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 _____	C 07/19/2017

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 and complaint survey started on July 17, 2017 and completed on July 19, 2017, the sample included four (4) residents for complete review, nine (9) residents for focused review, and two (2) closed records for review. The sample included nine (9) additional residents to verify specific concerns during the survey.	F 000		
F 156 SS=C	483.10(d)(3)(g)(1)(4)(5)(13)(16)-(18) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES (d)(3) The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care. §483.10(g) Information and Communication. (1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility. (g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including: (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes - (A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section; (B) A description of the requirements and procedures for establishing eligibility for	F 156		8/23/17

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

Electronically Signed | 08/12/2017

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F 156	Continued From page 1 Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act. (C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and (D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.)	F 156		

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F 156	Continued From page 2 [§483.10(g)(4)(ii) will be implemented beginning November 28, 2017 (Phase 2)] (iii) Information regarding Medicare and Medicaid eligibility and coverage; [§483.10(g)(4)(iii) will be implemented beginning November 28, 2017 (Phase 2)] (iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program; [§483.10(g)(4)(iv) will be implemented beginning November 28, 2017 (Phase 2)] (v) Contact information for the Medicaid Fraud Control Unit; and [§483.10(g)(4)(v) will be implemented beginning November 28, 2017 (Phase 2)] (vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives: (i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office,	F 156		

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F 156	Continued From page 3 adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and (ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community. (g)(13) The facility must 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. (g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay. (i) 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. (ii) The facility must also provide the resident with	F 156		

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F 156	Continued From page 4 the State-developed notice of Medicaid rights and obligations, if any. (iii) Receipt of such information, and any amendments to it, must be acknowledged in writing; (g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) 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 (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in paragraphs (g)(17)(i)(A) and (B) of this section. (g)(18) 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/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the	F 156		

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F 156	Continued From page 5 Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to post, in a manner accessible to all residents, the email addresses of state advocacy groups including the State Ombudsman, State Survey Agency, and Medicaid on 3 of 3 days of survey (July 17-19, 2017). Failure to provide this information has the potential to limit all residents and their families access to these agencies.	F 156	F 156 1. Email addresses were added to posted information 7/20/17. 2. Residents wanting to contact advocacy groups via email have the potential to be affected. 3. Director of Social Services contacted applicable advocacy groups 7/20/17 to	

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F 156	Continued From page 6 Findings include: Observation on July 17-19, 2017 showed the names of advocacy groups displayed on a wall near the entrance of the skilled care area. The facility failed to include/post email contact information for the State Ombudsman, State Survey Agency, and Medicaid. During an interview on 07/19/17 at 9:45 a.m., an administrative staff member (#5) confirmed the display lacked the required information.	F 156	ensure all contact information was correct. Annual verification of contact information will be completed. 4. Weekly review that correct information is posted will take place by Social Services Director or designee weekly x4, monthly x4, and PRN 5. 7/20/17	
F 176 SS=D	483.10(c)(7) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE (c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, record review, facility policy review, and staff interview, the facility failed to assess the safety of self-administration of medication (SAM) for 1 of 1 sampled resident (Resident #11) observed with medications left in the resident's room. Failure to determine if SAM is a safe practice for each resident has the potential to result in a medication error and/or harm to residents. Findings include: Review of the facility policy titled " Medications Self Administration of Meds" occurred on 07/19/17. This policy, revised May 2013, stated, ". . . After meeting specific criteria the resident	F 176	F 176 1. Resident #11s order was reviewed and updated as applicable. Resident #11 does not participate in Self Administration of Medications. Resident□s creams will be stored securely. 2. Residents with skin breakdown who rely on facility staff to apply protective cream have the potential to be affected. 3. Education with nursing staff regarding facility SAM policy as well as process for storing protective creams will take place at Nursing Department meetings 8/18/17 and 8/22/17. 4. Auditing by DON or Designee of rooms to ensure creams stored securely	8/23/17

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F 176	Continued From page 7 may participate in the self-administration process. . . . Initiate the Self Administration of Medication Assessment & [and] Flowsheet. Determine if the resident is cognitively able to self-medicate by a mini-metal score of at least 24. . . . " Review of Resident #11's medical record occurred on 07/19/17. A quarterly Minimum Data Set (MDS), dated 05/09/17 identified severely impaired cognition. Current physician's order stated, ". . . Tena [a protective cream/ointment] to peri-area daily and after each incontinent episode every day shift . . ." Observation on 07/19/17 at 9:40 a.m. showed a medication cup containing a white cream/ointment, placed on top of the nightstand in Resident #11's room. A certified nurse assistant (CNA) (#11) assisted Resident #11 onto the bed and positioned the resident for a nap. When asked about the cream/ointment, the CNA (#11) stated, "that is to be applied by the nurse." The CNA then left the room. During an interview on 07/19/17 at 11:15 a.m., an administrative nurse (#3) reported it is not an acceptable practice to leave medication on the residents' bedside table. During an interview on 07/19/17 at 11:30 a.m., when asked about the medication cup in Resident #11's room, a staff nurse (#10) stated, "I have not done [applied] it [cream/ointment] this morning it must be left from the night nurse." The nurse (#10) confirmed staff should not leave medications in the residents' room.	F 176	will take place starting 8/21/17 x5/week for 8 weeks, x3 week for 8 weeks, x1 week for 8 weeks and prn. Results will be brought to Quality Committee for review and recommendations. 5. 8/23/17	
F 246	483.10(e)(3) REASONABLE ACCOMMODATION	F 246		8/23/17

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F 246 SS=E	Continued From page 8 OF NEEDS/PREFERENCES 483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: (e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to accommodate the needs of 3 of 13 sampled residents (Resident #6, #10, and #12), 4 supplemental residents (Resident #16, #17, #18, and #19), and 1 of 1 confidential resident (A) dependent on call lights for staff assistance. Failure to place a resident's call light within reach and not answering in a timely manner does not allow the resident to receive the needed assistance and may result in unmet needs including an accident/injury. Findings include: On the morning of 07/17/17, observations and resident interviews identified the following: * Resident #6 in her bed yelling out for help to use the bathroom. The surveyor turned on the call light and observed an unidentified staff person look down this hallway, turn in the opposite direction, and walk away. An unidentified staff nurse walked past Resident #6's room while the call light remained on. The surveyor reported to the nurse Resident #6's need, and the nurse entered the resident's room.	F 246	F 246 1. Resident #6 does not consistently use call light. Evaluation of other ways resident expresses needs and approaches was reviewed 8/7/17 and care plan updated to reflect. Resident #10, 12 and 17 will have call lights within reach. Resident #16 is able to self-propel for short distances, including within room and at times she self-propels away from where her call light is placed and chooses to use other methods of communication. Resident #18 will have call light responded to in adequate period of time. Resident #19 had call light extender placed 8/7/17. 2. All residents who use call lights have the potential to be affected. 3. Education on meeting resident needs through call light placement and response will take place at nurse and CNA meeting 8/18/17 and 8/22/17. 4. Auditing by DON or Designee to include call light placement and call light	

