime daily from 11/19/10 through 11/30/10. Review of Resident #2's nurses' notes identified the following on 12/01/10: "Med [medication] Correction - Res [resident] discharge hosp. [hospital] orders were difficult to decipher. With discussion [with] Res. Mom, Res. was not to be taking Seroquel upon Hospital discharge. . ."	F 333	Physician orders for residents who are newly admitted or return from the hospital will have orders verified by two nurses. (current policy) The physician order process will be monitored through our QA process with random chart checks weekly x 3 then monthly x2 thereafter by the unit clinical coordinators and DON. These audits began on 5/24/11. These audits will be submitted to the facility QA committee for identification of any trends and ensuring continued compliance or need for any additional interventions.	

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F 333	Continued From page 21 During interview, on 04/20/11 at 8:05 a.m., a staff nurse (#17) confirmed that Resident #2 received Seroquel from 11/19/10 until 11/30/10 without a physician order. She also stated the facility did not clarify the hospital discharge orders for Seroquel at the time of Resident #2's readmission.	F 333		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, record review, manufacturer's recommendations, and staff interview, the facility failed to store, prepare, and serve foods in a safe and sanitary manner in 1 of 1 kitchen and 2 of 2 kitchenettes/service areas (North and South). This practice placed residents at risk for foodborne illness. Findings include: Review of the facility's policy titled "Meat Slicer" occurred on the afternoon of 04/20/11. The policy, revised November 2009, stated, ". . . Procedure: . . . 4. Remove the center plate by lifting center plate locking knob on the top of	F 371	F 371 FOOD PREP/STORAGE – SANITARY Meat slicers in all kitchen/kitchenettes were thoroughly cleaned according to policy. All utensils were examined and replaced as necessary. Dietary staff was educated on proper cleaning of meat slicer on 5/19/11, 5/20/11, 5/23/11 and 5/24/11. Supplements in all areas were checked for appropriate opening/thaw dates. Those without dates were destroyed. Dietary and nursing staff was educated on the policies and procedures for dating supplements. Education was done on 5/16/11, 5/18/11, 5/19/11, 5/20/11, 5/23/11 and 5/24/11. This process will be monitored through QA by performing random inspections monthly x4 by the LRD. QA inspections were started on 5/24/11.	5/23/11

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F 371	Continued From page 22 center plate and lift it from slicer. . . . 8. Clean the front side and back side of the knife with a non-abrasive pad. 9. Use clean cloth to work between the knife guard, starting at the base of the ring guard. Carefully work cloth around the knife using extreme caution. . . ." A main tour of the kitchen and kitchenettes/serving areas occurred on 04/20/11 at 9:15 a.m. with an administrative dietary staff member (#4). Observation of the main kitchen showed the following: *Meat slicer, covered to indicate clean and sanitized, with food debris on both sides of its blade/knife. *One rubber scraper with a rough uncleanable surface Observation of the North and South kitchenette/serving areas showed the following: *Five, sixteen ounce cartons of thawed, milk-based supplements, not labeled with the date thawed. The manufacturer labeled the supplements with the recommendation to "Use thawed product within 14 days." *Four rubber scrapers with rough uncleanable surfaces. During an interview on the morning of 04/20/11, the administrative dietary staff member (#4)confirmed equipment should be maintained clean and sanitized with cleanable surfaces and supplements should be labeled with the date thawed.	F 371	These audits will be submitted to the facility QA committee for identification of any trends and ensuring continued compliance or need for any additional interventions.	