DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/23/2015
FORM APPROVED
OMB NO. 0938-0391

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 _____	04/08/2015

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 04/06/15 and completed on 04/08/15, the sample included five (5) residents for complete review, eight (8) residents for focused review, and two (2) closed records for review.	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. The facility must inform each resident before, or	F 156	F 156 1. CMS 10124 Detailed Explanation of Non-Coverage forms will be issued to the persons acting on the behalf of former resident #10 and current resident #11. 2. Residents who request demand bills have the potential to be affected. 3. The demand bill process will be reviewed and a system put in place so that all steps including CMS 10124 Detailed Explanation of Non-Coverage are followed. 4. May 13, 2015 5. Auditing demand bills to ensure that the CMS 10124 has been issued will be completed as follows: 3 times/week for 4 weeks, 8 times/month for 2 months, 4 times/month for 3 months and prn. Results of audits will be brought to QA Committee for review and recommendation. → by Social Services or designee Per DON 5/14/15 KB	5/13/15

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

Karen K Seman, LNFA | Executive Director | 5/4/15

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 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. The facility must inform each resident of the name, specialty, and way of contacting the	F 156		

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F 156	Continued From page 2 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 review of the facility's Medicare billing notices, Medicare billing records, and staff interview, the facility failed to provide the required form "Detailed Explanation of Non-Coverage" for 2 of 2 sampled residents (Resident #10 and #11) who requested a demand bill. Failure to provide written notice to the resident or their responsible party regarding a detailed explanation of non-coverage is a violation of resident rights. Findings include: Review of the facility's Medicare billing records occurred on 04/07/15. Resident #10 and Resident #11 each requested demand bills after they were issued a notice of termination of Medicare coverage. The facility provided evidence the demand bills were submitted for these residents, but failed to issue the required "CMS [Centers for Medicare and Medicaid Services]-10124 Detailed Explanation of Non-Coverage" form to Resident #10 and #11 and/or the person acting on their behalf. During interview on the afternoon of 04/07/15, an	F 156		

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F 156	Continued From page 3 administrative staff nurse (#1) confirmed the facility did not provide the CMS-10124 Detailed Explanation of Non-Coverage form to Resident #10 and #11.	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, and resident interview, the facility failed to provide reasonable accommodation of needs regarding call lights for 1 of 13 sampled resident (Resident #3). Failure to provide an accessible call light may result in falls, avoidable incontinence, increased behaviors, and a decreased quality of life. Findings include: Review of Resident #3's medical record occurred on all days of survey. Diagnoses included anxiety, psychosis, and a history of shoulder joint replacement. The current care plan stated, ". . . Potential for falls r/t [related to] unsteady gait while standing/walking. . . . Transfers: Assist of 1 . . . . Resident is typically alert and oriented to person place and time, but does have episodes of confusion. . . . Keep call light within reach at all times when in room. . . ." The quarterly Minimum	F 246	F 246 1. Resident #3 had call light extender placed 4/8/15 prior to the end of survey. 2. An evaluation of all resident rooms was completed 4/8/15. One room of 55 remaining rooms has the same potential if furniture was arranged differently than current. 3. Education will be completed May 7, 2015 to nursing and maintenance staff of the need to have call lights within resident reach and the ability to accommodate various call light lengths as needed depending on room size and configuration. 4. May 13, 2015 5. Auditing of resident rooms to ensure the call lights are within reach will be completed by Environmental Services or designee as follows: 3 times/ week for 4 weeks, 8 times/month for 2 months, 4 times/month for 3 months and prn. Results of audits will be brought to QA Committee for review and recommendation.	5/13/15

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F 246	Continued From page 4 Data Set (MDS), dated 02/28/15, identified moderately impaired cognition and two or more falls since the last assessment. During the initial tour on 04/06/15, observation showed a bell sitting on Resident #3's bedside table. When asked what the bell is used for, Resident #3 stated she used it when she sat in her recliner due to her call light cord not reaching. Resident #3 also said the bell is not loud enough for staff to hear. Observation on 04/06/15 at 3:45 p.m. showed a certified nursing assistant (CNA) (#15) transferred Resident #3 to the recliner and secured the call light on the resident's wheelchair. The CNA asked the resident if she could reach the call light and Resident #3 replied "no". The CNA said she would look for a grabber for the resident to use to reach the call light and left the room. The CNA failed to provide the resident with a means to call for assistance and did not locate a grabber for Resident #3. On 04/07/15 at 9:30 a.m., during the environmental tour, the surveyor informed a managerial maintenance staff member (#16) Resident #3's call light cord was not long enough. On 04/07/15 at 2:39 p.m., a CNA (#10) transferred Resident #3 to the recliner and observation showed the call light did not reach the resident. The CNA failed to provide the resident with a means to call for assistance.	F 246		
F 278 SS=E	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the	F 278		

