STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355070	A. BUILDING _____ B. WING _____	C 09/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHEL LUTHERAN NURSING & REHABILITATION CENTER	**1515 2ND AVE WEST WILLISTON, ND 58801**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey and complaint survey started on September 19, 2016, and completed on September 22, 2016, the sample included five (5) residents for complete review, sixteen (16) residents for focused review, and three (3) closed records for review.	F 000		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.	F 225		10/27/16

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

Electronically Signed | 10/17/2016

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 225	Continued From page 1 The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to ensure alleged violations of neglect were reported to the State Agency for 1 of 1 sampled resident (Resident #9) who fell from a bath chair. Failure to identify the incident as possible neglect and report to the State agency placed residents at risk for mistreatment/neglect. Findings include: Review of the facility policy titled "Abuse Reporting" occurred on 09/22/16. This policy, dated August 2016, stated, ". . . When an alleged or suspected case of mistreatment, neglect, injuries of an unknown source, or abuse is reported, the facility administrator, or his/her designee, will notify the following persons or agencies of such incident: . . . State Licensing and Certification Agency (immediately)." Review of a progress note, dated 09/18/16 at 2:30 p.m., stated " . . . Upon entering bathroom resident was noted to be on floor on her back,	F 225	1. Resident #9 incident on September 18, 2016 was under investigation. Initial report was submitted on 09/22/2016 and final report submitted on 09/23/2016 to the North Dakota State Health Department. 2. Any resident has the potential to be affected. 3. Re-education was provided on abuse reporting to all staff at the "All Staff Meeting" held on September 28, 2016. Policy and procedure for "Abuse Reporting" and "Investigation of Injury of Unknown Origin" were reviewed. Will continue with requirements that staff complete upon hire and annual reviewing of the Policy and Procedures for "Abuse Reporting," "Investigation of Injury of Unknown Origin," and completing the abuse health care academy course. The Neighborhood Nursing Manager (or designee) will continue to include reporting on resident injuries during morning report Monday-Friday. On	

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F 225	Continued From page 2 top part of tub chair located under residents lower back; lower portion of tub chair was off to the side. Blood was noted on floor coming from behind resident's head. . . . CNA [Certified Nurse Aide] states resident was getting ready to take scheduled shower, tub chair placed beside shower chair for CNA to take resident's weight, when resident went to sit in tub chair, top part of tub chair quickly came off base of chair. CNA unable to stop resident from hitting floor. . . . Laceration noted to back of head with visible hematoma. . . . ER [Emergency room] called and given report by this nurse. . ." During an interview on 09/21/16 at 4:30 p.m., a maintenance staff member (#3) stated he checked the bath chair involved in the incident and it functioned correctly. This staff member (#3) also stated he attempted to re-enact the incident using the bath chair, but could not do so, and the CNA involved in the incident may have failed to lock the chair in place. During an interview on 09/21/16 at 5:19 p.m., an administrative staff member (#4) stated the incident is still under investigation, maintenance could not reproduce the incident, and there is a question if the chair was latched.	F 225	Saturday and Sunday (and during holidays) the House Supervisor will obtain report from the Neighborhood Charge Nurse's and notify either the Director of Nursing Service and/or Administrator of resident injuries and preliminary results of the investigation. Nursing staff will be re-educated on October 17th & 18th, 2016 on the procedure for "Abuse Reporting" and "Investigation of Injury of Unknown Origin." 4. The Neighborhood Nurse Manager (or designee) Monday through Friday and House Supervisor (or designee) on Saturday/Sunday (and Holiday's) will investigate resident injuries and notify either the Director of Nursing Services and/or Administrator of preliminary results. If concerns are identified, immediate corrective actions will be implemented. If required the Administrator (or designee) will notify the North Dakota Department of Health and other agencies as required. The Director of Nursing Service (or designee) will monitor resident injuries, investigation of these injuries, and results of the investigations daily for 4 weeks, three times per week for 4 weeks, then monthly for 10 months. The Director of Nursing Services (or designee) will report to the QA committee monthly resident injuries and results of investigations. 5. October 27, 2016.	
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility	F 281		10/27/16