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F 246	Continued From page 9 * Resident #16 in her room and sitting on the edge of her wheelchair motioning to go to the bathroom. The call light laid on the resident's bed and not within reach of the resident. * Resident #17 in bed with the call light hanging on the wall behind the bedside table and not within reach of the resident. Resident #17 stated the call light does no good when he/she is unable to locate or reach it. (Resident identified by the facility as interviewable) * Resident #18 stated staff members take a long time to respond to the call light. An admission Minimum Data Set (MDS), dated 04/27/17, identified the resident as cognitively intact. * Resident #19 in her room sitting in a wheelchair with the call light on the floor and not within the resident's reach. - On 07/19/17 at 8:00 a.m., observation showed Resident #12 in bed with the door closed and the soft touch call light draped across her legs not within reach of the resident. Resident #12 yelled out "someone please help me, I need to go to the bathroom bad and I don't want to have an accident." Resident #12 stated "I don't know where the call light is and I don't want to mess my pants." Upon surveyor request, a certified nurse assistant (CNA) (#11) entered Resident #12's room to provide assistance. - During an interview on 07/19/17 at 08:15 a.m., a CNA (#11) stated Resident #12 can use the call light if staff place it by her face, like this (the CNA removed the call light near Resident #12's legs and placed it by her face). - During a group interview on 07/17/17 at 3:00 p.m., Resident #10 stated he can't reach the call	F 246	wait time per resident interview will take place starting 8/21/17 x5/week for 8 weeks, x3 week for 8 weeks, x1 week for 8 weeks and prn. Results will be brought to Quality Committee for review and recommendations. 5. 8/23/17	

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F 246	Continued From page 10 light within the room as staff place it on the other side of the handrail, out of reach. Resident A stated he/she can't reach the call light at times to get help from staff. - During an interview on 07/19/17 at 9:00 a.m., Resident #10 stated, "I wait a long time for my call light to be answered, sometimes an hour." Review of Resident #10's medical record occurred on July 18-19, 2017. An annual MDS, dated 04/12/17, identified the resident as cognitively intact. During an interview on 07/19/17 at 2:35 p.m., an administrative staff member (#5) stated the CNAs have pagers that signal when a resident pushes their call light. If not answered within 5 minutes, the page goes to the charge nurse and after 8 minutes it goes to an administrative staff member. This staff member (#5) stated the facility educates all staff to answer the call light as soon as possible.	F 246		
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of	F 278		8/23/17

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F 278	Continued From page 11 the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) 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 (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE MINIMUM DATA SET (MDS) FOCUSED SURVEY COMPLETED ON 03/28/17. Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.14), and staff interview, the facility failed to ensure accurate coding of Minimum Data Sets (MDSs) for 1 of 13 sampled residents (Resident #2). Failure to accurately complete Section J (health conditions) and Section M (skin conditions) of the MDS does not allow each resident's assessment to reflect their current status/needs, and has the potential to affect the accurate development of a comprehensive care plan and the care provided	F 278	F278 1. Resident #2 no longer resides at facility. 2. All residents have the potential to be affected. 3. Education completed with all members who complete MDSs on 8/4/17 and 8/7/17 on completion of interviews in Section J within 5 day lookback and avoid utilizing dashes as well as accuracy. 4. Auditing by DON or Designee of MDS Assessment accuracy to ensure interview on Section J was completed within 5 day lookback and dashes avoided will take place starting 8/21/17 x5/week for 8 weeks, x3 week for 8 weeks, x1 week for	

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F 278	Continued From page 12 to the residents. Findings include: SECTION J: HEALTH CONDITIONS The Long-Term Care Facility RAI User's Manual, revised October 2016, Chapter 3, page J-4 through J-6, stated, "J0200: Should Pain Assessment Interview Be Conducted? Coding Instructions . . . Code 1, yes: if the resident is at least sometimes understood and an interpreter is present or not required. Continue to Pain Presence item (J0300). . . . J0300-J0600: Pain Assessment Interview. . . . 1. Interview any resident not screened out by the Should Pain Assessment Interview be Conducted? item (J0200). 2. The Pain Assessment Interview for residents consists of four items: the primary question Pain Presence item (J0300), and three follow-up questions Pain Frequency item (J0400); Pain Effect on Function item (J0500); and Pain Intensity item (J0600). If the resident is unable to answer the primary question on Pain Presence item J0300, skip to the Staff Assessment for Pain beginning with Indicators of Pain or Possible Pain item (J0800). . . . 9. If the resident chooses not to answer a particular item, accept his/her refusal, code 9, and move on to the next item. . . ." Review of Resident #2's medical record occurred on all days of survey. An admission MDS, dated 05/15/17, identified Resident #2 received scheduled pain medication, PRN (as needed) pain medication, and non-medication intervention for pain during the 5-day look-back period. J0200 identified the staff should conduct the pain	F 278	8 weeks and prn. Results will be brought to Quality Committee for review and recommendations. 5. 8/23/17	

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F 278	Continued From page 13 assessment interview. Sections J0300-J0700 identified all dashes. The facility failed to complete the pain interview with the resident. During an interview on 07/18/17 at 3:20 p.m., an administrative staff nurse (#3) confirmed staff failed to complete Resident #2's pain interview. SECTION M: SKIN CONDITIONS The Long-Term Care Facility RAI User's Manual, revised October 2016, Chapter 3, page M-22, stated, ". . . Coding Instructions for M0610 Dimensions of Unhealed Stage 3 or 4 Pressure Ulcers or Unstageable Due to Slough and/or Eschar. Enter the current longest length of the largest Stage 3, Stage 4, or unstageable pressure ulcer due to slough and/or eschar in centimeters to one decimal point. Enter the widest width in centimeter of the largest Stage 3, Stage 4 or unstageable pressure ulcer due to slough and/or eschar. Record the width in centimeters to one decimal point. . . ." Review of Resident #2's medical record occurred on all days of survey. An admission MDS, dated 05/15/17, identified Resident #2 had an unstageable pressure ulcer with measurements in M0610 documented as 01.0 cm in length and 02.6 cm in width. The Wound Care Flow Sheet for Resident #2, dated 05/15/17, identified the unstageable pressure ulcer as 2.6 cm in length and 1.0 cm in width. Staff entered the pressure ulcer measurements into the MDS incorrectly. During an interview on 07/19/17 at 9:24 a.m., an administrative nurse (#3) confirmed staff entered	F 278		

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F 278	Continued From page 14 the pressure ulcer measurements into the admission MDS incorrectly.	F 278		
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's	F 280		8/23/17

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F 280	Continued From page 15 strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.	F 280		