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F 278	Continued From page 5 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 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: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual (Version 3.0), and staff interview, the facility failed to ensure the Minimum Data Sets (MDSs) accurately reflected the residents' status for 10 of 13 sampled residents (Resident #1, #2, #3, #4, #5, #6, #7, #8, and #9) coded incorrectly on the MDS. Failure to code portions of the MDS correctly does not provide an	F 278	F 278 1. The MDSs for Residents 1, 2, 3, 4, 5, 6, 7, 8, and 9 will be evaluated and corrected as needed to accurately reflect current turning and repositioning program. 2. All residents have the potential to be affected. 3. The MDSs for all residents will be evaluated to ensure it accurately reflects any turning and repositioning programs. 4. May 13, 2015 5. Auditing of resident MDSs to ensure accuracy of turning and repositioning programs will be completed by Director of Culinary and Nutrition or designee as follows: 3 times/week for 4 weeks, 8 times/week for 2 months, 4 times, month for 3 months and prn. Results of audits will be brought to QA Committee for review and recommendation.	5/13/15

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F 278	Continued From page 6 accurate assessment of the resident's current status and needs and may prevent staff from developing an effective comprehensive care plan that meets the needs of the residents. Findings include: The Long-Term Care Facility RAI User's Manual, October 2014, stated the following: * Section M1200C (Turning/Repositioning Program), page M-38, stated, "The turning/repositioning program is specific as to the approaches for changing the resident's position and realigning the body. The program should specify the intervention (e.g. [example given] reposition on side, pillows between knees) and frequency (e.g. every 2 hours). Progress notes, assessments, and other documentation (as dictated by facility policy) should support that the turning/repositioning program is monitored and reassessed to determine the effectiveness of the intervention." Review of the medical record for Resident #1, #2, #3, #4, #5, #6, #7, #8, and #9 occurred April 06-08, 2015. - Resident #1's quarterly MDS, dated 03/08/15, identified a turning/repositioning program present during the seven day assessment period. The MDS identified no pressure ulcers, wounds, or other skin problems. The current care plan stated, "Potential for skin breakdown related to cognitive impairment . . . Assist resident to turn and reposition every 2 hours and prn [as needed], off-loading pressure for at least one minute. . . ." - Resident #2's admission MDS, dated 12/01/14, identified a turning/repositioning program present	F 278		

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F 278	Continued From page 7	F 278		

during the seven day assessment period. The MDS identified no pressure ulcers, wounds, or other skin problems. The current care plan stated, "Potential for skin breakdown related to decreased mobility . . . Assist resident to turn and reposition every 2 hours and prn, off-loading pressure for at least one minute. . . ."

- Resident #9's quarterly MDS, dated 02/23/15, identified a turning/repositioning program present during the seven day assessment period. The MDS identified no pressure ulcers, wounds, or other skin problems. The current care plan stated, "Potential for skin breakdown related to decreased mobility secondary to stroke . . . Assist resident to turn and reposition every 2 hours and prn, off-loading pressure for at least one minute. . . ."

- Resident #4's significant change MDS, dated 02/12/15, identified a turning/repositioning program present during the seven day assessment period. The current care plan stated, ". . . Potential for skin breakdown related to pressure areas . . . Assist resident to turn and reposition every 2 hour and prn, off-loading pressure for at least one minute. . . ."

- Resident #5's annual MDS, dated 02/28/15, identified a turning/repositioning program present during the seven day assessment period. The current care plan stated, ". . . Potential for skin breakdown related to impaired physical mobility/needing more assistance . . . Assist resident to turn and reposition every 2 hours and prn, off-loading pressure for at least one minute. . . ."

- Resident #8's annual MDS, dated 03/03/15,

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F 278	Continued From page 8	F 278		

identified a turning/repositioning program present during the seven day assessment period. The current care plan stated, ". . . Potential for skin breakdown related to decreased mobility . . . Assist resident to turn and reposition every 2 hours and prn, off-loading pressure for at least one minute. . . ."