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F 281	Continued From page 3 must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 09/24/15. Based on observation, record review, review of facility policy, manufacturer's recommendations, and staff interview, the facility failed to provide services to meet professional standards of practice for 4 of 21 sampled residents (Resident #11, #13, #14, and #18). Failure to correctly prime an insulin pen (Residents #13 and #14),ensure nursing staff followed the six rights of medication administration (Resident #11), identify the location of dressing changes (Resident #18) may adversely affect the therapeutic effect of medications and dressing changes. Findings include: Review of the following facility policies occurred on 09/21/16: * "Insulin Pen," dated April 2016, stated, ". . . 7. Prime before each injection. 8. Turn the dose knob to select 2 units. 9. Hold your pen with the needle pointing up. Tap the holder gently to collect air bubbles at the top. 10. Continue holding your pen with needle point up. Push the dose knob in until it stops, and "0" is seen in the dose window. Insulin should be noted at the tip of the needle. 11. If you do not see insulin, repeat the priming steps 8-10. 12. Turn the dose knob to prescribed unit. . . ." * "Medication Administration," dated July 2014,	F 281	F281 A 1. Staff member caring for Resident #13 and #14 was re-educated on the process of priming an insulin pen prior to the administration of insulin. 2. All Resident's receiving insulin via insulin pen have the potential to be affected. 3. Policy and procedure for "Priming of an Insulin Pen" was reviewed. Monitoring of priming of insulin pen prior to insulin administration was completed starting the week of 09/26/2016 and if required re-education was completed prior to administration of insulin. Nursing staff will be re-educated during nursing meetings held on October 17th & 18th, 2016. 4. The Director of Nursing Services (or designee) will monitor priming of the insulin pen prior to insulin administration weekly for 4 weeks, the monthly for 11 months. If concerns are identified, immediate corrective action will be implemented. The Director of Nursing services (or designee) will report results of monitoring monthly to the the QA committee for 12 months. 5. October 27, 2016. F281 B 1. Resident #11 order for alphagan eye drop was clarified. Resident #18 no longer has order for dressing change. 2. All Residents have the potential to be	

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F 281	Continued From page 4 "Policy Statement: To ensure proper and safe medication administration of drugs . . . 6. Completes the six rights . . . Right dose . . . Right medication, and Right documentation. The Licensed nurse will start at the top of the eMAR/eTAR [electronic medication administration record and/or electronic treatment administration record], checking each medication in order against the medication card [observation showed medication cards not utilized]. . . . 11. Administration of eye drops . . . c. Verifies medication and strength with eMAR/eTAR and Medication Card Label. Completes the six rights: . . . Right dose . . . j. Drop prescribed number of drops . . ." * "Clinical Record Content - Physician Orders," dated July 2014, stated . . . "Policy . . . will maintain clinical records on each resident in accordance with accepted professional standards . . . 1. At the time of admission the facility must have physician orders for the Resident's immediate care. . . . 3. Physician orders will include but not be limited to: . . . b. Treatments. . . ." - Observation on 09/20/16 at 11:52 a.m., showed a licensed nurse (#1) failed to prime Resident #13's NovoLog insulin pen prior to administration of the insulin injection. When asked, before administration of the insulin, the nurse (#1) identified facility policy is to prime new insulin pens, not insulin pens already opened. - Observation on 09/20/16 at 11:58 a.m., showed a licensed nurse (#1) failed to prime Resident #14's NovoLog insulin pen prior to administration of the insulin injection.	F 281	affected. 3. Licensed nursing staff were re-educated on the 6 rights of medication administration during the week of 09/26/2016 and will be on October 17th & 18th, 2016. Licensed nursing staff will be re-educated on October 17th & 18th, 2016 to clarify orders with medical providers when discrepancies are noted from administration label to written order and if order content is not specific enough i.e. location of wound care. Policy and procedure on "Clinical Record Content: Physician Orders was reviewed. 4. The Director of Nursing Services (or designee) will monitor thirty percent of physician orders. Monitoring will include content of orders, order is consistent with pharmacy label and eMAR, and medications are administered according to physician order. This monitoring will be conducted three times per week for 4 weeks, weekly for one month, and monthly for 10 months. If concerns are identified, immediate corrective action will be implemented. The results of monitoring will be reported to the QA committee by the Director of Nursing Services (or designee) monthly for 12 months. 5. October 27, 2016.	

