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OCT - 9 2012
Division of Health Facilities

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 _____	08/30/2012

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 started on 08/27/12 and completed on 08/30/12, the sample included five (5) residents for complete review, 16 residents for focused review, and three (3) closed records for review. The sample included two (2) additional residents to verify specific concerns during the survey.	F 000	**F 221** 1. Resident #8 had an assessment for assistance device/restraint reduction completed on ~~August~~ September 21, 2012. A physician order was obtained for the use of the table on the tilt-n-space chair on August 30th, 2012. Resident #8 care plan and group sheet have been updated to include utilization of the table on the tilt-n-space chair. 2. Any resident who requires the use of a restraint has the potential to be affected. 3. Mandatory nursing in-service was conducted on September 5th and 6th, as well as October 2nd, 3.rd, and 4th, 2012 to re-educate the staff on what constitutes a physical restraint, when an assessment is required to be completed, documentation that is required, and review of the policy and procedure for physical restraints. Policy and Procedure forms were reviewed by DON and facility Medical Director on September 6th, 2012. The nursing quarterly assessment form will be revised to include any physical restraint(s) and date of most recent assessment. A'd per telephone conversation w Tammy-DON on 10/15/12 @ 3:45pm	**10/04/2012**
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to assess and obtain a physician's order for the use of a physical restraint for 1 of 2 sampled residents (Resident #8) observed with a lap tray. Failure to perform an initial assessment, ongoing assessments, and release the restraint may have limited the resident's freedom of movement and placed her at risk for decreased physical functioning and skin breakdown. Findings include: Review of Resident #8's medical record occurred August 27-30, 2012. Diagnosis included dementia with behavioral disturbances, anxiety, depression, Alzheimer's disease, fracture of unspecified part of neck of femur closed (left), and after care for	F 221		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kurt Stone	Administrator	10-3-12

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

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F 221	Continued From page 1 healing traumatic fracture of hip. A quarterly Minimum Data Set, dated 07/06/12, identified Resident #8 as cognitively impaired, required extensive assistance of two or more persons for transfers and walking, experienced falls since prior assessment (two or more with no injury and two or more with injury), and physical restraints not used in chair. The current physician order for the lap tray, dated 11/22/11, stated, "Tilt-n-space chair [with] tray PRN [as needed]." Observations on all days of survey showed Resident #8 seated in a Tilt-N-Space wheelchair with a lap tray and tab style chair alert in place. At times, Resident #8 grabbed the lap tray, planted her feet on the footboard, and pulled/pushed off the chair as far as the lap tray allowed. On two occasions on the morning and once the afternoon of 08/28/12, Resident #8 slid down in the chair activating the chair alert. During three observed meals, staff fed Resident #8 with the lap tray in place. The facility's "Assistance Device/Restraint Reduction Assessment," dated 02/07/12, identified the facility assessed Resident #3 to utilize a velcro seat belt when sitting in her Tilt N' Space chair. The assessment summary stated, "Will use the velcro seat belt in her tilt-n-space PRN, instead of the tray. . ." Observation throughout the survey showed facility staff placed a lap tray and not a velcro seat belt for Resident #8 while seated in her Tilt N' Space chair. The current care plan, dated 07/25/12, for "impaired physical mobility" identified "Chair alert. Check functioning . . . Uses Tilt n' space chair with tray prn . . . Annual tilt n' space with tray	F 221	4. The Neighborhood Nurse Manager (or designee) will monitor residents who utilize restraints for compliance to policy and procedure on a monthly basis for 3 months, then quarterly. Monitoring results will be reported to the DON. The DON will report monthly to the QA committee. Residents who utilize restraints will be discussed at the Restraint Review Committee which meets at least 1 to 2 times a month, which will include documentation of the device being utilized, review of physician order, review of care plan and group sheet, due date of next assessment, and whether or not there have been changes in the resident condition. 5. October 04, 2012	

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F 221	Continued From page 2 assessment every April [and] prn." The facility failed to complete an assessment in April for the Tilt N' Space chair. During an interview on 08/29/12 at 12:02 p.m., an administrative nursing staff member (#12) indicated staff use the chair alert due to the resident sliding down so that she does not become trapped by the tray. This nursing staff member (#12) identified the facility reassess restraints as needed and at least on an annual basis.	F 221		
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	F 225	**F-Tag 225:** 1. Resident #14 August 02, 2012 incident was investigated. Staff interviewed do not remember resident #14 having any other incident other than the falls occurring July 30, 2012 and August 04, 2012. The resident has been transferred according to plan of care. Resident #14 is not interviewable related to cognition. Resident #18 April 24, 2012 incident was investigated. Staff interviewed recall the incident as documented in the resident record. No other incidents were identified. Staff members involved with this incident were re-educated in regard to assuring proper documentation and reporting are completed. Resident #18 is not interview-able related to cognitive status.	10/04/2012

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F 225	Continued From page 3 violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. 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: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 09/15/11. Based on review of facility policy, record review, and staff interview, the facility failed to investigate accidents and injuries to prevent future occurrences for 2 of 13 sampled residents (#14 and #18) dependent on staff for transfers. Failure to thoroughly investigate all alleged violations including injuries of unknown origin and accidents has the potential to place all residents at risk of further injury. Findings include: Review of the facility policy titled, "Abuse Investigation" occurred on 08/29/12. This policy, dated 2007, stated, "All reports of . . . injuries of an unknown source shall be promptly and thoroughly investigated. . . . 8. The results of the investigation will be recorded on the Investigation Report Summary. . . ."	F 225	2. Any resident has the potential to be affected. 3. Mandatory Nursing in-services were held on September 5th and 6th, 2012 as well as October 2nd, 3rd, and 4th, 2012 to re-educate staff on the requirements of F-Tag 225. Policy and Procedure of Abuse Prohibition, Abuse Reporting, and Abuse and Neglect and time requirements for reporting were reviewed. Our facility utilizes a 24 -hour report sheet for each neighborhood. The report sheets are part of the supervisors report Monday through Friday. The report sheet is utilized to identify changes in resident condition. The 24 hour report sheet has been updated to include injuries of unknown source. This process was reviewed with the nursing staff during mandatory in-service. This facility is and will continue to require staff complete upon hire and at least annually, review of the Policy and Procedure for Abuse and Neglect and complete the Health Care Academy module Abuse and Neglect. The Abuse Prohibition, Abuse Reporting, and Abuse and Neglect Policy and Procedures were updated to notify the NDSHD in 24 hours. 4. The Nurse Manager (or designee) and DON will review any reports of resident incidents. The DON (or designee) will review all reports and report to the QA committee monthly for three months. 5. October 04, 2012.	

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F 225	Continued From page 4 Review of the facility policy titled "Accidents/Incidents" occurred on 08/30/12. This policy, dated 2006, stated: "Reporting Accidents/Incidents: . . . It is the policy . . . to report resident and visitor incident/accidents by completing a written incident report . . . Other Purposes: . . . An employee who witnesses an accident/incident involving a resident . . . must report . . . to his/her immediate supervisor . . . Supervisors must report any accident/incident involving a resident . . . to the director of the department . . . Investigative Action: The charge nurse and/or unit manager must conduct an immediate investigation of the accident/incident . . . the completed incident report form is routed to: . . . QA [quality assurance] Coordinator . . ." - Review of Resident #14's record occurred on all days of survey. The resident's most recent Minimum Data Set (MDS) assessment identified she required extensive assistance of one person for bed mobility and extensive assistance from two people for transfers. Review of the Interdisciplinary Progress Notes (IDPN) revealed a note dated 08/06/12 at 10:45 a.m., which stated, "Received call from Dr. [MD's name] re: Xray from 8/3[/12]. There is a small fx [fracture] in L) [left] ankle. Dr. . . . suggested a cast book (sic) be placed to protect ankle." IDPN's previous to the above note included the following: * 07/30/12 at 10:20 a.m.: "Resident found on floor by CNA [certified nurse assistant). . . . found	F 225		

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F 225	Continued From page 5 resident laying on back on fall mat in front of bed. full ROM [range of motion] on assessment. . . ." * 07/31/12 at 8 p.m.: "[No] adverse effects from fall. . . Also noted she had full AROM [active range of motion] to all extremities. " * 08/02/12 at 3 a.m.: "Res [resident's] L) foot swollen et [and] slightly warm to touch. . ." * 08/02/12 at 8:10 a.m.: "Dr. . . visited for 60 day review. . . . (L) foot examined 3+ edema noted (L) foot and non pitting edema (R) [right] foot no reddness (sic) or warmth noted. Will try Ted Hose." * 08/03/12 at 4 a.m.: "(L) ankle swollen & bruised, passive ROM done [without] evidence of pain. . . ." * 08/03/12 at 8:15 a.m.: "Notified by noc [night] shift of bruised area to (L) ankle. Noted purplish area to area below and around ankle. . . . Notified Dr. of area & requested XRay. . . ." * 08/03/12 at 2:20 p.m.: "Resident returned from . . . XRay [with] [no] n/o [new orders] - reported nothing broken from clinic. . . ." * 08/04/12 at 4 a.m.: "(L) ankle remains bruised et swollen. . . ." * 08/04/12 at 4 p.m.: ". . . (L) ankle . . . swollen, bruised." * 08/04/12 at 9:35 p.m.: "This nurse called to Res [resident's] Rm [room]. Res sitting on floor between the wall & the bed. . . ." * 08/05/12 at 3:50 p.m.: ". . . (L) foot/ankle . . . swollen [with] bruising . . ." An interview with the Unit Manager (#12) occurred at 4:15 p.m. on 08/28/12. When asked how Resident #14's fracture (identified in the IDPN's on 08/06/12) occurred, this staff member indicated she did not know. When asked for an investigation into the cause of the fracture (an	F 225		