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F 280	Continued From page 16 (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to review and revise the comprehensive care plan to reflect the residents' status for 3 of 13 sampled residents (Resident #7, #8, and #9). Failure to review and revise the care plan limited staff's ability to communicate care needs and ensure continuity of care for each resident. Findings include: Review of the facility policy titled "Care Plans" occurred on 07/19/17. This policy, revised May 2013, stated, ". . . C. Documentation 1. Each discipline is responsible to address their individual needs . . . 2. Care plans will be updated and changes will be made as they occur to ensure the most current plan for the resident. . . ." - Review of Resident #7's medical record occurred on all days of survey. Diagnoses included rheumatoid arthritis, staphylococcal arthritis in right hip, ischial bursitis, and right hip pain. A quarterly MDS, dated 06/03/17, identified almost constant pain affecting activities and sleep and pain rated at an 8 on a scale of 0-10, 10 being the worst. Pain medications included Tylenol 325 mg daily, leflunomide 10 mg daily for rheumatoid arthritis, Plaquenil 200 mg twice daily for rheumatoid arthritis, and Tylenol 325 mg or 650 mg every 4 hours as needed (PRN).	F 280	F280 1. Resident #7 and #8□s care plans have been updated to reflect current status. Resident #9 thorough fall investigation was in process during survey review and within required timeframes of investigation. Immediate investigation following resident□s fall included review of hoyer lift to ensure safety as well as communication with staff verbally not to use hoyer lift until investigation completed. Full investigation included review of equipment and potential underlying factors of fall. Final investigation concluded that staff will no longer use hoyer lift to transfer Resident #9 and Care Plan has been updated accordingly. 2. All residents have the potential to be affected. 3. All resident Care Plans will be reviewed and updated as needed by 8/23/17. Education will take place with all members who Care Plans by 8/22/17 on complete and individualized care planning. 4. Auditing by DON or Designee of Care Plan accuracy will take place starting 8/21/17 x5/week for 8 weeks, x3 week for 8 weeks, x1 week for 8 weeks and prn. Results will be brought to Quality	

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F 280	Continued From page 17 Physician orders included: * 06/21/17 - Physical therapy to evaluate and treat for low back and hip pain * 06/29/17 - Apply K-pad to sore areas PRN * 07/06/17 - TENS [Transcutaneous electrical nerve stimulation] unit PRN for pain The care plan failed to address the resident's ongoing pain issues and approaches to the pain, including assessing the effectiveness of physician ordered pain interventions. - Review of Resident #8's medical record occurred on all days of survey. Diagnoses included weakness, dementia, thumb pain, and osteoarthritis. The current care plan identified ". . . TED hose [anti-embolism stockings] as ordered . . . Resident to wear thump [sic] spica [splint] to right hand . . ." During an interview on 07/19/17 at 2:30 p.m., an administrative staff (#3) stated Resident #8 no longer needs to wear the antiembolism stockings, does not wear a thumb splint, and staff should remove these from the care plan. - Review of Resident #9's medical record occurred on all days of survey. Diagnoses included stroke, weakness, and falls. The current care plan identified ". . . Toileting: assist of two to toilet with hoyer [mechanical transfer lift]/ceiling lift . . . Transfers: assist of two and hoyer/ceiling lift. . . . Prevalon boots [pressure relieving boots] on while in bed. . . ." The progress notes dated, 07/15/17, identified ". . . fell from hoyer lift . . . hoyer tipped over going	F 280	Committee for review and recommendations. 5. 8/23/17	

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F 280	Continued From page 18 from bathroom to bed . . . hit right side of forehead, still strapped in it . . ." During an interview on 07/19/17 at 10:15 a.m., an administrative staff member (#3) stated staff will no longer use the hoyer lift to transfer Resident #9. The staff should have updated the care plan to remove the hoyer lift. The facility failed to review and revise the comprehensive care plan to reflect the residents' current status.	F 280		
F 281 SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON 05/05/16 PRIMING INSULIN PENS 1. Based on observation, review of facility policy, review of manufacturer's guidelines, and staff interview, the facility failed to follow professional standards of practice for 1 of 1 supplemental resident (Resident #20) observed during medication pass with an insulin pen. Failure to appropriately prime an insulin pen has the potential for inaccurate doses of medication administration.	F 281	F281 1. Resident #20□s insulin pen will be primed appropriately prior to insulin administration. Resident #1 and 20 will receive medications as ordered. 2. Residents having the potential to be affected include residents who have insulin pens and residents who receive PRN pain medications. 3. Education including return demonstration with insulin pens and PRN medication administration will take place at the nursing department meeting	8/23/17

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F 281	Continued From page 19 Findings include: Manufacturer's instructions for TRESIBA FlexTouch Pen stated, ". . . Priming your Tresiba FlexTouch Pen: Turn the dose selector to select 2 units. Hold the pen with the needle pointing up. Tap the top of the pen gently a few times to let any air bubbles rise to the top. Hold the pen with the needle pointing up. Press and hold in the dose button until the dose counter shows "0". The "0" must line up with the dose pointer. A drop of insulin should be seen at the needle tip. . . ." Review of the facility policy titled "Medication Administration Information" occurred on 07/19/17. This policy, revised October 2016, stated, "Medications (all routes) . . . Purpose is to provide safe and effective drug therapy for the residents . . ." - Review of Resident #20's medical record occurred on 07/18/17. The current physician orders stated Tresiba Flextouch solution pen-injector 100 unit/ML (milliliter) inject 40 units subcutaneously one time a day for type 1 diabetes. Observation during medication pass on 07/18/17 at 7:50 a.m., showed a nurse (#1) failed to prime the Tresiba insulin pen according to the manufacture guidelines. During an interview on 07/19/17 at 10:05 a.m., two nurse managers (#3 and #4) confirmed staff should prime the Tresiba pen before administering the medication.	F 281	8/18/17 and 8/22/17. Residents with specific requests regarding PRN pain will have orders reflecting flexibility of request. 4. Auditing by DON or Designee of insulin pen priming as well as random audit of prn pain medications will take place starting 8/21/17 x5/week for 8 weeks, x3 week for 8 weeks, x1 week for 8 weeks and prn. Results will be brought to Quality Committee for review and recommendations. 5. 8/23/17	

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F 281	Continued From page 20 MEDICATION ADMINISTRATION 2. Based on record review, review of professional reference, and staff interview, the facility failed to follow professional standards of practice for 1 of 13 sampled residents (Resident #1). Failure to follow physician orders places the resident at risk for pain control complications and may result in incorrect treatment of residents' conditions. Findings include: Kozier & Erb's "Fundamentals of Nursing: Concepts, Process, and Practice, " 10th ed., Pearson Education, Inc., New Jersey, page 773, states, ". . . Ten "Rights" of Medication Administration. Right Medication -The medication given was the medication ordered. Right Dose . . . Right Time - Give the medication at the right frequency and at the time ordered . . . " Review of Resident #1's medical record occurred on all days of survey. The current care plan stated, " . . . Potential for discomfort r/t [related to] right sided weakenss [sic]. . . . Administer pain medications as ordered. Monitor for effectiveness and side effects. Keep practitioner updated on effectivness of pain control measures. . . ." Resident #1's medication administration record (MAR) for June 2017 identified resident receiving Norco 5/325 milligrams (mg) two times a day at 11:00 a.m. and 9:00 p.m. June 05-26, 2017. The MAR identified the Norco dose changed on 06/27/17 to 5/325 mg at 9:00 p.m. and 5/325 mg	F 281		