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F 281	Continued From page 5 Failure of nursing staff to prime insulin pens may result in an inaccurate dose of insulin to be administered to Resident #13 and #14. During an interview on the afternoon of 09/21/16, an administrative nurse staff member (#2), verified the facility policy is to prime insulin pens with each use. - Review of Resident #11's medical record occurred on September 20-21, 2016. Diagnoses included glaucoma and dementia. Current physician's orders included "Brimonidine Tartrate Solution [generic for Alphagan] 0.1% Instill 1 drop in right eye three times a day related to UNSPECIFIED GLAUCOMA," with an order date of 12/09/15. Alphagan is indicated to reduce intraocular pressure in patients with glaucoma or ocular hypertension. During observation of medication pass on 09/20/16, a nurse (#1)administered one Alphagan eye drop into each of Resident #11's eyes. The physician's order and electronic medication administration record (eMAR) showed to administer one eye drop to the right eye. The label on the eye drop carton stated to administer one drop to each eye. On 09/21/16 at 11:20 a.m., during observation of the second administration of the Alphagan eye drops, the nurse (#1) stated nursing staff should follow the eMAR verses the label during administration of medications, stated the order was changed to both eyes on 06/24/16, and then incorrectly transcribed onto the eMAR. The nurse provided a dated document, dated 06/24/16, from the pharmacy which confirmed a change in the	F 281		

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F 281	Continued From page 6 prescribed dose from one eye drop into the right eye only to one drop into both eyes on 06/24/16. Facility staff failed to identify a discrepancy between the eMAR and the label on the medication, and administered the medication based on the label on the box. - Observation on 9/22/16 at 9:00 a.m., identified Resident #18 with a dressing to her left forearm. Resident #18 stated she was transferred to the emergency room on 09/20/16 for assessment of her left arm and treated for cellulitis. Resident #18's plan of care identified the following: . . . "Focus: I am on Antibiotic Therapy r/t [related to] cellulitis in my left elbow. . . Interventions: I have a dressing over the area the rod pocked [sic] through. I [sic] needs to be changed daily. Date initiated: 09/20/2106.. . . " Review of Resident #18's physician's orders dated 09/20/2016, identified, . . . "Daily skin and dressing change. Cleanse area with NS [normal saline] and pat dry. Apply 2 x 2 foam dressing and wrap snug with kerlix and paper tape. Monitor drainage. Every day shift.. . ." The facility failed to clarify physician's order to determine the site of dressing.	F 281		
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.	F 309		10/27/16