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F 225	Continued From page 6 injury of unknown origin), this staff member provided an Incident Report dated 07/30/12. Review of the Incident Report included information relating to a fall. The section titled "Investigation of Event and interventions," stated, "Found that resident able to reach bed controls by leaning out over edge of bed resulting in fall." The report lacked information relating to any injury resulting from the fall or the subsequent left ankle fracture. An interview occurred with the Director of Nursing (#3) on 08/29/12 at 2:15 p.m. regarding an investigation into Resident #14's left ankle fracture. This staff member indicated there is no documentation of an investigation regarding Resident #14's left ankle fracture. Staff did not document any information until after the X-Ray results came back on 08/06/12. This staff member (#3) agreed there is no record of an investigation into Resident #14's left ankle fracture. - Review of Resident #18's medical record occurred on August 29-30, 2012. Diagnoses included dementia, osteoarthritis, blindness, and gout. The MDS, dated 02/17/12, identified the resident required extensive assistance of one person for transfers and bathing. Review of Resident #18's IDPN notes identified the following: * 04/24/12 at 10:45 a.m. - "Residents right foot bumped on tub chair when being lifted back into chair - when resident got out of tub swelling and bruising noted - No difficulties walking noted @ [at] this time - Dr. [name] faxed and son [name] notified."	F 225		

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F 225	Continued From page 7 There is no evidence that the facility investigated the swelling of bruising of Resident #18's right foot to determine if it occurred as a result of being bumped on the tub chair or if the injury occurred prior to the resident receiving her bath. The next IDPN note regarding Resident #18's right lower extremity occurred 10 days later and stated: * 05/04/12 at 4:00 p.m. - "Right leg remains reddened and scaley [sic] - warm to touch & [and] area noted [with] sm [small] bruises - tender to touch. scheduled for lab work next wk [week]." * 05/05/12 at 12:00 p.m. - "Resident [right] lower extremely [sic] warm to touch et [and] tender to touch, from ankle to toes. Hx [history] of cellulitis. Resident is afebrile. On call physician notified et prescribed [antibiotic] . . ." Review of the "Skin Integrity Record" (used to identify skin concerns such as bruises, rashes, skin tears, etc.) identified an assessment, dated 05/04/12, which stated, "Right leg remains reddened and scaly [sic] from mid calf down to toes warm to touch - & sm bruised area noted to outer aspect of leg - warm to touch." This record failed to identify the cause and/or state a correlation with the incident on 04/24/12. During an interview on 08/30/12 at 10:50 a.m., an administrative nurse (#3) stated the facility did not complete an incident report or conduct an investigation related to the above incident.	F 225		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or	F 241	**F-Tag 241:** 1. All staff working on the neighborhoods where resident's #17, #18, #1, #25, #21, #6 and #8 reside were re-educated on maintaining dignity during dining by using proper feeding techniques; maintaining privacy during personal cares; and knocking on resident doors prior to room entry.	10/04/2012

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F 241	Continued From page 8 enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to promote care in a manner which enhanced dignity and respect for 6 of 21 sampled residents, 1 supplemental resident, and 1 unidentified resident. Failing to ensure doors remained closed during personal cares (Resident #17 and Resident #18); failure to ensure dignified feeding practices were implemented by staff (Resident #1, Resident #18, and 1 unidentified resident); and failure of staff to knock prior to entering residents' rooms (Resident #1, Resident #18 and Resident #25); did not maintain or enhance the residents' dignity, self worth, or self esteem. Findings include: - Observation on 08/28/12 at 8:15 a.m., showed an unidentified certified nurse assistant (CNA) assisted Resident #18 and another resident in the dining room. The CNA obtained a spoonful of Resident #18's thickened pink beverage, dipped the spoon into the residents hot cereal, and fed the resident the two items from one spoon. This CNA used the same technique to feed an unidentified resident pureed meat and breakfast cereal from the same spoon. - Observation during medication pass on 08/28/12 at 8:30 a.m., showed a licensed nurse (#4) failed to knock or announce herself prior to entering Resident #25's room to give the resident	F 241	2. Any resident has the potential to be affected. 3 Mandatory nursing in-services were held on September 5th and 6th, 2012 as well as October 2nd, 3rd, and 4th, 2012. A memo was sent out on September 16th, 2012 to re-educate staff on F-tag 241 requirements. 4. The Nurse Manager (or designee) will monitor resident dignity concerns to include; staff knocking on doors prior to entering the resident room, proper feeding techniques during meal times, and privacy during bathing and toileting. Monitoring will be conducted weekly for four weeks, then monthly for three months. Real time education will be provided to the staff. DON will report results to the QA committee monthly for 3 months. 5. October 04, 2012	

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F 241	Continued From page 9 her morning medications. - On 08/28/12, observation during the breakfast and noon meals showed a CNA (#9) assisted Resident #8 with eating. At the breakfast meal, observation showed the CNA (#9) assisted Resident #8 to eat pureed foods and thickened liquids, and scraped the excess food/beverage from the resident's mouth/chin with the spoon. The CNA (#9) also used the spoon to gather fallen food on Resident #8's clothing protector and lap tray. This CNA then mixed all the foods/beverages scraped from Resident #8's face, and gathered from her clothing protector and lap tray, back into the resident's food and refed this food to Resident #8. During the noon meal, the CNA (#9) assisted Resident #8 to eat pureed foods and thickened liquids from a spoon, scraped the excess food/beverage from the resident's mouth/chin with the spoon, and refed the scraped food to Resident #8. During an interview on 08/29/12 at 12:02 p.m., an administrative nursing staff member (#12) confirmed staff are trained not to scrape food from a resident's face, clothing protector, or lap tray and that scraped food is not to be refed to the resident. - Observation on 08/28/12 at 1:50 p.m., showed an unidentified CNA delivered water to Resident #6's room without knocking or identifying herself prior to entering. - Observation on 08/29/12 at 1:10 p.m. showed the door to the 2nd floor central tub room open. The nurse (#27) entered the tub room without knocking or announcing herself and found an	F 241		

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F 241	Continued From page 10 unidentified staff member assisting Resident #17 with her bath and the resident fully exposed. Before leaving the tub room, the nurse (#27) pulled the privacy curtain between the door and the bathtub, but failed to shut the door. - On 08/29/12 at 5:00 p.m., observation occurred in Resident #21's room. Two CNA's (#10 and #11) entered the room and transferred the resident from the bed to the wheel chair using a Hoyer lift. During this observation, an unknown staff member opened the door and entered the room without knocking and/or announcing herself. This staff member spoke briefly to one of the CNA's in the room and then left. - Observation on 08/30/12 at 7:45 a.m. showed the door to Resident #18's room open, the door to her bathroom open, and the resident seated on the toilet. A CNA (#25) entered the room and failed to shut the door. As the CNA assisted Resident #18 with personal cares, another CNA (#26) knocked on the door frame and entered the room without announcing herself or waiting for a reply. During an interview on 08/30/12 at 10:45 a.m., an administrative nurse (#3) agreed facility staff should knock and wait for a reply before entering a resident's room.	F 241		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For	F 274	**F-Tag 274:** **10/04/2012** 1. Resident #5 assessment was completed on June 18, 2012. Resident #11 has expired. 2. ~~Any resident has potential to be affected.~~	

PRINTED: 09/20/2012
FORM APPROVED
OMB NO. 0938-0391

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

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 _____	08/30/2012

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 274	Continued From page 11 purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long Term Care Facility Resident Assessment Instrument (RAI) User's Manual, and staff interview, the facility failed to complete a comprehensive assessment within 14 days for 2 of 2 sampled residents (Resident #5 and #11) who experienced a significant change in physical status. Failure to complete a comprehensive assessment when residents experience a decline in physical functioning and placed the residents at risk for continued decline and the lack of appropriate interventions to restore or maintain physical function. Findings include: The Centers for Medicare and Medicaid Services Long-Term Care Facility Resident Assessment Instrument User's Manual, Version 3.0, April 2012, pages 2-20 through 2-23 states, "Significant Change in Status Assessment (SCSA) . . . is appropriate when: There is a determination that a significant change (either improvement or decline) in a resident's condition from his/her baseline has occurred as indicated	F 274	3. Mandatory Nursing Staff in-services were held on September 5th and 6th, as well as October 2nd, 3rd, and 4th, 2012 to re-educate staff to communicate changes of resident status (whether improved or declined) on 24 hour report sheet and/or to neighborhood Nurse Manager. The 24 hour report sheet has been revised and will include notification of significant change in the resident's condition. The 24 hour report sheets are read at the morning report in which the MDS nurses attend. A laminated education sheet has been placed in the MAR for all the licensed nurses to review. 4. The unit manager (or designee) will monitor resident changes in condition and report these changes to the MDS coordinators. Monitoring will be done weekly for 2 months, then quarterly for 2 quarters. Results will be reported to the QA committee by the DON. 5. October 04, 2012	

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by comparison of the resident's current status to the most recent Comprehensive assessment and any subsequent Quarterly assessments; and the resident's condition is not expected to return to baseline within two weeks . . . A SCSA is also appropriate if there is a consistent pattern of changes, with either two or more areas of decline or two or more areas of improvement. This may include two changes within a particular domain . . . Decline in two or more of the following: . . . Any decline in an ADL [activity of daily living] physical functioning area where a resident is newly coded as extensive assistance . . . ."

- Review of Resident #5's medical record occurred on August 27-30, 2012 and identified diagnoses of osteoporosis, diabetes mellitus, and dementia.

A quarterly Minimum Data Set (MDS), dated 03/18/12, identified Resident #5 as cognitively intact and independent with all ADLs including bed mobility, transfer, ambulation, dressing, toilet use, and personal hygiene.

Resident #5 fell twice (once on April 5 at 11:30 p.m. and once on April 6 at 9:00 a.m.). The facility transferred Resident #5 to the hospital on 04/06/12 and the resident returned to the facility on 04/07/12 with a diagnosis of a right hip fracture. Resident #5's medical record identified this hip fracture as "nonsurgical" repairable. Resident #5's physician orders for activity level upon return to the facility stated "non-weight bearing" on the right leg.