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F 281	Continued From page 21 as needed (prn) for pain every a.m. Review of Resident #1's MARS for June and July 2017 identified the order for Norco 5/325 mg one tablet by mouth as needed for pain every a.m. The MARS showed nursing did not administer the medication in the a.m. as ordered: * 06/28/17 at 1:19 p.m. * 07/05/17 at 1:41 p.m. * 07/08/17 at 1:54 p.m. * 07/11/17 at 1:04 p.m. * 07/15/17 at 1:50 p.m. * 07/16/17 at 1:38 p.m. * 07/18/17 at 1:03 p.m. During an interview on 07/18/17 at 2:30 p.m., an administrative nurse (#4) verified that facility nursing staff should not be giving Norco prn in the afternoon when the order states prn every a.m.	F 281		
F 309 SS=E	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. 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, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure	F 309		8/23/17

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F 309	Continued From page 22 that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: HOSPICE 1. Based on record review, review of the hospice contract, and staff interview, the facility failed to provide the necessary care and services for 2 of 3 residents (Resident #3 and #4) receiving hospice services. Failure to provide access to the residents' hospice plan of care for all practitioners and staff involved in the residents' care limits coordination of care and services for the residents. Findings include: Review of the facility services agreement between the facility and the hospice agency	F 309	F309 1. Resident #3□s Hospice and Facility care plans have been compared and updated to coordinate as needed. Resident #4 no longer resides in facility. Residents #10 and 11 will receive skin creams as ordered. 2. Residents receiving hospice services and physician ordered skin creams have the potential to be affected. 3. Facility and hospice will collaborate to provide services to residents receiving hospice care. Upon admission, hospice and facility care plans will be reviewed and updated as needed. Education with IDT and nursing staff on updating facility	

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F 309	Continued From page 23 occurred on 07/19/17. This agreement, dated 04/05/15, stated, ". . . 3. Responsibilities of Hospice Program . . . (f) Provision of Information . . . At a minimum, Hospice shall provide the following information to Facility for each Hospice Patient residing at facility: (i) Plan of Care, Medications and Orders. The most recent Plan of Care . . ." - Review of Resident #3's medical record occurred on all days of survey. The record identified an admission to hospice services on 10/04/16, but failed to contain a copy of the hospice care plan. - Review of Resident #4's medical record occurred on all days of survey. The record identified an admission to hospice services on 02/14/17, but failed to contain a copy of the hospice care plan. During an interview on 07/19/17 at 9:50 a.m., an administrative nurse (#4), when asked regarding the availability of care plans for those residents receiving hospice services, stated, "I don't have access to the portal the receptionist has that." When the staff member (#4) provided the care plans, she reported having difficultly getting in, "so we called and they [hospice agency] faxed them [the care plans] to us." SKIN TREATMENTS 2. Based on observation, record review, review of facility policy, staff and resident interview, and an anonymous concern, the facility failed to ensure staff provided the necessary care and services for 2 of 5 sampled residents (Resident #10 and	F 309	care plans upon changes to hospice care plan as well as process for physician ordered skin creams will take place 8/7/17, 8/18/17, and 8/22/17. 4. Auditing by DON or Designee residents on hospice care plans and physician ordered skin creams will take place starting 8/21/17 x5/week for 8 weeks, x3 week for 8 weeks, x1 week for 8 weeks and prn. Results will be brought to Quality Committee for review and recommendations. 5. 8/23/17	

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F 309	Continued From page 24 #11) who required a nurse to apply an ointment to peri area skin issues. Failure to consistently apply the required ointment for Resident #10 and #11 may result in further skin breakdown, increased treatments, and discomfort/pain. Findings include: Review of the facility policy titled "Skin Assessment" occurred on 07/19/17. This policy, revised July 2015, stated, ". . . The nurse is responsible for: . . . Providing treatment per facility standard or practitioner order. . . ." An anonymous concern identified an issue regarding nurses not applying residents' physician ordered skin creams on a daily basis, and the skin creams sat on the residents' tables in plastic medication cups for several days. The concern indicated only nurses applied physician ordered creams, and residents' skin issues failed to resolve due to inconsistent treatment. - Review of Resident #10's medical record occurred on July 18-19, 2017. Diagnoses included diabetes and peripheral vascular disease. An annual Minimum Data Set (MDS), dated 04/21/17, identified cognitively intact, always incontinent of urine, and extensive assist of two or more staff for toileting and personal hygiene. The current care plan stated, "Potential for skin breakdown related to urinary incontinence and mobility impairment . . . Monitor for changes in skin integrity when providing cares and provide appropriate follow up if areas of concern are noted. . . ." The current certified nursing assistants' (CNA) care sheet showed no direction for CNAs to apply any skin	F 309		

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SHEYENNE CROSSINGS CARE CENTER/TCU	125 13TH AVENUE WEST WEST FARGO, ND 58078

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F 309	Continued From page 25 creams/ointments for Resident #10. Review of physician orders and the June and July 1-18, 2017 electronic Medication Administration Record (eMAR) showed the following: * 05/08/17 - Apply Aquaphor Ointment as needed (PRN) twice daily to penis and scrotum - eMAR documented applied 8 times since June 1, 2017. * 06/20/17 - Apply Nystatin cream twice daily for two weeks to penis * 06/27/17 - Apply hydrocortisone 1% twice daily for seven days to penis * 07/18/17 - Apply Econazole Nitrate Cream 1% to penis topically daily for 14 days. During an interview on the morning of 07/19/17, Resident #10 stated the nurse had not applied the cream/ointment to his peri area this morning, and "I haven't seen that cream for weeks. It burns so bad today I can hardly [urinate]." Resident #10 also stated his skin all over his body has itched for years and nothing seems to help. The label of a bottle of Aveeno Anti-Itch Lotion on the bedside table stated, "Apply daily to itchy areas, order date 04/11/17." The resident stated, "The lotion doesn't work. It's worthless!" - Review of Resident #11's medical record occurred on 07/19/17. Current physician's order stated, ". . . Tena [a protective cream/ointment] to peri-area daily and after each incontinent episode every day shift . . ." Observation on 07/19/17 at 9:40 a.m. showed a medication cup containing a white cream/ointment, placed on top of the nightstand	F 309		

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F 309	Continued From page 26 in Resident #11's room. A certified nurse assistant (CNA) (#11) assisted Resident #11 onto the bed and positioned the resident for a nap. When asked about the cream/ointment, the CNA (#11) stated, "that is to be applied by the nurse." The CNA then left the room. During an interview on 07/19/17 at 11:30 a.m., when asked about the medication cup in Resident #11's room, a staff nurse (#10) stated, "I have not done [applied] it [cream/ointment] this morning it must be left from the night nurse."	F 309		
F 314 SS=D	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy review, and resident interview, the facility failed to provide the necessary care and services for 3 of 5 sampled residents (Resident #2, #7, and #9)	F 314	F314 1. Resident #7 and 9 will receive interventions as needed to prevent and treat pressure ulcers.	8/23/17