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F 309	Continued From page 7 This REQUIREMENT is not met as evidenced by: 1. Based on record review, review of facility protocol, and staff interview, the facility staff failed to follow their bowel protocol to promote regular bowel elimination for 8 of 24 sampled residents (Resident #7, #8, #12, #16, #19, #21, #22, and #24) with bowel elimination exceeding the recommended three days without receiving as needed (PRN) bowel medications. Failure to follow the bowel protocol may have contributed to residents experiencing constipation and discomfort due to delayed bowel elimination. Findings include: Review of the facility protocol titled "ROUTINE BOWEL PROTOCOL" occurred on 09/22/16. This protocol, revised July 2014, stated, ". . . 4. Approaches through the use of medications . . . b. Stools hard to pass or required straining to expel. Implement stool softener or stimulant . . . 3. If no BM [bowel movement] on 3rd day may administer Milk of Magnesia 30 ml [milliliters] orally as needed. c. If no bowel movement is noted initiate the following as needed: 1. Bisacodyl (Dulcolax) 10 mg [milligrams] suppository one rectally on day #4 if no results from the Milk of Magnesia. . . ." - Review of Resident #7's medical record occurred on all days of survey. Diagnoses included dementia. Medications to prevent constipation included Magnesium Hydroxide Suspension one ounce as needed. The current	F 309	F309 #1: 1. Staff providing care to Resident #7, #8, #12, #16, and #21 were re-educated on bowel protocol and automatic dash board alerts signifying that the resident did not have a bowel movement. Resident #19, #22, and #24 are no longer in the facility. 2. Any Resident in the facility has the potential to be affected. 3. Licensed Nursing Staff were re-educated on the routine bowel protocol the week of 09/26/2016 and will be on October 17th & 18th, 2016. The electronic medical record is set up to automatically send alert on the third day that a resident has not had a bowel movement. Staff will be re-educated on the resident alerts from electronic medical record and the use of prune juice cocktail on October 17th & 18th, 2016. 4. The Director of Nursing Service (or designee) will monitor the dash board from the electronic medical record for alert for absence of bowel movement three times per week for 4 weeks, then weekly for 4 weeks, then monthly for 10 months. If concerns are noted, immediate corrective actions will be implemented. The results of monitoring will be reported to the QA committee by the Director of Nursing Service (or designee) monthly for 12 months. 5. October 27, 2016	

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F 309	Continued From page 8 care plan stated, ". . . Focus: I have the potentail [sic] for constipation r/t [related to] decreased mobility . . . Interventions . . . Follow [the facility] protocol for bowel management or as ordered by MD [medical doctor]. . . ." Review of the September 2016 bowel movement (BM) record showed one occasion where Resident #7 had no BM for three days with no PRN medications administered. On another occasion Resident #7 had no BM for four days and on the fourth day facility staff administered prn Milk of Magnesia (MOM). Facility staff failed to administer MOM on the third day and failed to administer a Bisacodyl suppository on the fourth day. - Review of Resident #8's medical record occurred on all days of survey. PRN medications included MOM 1 ounce. The current care plan stated, ". . . Focus: I have the potential for constipation r/t history of constipation. I have orders for Miralax and fibertabs. . . . Interventions . . . Follow [the facility] bowel protocol for bowel management or as ordered by MD. . . ." Review of the August 2016 BM record showed one occasion where Resident #8 had no BM for four days with no PRN medications administered. Facility staff failed to administer MOM on the third day and failed to administer a Bisacodyl suppository on the fourth day. Review of the September 2016 BM record showed one occasion where Resident #8 had no BM for three days with no PRN medications administered. Facility staff failed to administer MOM on the third day.	F 309	F309 #2: 1. Resident #10 is no longer in facility. 2. All Residents have the potential to be affected. 3. Nursing staff will be re-educated on October 17th & 18th, 2016 on intervention to prevent skin breakdown (or assist with healing), which include turning and repositioning every 2 hours or more as needed and floating of feet off mattress. Care plans for residents who are bedfast and chairfast were reviewed and if required interventions were updated. Policy and procedure for "Nursing Practice Guidelines-Nursing Service Department," "Pressure Ulcer Management," and "Skin Assessment and Skin Care" were reviewed. 4. The Director of Nursing (or designee) will monitor three times per week for 4 weeks, weekly for 4 weeks, then monthly for 10 months. Monitoring will include care plan, documentation of care provided i.e. turning and repositioning and floating of feet off mattress, and observation of cares provided. If concerns are identified, immediate corrective actions will be implemented. Results of the monitoring will be reported to the QA committee by the Director of Nursing Service (or designee) monthly for 12 months. 5. October 27, 2016.	