The facility completed a significant change MDS assessment on 06/18/12 (ten weeks after

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F 274	Continued From page 13 Resident #5 fell and sustained a hip fracture). This MDS identified the resident displayed severe cognitive impairment, and required extensive two-person physical assistance with all ADLs including bed mobility, transfer, ambulation, dressing, toilet use, and personal hygiene. During interview on 08/30/12 at 9:45 a.m., an administrative nurse (#1) confirmed the facility failed to complete a SCSA for Resident #5's functional decline in a timely manner. - Review of Resident #11's medical record occurred on August 27-30, 2012 and identified diagnoses including dementia, history of falls, and pelvic fracture. The quarterly MDS, dated 02/10/12, identified Resident #11 as cognitively intact, and independent with all ADLs including bed mobility, transfers, dressing, toilet use, and bathing. Resident #11 fell and the facility transported her to the hospital on 03/29/12. She returned to the facility on 03/31/12 with a diagnosis of pelvic fracture. The facility completed a quarterly MDS on 04/06/12. This MDS identified the resident displayed moderate cognitive impairment and required extensive assistance with all ADLs including bed mobility, transfer, dressing, toilet use, and bathing. The interdisciplinary progress notes, dated 04/11/12, stated, "For ARD [Assessment Reference Date] 04/06/12. At this time I will not do a significant change. [Resident #11] fell and	F 274		

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F 274	Continued From page 14 has a pelvic fracture and is on bed rest. I will continue to monitor her to see if she returns to her normal as coded on the previous assessment ARD 1-28-12." During interview on 08/28/12 at 10:30 a.m., an administrative nurse (#1) confirmed she had failed to document any monitoring of Resident #11's status. She also confirmed Resident #11 did not return to baseline within two weeks and the facility failed to complete a SCSA.	F 274		
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 09/15/11. 1. Based on record review, staff interview, and review of facility policy and procedure, the facility failed to provide the necessary care and services to ensure treatment for 1 of 1 sampled resident (Resident #11) who experienced unresolved pain following a fall. Failure to promptly complete a comprehensive pain assessment, implement interventions, and evaluate the effectiveness of the interventions related to pain management resulted in Resident #11 experiencing avoidable	F 309	**F-Tag 309:** **10/04/2012** **A. Pain Management:** 1. Resident #11 has expired 2. Any resident experiencing pain has the potential to be affected. 3. Mandatory in-services were conducted on September 5th and 6th, as well as October 2nd, 3rd, and 4th, 2012 to re-educate nursing staff on our pain assessment policy and procedure, interventions for pain management and evaluation of effectiveness of the interventions. 4. The DON (or designee) will monitor PRN medication administration records to identify residents receiving PRN medications greater than 50% of days of the month and/or unrelieved pain. Monitoring will be done weekly for 4 weeks, monthly for 2 months, then quarterly for 2 quarters. Results will be reported to QA committee by the DON. 5. October 04, 2012	

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F 309	Continued From page 15 pain. Findings include: Review of the facility policy titled "Pain Assessment" occurred on 08/30/12. This policy, updated April 2012, stated, ". . . Policy Statement Bethel Lutheran & Nursing Rehabilitation Center attempts to reduce pain and suffering for all residents in our facility by identifying those residents who are experiencing pain by implementation of appropriate pain assessment and management protocols. . . . Policy . . . Implementation . . . 2. Conditions/Diagnosis Associated with potential for pain . . . g. Falls . . ." Review of Resident #11's medical record occurred on August 27-30, 2012 and identified diagnoses including anxiety, dementia, osteoporosis, osteoarthritis, degenerative disc disease, multiple thoracic and lumbar spine compression fractures, history of falls with pelvic fracture, and pain. The quarterly Minimum Data Set (MDS), dated 06/30/12, identified the resident as cognitively intact, and having experienced almost constant moderate pain and received scheduled pain medications. The current care plan stated the following, ". . . Problem: . . . Chronic low back pain . . . Approaches: . . . Assess characteristics of pain . . . Offer analgesic Q [every] 4-6 hours PRN [as needed] as per physician orders, Nonpharmacologic methods to reduce pain. a. Back Rubs. b. Repositioning. c. Diversional Activity . . . d. Application of warm or cold packs. e. Assist with activities of daily living as needed . . . f. Deep breathing."	F 309	**B. Swallowing Safety:** 1. Resident #26 will be evaluated by the occupation therapist on October 03, 2012 for any recommendation. 2. Any resident experiencing difficulty swallowing has the potential to be affected. 3. Mandatory in-services were conducted on September 5th and 6th, as well as October 2nd, 3rd, and 4th, 2012 to re-educate nursing staff on identification of swallowing disorders, signs of distress during mealtime and possible interventions. A memo was sent out to all nursing staff regarding signs and symptoms of aspiration and potential intervention. 4. All neighborhood dining areas are being monitored by nursing and/or dietary staff on a daily basis for 4 weeks, then monthly for 2 months. Monitoring will include, but not limited to, observation and knowledge of staff to signs/symptoms of aspiration as well as intervention. Results will be reported to QA committee by the DON monthly for 3 months. 5. October 04, 2012 **C. Bowel Management:** 1. Resident #5 care plan was reviewed and bowel management intervention updated. Staff caring for resident #5 were informed of and re-educated in the need to monitor resident bowel movement and report changes to the charge nurse 2. Any resident has the potential to be affected.	

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F 309	Continued From page 16 Review of the interdisciplinary progress notes identified the following: * 07/14/12 at 6:50 p.m., "Found on floor by aide. Resident was falling as aide passed her doorway but could not break her fall. . . . c/o [complained of] pain at level '6' in right buttock. No c/o pain with ROM [range of motion]. Assisted back to bed. Evening medications administered. including Ativan [for anxiety] and Percocet [for pain]. Instructed to breath slowly in and out to calm anxiousness." * 07/15/12 at 4:20 a.m., "Still complaining of pain in (L) [left] buttock - lower back area. Percocet x [times] 1 plus warm packs to affected area. . . ." * 07/15/12 at 5:30 p.m., "Medicated x 2 for c/o lower back pain." * 07/16/12 at 4:15 a.m., "Medicated x 2 for lower back pain." * 07/18/12 at 4:00 p.m., "Called over to clinic x 3 to talk to [Physician's] nurse about her pain - appointment need or x-ray) with no return call back - medicated x 2 with Percocet - resident [up] walking with walker per [one] assistance - appetite poor - refused to come out of room . . ." * 07/22/12 ". . . much encouragement need [sic] to come out of room - continues to use pain rx [prescribed medications] routinely. . . ." * 07/25/12 at 11:00 a.m., "Resident continues with lower back pain - wants x-ray - no response from [Physician] last week - today he is out of the office - called the nurses [sic] manager . . . to get orders for x-ray this [after]noon [at] [Hospital Name] - she states she will see what she can do and get back to me . . ." * 07/25/12 at 1:00 p.m., "nurse manager returned call and set up appointment for resident with [Physician] this [after)noon . . . "	F 309	3. Mandatory in-services were conducted September 5th and 6th, 2012 and October 2nd, 3rd, and 4th, 2012 these in-services will be for all nursing staff and will provide education regarding bowel management policy and procedure. The policy and procedure for bowel management has been reviewed and revised. The 24 hour report sheet has been updated to include bowel management concerns for any resident. The facility will continue to complete the bowel and bladder assessment on admission of the resident, annually and with any significant change. 4. The nurse manager (or designee) will monitor documentation regarding bowel movements for a random sample (30%) of residents. Residents with chronic constipation will be noted and their care plan reviewed and revised as needed. A bowel assessment, notification of the physician and implementation of pharmacological and/or non pharmacological interventions (dietary) may be initiated based on resident need. Monitoring will be conducted weekly for 4 weeks, then monthly for 2 months, then quarterly for 2 quarters. Results of the monitoring are reported to the DON who will report to the QA committee monthly for 3 months, then quarterly for 2 quarters. 5. October 04, 2012 **D. Insulin dependent resident /glucose Monitoring:** 1. Resident #6, #17 and #18 care plans have been reviewed. Staff caring for these residents (licensed nursing staff, CMA's and CNA's) have been informed of and re-educated on the importance of timely documentation of the good glucose readings, and follow up if the resident is experiencing hyperglycemia / hypoglycemia.	

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F 309	Continued From page 17 • 07/25/12 at 4:45 p.m., "returned from the clinic - [increased] her pain patch - new script sent to Pharmacy . . ." • 07/25/12 at 5:30 p.m., "Resident states that she had x-ray's with no fracture . . ." • 07/25/12 at 10:30 p.m., "[Increased] dose of Duragesic applied at 7:00 p.m., c/o low back pain. rate 8/10. . . ." The "Comprehensive Pain Assessment Form," dated 07/25/12, identified Resident #11 experienced intermittent, stabbing/shooting pain with movement and/or coughing. She rated the intensity of her pain as being an 8 on a 10 point scale. The "Clinic Appointment Sheet," dated 07/25/12, stated, "07/14/12 fell in room . . . resident has [sic] complaining of lower back pain - unable to get app [appointment] - or x-ray for resident — Resident loves pain meds [medications] . . . and likes the attention . . ." The radiology report, dated 07/25/12, identified "Diffuse osteopenia is seen. Multiple levels of superior and inferior endplate compression fractures are seen throughout the lower thoracic spine and throughout the lumbar spine sparing L5. No subluxation is identified. . . ." The PRN medication administration record (MAR), dated June 01, 2012 -July 14, 2012, showed the resident received Percocet (prior to her fall) a total of two time for headache and pain in her hands. From July 15-25, 2012, the PRN MAR showed the resident received Percocet (following her fall) a total of 26 times for lower back/buttock pain. Resident #11 rated her pain	F 309	2. Any insulin dependent diabetic resident has the potential to be affected. 3. Mandatory nursing in-services were held September 5th and 6th, 2012 and October 2nd, 3rd, and 4th, 2012. The facility policies and procedures were reviewed with staff. Signs and symptoms of either hypo or hyperglycemia were reviewed as well as the hypoglycemia guidelines. Staff were re-educated in the importance of reporting changes in the resident condition to the charge nurse: the charge nurses were re-educated in the importance of documentation of the blood glucose level, insulin administration, and appropriate intervention. This also includes notification of the physician. The pre and post prandial blood glucose record has been revised to include re-check and comments. 4. The nurse manager (or designee) will monitor a random number (30%) of insulin dependent diabetic resident records. Monitors will include documentation of the blood glucose readings at the proper time of insulin administration and appropriateness of interventions. Monitoring will be done weekly for 4 weeks, then monthly for 2 months. Results of the monitoring will be reported to the QA committee by the DON monthly for 3 months. 5. October 04, 2012	