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F 314	Continued From page 27 with a current and/or history of pressure ulcers. Failure to follow physician's orders and consistently implement interventions to reduce pressure on susceptible areas may contribute to the development or delayed healing of a pressure ulcer. Findings include: Review of the facility's policy titled, "Skin Assessment" occurred on 07/19/17. This policy, revised July 2015, stated, ". . . All assessments will be documented in the medical record with problems included in the care plans (nursing and CNA [certified nursing assistant]). The nurse is responsible for: Accurately assessing skin and identifying individuals at risk . . . Providing cares that will assist in pressure ulcer prevention. . . ." An anonymous concern identified staff failed to complete all resident cares and take the time to check skin concerns/issues on a daily basis. - Review of Resident #7's medical record occurred on all days of survey. Diagnoses included cellulitis, Methicillin Resistant Staphylococcus Aureus (MRSA) infection right hip abscess, Type 2 Diabetes Mellitus with chronic kidney disease, rheumatoid arthritis, ischial bursitis, pain in right hip, dependence on wheelchair, other abnormalities of gait and mobility. A quarterly MDS, dated 06/03/17, identified cognitively intact, extensive assist of two or more staff for bed mobility, transfer, dressing, and toileting, total assist of one for bathing, and at risk for pressure ulcers. The current care plan stated, ". . . Potential for skin breakdown r/t [related to] history of pressure	F 314	Resident #2 no longer resides in facility. 2. Residents at risk for skin breakdown have the potential to be affected. 3. Education to include prevention and treatment and interventions of pressure ulcers will take place at nursing department meeting 8/18/17 and 8/22/17. 4. Auditing by DON or Designee of residents identified to be at risk for skin breakdown will take place starting 8/21/17 x5/week for 8 weeks, x3 week for 8 weeks, x1 week for 8 weeks and prn. Results will be brought to Quality Committee for review and recommendations. 5. 8/23/17	

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ulcer and impaired mobility. . . . Monitor for changes in skin integrity when providing cares and provide appropriate follow up if areas of concern are noted. . . ."

Review of Resident #7's progress notes showed the following:
* 06/26/17 8:42 a.m. - "In between resident's R) [right] great toe there is an area of redness with white/moist center where adjoining toe rests on great toe. The area is blanchable and per resident sore when touched. This nurse applied a toe sleeve and added order to monitor daily and apply toe sleeve daily until resolved. Will continue to monitor."
* 07/01/17 1:27 a.m. - "SKIN CHECK . . . R) great toe which had a toe sleeve over area due to redness is a pressure ulcer Stage II 0.2cm [centimeters] x [by] 0.3cm, located on medial side of toe, scant, serous drainage, surrounding tissue is red but blanchable, wound bed is pink, resident complains of some discomfort to area, mepilex applied to area. Resident received a bed bath due to pain to lower back. . . ."

Review of the Wound Care Flow Sheet, dated 07/01/17 showed a Stage II pressure ulcer to the right toe measuring 0.2 cm x 0.3 cm, scant serous drainage, wound bed moist and pink with epithelial tissue, mild odor present, warm to touch, surrounding tissue intact, red, but blanchable, resident's pain at a 2 out of 10 per verbal pain scale, mepilex applied over area, staff to change every three days and as needed, staff to complete Wound Care Flow sheet weekly, and to monitor area.

During an interview on the mornings of 07/18/17

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and 07/19/17, Resident #7 stated the right toe pressure ulcer started when staff failed to clean and dry between her right big toe and the adjoining overlapping toe. She stated nurses complete a skin check every Friday on bath day, but CNA's do not have time to wash or check her feet everyday before putting on socks and shoes.

- Review of Resident #2's medical record occurred on all days of survey. Diagnosis include fracture of lower end of left femur. The admission MDS, dated 05/15/17, identified an unstageable pressure ulcer present on admission. The current physician's orders identified an order on 07/04/17 for Mepilex to left heel pressure area, change daily and prn as needed for left heel pressure area.

The current care plan stated, "Focus: Potential for skin breakdown related to decreased mobility. Goal: Will not develop pressure ulcers. Interventions: . . . Monitor for changes in skin integrity when providing cares and provide appropriate follow up if areas of concern are noted. . . ."

An observation on 07/18/17 at 8:15 a.m. identified a facility staff nurse (#1) completing a dressing change to Resident #2's left heel. After removing the old dressing from the site, the nurse (#1) redressed Resident #2's heel using a folded 4 x 4 gauze and paper tape. The nurse (#1) failed to follow the physician's order for the type of dressing on the left heel pressure ulcer.

- Review of Resident #9's medical record occurred on all days of survey. Diagnoses included stroke, diabetes, osteoarthritis, and

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F 314	Continued From page 30 cerebral vascular disease (CVA). The quarterly MDS, dated 05/07/17, identified extensive assistance of two needed for bed mobility, high risk for pressure ulcers, and pressure reducing devices for chair and bed. The practitioner's order, dated 04/19/17, identified "while in bed - . . . boots [pressure relieving] for prevention of heel breakdown." The current care plan stated, ". . . Potential for skin breakdown related to incontinence, diagnosis of diabetes, decreased physical mobility . . . has history of pressure ulcer. . . . boots [pressure relieving] on while in bed. . . ." Observation showed the following: * 07/17/17 at 12:30 p.m. and 3:55 p.m., Resident #9 laid in bed on her back with her heels resting directly on the mattress. * 07/18/17 at 10:55 a.m., 11:55 a.m., 12:45 p.m., 2:00 p.m., 3:00 p.m., and 4:30 p.m., Resident #9 laid in bed with her heels resting directly on the mattress. The facility staff failed to apply the heel protector boots to reduce pressure on susceptible areas. During an interview on 07/19/17 at 2:30 p.m., an administrative staff member (#3) stated Resident #9 spends a lot of time in bed and should have the heel protector boots on when she is laying down.	F 314		
F 325 SS=D	483.25(g)(1)(3) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE (g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and	F 325		8/23/17

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F 325	Continued From page 31 enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- (1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; (3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. 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 for 2 of 4 sampled residents (Resident #6 and #7) with a history or risk of weight loss. Failure to identify the accuracy of weights in a reasonable time may delay needed treatment for weight loss or gain and not allow residents to maintain a adequate nutritional status. Findings include: Review of the facility policy titled "Weight Changes Assessment/Documentation" occurred on 07/19/17. This policy, revised April 2014, stated, ". . . 3. Dietitian is to review all weights at least monthly. . . . 4. Any resident experiencing significant weight gain/loss of 5% or more in 1 month, 7.5% in 3 months, and/or 10% in 6 months, will be assessed by the dietitian. . . ." - Review of Resident #6's medical record	F 325	F325 1. Resident #6 will receive necessary interventions to maintain adequate nutritional status. A review of potential contributing factors to Resident #7s fluctuation in weights took place 8/7/17. Resident #7 will not have weights taken while wearing built up shoes. 2. Residents at risk for weight loss have the potential to be affected. 3. Resident weights will be reviewed by nursing weekly. Residents with 5lbs or more weight change will be reweighed and then reported to Dietician to review. Education regarding obtaining weights and procedures to address weight changes will take place at nursing department meetings 8/18/17 and 8/22/17. 4. Auditing by Director of Nutrition and Culinary Services or Designee of random	