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F 309	Continued From page 9 - Review of Resident #24's medical record occurred on September 21-22, 2016. Diagnoses included constipation. The current care plan stated, ". . . Focus: I have the potential for constipation r/t decreased mobility, medications side effects . . . Interventions . . . Follow [the facility] bowel protocol for bowel management or as ordered by MD. . . ." Review of the July 2016 BM record showed one occasion where Resident #24 had no BM for seven days with no PRN medications administered. Facility staff failed to administer MOM on the third day and failed to administer a Bisacodyl suppository on the fourth day. On another occasion Resident #24 had no BM for three days with no PRN medications administered. Facility staff failed to administer MOM on the third day. - Review of Resident #12's medical record occurred on all days of survey. Diagnoses included Parkinson's disease. The facility identified Resident #12 as interviewable. Medications to prevent constipation, ordered/start date of 09/15/16, included prn medications of MOM every 24 hours and a Bisacodyl suppository rectally every 24 hours. The current care plan stated, ". . . Focus: I have problem or potential nutritional problem . . . Interventions: I have nutrition interventions . . . for bowel management. I stated that my usual bowel movement is every 3-5 days. . . ." and ". . . I have the potential for constipation r/t lack of privacy, aging process. . . . Interventions: . . . Follow [facility] bowel protocol for bowel management or as ordered by MD . . . Record bowel movement	F 309		

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F 309	Continued From page 10 pattern each day. Describe amount, color and consistency." Review of Resident #12's September 2016 BM records showed the resident had no BM documented for a five day period between 09/11/16 and 09/15/16. During interview on 09/22/16 at 9:20 a.m., Resident #12 reported having a problem with constipation once in the last couple of weeks and was given prune juice in the morning and at bedtime, and "had to have MOM also." The progress notes and electronic medication administration record (eMAR) lacked information regarding the constipation, giving of prune juice and the administration of the MOM. - Review of Resident #19's medical record occurred on 09/22/16. Diagnoses included hemiplegia and hemiparesis related to a stroke. The facility identified the resident as interviewable. The current care plan stated, ". . . Focus: . . I have the potential for constipation r/t [related to] decreased mobility. . . . Interventions: . . . Follow [facility] bowel protocol for bowel management or as ordered by MD . . . Record bowel movement pattern each day. Describe amount, color and consistency." Review of Resident #19's September 2016 BM records showed the resident had no BM documented for three days and six days apart. The eMar showed no PRN medications administered between those dates for treatment of constipation. - Review of Resident #22's medical record occurred on 09/22/16. Physician orders included a Bisacodyl suppository every 24 hours as	F 309		

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	355070	A. BUILDING _____ B. WING _____	C 09/22/2016

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F 309	Continued From page 11 needed on day #4 if no BM, after MOM on day #3. Review of Resident #22's June 2016 BM records showed the resident had no BM documented from three to six days apart. The July BM records showed the resident had no BM documented for 13 days. The eMar showed no PRN medications administered during those times for treatment of constipation. During interview on the morning of 09/22/16, an administrative nursing staff member (#12) stated awareness of staff failing to check resident's BM elimination, charting correctly, and following the facility protocol. - Review of Resident #16's medical record occurred on September 21-22, 2016. Current physician's orders stated, MOM 30 ml every 24 hours as needed and MiraLax Power (a laxative) 17 grams every 24 hours as needed. Review of Resident #16's August-September 22, 2016 eMAR and BM record showed the following: August: No BM for three - six days on three separate occasions with no PRN medications administered during those times for treatment of constipation. No BM for six days, MOM given on the 4th day and 6th day. September: No BM for six days and MOM given on the 6th day. - Review of Resident #21's medical record occurred September 21-22, 2016. Medications for prn treatment of constipation included one Docusate Sodium Tablet 100 mg (ordered 09/15/16), one FiberCon Tablet 625 mg (ordered	F 309		