- Resident #3's quarterly MDS, dated 02/28/15, identified a turning/repositioning program present during the seven day assessment period. The MDS identified no pressure ulcers, wounds, or other skin problems. The current care plan stated, ". . . Potential for skin breakdown related to decreased mobility and decreased mobility of right shoulder/arm . . . Ind [independent] with bed mobility. . . ."

- Resident #6's quarterly MDS, dated 02/21/15, identified a turning/repositioning program present during the seven day assessment period. The MDS identified at risk of pressure ulcers, no wounds, or other skin problems. The current care plan stated, ". . . Potential for skin breakdown related to increased weakness and a high fall risk. . . . Assist of 1 to turn and reposition every 2 hours and prn, off-loading pressure for at least one minute. . . ."

- Resident #7's quarterly MDS, dated 03/16/15, identified a turning/repositioning program present during the seven day assessment period. The MDS identified no pressure ulcers, wounds, or other skin problems. The current care plan stated, ". . . Potential for skin breakdown related to bladder incontinence. . . ." The care plan failed to identify a repositioning schedule.

The medical records lacked documentation to

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F 278	Continued From page 9 support an individualized repositioning schedule. During an interview on the afternoon of 04/08/15, an administrative nurse (#1) agreed the MDSs for Resident #1, #2, #3, #4, #5, #6, #7, #8, and #9 were coded incorrectly for a turning and repositioning program.	F 278		
F 309 SS=E	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 record review, review of facility policy, and staff interview, the facility failed to provide the necessary care and services to manage behavioral symptoms of dementia for 4 of 8 sampled residents (Resident #1, #6, #11, and #13) with behaviors and receiving psychopharmacological medications. Failure to thoroughly assess the residents' behaviors and attempt non-pharmacological interventions prior to administering psychopharmacological medications may result in decreased physical, mental, and psychosocial well-being and negatively impact these residents' quality of life. Findings include: Review of the facility policy titled	F 309	F 309 1. For residents 1, 6, 11, and 13, any behaviors will be assessed and non-pharmacological interventions will be attempted prior to administering PRN psycho-pharmacological medications. 2. Residents receiving psycho-pharmacological medications have the potential to be affected. 3. A committee will be formed to review and make recommendations regarding the use of psycho-pharmacological medications. An individualized list of non-pharmacological interventions will be created for each resident receiving psycho-pharmacological medications. Education on committee actions as well as necessary supporting documentation will be completed with nurses May 7, 2015. 4. May 13, 2015 5. Auditing of resident nursing documentation to ensure the use of non-pharmacological approaches prior to administering PRN psycho-pharmacological medications will be completed by Resident Care Manager or designee as follows: 3 times/ week for 4 weeks, 8 times/month for 2 months, 4 times/month for 3 months and prn. Results of audits will be brought to QA Committee for review and recommendation.	5/13/15

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F 309	Continued From page 10 "Psychopharmacological Medication Use" occurred on 04/07/15. This policy, revised January 2015, stated, ". . . Medication Management must include: 1. Appropriate indications for use of medications ordered . . . 5. Prevention, identification, and response to adverse effects of the medication, PRN [as needed] administration document interventions prior to administration, effectiveness . . ." - Review of Resident #1's medical record occurred on all days of survey. Diagnoses included anxiety, depression, dementia, and psychosis. Daily medications included buspirone (antianxiety) 0.5 milligrams (mg) three times a day; Ativan (antianxiety) 0.5 mg twice a day and 1 mg once a day; Celexa (antidepressant) 10 mg daily; Remeron (antidepressant) 45 mg daily; Seroquel 37.5 mg three times a day; and PRN Ativan 0.25 mg twice daily. Resident #1's quarterly Minimum Data Set (MDS), dated 03/08/15, identified long and short term memory problems, inattention, disorganized thinking, and wandering. The care plan stated, "Focus: The resident has impaired cognitive function/dementia or impaired thought process . . . Interventions: . . . Reduce any distractions-turn off TV, radio, close door etc. The resident understands consistent, simple, directive sentences. Provide the resident with necessary cues-stop and return if agitated . . . Engage her in simple, structured activities . . . Keep the resident's routine consistent and try to provide consistent caregivers as much as possible in order to decrease confusion/restlessness . . . Focus: . . . family notes some confusion/forgetfulness . . . Interventions:	F 309		

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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 _____	04/08/2015