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F 325	Continued From page 32 occurred on all days of survey and identified weekly weights ordered by the physician. The current care plan for Resident #6 stated ". . . will maintain a weight 110-120# [pounds] . . . monitor weights . . ." Review of Resident #6's weekly weights showed the following: * 03/28/17 - 112.2 pounds (lbs.) * 04/04/17 - 108.8 lbs. * 04/11/17 - 107.9 lbs. * 04/18/17 - 112.4 lbs. * 04/25/17 - 111.2 lbs. * No weekly weight documented for 04/28/17 * 05/09/17 - 109.2 lbs. * 05/16/17 - 107 lbs. * 05/23/17 - 105.8 lbs. * 05/30/17 - 106.8 lbs. * No weekly weight documented for 06/06/17 * 06/13/17 - 106 lbs. * No weekly weight documented for 06/20/17 * No weekly weight documented for 06/27/17 * 07/04/17 - 94 lbs. (12 lbs. or 11.4% weight [wt] loss in 21 days) During an interview on 07/19/17 at approximately 11:50 a.m., a dietary supervisor (#6) stated she receives no notification of weight loss or gains from staff, and reviews each resident's weight as needed. Do to this lack of communication, timely assessment and necessary interventions to stop unwanted weight loss were not evident. - Review of Resident #7's medical record occurred on all days of survey and identified weekly weights ordered by the physician. The current care plan stated, ". . . at risk for changes in weight and nutritional status d/t [due to] MRSA	F 325	resident weights to determine accuracy and appropriate communication will take place starting 8/21/17 x5/week for 8 weeks, x3 week for 8 weeks, x1 week for 8 weeks and prn. Results will be brought to Quality Committee for review and recommendations. 5. 8/23/17	

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F 325	Continued From page 33 [Methicillin-resistant Staphylococcus aureus] in hip incision r/t [related to] THA [total hip arthroplasty], pressure ulcer to L [left] buttock, a decrease in appetite, and increased assistance at meals. . . . diagnosis of pneumonia, staph [staphylococcal infection] arthritis, SOB [shortness of breath], dysphagia, respiratory failure, CKD [chronic kidney disease], DM [diabetes mellitus] type II, and HTN [hypertension]. . . . Resident will not have a significant weight change in 30, 90, or 180 days . . . Monitor weights recorded . . . Soft diet with thin liquids . . . Give regular texture as diet refusal is signed. . . ." Review of Resident #7's weekly weights showed the following: * 03/24/17 - 102 lbs * No weekly weight documented for 03/31/17 * 04/07/17 - 99.6 lbs (5.4 lbs. or 5.1% wt loss in 33 days) * No weekly weight documented for 04/14/17 * 04/21/17 - 91.2 lbs (11.1 lbs or 10.8% wt loss in 4 months) * 04/28/17 - 100.4 lbs (9.2 lbs or 10.1% wt gain in 7 days) * 05/05/17 - 102.8 lbs * 05/14/17 - 104.1 lbs * Weekly weights varied from gain/loss of 1 to 3 lbs from 05/14/17 through 07/07/17 * 07/07/17 - 105.6 lbs * 07/15/17 - 97.4 lbs (8.2 lbs or 7.8% wt loss in 1 month) A nutrition progress note, dated 05/31/17, stated, "Suspect some of her weights inaccurate." The note went on to indicate that the last 6 months of weights reviewed had varied.	F 325		

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F 325	Continued From page 34 The facility failed to provide evidence of assessments to determine what was causing the weight loss/gain and interventions on how to prevent weighing inaccuracies.	F 325		
F 328 SS=D	483.25(b)(2)(f)(g)(5)(h)(i)(j) TREATMENT/CARE FOR SPECIAL NEEDS (b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments (f) Colostomy, ureterostomy, or ileostomy care. The facility must ensure that residents who require colostomy, ureterostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. (g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to … prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. (h) Parenteral Fluids. Parenteral fluids must be	F 328		8/23/17

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F 328	Continued From page 35 administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. (i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. (j) Prostheses. The facility must ensure that a resident who has a prosthesis is provided care and assistance, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, to wear and be able to use the prosthetic device. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of professional reference, review of facility policy, and staff interview, the facility failed to provide the necessary care and services for 1 of 1 sampled residents (Resident #9) receiving oxygen therapy. Failure to follow the medical providers orders and provide guidance to the facility staff on oxygen usage does not allow the facility or the health care provider to assess the effectiveness of the resident's oxygen therapy. Berman and Snyder, S., "Kozier & Erb's Fundamentals of Nursing Concepts, Process,	F 328	F328 1. Resident #9 will receive necessary care and services for oxygen therapy. 2. Residents receiving O2 have the potential to be affected. 3. Oxygen bubbler process was reviewed 8/7/17 and changes made to provide clarity to staff. Education regarding use of O2 bubblers will take place at nursing department meetings 8/18/17 and 8/22/17. 4. Auditing by DON or Designee of residents on O2 to determine appropriate	

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F 328	Continued From page 36 and Practice," 10th ed., Pearson Education, Inc., New Jersey, page 1252 states, ". . . Humidifiers are devices that add water vapor to inspired air. . . . used with oxygen delivery systems to provide moistened air directly to the client. Their purposes are to prevent mucous membranes from drying and becoming irritated and to loosen secretions for easier expectoration. . . ." Review of the facility's policy titled, "Oxygen Use & Storage" occurred on 07/19/17. This policy, revised May 2013, stated, ". . . Oxygen Humidifier . . . Fill the jar to the maximum fill line with distilled water. Do not allow the water to fall below the minimum fill line. . . ." - Review of Resident #9's medical record occurred all days of survey. Diagnoses included dependent on oxygen, stroke, acute respiratory failure, congestive heart failure (CHF), and pneumonia. A physician order, dated 02/28/15, stated, "Oxygen at 4 liters/minute per nasal cannula every shift." The treatment administration record (TAR), dated July 2017, identified, "Fill oxygen bubbler with H2O q shift. Every evening shift." The documentation on the TAR, July 17 through the 19th, 2017, showed the oxygen bubbler filled each day. Observation on all days of survey, showed Resident #9 received oxygen at 4 liters/minute by nasal cannula and the oxygen bubbler remained empty. These observations conflicted with the TAR. During an interview on 07/19/17 at 2:30 p.m.,	F 328	bubbler use will take place starting 8/21/17 x5/week for 8 weeks, x3 week for 8 weeks, x1 week for 8 weeks and prn. Results will be brought to Quality Committee for review and recommendations. 5. 8/23/17	