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F 309	Continued From page 18 between 4-8 on a 10 point scale. Review of Resident #11's medical record identified the following: * Percocet 5/325 mg [milligrams] 1 tablet every night and 1-2 tablets every 4 hours prn for pain (Ordered 04/30/12) * Fentanyl Patch 25 mcq/hr [micrograms/hour] for pain (Ordered 04/30/12 - increased to 25 mcq/hr on 07/25/12) During interview on the morning of 08/30/12, two administrative nursing staff members (#2 and #3) confirmed facility staff failed to promptly address the resident's unresolved pain. Resident #11's record showed no evidence of a pain assessment completed until 11 days after her fall, no evidence the facility followed up when the physician's nurse failed to return calls on 07/18/12 and no evidence the x-ray was completed until the resident requested to have one done. Failure of facility staff to adequately assess and intervene delayed the provision of additional pain medication until 11 days after the fall/fractures occurred and resulted in Resident #11 experiencing unrelieved pain without appropriate management. THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 09/15/11. 2. Based on observation, record review, and review of professional literature, the facility failed to ensure 1 of 1 supplemental resident (Resident #26) with a history of aspiration pneumonia, received the care and services necessary to	F 309		

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F 309	Continued From page 19 attain the highest degree of safety possible while being fed in the dining room. Failure to adequately assess and provide services based on the assessment has the potential to affect the resident's overall swallow safety, putting him at greater risk of aspiration and limiting his nutritional intake. Findings include: Nancy B. Swigert, The Source for Dysphagia: Third Edition, LinguiSystems, Inc, pages 9-16 stated a sign of oral phase dysphagia (difficulty swallowing) include pocketing of food; while signs of pharyngeal dysphagia include coughing or choking during a meal or a wet, gurgly vocal quality. Review of Resident #26's medical record occurred on 08/30/12. Medical diagnoses include vascular dementia with delusions and Down's syndrome (an intellectual disability). Resident #26's significant change Minimal Data Set (MDS) dated 07/31/12, identified the resident as rarely/never understood; requires extensive assistance with bed mobility and transfers; total assistance with locomotion, dressing, eating, and toilet use; and swallowing disorders of a loss of liquid/solids when eating or drinking and coughing/choking during meals or when swallowing medications. Resident #26's current care plan, dated 08/20/12, identified a problem of "Nutrition and Hydration . . . " and interventions including ". . . Assist resident with Liberal ADA [American Dietetic Association], Puree, Small Portion Diet Nectar-Thick Liquids . .	F 309		

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F 309	Continued From page 20 . . ." Resident #26's Interdisciplinary Progress Notes (IPNs) from July -August 2012 stated: *07/08/12 at 5:30 p.m. - "Noted patient shivering. Took vitals. T [temperature] 100.1 [degrees Fahrenheit] . . . O2 [oxygen] sat [saturation] 82% . . . ." The facility notified the physician and transferred Resident #26 to the emergency department (ED). Resident #26 returned from the ED with orders for an oral antibiotic and oxygen to maintain adequate saturation. Resident #26 continued on pureed diet and thickened liquids. *07/12/12 at 4:30 a.m. - "Resident had coughing spell which increased to small emisis [sic] at supper . . . ." *07/12/12 at 2:00 p.m. - "Resident continues on Augmentin [an oral antibiotic] for aspiration PNE [pneumonia] . . . ." *07/23/12 at 1:25 p.m. - ". . . Resident also noted to have loose wet cough. Lungs noted to have rubs [and] rhonchi throughout. Cont [continue] to monitor for any [changes] in condition." *07/24/12 at 9:35 a.m. - "Received fax from [name of doctor] re: [regarding] cough [and] Hospice . . . ." 07/25/12 at 9:20 a.m. - "Resident continues to have coarse rhonchi to [bilateral] [upper] lung fields [with] diminished bases . . . Noted loose wet cough continuing . . . ." *08/26/12 at 4:00 p.m. - " . . . Noted [increased] coughing and crackles throughout all lung fields . . . ." Observation of Resident #26 in the Harmony Dining Room on 08/30/12 at 8:40 a.m. showed the resident seated in a high-back wheelchair with his neck hyper-extended and a pillow	F 309		

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F 309	Continued From page 21	F 309		

positioned behind his neck. A certified nurse aide (#8) fed Resident #26 approximately three spoonfuls of thickened cream of wheat hot cereal. Resident #26 failed to immediately swallow and held the food in his mouth. The CNA (#8) failed to provide verbal cueing or reposition the resident's neck to encourage him to swallow. Observation revealed Resident #26 displayed wet and raspy respirations. After a couple of minutes, the resident swallowed the food. The CNA (#8) continued to provide food to Resident #26. Observation showed Resident #26 coughed throughout the breakfast meal. After approximately fifteen minutes, an unidentified staff nurse entered the DR, observed Resident #26 coughing, and showed the CNA how to reposition Resident #26's neck (tuck the resident's chin to his chest) to facilitate his ability to swallow.

Facility staff providing meal assistance to Resident #26 failed to immediately identify signs/symptoms of aspiration and implement interventions to prevent aspiration or stop feeding the resident.

3. Based on record review, policy and procedure review, review of professional literature, and staff interview, the facility failed to implement interventions to ensure 1 of 1 sampled resident (Resident #5) maintained normal bowel elimination patterns to prevent constipation/fecal impaction. Failure to conduct a comprehensive assessment and implement approaches/interventions for constipation resulted in Resident #5 requiring manual extraction of stool. Manual extraction of stool has the potential to cause the resident great discomfort and

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BETHEL LUTHERAN NURSING & REHABILITATION CENTER	1515 2ND AVE WEST WILLISTON, ND 58801

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F 309	Continued From page 22 irritation of the rectal mucosa. Findings include: Berman, Snyder, Kozier, Erb, "Fundamentals of Nursing, Concepts, Process, and Practice," 9th edition, Pearson Education, Inc., New Jersey, pages 1349-1350, stated, "Constipation may be defined as fewer than three bowel movements per week. This infers the passage of dry, hard stool or the passage of no stool. . . . It is important to define constipation in relation to the person's regular elimination pattern. Some people normally defecate only a few times a week; other people defecate more than once a day . . . Many causes and factors contribute to constipation. Among them are the following: Insufficient fiber intake, Insufficient fluid intake, Insufficient activity . . . Emotional disturbances such as depression or mental confusion . . . Medications such as opioids [for pain]. . . ." Review of the facility policy titled "Nursing Care Protocols" occurred on 08/30/12. This policy dated, March 2001, stated, "The following guidelines will be utilized to attend to resident needs that arise on an intermittent basis . . . III. GI System Protocol: as determined by assessment . . . e. May receive a high fiber supplement . . . IX. Elimination. a. Adequacy of bowel elimination should be assessed and maintained by: . . . 1. Checking and recording BM [bowel movements] daily. 2. Giving enemas, laxatives, and suppositories when ordered and indicated. 3. Encouraging fluids and activity and change in diet, if appropriate . . . ." Review of Resident #5's medical record occurred	F 309		

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F 309	Continued From page 23 on August 27-30, 2012 and identified diagnoses of osteoporosis, diabetes mellitus, dementia, depression, coronary atherosclerosis, asthma, anemia, and chronic renal failure. Resident #5 sustained a fractured right hip following a fall in April 2012. A significant change Minimum Data Set (MDS), dated 06/18/12, identified the resident displayed severe cognitive impairment and required extensive two-person physical assistance with bed mobility, transfer, ambulation, dressing, toilet use, and personal hygiene, continent of bladder and bowel, and utilizing scheduled and as needed pain medications. Resident #5's medications include: * Fentanyl (an opioid analgesic pain medication applied to the skin to manage moderate to severe chronic pain for individuals who require around-the-clock dosing) patch 25 micrograms every 72 hours. * Tylenol (also known as Acetaminophen, an over-the-counter [OTC] pain medication), 650 milligrams (mg) three times a day. * Oxycodone (an opioid analgesic pain medication used to manage moderate to severe pain). Resident #5's medication regime failed to include any routine oral laxative medication. One of the side effects of all of these medications is constipation. Resident #5's July Medication Administration Record (MAR) showed, in addition to receiving regular doses of Fentanyl patch and Tylenol, the resident received six PRN doses of Oxycodone 5 mg.	F 309		

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F 309	Continued From page 24 An Interdisciplinary Progress Note, (written by a staff nurse [#7]) on 07/25/12 at 7:00 p.m., stated "Resident denies having pain. Was constipated today and impacted. Gave MOM [Milk of Magnesia] and it didn't help. Helped [with] her impaction and also did a Fleets enema. Able to have a bowel movement [times] 2 . . . ." During an interview on 08/29/12 at 1:55 p.m., a staff nurse (#7) stated she "helped" Resident #5 by manually removing hard stool from Resident #5's rectum. This staff nurse stated she failed to inform Resident #5's physician and/or dietary department of the resident's constipation problem. Review of Resident #5's care plan, dated 07/05/12, failed to identify a problem of constipation or any dietary approaches or medications to prevent additional episodes of constipation. During interview on the morning of 08/30/12, an administrative nurse (#3) confirmed Resident #5's current care plan lacked specific dietary interventions following the resident's episode of fecal impaction. Failure of facility staff to complete a comprehensive assessment, inform the physician and dietary staff of Resident #5's constipation problem, and implement both pharmacological and non-pharmacological interventions placed this resident at risk for repeat manual assistance to extract stool. 4. Based on record review, review of facility policy, and staff interview, the facility failed to	F 309		