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 309	Continued From page 11 Administer medications as ordered and monitor effectiveness and side effects. Update practitioner as needed . . ." Review of the nurses' notes and medication administration record (MAR) from 01/01/15 through 04/08/15 identified Resident #1 received PRN Ativan 37 times. Twelve of the 37 times the resident received the PRN medication, the facility staff failed to attempt non-pharmacological interventions prior to the administration. - Review of Resident #13's medical record occurred on 04/08/15. Diagnoses included depression and anxiety. Medications included Ativan (an antianxiety medication) prn [as needed]. Resident #13's admission MDS, dated 02/17/15, identified moderate cognitive impairment. The current care plan stated, ". . . Diagnoses of depression and anxiety . . . Follow resident's preferred, consistent routines as able. Medications as ordered. . . . Offer emotional support and encourage family involvement. Provide consistent caregivers as able. Provide support and reassurance as needed when resident appears/verbalizes being frustrated. . . ." Review of the nurses' notes and MARs 02/01/15 through 03/31/15 identified Resident #13 received PRN Ativan 37 times. Twenty-nine of the 37 times the resident received the PRN medication, the facility staff failed to attempt non-pharmacological interventions prior to the administration. - Review of Resident #6's medical record occurred on all days of survey. Diagnoses included dementia, anxiety, and depression. Medications included Ativan as needed for acute	F 309		

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F 309	Continued From page 12 agitation. The quarterly MDS, dated 02/21/15, identified long and short term memory problems, inattention, disorganized thinking, and wandering. The current care plan stated, ". . . Focus: Diagnosis of depression and anxiety. . . . Interventions . . . Provide 1:1 visits for conflict resolution/problem solving/redirection as needed. . . . Provide support and reassurance as needed when resident appears/verbalized being frustrated. . . . Focus: The resident has the potential to demonstrate physical behaviors r/t [related to] dementia. Wanders off unit at times. . . . Interventions . . . Family in agreement with using therapeutic work to distract her when anxious . . . such as folding clothes, holding life like baby doll. Reapproach [sic] with different staff member if resident's agitation continues and approaches ineffective. . . . When the resident becomes agitated: Intervene before agitation escalates; Guide away from source of distress; Engage calmly in conversation; If response is aggressive, staff to walk calmly away, and approach later. . . . Focus: May become verbally and physically abusive to staff, other residents, or visitors due to Dementia. . . . Interventions: Nursing to redirect resident using 'Creating Moments of Joy' tactics. Offer bathroom, snack, or 1:1 visit with staff to redirect. Secure resident into safe position and leave residents room to let calm and reproach at later time when combative. . . ." Review of Resident #6's January 2015 through April 2015 progress notes and MARs identified PRN Ativan administered nine times. Five out of the nine times facility staff failed to attempt non-pharmacological interventions prior to the administration.	F 309		

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F 309	Continued From page 13	F 309		

- Review of Resident #11's medical record occurred on 04/08/15. Diagnoses included dementia with behaviors and psychosis. Medications included Haldol as needed for agitation and Ativan as needed for agitation. The significant change MDS, dated 03/09/15, identified long and short-term memory problems and disorganized thinking.

The current care plan stated, ". . . Focus: Resident is alert and oriented to family. Has episodes of paranola, agitated and aggressive behavior, has short term memory loss. . . . Interventions . . . Offer non medication interventions, (e.g. [example given] offer 1:1 [one-to-one] visitation, soothing music, or ambulation on unit) to reduce agitation, anxiety. . . . Focus: May become physically abusive to staff, other residents, or visitors. . . . Interventions: Call family . . . to come in and visit with resident when having increased agitation and behaviors towards others. Encourage to pray. If resident appears angry, agitated or upset remove her from the area of other residents or remove others from around her. Play hymns/Christian worship music on CD player. . . . Use prn ativan as ordered and chart symptoms/behavior before and after med is given . . . Focus: Diagnosis of Dementia with behavioral disturbances. May resist cares, physical aggressiveness has been noted. . . . Interventions . . . Provide 1:1 visits for conflict resolution/problem solving/redirection as needed. Provide support and reassurance as needed when resident appears/verbalizes being frustrated. . . ."