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F 328	Continued From page 37 with an administrative staff member (#3) stated she expected facility staff to fill the oxygen bubbler according to the policy and the orders written.	F 328		
F 332 SS=D	483.45(f)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE (f) Medication Errors. The facility must ensure that its- (1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON 05/05/16. Based on observation, record review, review of policies/procedures, and staff interview, the facility failed to ensure a medication error rate of less than five percent for 2 of 3 sampled residents (Resident #20 and #21) observed receiving long acting insulin and laxatives. Two errors occurring during staff administration of 27 medications, resulted in a seven percent error rate. Failure to ensure staff administered medications correctly may result in the potential for harm. Findings include: Review of the facility policy titled "Medication Administration Information" occurred on 07/19/17. This policy, revised October 2016, stated, ". . . Purpose is to provide safe and effective drug therapy for the residents . . ." - Review of Resident #20's medical record	F 332	F332 1. Resident #20 and 21 will receive medications as ordered. 2. All residents have the potential to be affected. 3. Education to include administration of insulin via insulin pen, entering medication order changes, and medication administration process will take place at nursing department meeting 8/18/17 and 8/22/17. 4. Auditing by DON or Designee of sample residents medication pass including residents with insulin pen and Senna/Senna Plus ordered. These audits will take place starting 8/21/17 x5/week for 8 weeks, x3 week for 8 weeks, x1 week for 8 weeks and prn. Results will be brought to Quality Committee for review and recommendations. 5. 8/23/17	8/23/17

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F 332	Continued From page 38 occurred on 07/18/17. Physician orders included Tresiba [insulin] FlexTouch Solution Pen-Injector 100 unit/ML inject 40 units subcutaneously one time a day for Type 1 diabetes. Observation of medication pass on 07/18/17 at 7:50 a.m., showed a LPN (licensed practical nurse) (#1) administered 41 units of Tresiba to Resident #20. - Review of Resident #21's medical record occurred on 07/18/17. Physician orders included Senna (laxative) tablet give one tablet orally every other day. Observation of medication pass on 07/18/17 at 8:30 a.m., showed a LPN (#2) administered one Senna plus (laxative and stool softener) tablet to Resident #21. The staff nurse (#2) failed to administer the correct medication. During an interview on 07/19/17 at 10:05 a.m., two nurse managers (#3 and #4) confirmed nurses should follow the prescribed orders for administration of medications.	F 332		
F 356 SS=C	483.35(g)(1)-(4) POSTED NURSE STAFFING INFORMATION 483.35 (g) Nurse Staffing Information (1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours	F 356		8/23/17

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F 356	Continued From page 39 worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law) (C) Certified nurse aides. (iv) Resident census. (2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. (3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. (4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by:	F 356		

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F 356	Continued From page 40 Based on observation, group interview, and staff interview, the facility failed to post the actual hours worked per shift (posting of staff) by registered nurses (RN), licensed practical nurses (LPNs), and certified nurse aides (CNAs) directly responsible for resident care at the beginning of each shift and in a prominent location during 3 of 3 days of survey (July 17 - July 19, 2017). Failure to post the nurse staffing data at the beginning of each shift and in a prominent place denied residents and visitors the opportunity to be informed of current staffing levels. Findings include: Observation on the morning of 07/17/17 at 1:25 p.m., showed the facility last posted staffing information on 07/13/17 (4 days). Observation on the morning of 07/17/17 to 07/19/17, showed the posting of staff was placed along reading books on a book shelf by the main lobby. The facility failed to post the nurse staffing data in a prominent place readily accessible to residents and visitors. The group interview occurred on 07/17/17 at 3:00 p.m., with nine residents identified as interviewable. When asked the group could not identify the location of the posting of staff. During an interview on 07/19/17 at 10:05 a.m., an administrative nurse (#4) confirmed the facility had not updated the staff posting for 07/17/17 since 07/13/17 (4 days).	F 356	F356 1. Nursing staffing information was updated 7/17/17. 2. Residents wanting to view nursing staffing information have the potential to be affected. 3. The process for posting nursing staffing information on weekends has been reviewed and changes made accordingly. Education with staff responsible for posting will take place 8/16/17. Residents will be informed on a regular basis through Resident Council where to locate nursing staffing information. 4. Weekly review that correct information is posted will take place by Executive Director or designee weekly x4, monthly x4, and PRN 5. 7/20/17	
F 367 SS=E	483.60(e)(1)(2) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN	F 367		8/23/17

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F 367	Continued From page 41 (e) Therapeutic Diets (e)(1) Therapeutic diets must be prescribed by the attending physician. (e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law. This REQUIREMENT is not met as evidenced by: Based on record review, observation, anonymous concern, staff interview, and review of facility's food recommendations for a therapeutic diets, the facility failed to follow the diet prescribed by the attending physician for 2 of 4 sampled residents (Resident #11 and #12) and 2 supplemental residents (Resident #22 and #24) with a therapeutic diet (altered texture). Failure to consistently provide an altered texture diet as ordered hinders the palatability of foods for some residents and has the potential to place other residents at risk for choking and/or aspiration. Finding include: Review of the facility's guidelines on food recommendation for therapeutic diets stated "Mechanically Soft . . . Foods Not Recommended . . . dry bread, toast . . . broccoli, corn . . . Dysphagia Level 3: Advanced . . . Foods Recommended . . . well-moistened breads . . .need to add adequate syrup, jelly, margarine, butter, etc. to moisten well . . . ground meat . . . all starches . . . all cooked vegetables . . . Foods Not Recommended . . . dry bread, toast . . ."	F 367	F 367 1. Resident #11 and 24 are on dysphasia advanced diet. Resident will not receive food that does not fall under diet ordered or modified to meet diet order. Resident #12□s is on a Mechanical Soft diet for chewing difficulties. Her diet was reviewed by Speech Therapy and Dietician. Food that resident received was modified to meet diet restriction. Resident has since signed Feeding Risk Advisory 8/9/17. Resident #22 was changed from mechanical soft diet to regular diet at 3:00pm 7/18/17. Received mechanical soft diet only at supper 7/18/17 and regular diet starting 7/19/17. 2. Residents who on modified diets or have recent diet changes have the potential to be affected. 3. Education with dietary staff on residents□ diets and what foods fall into each diet category will take place 8/16/17. The process for notifying staff when a diet is upgraded was reviewed 8/7/17.	