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F 309	Continued From page 25 ensure 3 of 5 sampled insulin dependent diabetic residents (Resident #6, #17, and #18) received the necessary care and services regarding blood sugar (BS) monitoring and/or insulin administration. Failure to monitor residents' BS levels and/or administer insulin placed the residents at risk of hypoglycemia or hyperglycemia (low and high blood sugar), and including coma and death. Findings include: Review of the facility policy titled "Medication Monitoring" occurred on 08/30/12. This policy, dated February 2006, stated, ". . . 10. INSULIN AND ORAL HYPOGLYCEMIC MEDICATIONS - Accuchecks as ordered by Physician. Contact physician if two weekly glucose reading are less than 70 or guidelines set by physician. - If resident is fasting and fingerstick glucose is less than 60, hold insulin or oral hypoglycemic and administer after resident has eaten . . ." Review of the facility policy titled "Adult Insulin Supplement ('Sliding Scale')" occurred on 08/30/12. This policy, dated May 2010, identified blood glucose levels with the number of units of insulin to be administered. For a blood glucose reading of "under 80 [milligrams/deciliter (mg/dL)]" this policy instructs facility staff to "Follow Hypoglycemia Policy/[Guidelines]" and for blood glucose reading of "over 400 [mg/dL)" for facility staff to "Call physician." The "Hypoglycemia Guidelines," stated: "Blood Glucose: under 80 - Action" [for staff to follow] "4-6 ounces concentrated carbohydrate (blood glucose in 1 hr [hour])"	F 309		

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F 309	Continued From page 26 60-70 - Action - 4-6 ounces concentrated carbohydrate* 50-60 - Action - 8 ounces of concentrated carbohydrate* Under 50 - responsive - Give 8 ounces of concentrated carbohydrate* *Recheck glucose in 15-30 minutes and repeat above as necessary. May substitute any juice, milk or glucose gel in place of Gatorade per resident tolerance." Review of the facility policy titled "Hyperglycemia/Hypoglycemia" occurred on 08/30/12. This policy, dated May 2010, stated, "Hyperglycemia (abnormally high serum glucose level) . . . Blood sugar: greater that 350. Hypoglycemia (abnormally low serum glucose level) . . . Blood Sugar: less than 70. Treatment: As per physician order for hypoglycemic reaction or administration of concentrated carbohydrate 4-6 ounces [oz] Gatorade, orange juice, milk, glucose gel) as per sliding scale insulin protocol. In the event of severe hypoglycemia accompanied by unresponsiveness administer 0.5 mg [milligram] [intramuscularly] glucagon and notify physician. Document any incident of either hyper-or hypoglycemia in the clinical record (interdisciplinary progress note or glucose monitoring record . . .)." - Review of Resident #17's medical record occurred on August 29-30, 2012. Diagnoses included diabetes mellitus. Medications included Novolog (insulin) 70/30 18 units at 8:00 a.m. and 11 units at 5:30 p.m., and sliding scale Novolog four times a day based on the resident's blood sugar level. Resident #17's blood glucose is to be monitored at 7:00 a.m, 11:00 a.m., 5:00 p.m., and	F 309		

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F 309	Continued From page 27 9:00 p.m. Review of Resident #17's glucose monitoring records and medication administration records (MARs) from March 2012 through August 29, 2012 identified the following concerns: * 03/04/12 - no documentation of a blood sugar (BS) level at 9:00 p.m. * 03/06/12 - as above * 03/11/12 - BS at 7:00 a.m. 102 mg/dL; 11:00 a.m. 137 mg/dL; 5:00 p.m. 210 mg/dL; 9:00 p.m. 172 mg/dL. The MAR identified the resident's insulin as held all day without further explanation. * 05/04/12 - BS at 11:00 a.m. 58 mg/dL; 12:00 p.m. 34 mg/dL; 12:15 p.m 44 mg/dL; 12:30 p.m. 79 mg/dL; 5:00 p.m. 75 mg/dL. The only comment documented on the glucose monitoring record stated, "was given lunch [with] assistance." * 05/27/12 - no documentation of BS level at 9:00 p.m. * 06/05/12 - BS at 11:00 a.m. 68 mg/dL; rechecked (no time indicated) and BS 153 mg/dL. Neither the glucose monitoring record or the progress notes identified the action taken by facility staff related to the resident's low blood glucose level. * 06/27/12 - BS at 9:00 p.m. 49 mg/dL. BS rechecked at 11:00 p.m. and measured 73 mg/dL. Neither the glucose monitoring record or the progress notes identified the action taken by staff related to the resident's low blood glucose level. Facility staff failed to recheck the resident's BS every 15 to 30 minutes as per facility policy. * 08/09/12 - BS at 11:00 a.m. 37 mg/dL and 75 mg/dL at 5:00 p.m. A comment on the glucose monitoring record stated, "Held 17 [5:00 p.m.] insulin. Facility staff failed to document the actions taken related to the resident's BS level at	F 309		

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F 309	Continued From page 28 11:00 a.m. and failed to recheck the resident's BS every 15 to 30 minutes as per facility policy. * 08/14/12 - BS at 9:00 p.m. 200 mg/dL. A comment on the glucose monitoring record stated, "Held HS [bedtime] Insulin." The record failed to identify why the insulin was held. * 08/28/12 - no documentation of BS level at 9:00 p.m. - Review of Resident #18's medical record occurred on August 29-30, 2012. Diagnoses included diabetes mellitus. Medications included Novolog 70/30 18 units at breakfast time and 6 units at supper time. Resident #18's blood glucose is to be monitored at 7:00 a.m. and 5:00 p.m. Review of Resident #18's glucose monitoring record and MAR from March 2012 through August 29, 2012 identified the following concerns: * 03/20/12 - BS 80 mg/dL at 5:00 p.m. and eight ounces of Gatorade given and no documentation of insulin administered. * 04/11/12 - no BS levels recorded and insulin administered at 7:00 a.m. and 5:00 p.m. * 04/20/12 - no documentation of insulin administered at supper time * 04/21/12 - as above * 04/22/12 - BS 68 mg/dL at 5:00 p.m. and no documentation facility staff followed protocol related to low BS levels * 05/29/12 - no documentation of BS level or insulin administered at 5:00 p.m. * 06/03/12 - no BS level recorded at 5:00 p.m. and insulin administered at 6:00 p.m. * 07/27/12 - BS 87 mg/dL at 5:00 p.m. and no insulin administered * 08/07/12 - no BS documented at 5:00 p.m.	F 309		

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F 309	Continued From page 29 * 08/20/12 - as above * 08/22/12 - BS level 59 mg/dL. The record stated the resident's insulin held but failed to identify the actions taken, if any, for the low BS level. During an interview on 08/30/12 at 10:05 a.m. with an administrative nurse (#13), and at 10:50 a.m. with an administrative nurse (#3), both nurses were unable to provide any clarification regarding the above discrepancies documented on Resident #17 and #18's MARs or glucose monitoring records. - Review of Resident #6's medical record occurred on August 27-30, 2012. Current diagnoses included diabetes mellitus. Physician orders included blood sugar checks 4 times per day (7:00 a.m., 11:00 a.m., 5:00 p.m., and 9:00 p.m.), and scheduled insulin injections four times a day of 15 units of humalog in the morning and at noon, 18 units of humalog at supper, and 42 units of lantus (long acting insulin) before bed. Resident #6's medical record lacked parameters for blood sugar levels. Review of Resident #6's glucose monitoring records, nurses notes, and MARs from April 2012 through August 29, 2012 identified the following concerns: * 04/05/12 - BS 69 mg/dL at 11:00 a.m., the resident received 6 oz. of Gatorade, no recheck on glucose monitoring record * 04/13/12 - no documentation of BS levels at 7:00 a.m., 11:00 a.m., and 5:00 p.m. * 04/15/12 - no documentation of a BS level at 9:00 p.m.	F 309		

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F 309	Continued From page 30 * 05/10/12 - BS 66 mg/dL at 11:00 a.m.; received 6 oz. of Gatorade with an untimed recheck of 114 mg/dL * 05/15/12 - no documentation of a BS level at 11:00 a.m. * 05/17/12 - no documentation the scheduled 5:30 p.m. insulin dose administered * 05/21/12 - no documentation of BS levels at 7:00 a.m., 11:00 a.m., 5:00 p.m., and 9:00 p.m. * 05/23/12 - no documentation of a BS level at 11:00 p.m. * 05/24/12 - no documentation the noon and 5:30 p.m. dose of insulin administered; BS levels at 11:00 a.m. - 341 mg/dL, at 5:00 p.m. - 352 mg/dL, and at 9:00 p.m. - 364 mg/dL * 05/26/12 - no documentation of a BS level at 9:00 p.m. * 05/29/12 - a BS of 66 mg/dL at 7:00 a.m.; received 4 oz. of Gatorade with an untimed recheck of 108 mg/dL * 05/30/12 - no documentation of a BS level at 5:00 p.m. and 9:00 p.m., and no documentation the scheduled 9:30 p.m. insulin dose administered * 06/05/12 - no documentation of a BS level at 7:00 a.m., 11:00 p.m., and 5:00 p.m. * 06/08/12 - no documentation of a BS level at 5:00 p.m. and insulin not signed off at 5:30 p.m. with the BS level at 9:00 p.m. being 322 mg/dL * 06/11/12 - no documentation of BS levels at 11:00 a.m. and 5:00 p.m. * 06/19/12 - BS at 7:00 a.m. 68 mg/dL with untimed recheck of 131; BS at 11:00 a.m. 68 mg/dL with no recheck or documentation related to intervention provided * 06/26/12 - no documentation of a BS level at 5:00 p.m. * 06/29/12 - no documentation of a BS level at	F 309		