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F 309	Continued From page 12 09/19/16), or one Fleet Enema Enema (ordered 09/21/16). The current care plan stated, ". . . Focus: I have the potential for constipation r/t surgical incisions to abdomen . . . Interventions . . . Follow [the facility] bowel protocol for bowel management or as ordered by MD. . . ." Review of the September 2016 BM record showed Resident #21 failed to have a BM for seven days. Facility staff failed to administer MOM on the third day. On the fourth day, staff administered one docusate sodium, identified as effective, but failed to record it on the BM record. The sixth day staff administered two doses of docusate sodium, both ineffective, and an enema, identified as effective but failed to record the results on the BM record. 2. Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide the necessary care and services to prevent the occurrence and promote the healing of vascular ulcers for 1 of 2 sampled residents (Resident #10) with vascular ulcers. Failure to provide timely and appropriate interventions and ensure staff consistently implement those interventions may have resulted in the development of new vascular ulcers to Resident #10. Findings include: Review of the facility policy titled, "Nursing Practice Guidelines-Nursing Service Department" occurred on 09/21/16. This policy, dated September 2015, stated, "Hygiene and physical comfort will be maintained by . . . Giving special attention to areas susceptible to breakdown may	F 309		

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F 309	Continued From page 13 include but not limited . . . Turning and repositioning at least every two hours . . ." Review of Resident #10's medical record occurred September 20-22, 2016. Diagnoses included hemiplegia and hemiparesis following a cerebral infarct, type 2 diabetes, complete traumatic amputation of left lesser toe, and vascular ulcers to the left foot. The significant change Minimum Data Set (MDS), dated 08/31/16, identified extensive assist of 2 needed for bed mobility. The resident's care plan stated . . . "I have the potential for impairment to skin integrity r/t [related to] diabetes, decreased mobility . . ." Resident #10's progress notes identified the following: * 06/21/16 at 9:03 a.m.: ". . . lateral portion of foot is more bruised. New orders to off load the foot with pillows under the calf." * 06/22/16 at 12:40 p.m.: "Redness noted to inner left foot with deep purple bruise to bony prominence . . ." * 06/27/16 at 12:09 p.m.: ". . . New superficial ulcer on dorsal foot . . . Appears to be from strap pressure from off loading boot. Will try alternative." * 06/28/16 at 12:32 p.m.: "Both sides of foot have large black areas that provider thought to be bruising but continue to be black in color and are larger every day . . . " * 06/28/16 at 21:00 p.m.: "Off load left foot with pillows under calf noted and podus boot on as ordered by [provider's name] to prevent further injury to left foot. Both sides of foot have large black areas noted . . ." * 06/29/16 at 1;30 p.m.: ". . . left foot . . . deep	F 309		

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F 309	Continued From page 14	F 309		

purple area to bony prominence is intact with red surrounds, non-blanchable. Redness noted to top of foot with scab formation, outer left foot has dark area with red surrounds. Treatment by [provider name]."
* 07/20/16 at 11:15 a.m.: "Resident to hospital for outpatient surgery for procedure and dressing change to left foot."
* 07/26/16 at 3:35 p.m.: "Off load left foot with pillows under calf. Wear podus boot to prevent injury to left foot."
* 08/09/16 at 9:24 a.m.: "Outer left foot continues with necrotic tissue and red surrounds, inner left foot had area which is 80% [percent] necrotic tissue and 20% slough with red surrounds, small amount of drainage noted, no odor . . ."
* 08/31/16 at 3:53 p.m.: "Air mattress on . . ."

The physician Nursing Home Note, dated 6/01/2016, identified the ulcers as, "vascular ulcers presumed staph infections" and "vascular versus diabetic foot ulcers."