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F 367	Continued From page 42 - Review of Resident #11's medical record occurred on July 18 - 19, 2017 and identified the physician ordered a regular, dysphagia advanced soft diet. - Review of Resident #12's medical record occurred on 07/19/17 and identified the physician ordered a regular, mechanical soft texture, thin consistency diet. - Review of Resident #22's medical record occurred on 07/19/17 and identified the physician ordered a regular diet. - Review of Resident #24's medical record occurred on 07/19/17 and identified the physician ordered a regular, dysphagia advanced soft diet. Observation during meal service on 07/18/17 showed Resident #11 received goulash (hamburger pasta casserole), and a dry dinner roll. Resident #12 received goulash, toast (2 pieces) with jelly on it, rhubarb cake, coffee, and water. Resident #22 received blended turkey on bread, broccoli, and jellied cranberries. Resident #24 received blended goulash, broccoli, and a dry piece of bread. The facility failed to provide food consistent with physician order. An anonymous concern identified residents' dietary cards/tickets do not match the food served to them. For example, a resident on a mechanical soft diet received the same food as other residents on a regular diet, and many of those foods were not mechanical soft. During an interview on 07/18/17 at 6:30 p.m., a dietary aide (#7) stated "I do not really know the	F 367	Education on this process will take place at the Dietary meeting 8/16/17 and nursing meetings 8/18/17 and 8/22/17. 4. Auditing by Director of Nutrition and Culinary Services or Designee of sample residents to ensure receiving correct food based on diet as staff ability to identify foods within diets will take place starting 8/21/17 x5/week for 8 weeks, x3 week for 8 weeks, x1 week for 8 weeks and prn. Results will be brought to Quality Committee for review and recommendations. 5. 8/23/17	

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F 367	Continued From page 43 difference between a mechanical soft and dysphasia advanced diet. I was never really taught the difference between diets." During an interview on 07/18/17 at 6:41 p.m., a dietary aide (#8) stated "I do not know the difference between a mechanical soft and dysphasia advanced diet, however the diet cards will say to cut or grind certain food items."	F 367		
F 371 SS=F	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced	F 371		8/23/17

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F 371	Continued From page 44 by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON 05/05/16 DISHWASHER TEMPERATURES 1. Based on observation, review of facility policy, review of the Food and Drug Administration (FDA) Food Code, and staff interview, the facility failed to wash dishes at appropriate temperatures in 1 of 2 dishwashers (dish room). Failure to maintain utensil surface temperatures above 160 F (degrees Fahrenheit) and properly use a dishwasher thermometer has the potential to increase the risk of foodborne illness and can affect all residents who consume food prepared with these dishes. Findings include: The FDA Food Code 2013, page 145, stated, ". . . Sanitization of equipment and utensils . . . Hot water mechanical operations . . . achieving a utensil surface temperature of 160 F as measured by an irreversible registering temperature indicator. . . ." Review of the facility policy titled "Dishwashing" occurred on 07/20/17. This policy, revised 04/17/14, stated, ". . . It is the policy of Eventide to properly clean and sanitize dishes and utensils. Purpose is to establish guidelines for dishwashing to comply with health codes. . . ." An initial tour of the facility's Skilled Care kitchen on 07/17/17 at 1:00 p.m., showed a dietary manager (#6) placed a thermometer in the dishwasher and was unable to identify the	F 371	F371 1. Utensil surface temperatures of dishwasher will be maintained above 160F. Proper infection control procedures will be followed. 2. All residents have the potential to be affected. 3. Review of equipment including dish machine, thermometers, and booster heater took place by 8/10/17. Education with staff to include topics of operating dishwashing process and equipment, as well as infection control practices will take place 8/16/17. 4. Auditing by Director of Nutrition and Culinary Services or Designee of dishwashing temperatures and hand hygiene will take place starting 8/21/17 x5/week for 8 weeks, x3 week for 8 weeks, x1 week for 8 weeks and prn. Results will be brought to Quality Committee for review and recommendations. 5. 8/23/17	

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F 371	Continued From page 45 maximum temperature on the thermometer with temperatures fluctuating below 160 F. A tour of the facility's kitchen occurred on 07/18/17 at 2:00 p.m. Observation of the dish room dishwasher showed the dietary manager (#6) placed a thermometer through the wash multiple times obtaining readings fluctuating below 150 F and unable to identify the maximum temperature setting. A hotplate thermometer placed in the dish room dishwasher by the surveyor showed the maximum utensil temperature to be 155.8 F. During an interview on the afternoon on 06/18/17, the dietary manager (#6) confirmed the dishwasher should maintain hot water surface temperatures at 160 F, the facility had trouble with dishwasher temperatures in the past, and she was unaware of a maximum temperature setting on the dishwasher thermometer. Failure to properly use a dishwasher thermometer and maintain dishwasher surface temperatures at 160 F may result in a foodborne illness. HAND HYGIENE 2. Based on observation, review of facility policy review, and staff interview, the facility failed to follow infection control practices for 3 of 4 kitchen areas (long term care, transitional care unit, and dish room). Failure to follow infection control practices related to hand hygiene with food serving and dirty to clean dish handling has the potential to spread infection to residents, staff, and visitors.	F 371		

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F 371	Continued From page 46 Findings include: Review of facility policy titled "Hand Hygiene" occurred on 07/19/17. This policy, revised 11/20/13, stated, ". . . It is the policy of Eventide that the proper hand hygiene procedure will be followed. Hand hygiene will be done: . . . before every clean procedure . . . after every dirty procedure . . . as needed. . . ." An initial dietary tour occurred on 07/17/17 at 1:00 p.m. A dietary assistant (#9) washed soiled dishes using gloves in the dish room dishwasher, removed her soiled gloves and did not wash her hands, and touched clean dishes with dirty hands. During meal pass on 07/18/17 at 6:00 p.m., a dietary assistant (#8) served food to residents on the transitional care unit (TCU). During serving, the dietary assistant (#8) touched his face twelve times with the same gloves and touched bread served to residents. The dietary assistant (#8) left the serving kitchen and touched the door handle wearing the same gloves, grabbed a fork in the hallway, returned touching the door handle to the kitchen wearing the same gloves, and then touched bread he served to residents. The staff member failed to change gloves between tasks and prior to serving residents food. Observation of meal service in the long term care unit occurred on 07/18/17 at 6:00 p.m.. A dietary assistant (#7) served residents' food in the long term care unit while touching multiple areas throughout the environment, without changing gloves, and proceeded to serve buns/bread with	F 371		

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F 371	Continued From page 47 the same soiled gloves. Several unidentified CNA's handled the meal tickets that the dietary assistant (#7) touched and placed meal tickets on top of prepared food for residents. The dietary assistant (#7) cleaned the blender in the sink after each use and with the same soiled gloves continued to serve buns/bread to residents. During an interview on 07/19/17 at 8:40 a.m., a dietary manager (#6) confirmed staff should wash their hands in the kitchen when re-entering the dietary area, when touching dirty dishes, and moving to clean dishes, and after touching their face while serving food.	F 371		
F9999	FINAL OBSERVATIONS A complaint investigation was conducted in conjunction with the standard Medicare/Medicaid recertification survey. The complaint issues regarding nursing staff cooking and preparing food as well as cleaning tables and doing dishes without adequate training could not be substantiated.	F9999		