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F 309	Continued From page 31 5:00 p.m.; a BS at 9:00 p.m. 398 mg/dL * 07/21/12 - BS levels at 11:00 a.m. 589 mg/dL, at 5:00 p.m. 508 mg/dL, and at 9:00 p.m. 516 mg/dL; a nurses note at 11:00 p.m. stated, "Blood sugar 516 called [physician's name] to give 15 units of humalog. recheck 109." No documentation for the treatment of the previous blood sugars greater than 400 mg/dL and/or of physician notification. * 08/04/12 - BS at 5:00 p.m. 57 mg/dL, per monitoring record snack given at 4:00 p.m. with an untimed recheck of 137 mg/dL * 08/06/12 - no documentation of a BS level at 11:00 a.m. and 5:00 p.m.; BS at 9:00 p.m. was 511 mg/dL. A nurse's note at 4:00 p.m. stated, "One time sliding scale 15 U [units] see PO [physician's order]." A physician ordered timed at 6:30 p.m. stated, "Chk [check] BS two hours after supper if over 400 give 15 U humalog . . ." The medical record lacked a BS level prior to obtaining a physician order at 6:30 p.m. to give additional insulin and lacked a blood sugar after the additional humalog administered. * 08/16/12 - no documentation of a BS level at 5:00 p.m. * 08/28/12 - BS at 7:00 a.m. 86 mg/dL with juice provided and an untimed recheck of 113 mg/dL, BS at 5:00 p.m. 75 mg/dL with an untimed recheck of 105 mg/dL after intervention provided. During an interview on 08/29/12 at 8:17 a.m., a nurse (#24) stated missing blood glucose checks on the monitoring record can occur when a nurse forgets to write them in or if a resident is off the floor (at meals). This nurse stated insulin should be circled on the MAR if it was held. During an interview on 08/30/12 at 9:23 a.m., an	F 309		

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F 309	Continued From page 32 administrative nurse (#2) stated staff should recheck blood sugars per policy and should indicate the time a blood sugar level is rechecked. Failure to administer insulin or monitor blood sugar levels placed Resident #6, #17, and #18 and other diabetic residents at risk of illness and complications related to hypoglycemia and hyperglycemia and limited the physicians' ability to ensure acceptable quality of care.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on resident and group interview, record review, and staff interview, the facility failed to ensure residents received services to maintain personal hygiene for 1 of 1 sampled resident (Resident #16) who did not receive a bath in a six-week period. Failure to provide bathing increased the risk for skin breakdown and odors, and failed to enhance the residents' personal dignity. Findings include: During the group interview, on 08/28/12 at 10:45 a.m., Resident #16 said she had not received a bath/shower for nearly two months.	F 312	**F-Tag 312:** **10/04/2012** 1. Resident #16 has received a tub bath, and will continue to receive a bath/shower at least weekly and more often as she desires. 2. Any resident has the potential to be affected if they leave the facility for extended periods of time on a frequent basis. 3. Mandatory in-services for all nursing staff were held September 5th and 6th, 2012 and October 2nd, 3rd, and 4th, 2012. The importance of proper documentation of resident personal cares on the CNA flow sheet was discussed.	

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F 312	Continued From page 33 On 08/29/12 at 1:45 p.m., a resident interview occurred with Resident #16. During this interview, when asked if she has received a bath recently, the resident indicated she hasn't received a bath "since the middle of July." Following the resident interview, record review occurred. Review of the Certified Nurse Aide (CNA) charting (both Nurses Assistant Flowsheets and the ADL [activities of Daily Living] Assessment Form showed the last documented bath/shower for Resident #16 was 07/05/12 (seven weeks ago). On 08/29/12 at 3:05 p.m., during interview, the Unit Manager (#12)reviewed the same CNA charting identified above. After being told Resident #16 said she hadn't received a bath for nearly two months, the Unit Manager indicated it could have happened because the resident does go home with her family frequently. This staff member (#12) said there is no way to know if Resident #16 had received a bath since 07/05/12. She indicated that Resident #16 is very alert and if that is what she (the resident) said happened, then that is what happened.	F 312	4. The nurse manager, staff coordinator, and/or designee will monitor the CNA flow sheets for documentation of bath/shower for a random sample of residents. Staff will also interview a random sample of interview-able residents regarding bathing preferences etc.. Monitoring will be done weekly for 4 weeks then monthly for 2 months, results of the monitoring will be reported by the DON to the QA committee monthly for 3months. 5. October 04, 2012	
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		

PRINTED: 09/20/2012
FORM APPROVED
OMB NO. 0938-0391

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

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 _____	08/30/2012

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F 323	Continued From page 34 This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to assess and implement fall prevention measures, including determining causative factors following a fall, and provide adequate supervision for 2 of 3 sampled residents (Resident #6 and #11) who experienced falls with fractures at the facility; failed to properly utilize a gait belt and appropriate equipment, a hemicane (a half walker) and wheelchair foot rests, for 5 of 13 sampled residents (Resident #1, #8, #12, #13, and #18) who required staff assistance for transfers or transport. Failure to assess the causative factors and failure to provide appropriate staff assistance related to a fall with fracture experienced in an elevator (Resident #6) and a fall with fracture related to oxygen tubing (Resident #11). Failure to utilize assistive devices and/or use them correctly may result in residents experiencing falls, injury, and/or pain. Findings include: Review of the facility policy titled "Transfer/Gait Belts . . ." occurred on 08/30/12. This policy, dated 2010, stated, "PURPOSE: Ensure safety for residents and staff. PROCEDURE: 1.1 Staff transferring residents will properly apply and use a transfer/gait belt as identified on care plan when ambulating or transferring residents whose: 1.1.1 Ability to ambulate or transfer is unknown. 1.2.2 Balance is impaired 1.1.3 Muscle tone and/or strength is decreased 1.1.4 Care plan identifies use of the transfer/gait . . . Application of Gait Belt: 3.1 Place gait belt snugly around resident's	F 323	**F-Tag 323:** 1. Resident #11 has expired. Staff providing care for resident's #6, #1, #8, #12, #13 and #18 have been informed of the concern identified. All of these residents care plans were reviewed and CNA assignment sheets reviewed and revised as needed. 2. Any resident requiring an assistive device and/or at risk for falling has the potential to be affected. 3. The restraint review committee does and will continue to meet at least 1 or 2 times a month to review residents with two or more falls in the past month. Falls are reviewed as to time, location and causative factors. Resident falls are also noted on the 24 hour report sheet and these falls are reported during morning report Monday through Friday. Mandatory nursing in-services were held September 5th and 6th, 2012 and October 2nd, 3rd, and 4th, 2012 to fall prevention measures and/or proper utilization of assistive devices to prevent falls, injury and/or pain to the resident. An in-service on correct transfer techniques and use of assistive devices presented by T. Harstad, PTA will be scheduled. 4. The staff coordinator, nurse manager, or designee will monitor transfer of residents, use of assistive devices and also gait belt use. The restraint review committee will review all resident falls. Monitoring will be done weekly for 4 weeks then monthly for 2 months. Results will be reported to the QA committee monthly by the DON 5. October 04, 2012	10/04/2012

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F 323	Continued From page 35 waist, . . . 3.3 When resident is up in chair assure after standing gait belt is adjusted to fit snugly." - Review of Resident #6's medical record occurred on August 27-30, 2012 and identified diagnoses including weakness, dementia, hypertension and an ankle fracture which occurred 05/17/12. A quarterly Minimum Data Set (MDS) dated 04/25/12, identified the resident as having three falls and one with a minor injury, during the assessment period. The resident required extensive assistance of one person for transfers, walking in room, and locomotion on and off the unit, and required limited assistance of one person for walking in corridor per MDS. A MDS note, dated 05/07/12 at 3:45 p.m., stated, ". . . [Resident's name] was extensive assistance for ADL's due to an URI [upper respiratory infection] and to falls. I interviewed direct care staff and [resident's name] is returning to her normal . . ." Resident #6's "Nurses Assistant Flowsheet," updated 04/30/12, indicated certified nursing assistants (CNAs) to ambulate in hallway with a front wheeled walker and stand by assist, and to use wheelchair for mobility. Prior to the fall on 05/17/12 when Resident #6 experienced an ankle fracture, an "ADL [activity of daily living] Assessment" identified CNAs provided one person physical assistance or limited assistance during the day shift for locomotion on and off the unit on all days between 05/07/12 and 05/17/12. During an interview on 08/30/12 at 9:50 a.m., a	F 323		

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F 323	Continued From page 36 MDS nurse (#23) reported limited assistance involves staff holding onto a gait belt without using muscles to help hold a resident up if the resident needed help. A nurses note dated 05/17/12 at 9:30 a.m., stated, "Resident was in elevator [with] staff [and] became weak. She fell down [with] her FWW [front wheel walker]. . . . Ankle (left) was obviously deformed. Assisted out of elevator by 5 staff [with] 1 supporting ankle . . . Denied pain once out of elevator . . . Ambulance took resident out of building at [9:30] a.m. . . ." An "Accident/Incident Report," dated 05/17/12, stated, " . . . me and another CNA took [Resident #6] upstairs we stopped on 3 [3rd floor] and took 3 residents off then [Resident #6] got weak and collapsed. She hit her head on railing in elevator on her way down. . . . sent to ER [emergency room] returned [with] . . . ankle fracture . . ." The incident report failed to identify the use of a walker by the resident. Review of the nurses notes and incident report, dated 05/17/12, failed to address if facility staff had utilized a gait belt. The CNA flowsheets on this date identified Resident #6 required one person, limited assistance for walking in room and corridor, and locomotion on and off unit during the day shift, which per staff interview noted above, as using a gait belt with one staff holding onto the gait belt. During an interview on 08/30/12 at 9:23 a.m., an administrative nurse (#3) read the incident report and was unable to tell if a CNA was always present with Resident #6 in the elevator at the	F 323		

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time of the fall related to the CNAs taking residents in and out of the elevator.

Failure to ensure adequate supervision and failure to ensure proper gait belt use for Resident #6 resulted in the resident experiencing a fall and fracture and to her ankle.

- During the initial tour on 08/27/12 at 12:45 p.m., observation showed Resident #11 lying on her bed. Her oxygen tubing lay coiled (two-to-three large coiled loops) on the floor between the resident's dresser and the bathroom.