The skin integrity records identified the following:
* 09/13/16 at 1:36 p.m.: . . . Left buttock abrasion 0.2 cm [centimeters] long by 0.2 cm wide, inner left foot with necrotic tissue 10 cm long by 5 cm wide, and outer left foot with necrotic tissue 6 cm long by 3.3 cm wide and outer left foot with necrotic tissue 1.3 cm long by 1.4 cm wide. Coccyx with redness. ". . . abrasions to left buttock are dry and healing. . ."
* 09/14/16 at 2:51 p.m.: Left buttock with abrasion measuring 0.2 cm long by 0.2 cm wide. ". . . Abrasion on left buttocks almost completely healed. . ."
* 09/16/16 at 9:33 a.m.: ". . . necrotic tissue continues to outer and inner left foot, outer edges

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F 309	Continued From page 15 are moist and lifting with red surrounds, some bleeding noted to outer edges of necrotic tissue on outer left foot, both sites to outer left foot have grown together and become one . . ." * 09/20/16 at 9:54 a.m.: Inner left foot with necrotic tissue measuring 10 cm long and 5 cm wide. Outer left foot with necrotic tissue measuring 9 cm long by 3.8 cm wide. ". . . 2 [two] areas of necrotic tissue to outer left foot have grown into 1 [one] and is black and lifting around the edges with redness to surrounding skin, necrotic tissue to inner left foot is black with yellow tissue around edge which is moist and lifting, surrounding skin is red . . ." Observations and interviews included the following: * All observations of Resident #10 showed an air mattress in place and Podus boot on his left foot. * 09/20/16 at 10:14 a.m.: Two certified nurse assistants (CNA's) (#5 and #10) repositioned Resident #10 to his right side and placed a pillow behind his back and under his knees. The CNAs failed to suspended his feet off the mattress. * During and interview on 09/20/16 at 1:30 p.m., a CNA (#5) reported Resident #10 had been turned and repositioned to his back at 1:00 p.m. * 09/20/16 at 3:30 p.m.: Resident #10 lying in bed on his back with his left foot against the foot board and feet not suspended off the mattress. * 09/20/16 at 5:25 p.m.: Resident #10 on his back with his left foot up against foot board of the bed and feet not suspended off the mattress. * 09/20/16 at 6:05 p.m.: Resident #10 lying on his back with left foot against the foot board of the bed and feet not suspended off the mattress. * 09/21/16 at 9:04 a.m.: CNA (#6 and #7) repositioned Resident #10 on his right side and	F 309		

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F 309	Continued From page 16 placed pillows under his knees. The CNAs failed to suspend his feet off the mattress. * 09/21/16 at 10:44 a.m.: CNA (#6 and #7) repositioned Resident #10 to his left side and placed a pillow under his knees. The CNAs failed to suspend his feet off the mattress. * 09/21/16 at 3:16 p.m.: CNAs (#8 and #9) repositioned/turned Resident #10 to his right side and placed a pillow between his knees. The CNAs failed to suspended his feet off the mattress. * Observations showed staff failed to turn/reposition Resident #10 from 10:44 a.m. to 3:16 p.m. (approximately 4 1/2 hours) on 09/21/16. During an interview on 09/21/16 at 2:55 p.m., a unit manager (#11) identified Resident #10 as bedridden and staff were expected to turn him every two hours and place a pillow under his [calves] to float them off the mattress. Failure to suspend Resident #10's feet off the bed and turn/reposition every two hours per policy may have contributed to the development of new pressure ulcers and the delayed healing of current vascular ulcers.	F 309		
F 363 SS=E	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed.	F 363		10/27/16