Review of Resident #11's January 2015 through April 2015 progress notes and MARs identified

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F 309	Continued From page 14 PRN Ativan administered eight times and PRN Haldol administered three times. Four of the eight times the resident received Ativan and two of the three times the resident received Haldol the facility staff failed to attempt non-pharmacolgoical interventions prior to the administration. During an interview on 04/08/15 at 5:00 p.m., an administrative nurse (#1) stated she expected facility staff to document interventions attempted prior to administration of psychopharmacological medications.	F 309		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy and procedure review, and staff interview, the facility failed to provide the necessary care and services to promote healing and prevent recurrence of pressure ulcers for 1 of 2 sampled residents (Resident #8) with a facility acquired pressure ulcer. Failure to ensure staff consistently implemented existing interventions placed Resident #8 at risk for the development of new pressure ulcers and the reoccurrence of a	F 314	F 314 1. Resident #8 will be evaluated for toileting program and turning and repositioning program to prevent new development of pressure ulcers and the recurrence of healed pressure ulcers. 2. Residents at risk for skin breakdown have the potential to be affected. 3. All residents at risk for skin breakdown will be evaluated for the need of a turning and repositioning program. Individualized programs will be implemented as needed. Residents identified on their care plan of being incontinent of bowel and/or bladder will have toileting programs followed. These programs will be assessed quarterly and with change in condition. Education on prevention and treatment of pressure sores will be completed with nursing staff May 7, 2015. 4. May 13, 2015 5. Auditing of resident turning and repositioning programs being followed will be completed by Director of Nursing or designee as follows: 3 times/week for 4 weeks, 8 times/week for 2 months, 4 times/month for 3 months and prn. Results of audits will be brought to QA Committee for review and recommendation.	5/13/15

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F 314	Continued From page 15 recently healed pressure ulcer. Findings include: Review of the facility's policy titled "Skin Assessment" occurred 04/08/15. The policy, not dated, indicated, ". . . Braden 'Risk Level Protocols' are as follows: At Risk (15-18): Frequent turning . . . Manage moisture . . ." Review of Resident #8's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease, muscle weakness, osteoarthritis, and a fracture of left femur, not surgically repaired. The annual Minimum Data Set (MDS), dated 03/03/15, identified the resident required extensive assistance of two persons with bed mobility and toileting. Resident #8's "Braden Scale for Predicting Pressure Sore Risk," effective 03/01/15, identified a score of 15. Resident #8's current care plan stated, ". . . Potential for skin breakdown related to decreased mobility. Has Stage [two] pressure ulcer to coccyx, revised, 03/16/15, . . . Assist resident to turn and reposition every 2 hours and prn [as needed], off-loading pressure for at least a minute . . . Potential for changes to bowel and bladder function r/t [related to] decreased mobility . . . Check disposable incontinent product [every] 2 hrs [hours] with toileting and change prn . . ." Resident #8's progress notes identified the following: *03/30/15 at 9:52 a.m. - ". . . open area remains to coccyx . . ." Observation on 04/06/15 at 1:30 p.m. showed two CNAs (#2 and #4) transferred Resident #8 from	F 314		

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F 314	Continued From page 16 her wheelchair to the bed. The CNA (#2), when asked, reported she last provided incontinence cares four and a half hours prior. No toileting (check and change brief in bed) or a change of position occurred during this time period. The CNAs (#2 and #4) removed the resident's brief which showed the resident incontinent of bowel and a new reddened area on her right buttock. The CNAs (#2 and #4) failed to reposition Resident #8 and check and change her brief as care planned. Observation on 04/07/15 at 8:25 a.m. through 9:05 a.m. showed two certified nursing assistants (CNAs #2 and #3) provided morning cares for Resident #8. A nurse (#4) entered the room and removed a foam dressing from Resident #8's coccyx. The nurse identified the pressure ulcer as closed with a darkened area of skin, 0.4 by 0.5 centimeters (cm) in size. During an interview on 04/08/15 at 5:00 p.m., an administrative nursing staff member (#1) confirmed she would expect facility staff to reposition Resident #8 and provide toileting every two hours. Failure to provide toileting and repositioning placed Resident #8 at risk for developing additional pressure ulcers or reoccurrence of the healed pressure ulcer.	F 314		
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	F 323		