Observation on 08/28/12 at 7:45 a.m. showed Resident #11 sitting on the edge of her bed. Her oxygen tubing lay coiled (one large coiled loop) on the floor near the resident's left foot.

Observation on 08/30/12 at 9:45 a.m. showed Resident #11 sitting on the edge of her bed. Her oxygen tubing lay on the floor between the resident's feet.

Review of Resident #11's medical record occurred on August 27-30, 2012 and identified diagnoses including anxiety, dementia, osteoporosis, osteoarthritis, degenerative disc disease, multiple thoracic and lumbar spine compression fractures, history of falls with pelvic fracture, and pain. The quarterly MDS, dated 06/30/12, identified the resident as cognitively intact and independent with her ADLs.

The current care plan stated the following, ". . . Problem: . . . Impaired physical mobility . . . at risk for falls. . . . Left pelvic fracture. . . . Approaches: . . . Monitor resident for safety. . . . Remind

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F 323	Continued From page 38 resident of 02 [oxygen] tubnig [sic] and move to side when walking to bathroom. . . ." An interdisciplinary progress notes, dated 12/18/11 at 6:30 p.m., stated, "Resident found sitting on floor with legs bent in front of her end table. Resident stated she was trying to shut her blinds. Hit head on end table. No c/o [complaints of] pain with ROM [range of motion]. Full ROM to all extremities. Buttock sore from landing on floor. . . ." The accident/incident report, dated 12/18/11, stated, ". . . Investigation of Event . . . Resident got tangled in 02 tubing. . . . Intervention to Prevent Recurrence . . . Non slip slippers or shoes applied. . . ." The interdisciplinary progress notes stated the following: * 03/29/12 at 8:30 p.m., "Aide heard resident crying for help. She had fallen in her room and was found lying on the floor next to the TV/dresser.Upon moving her (L) [left] leg she grimaced in pain. . . . All other ROM WNL [within normal limits]. . . ." * 03/29/12 at 9:00 p.m., "Ambulance crew here and resident transported to ER." * 03/30/12 ". . . [Resident #11] has a pelvic fx [fracture]. . . . the plan is to get pain under control [and] may return tomorrow. . . ." The accident/incident report, dated 03/29/12, stated, ". . . Investigation of Event . . . Resident was talking on phone w [with] daughter and was walking in room and caught her feet in her oxygen tubing. . . . Intervention to Prevent Recurrence . . . Medication review warranted with	F 323		

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F 323	Continued From page 39 physician. . . . Other . . . spoke with [Resident #11] at earlier date and refused to have 02 tubing shortened as likes to walk around her room. . . ." The history and physical examination report, dated 03/29/12, stated, "She [Resident #11] reports that she was at the nursing home on the toilet when the phone range [sic]. She tried to hurry to the phone but got tangled in her oxygen tubing and fell. . . . In the emergency room she was found to have a pelvic fracture . . ." The interdisciplinary progress notes, dated 07/14/12 at 6:50 p.m., stated, "Found on floor by aide. Resident was falling as aide passed her doorway but could not break her fall. [Resident #11] was walking to her dresser and then attempted to walk back to her bed. Her 02 tubing got caught on her wheelchair pedal which pulled her off balance. . . . c/o [complained of] pain at level '6' in right buttock. . . ." The accident/incident report, dated 07/14/12, stated, ". . . Investigation of Event . . . Resident stated she was walking to her dresser. 02 tubing was caught on pedal of wheelchair which caused her to lose her balance. . . . Intervention to Prevent Recurrence . . . Shorter tubing jar concentrator. . . . Education . . . Reminded to be aware of surroundings and 02 tubing and move to side when walking to bathroom. . . ." During an interview on the afternoon of 08/29/12, when asked if her oxygen tubing posed a tripping hazard, Resident #11 stated, "I've tripped on the oxygen tubing more than once. I got it caught around my foot." When asked why her concentrator is stored in the bathroom, she	F 323		

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F 323	Continued From page 40 stated, "Due to the noise." She explained her previous concentrator made noise and she had difficulty falling asleep. She stated facility staff placed the new, quieter concentrator in the bathroom out of "habit." When asked what interventions facility staff have attempted to reduce the tripping hazard, she stated, "What can they do with the tubing?" During interview on the morning of 08/30/12, two administrative nursing staff members (#2 and #3) agreed Resident #11's oxygen tubing continues to pose a tripping hazard. - Review of Resident #13's medical record occurred on August 27-30, 2012 and identified diagnoses including weakness and transient cerebral ischemia. The quarterly MDS, dated 07/22/12, identified the resident as having a moderate cognitive impairment and requiring extensive assistance with transfers and walking in her room. Observation on 08/28/12 at 11:05 a.m., showed two CNAs (#5 and #6) transferring Resident #13 to the bathroom using a gait belt and front-wheeled walker. One CNA (#5) utilized the gait belt as the other CNA (#6) assisted Resident #13 to a standing position by pulling upward under the resident's arms. During interview on the morning of 08/30/12, two administrative nursing staff members (#2 and #3) confirmed staff members should utilize a gait belt during transfer. - Review of Resident #1's medical record occurred on August 27-30, 2012 and identified	F 323		

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diagnoses including history of cerebrovascular accident with left sided weakness, dementia, and hypertension. A quarterly MDS, dated 08/03/12, identified the resident as having severe cognitive impairment and requiring extensive assistance with transfers, toilet use, and walking in his room.

Resident #1's current care plan stated, ". . . PROBLEM . . . Impaired physical mobility . . . due to Cerebrovascular Accident with left side hemiparesis. Arthritis, At risk for falls. Unsteady gait . . . APPROACHES . . . Transfer [and] ambulate in room using hemicane, left AFO [ankle-foot orthotic brace], gait belt & 1-2 assist . . . Sits on side of toilet and uses rail for transfers . . . " The resident's "Functional Assessment," dated 02/01/12, identified Resident #1 needed a gait belt and hemicane for transfers. The next two assessments, dated 05/03/12 and 08/07/12, failed to identify specific transfer needs, but noted Resident #1 with no functional changes in condition.

Observation the morning of 08/28/12 at 9:32 a.m., showed a CNA (#15) assisted Resident #1 to transfer from his wheelchair to his recliner. The CNA placed the hemicane on the resident's right side (strong side) between wheelchair and recliner. The CNA stood behind Resident #1's wheelchair, held onto the gait belt with both hands while behind the wheelchair, and when the resident stood to pivot to his right side, the resident's weak left leg shook with a spastic movement while his left foot drug across the floor. By placing the wheelchair between the CNA and the resident, the CNA not in a location to ensure a safe transfer.

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F 323	Continued From page 42 Observation of Resident #1 on 08/28/12 at 2:07 p.m., showed a CNA (#15) assist the resident after using the restroom. The CNA applied a gait belt which had a twist in the belt, and when the resident stood up, the CNA held underneath the resident's right axilla (armpit) with her right hand. The CNA's left hand held the twisted gait belt which slide up the resident's back. The resident held onto the grab bar next to the toilet while the CNA (#15) lowered the twisted gait belt to the residents waist with her left hand. The CNA failed to tightened the gait belt prior to the CNA completing personal cares and assisting the resident to pivot to the wheelchair. Observation on 08/29/12 at 9:00 a.m., showed a CNA (#20) assist Resident #1 to transfer from the recliner to his wheelchair. During this transfer the CNA stated, she was not using the "transfer walker" due to it not being safe and stated, "For his safety and mine . . . I'm not going to use it . . ." This CNA then shook the hemicane demonstrating the screws were loose. The CNA (#20) held onto the left and right side of the gait belt, and transferred the resident to the recliner. On the afternoon of 08/29/12, rehab staff provided Resident #1 with a new hemiwalker. During an interview on 08/30/12 at 9:03 a.m., two physical therapy staff members (#21 and #22) reported Resident #1 should use a hemiwalker for transfers. - Review of Resident #18's medical record occurred on August 29-30, 2012. Diagnoses included osteoarthritis. The current MDS, dated 05/18/12, identified the resident required extensive assistance of one person for bed	F 323		

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mobility, transfers, and toilet use.

Resident #18's current care plan stated, "Impaired physical mobility . . . at risk for falls: . . . FWW [front wheeled walker] [with] [assist of two] and gait belt for amb [ambulation] in rm [room] and to BR [bathroom] . . ."

Observation on 08/30/12 at 7:45 a.m. showed Resident #18 seated on the toilet in her bathroom and her FWW in front of her. The CNA (#25) asked the resident to stand and assisted her by lifting under her left arm. After the CNA completed pericares, Resident #18 walked to the wheelchair with her FWW as the CNA held onto her pants.

The CNA (#25) failed to utilize a gait belt to assist Resident #18 to stand for pericare cares and to walk from the bathroom to the wheelchair.

- Review of the medical record for Resident #8 occurred August 28-30, 2012. A quarterly MDS, dated 07/06/12, identified the resident required extensive assistance of two or more persons for transfers, walking in room and corridor. The current care plan, dated 07/25/12, for "impaired physical mobility" identified "Transfers with gaitbelt & 2 assist."