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F 363	Continued From page 17 This REQUIREMENT is not met as evidenced by: Based on observation, review of facility menus, review of facility policy, and staff interview, the facility failed to meet the nutritional needs of the residents by serving incorrect portion sizes in 4 of 5 dining rooms (Horizon Towers, Legacy, Pineview and Harmony). Failure to follow recommended portion sizes as outlined in the facility's menus may result in weight changes and/or inadequate nutritional intake for all residents. Findings include: Review of the facility policy titled "Portion Control" occurred on 09/22/16. This policy, dated June 2009, stated, ". . . 2. The menu should list the specific portion size for each food item. Menus and tray cards have proper portioning of servings for each diet for staff to refer to. . . . Portions that are too small result in the individual not receiving the nutrients needed. . . ." - Observation of tray line occurred in the Horizon Towers dining room on 09/20/16 during the noon meal. Observation showed the following inconsistencies between portion sizes listed on the facility's menus and the actual amount served to residents: * Potato salad served with a 1/3 cup scoop. The menu identified 1/2 cup. * Pureed vegetable served with a 3 ounce scoop. The menu identified 4 ounces. * Mechanical chicken served with a 2 ounce scoop. The menu identified 3 ounces. * Pureed chicken served with a 3 ounce scoop. The menu identified 6 ounces.	F 363	1. There were no residents identified. Dietary staff serving meals on Horizon Towers, Legacy, Pineview, and Harmony Neighborhoods for all meals were re-educated on correct use of spoodles and scoops. 2. Any resdient has the potential to be affected. 3. Policy and procedure for "Portion Control," and laminated tools for use of scoops and spoodles were reviewed on September 22, 2016. Dietary staff were re-educated on the policy and procedure for "Portion Control" and laminated tools for use of scoops and spoodles on September 22, October 4, and will be on October 18, 2016. Stand-up meetings are conducted daily Monday through Friday with review of scoops and spoodles utilized for different foods and portions. Spread sheets have been provided for staff to utilize for what portions and what scoop/spoodle to utilize with different foods. Process has changed for the distribution of spoodles and scoops prior to meal service. Each dietary aide is expected to follow a spread sheet when gathering their own scoops and spoodles. Cooks and prep cook (or designee) have been instructed to monitor this process. 4. The Director of Food Service (or designee) will monitor each neighborhood for all three meals for correct portion size served to the resident five times per week for 2 weeks, then two times per week for 8 weeks, then 1 time per week for 10	

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F 363	Continued From page 18 * Pureed sloppy joe served with a 3 ounce scoop. Interview with an administrative dietary staff member identified the serving size as 2/3 cup, approximately five ounces. - Observation of food service for Pineview occurred on 09/20/16 with the noon meal. A dietary staff member (#13) just sent out the last tray, and was preparing to take end of meal food temperatures. As temperatures were taken, interview with the dietary staff member (#13) identified the following inconsistencies between portion sizes listed on the facility menu and amounts served to residents: * Potato salad served with a 1/4 cup scoop. The menu identified 1/2 cup regular portion and 1/3 cup for small portion. * Pureed chicken served with a 1/4 or 1/3 cup scoop. The menu identified a 3/4 cup portion. - Observation of tray line occurred in the Legacy dining room on 09/20/16 during the evening meal. Observation showed the following inconsistencies between portion sizes listed on the facility's menus and the actual amount served to residents: * Pureed soup served with a 3 ounce scoop. The menu identified 4 ounces. * Pureed Hamburger Rice Casserole served with a 1/3 cup scoop. The menu identified 3/4 cup. * Pureed green beans served with a 3 oz scoop. The menu identified 4 ounces. * Hamburger Rice Casserole with no onions served with a 1/3 cup scoop. The menu identified 3/4 cup. - Observation of tray line occurred in the Harmony serving area on 09/20/16 during the	F 363	months. If concerns are identified, immediate corrective actions will be implemented. The Director of Food Service (or designee) will report to the QA committee monthly for 12 months. 5. October 27, 2016.	

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F 363	Continued From page 19 evening meal. Observation showed the following inconsistencies between portion sizes listed on the facility's menus and the actual amount served to residents: * Green beans served with a 1/3 cup scoop. The menu identified 1/2 cup. During an interview on 09/21/16 at 3:45 p.m., a dietary supervisory staff member (#14) stated staff should follow portion sizes listed on the resident tray card and reference the tray card when dishing resident portions. This staff member (#14) identified the portion size listed on the tray card links to the menu for the resident's diet order.	F 363		
F9999	FINAL OBSERVATIONS Based on observation, record review, review of facility policy and procedures, and staff interview, the complaint issues regarding wound care, activities of daily living and care provided in relation to, infection control, and missing clothing items could not be substantiated.	F9999		