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F 323	Continued From page 17 prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and review of facility policy, the facility failed to provide adequate assistance devices (gait belt) for 3 of 8 sampled residents (Resident #2, #3, and #6) observed during transfers. Failure of the facility to ensure staff properly used a gait belt placed the residents at risk for accident and/or injury. Findings include: Review of the facility's policy titled "Standards of Care" occurred on the afternoon of 04/08/15. The policy, dated May 2013, stated, ". . . Safety: 1. Gait belt use for assisted transfers and ambulations . . ." - Review of Resident #2's medical record occurred on all days of survey. Diagnoses included Parkinson's disease and debility. The admission Minimum Data Set (MDS), dated 01/07/15, identified extensive assistance required for all activities of daily living (ADLs), including transfers. The current care plan stated, "Potential for falls . . . Interventions: Assist x2 [of two] and gait belt with ambulation . . ." Observation on 04/07/15 at 9:03 a.m. showed the certified nursing assistant (CNA) (#10) transported Resident #2 to the bathroom via wheelchair, applied a gait belt, and assisted the resident to an upright position by pulling up on the back of his pants. The CNA (#10) failed to use	F 323	F 323 1. Gait belts will be used with ambulation and transfers for residents #2, 3, and 6. 2. Residents requiring assistance with transfers and ambulation have the potential to be affected. 3. Gait belts will be used with residents identified on their care plan as needing assistance with transferring and ambulation. This need for assistance will be assessed quarterly and with change in condition. Education for nursing staff on the use of gait belts with transfers and ambulation will be completed May 7, 2015. 4. May 13, 2015 5. Auditing of gait belt usage with resident transfers will be completed by Resident Care Manager or designee as follows: 3 times/week for 4 weeks 8 times/month for 2 months, 4 times/month for for 3 months and prn. Results of audits will be brought to QA Committee for review and recommendation.	5/13/15

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F 323	Continued From page 18 the gait belt. Observation on 04/07/15 at 1:10 p.m. showed Resident #2 seated in his wheelchair. The CNA (#10) applied a gait belt and assisted the resident to an upright position by lifting under his arm. The CNA failed to use the gait belt. - Review of Resident #3's medical record occurred on all days of survey. Current diagnoses included muscle weakness and anxiety. The current care plan stated ". . . Potential for falls r/t [related to] unsteady gait while standing/walking. . . . Transfers: Assist of 1 . . ." Observation on 04/07/15 at 2:39 p.m. showed a CNA (#10) transferred Resident #3 from her bed to the wheelchair, from the wheelchair to the toilet, from the toilet to the wheelchair, and from the wheelchair to the recliner. The CNA failed to utilize a gait belt. - Review of Resident #6's medical record occurred on all days of survey. Current diagnoses included muscle weakness, difficulty in walking, dementia, and personal history of falls. The current care plan stated ". . . Potential for falls r/t very high fall risk d/t [due to] history of recent falls, dementia and use of meds [medications]. Is impulsive and frequently attempts to self transfer. . . . Transfers: assist of one . . ." Observation on 04/07/15 at 7:45 a.m. showed a CNA (#13) transferred Resident #6 from the toilet to her wheelchair. The CNA failed to utilize a gait belt.	F 323		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		

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F 441	Continued From page 19 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	F 441 1. Proper hand hygiene will be used with cares for resident #8. Resident #12 no longer resides in facility as of 4/24/15. 2. All residents receiving assistance with incontinent care and catheter cares have the potential to be affected. 3. Education with nursing staff on the proper infection control practices of glove usage and hand hygiene will be completed May 7, 2015. 4. May 13, 2015 5. Auditing of hand hygiene with resident incontinent and catheter care will be completed by Resident Care Manager or designee as follows: 3 times/week for 4 weeks, 8 times/month for 2 months 4 times/month for 3 months and prn. Results of audits will be brought to QA Committee for review and recommendation.	5/13/15

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F 441	Continued From page 20 This REQUIREMENT is not met as evidenced by: Based on observation and policy and procedure review, the facility failed to follow standard infection control practices for 2 of 10 residents (Resident #8 and #12) observed receiving assistance with personal cares. Failure to perform hand hygiene after completing perineal/catheter care has the potential to spread infection within the facility. Findings include: Review of the facility's policy titled "Hand Hygiene" occurred on the afternoon of 04/08/15. The policy, dated 11/20/13, stated, "Hand hygiene will be done: . . . a. Before and after resident contact (before you leave the room) . . . c. after every dirty procedure . . ." - Observation on 04/07/15 at 4:15 p.m. showed two certified nursing assistants (CNAs) (#7 and #8) provided personal cares for Resident #8 after an episode of bowel incontinence. While Resident #8 laid in bed, the CNA (#8) provided perineal care. The CNA (#8) removed his gloves, repositioned the bed with its control buttons, covered the resident with a blanket, and offered the resident a drink of water from a nearby mug. The CNA (#8) failed to perform hand hygiene after providing perineal care prior to doing other tasks. - Observation on 04/08/15 at 3:47 p.m. showed a CNA (#14) emptied Resident #12's catheter bag and failed to perform hand hygiene prior to exiting the room.	F 441		