Observation, on 08/28/12 at 8:45 a.m., showed staff assisted Resident #8 with personal cares. Following cares, two CNAs (#9 and #18) ambulated the resident using a gait belt, with the staff nurse (#19) following with Resident #8's Tilt-N-Space wheelchair. When Resident #8 requested to sit, the CNAs (#9 and #18) lifted Resident #8 into the wheelchair. The CNA (#9)

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F 323	Continued From page 44 lifted the resident using the resident's axilla (armpit) and thigh while the other CNA (#18) lifted Resident #8 using the gait belt and thigh. Observation, on 08/28/12 at 1:50 p.m., showed staff assisted Resident #8 with personal cares. Following cares, two CNAs (#9 and #16) ambulated the resident using a gait belt, with another CNA (#17) following with Resident #8's Tilt-N-Space wheelchair. Resident #8 and the CNAs (#9 and #16) were about halfway to the lounge when Resident #8 began to sit down. The two CNAs (#9 and #16) stopped, the third CNA (#17) positioned the wheelchair while the two CNAs (#9 and #16) lifted Resident #8 into the wheelchair. One of the CNAs (#9) directed the other CNA (#16) to let go of the gait belt and lift Resident #8 using her axilla and thigh. The two CNAs (#9 and #16) then lifted Resident #8 into the wheelchair as directed by the CNA (#9). Upon sitting, the resident immediately stood again, and the staff continued to ambulate the resident. When Resident #8 again signaled she was ready to sit, the CNAs (#9 and #16) lifted Resident #8 by the axilla and leg to position her into the wheelchair. During an interview on 08/29/12 at 12:02 p.m., an administrative nursing staff member (#12) identified the facility train staff to lift a resident using the gait belt and a leg when positioning them into a wheelchair. - Review of Resident #12's medical record occurred on August 27-30, 2012 and identified diagnoses including dementia with behaviors and cerebrovascular accident (CVA) with hemiplegia. The quarterly MDS, dated 06/15/12, identified the	F 323		

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	355070	A. BUILDING _____ B. WING _____	08/30/2012

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

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F 323	Continued From page 45 resident as having severe cognitive impairment and totally dependent for locomotion on/off the unit. Observation on the morning of 08/29/12 showed an unidentified CNA transported Resident #12 to her room in her wheelchair with her right foot between her foot pedals. Resident #12's right foot/shoe caught and bounced or pulled back under her wheelchair as staff transported her down the hallway . During interview on the morning of 08/30/12, two administrative nursing staff members (#2 and #3) confirmed facility staff should have cued the resident and/or ensured her foot/shoe cleared the floor during transport.	F 323		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure residents were free of any significant medication errors for 1 of 1 sampled resident (Resident #17) who did not receive a scheduled antianginal medication (prevent chest pain/discomfort) for 12 consecutive days. Failure to ensure the administration of the medication and inform the physician regarding it's unavailability has the potential to affect Resident #17's health and may result in unnecessary pain and/or discomfort.	F 333	**F-Tag 333:** **10/04/2012** 1. Resident #17 order for Nitro 2.5mg po bid was discontinued 04/02/2012. This patient did not have any complaints of chest pain. 2. Any resident has the potential to be affected. 3. Mandatory nursing in-services were held September 5th and 6th, and October 2nd, 3rd and 4th, 2012. Licensed nursing staff were informed the importance of the need to ensure all residents receive their medications as prescribed. The policy and procedure for medication administration has been reviewed and revised. If a medication is not available, the pharmacy should notify the facility as soon as possible and the physician notified.	

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F 333	Continued From page 46 Findings include: Review of Resident #17's medical record occurred on August 29-30, 2012. Diagnoses included chronic ischemic heart disease. Medications included, "Nitro [nitroglycerin] 2.5 mg [milligrams] PO [by mouth] BID [twice a day]," initiated on 10/27/06. Review of the medication administration records (MARs) for March and April 2012, revealed Resident #17 did not receive her scheduled nitroglycerine from the afternoon of 03/22/12 through the morning of 04/02/12. A note on the MAR, dated 03/24/12, stated, "Nitro not sent w/ [with] cycled pharm. [pharmacy] drugs. [Name of drug store] states it's 'too hard to get a hold of.' MD [medical doctor] faxed." Resident #17's medical record failed to identify a fax to the MD dated 03/24/12. A fax found in the medical record, dated 04/02/12, to Resident #17's physician stated, "[Doctor's name] Res. [Resident] has a current order for Nitro 2.5 mg PO BID. Pharmacy states this med is no longer available. 1) May we please have order to D/C [discontinue]? . . ." The physician responded on the same day, "DC Nitro 2.5 mg." The facility failed to ensure Resident #17 received her prescribed medication for 12 days.	F 333	4. The nurse manager reviews the medication administration records for all residents on a monthly basis. The nurse manager or designee will monitor a random number of resident records to assure that medications are administered according to schedule. Monitoring will be done for 2 months. Results will be reported to the QA committee by the DON monthly. 5. October 04, 2012	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local	F 371	**F-Tag 371:** **10/04/2012** 1. There were no residents identified in this deficiency. 2. Any resident has the potential to be affected.	

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F 371	Continued From page 47 authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, review of manufacturer's recommendations, review of professional reference, and staff interview, the facility failed to store, prepare, and serve foods in a safe and sanitary manner in 1 of 1 kitchen, and 3 of 4 kitchenette/food service areas (Horizon Towers, Legacy, and Pineview). The facility failed: to follow manufacturer's guidelines for mixing sanitizing solutions (Main Kitchen and Horizon Towers); to ensure proper drying of glasses prior to storage (Pineview); to clean reusable utensils and to properly store scoops, and utensils used for dishing powdered substances (Main Kitchen and Legacy). These practices placed residents at risk for contamination of foods during preparation which can lead to foodborne illness. Findings include: Review of the facility policy titled "Handling Clean Equipment and Utensils" occurred on 08/30/12. This undated policy stated, ". . . When handling cleaned and sanitized equipment and utensils, staff will avoid touching the parts that will come in contact with the food or the mouth. Be especially careful with silverware. . . . Clean equipment and utensils will be stored in a clean, dry location in a way that protects them from contamination . . . "	F 371	3. Dietary staff were re-educated on September 26, 2012the proper mixing of sanitizers. Automatic sanitizer dispensers have been ordered for each neighborhood kitchenette. Meal temperature loop have been revised to include testing sanitizer strength and staff initial when testing is completed. Guidelines for sanitizer use have been posted in the dish room and copies placed in staff binders in each neighborhood. All disposable scoops, measuring spoons, etc., will be washed and sanitized at the end of each shift. Staff were re-educated on proper handling of clean equipment and utensils to ensure safe practices. All the glasses and cups sent to Pine View neighborhood will be placed on trays with plastic mesh to ensure no glasses or sups are stacked when wet. Dietary and nursing staff will be re-educated on current policy for not stacking wet dished. 4. The dietary food service manager, dietary clerk, and/or dietician will test sanitizer solution weekly for 4 weeks to ensure guidelines are being followed. 5. October 04, 2012	

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Review of the facility policy titled "Employee Sanitary Practices" occurred on 08/30/12. This undated policy stated, ". . . All kitchen employees shall: . . . 7. Clean equipment and work units after use. . . ."

The 2009 Food and Drug Association Food Code, page 186 states, " . . . Chemical SANITIZERS and other chemical antimicrobials applied to FOOD-CONTACT SURFACES shall meet the requirements specified in 40 CFR [Code of Federal Regulation] 180.940 . . ." Review of this CFR section stated, ". . . dimethyl ethylbenzyl ammonium chloride [an active ingredient in the sanitizer used at the facility] . . . When ready for use, the end-use concentration of all quaternary chemicals in the solution is not to exceed 200 parts per million [ppm]. . . ."

The manufacturer's instructions on the container of sanitizing solution stated, ". . . to sanitize food contact surfaces prepare a 200 ppm active quaternary solution by adding 1 ounce of sanitizer to 4 gallons of water. . . ."

The following observations showed the facility mixed sanitizer at incorrect concentrations:

* 08/27/12 at 1:35 p.m. in the main kitchen, showed a unidentified dietary staff member filled a bucket with sanitizer and water. The dietary staff member tested the solution with a strip which indicated a concentration of 400 ppm. The dietary staff member added water to the solution. At 1:45 p.m. the staff member retested the same bucket of sanitizer, per request of the surveyor, and received a concentration reading of between

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F 371	Continued From page 49 300-400 ppm. * 08/28/12 at 8:37 a.m. in Horizon Towers, showed a dietary staff member (#14) put two squirts of sanitizer into a red bucket and then added water to the bucket. When asked how the staff member knows how to mix up the sanitizer, she stated, "probably should have only used one squirt" to a half full container of water. The staff member looked for test stripes and unable to find any, reported she would test it later. At 9:15 a.m., the same dietary staff member (#14) used the sanitizer from the bucket to clean off tables. When asked if she tested the solution she replied "yes" and she reported emptying some water out of the bucket and adding more water to get it to 200 ppm. When asked what the solution tested prior, she reported "400" and she "always makes too much." * 08/29/12 at 1:35 p.m. in the main kitchen- showed 2 buckets of sanitizers at approximately 300 ppm and at 2:05 p.m. one bucket of sanitizing solution at less than 200 ppm. Observation on 08/29/12 at 1:35 p.m., showed two cans of protein powder with used measuring utensils in a plastic bag tucked under the lids allowing the bags to hang off the side each can, and two utensils in a plastic bag hanging on the side of a powdered thickener. The utensils had powder residue on them and the bags contained powder inside them. The dietary manager (#28) took the utensils to wash and threw away the bags. Observation on 08/29/12 at 3:02 p.m., showed two dietary staff members (#29 and #30) mixing a powdered thickener and protein into resident drinks. When asked, the staff members reported	F 371		

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F 371	Continued From page 50 they would place the used measuring scoops back inside the plastic bags and hang the bags on the cans when finished. When ask when they wash the scoops, the staff members stated they do not wash the measuring utensils after each use, and one staff member (#30) reported he/she "Has never washed" the utensils prior to storing the utensils in the same plastic bag. Observation in the main kitchen on 08/29/12 at 1:35 p.m. showed an opened two gallon container of powdered milk with a styrofoam cup in it and at 2:23 p.m., in the Legacy dining room, observation showed an opened container of protein powder contained a measuring scoop. Observation in the Pineview dining area on 08/29/12 at 3:47 p.m., showed approximately 18 glasses stacked in a cupboard with water drops in-between the glasses. The dietary manager (#28) removed the glasses. During an interview on 08/29/12 at 1:35 p.m., the dietary manager (#28) stated the chemical sanitizer chart instructs for staff to have the concentration at 150 ppm to 400 ppm, which conflicts with the instructions by the manufacturer, which stated a concentration of 200 ppm.	F 371		