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 _____	C 08/29/2013

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, in conjunction with a complaint survey, started on August 26, 2013 and completed on August 29, 2013, the sample included five (5) residents for complete review, sixteen (16) residents for focused review, and three (3) closed records for review. The sample included six (6) additional residents to verify specific concerns during the survey.	F 000		
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, record review, policy review, and staff interview, the facility failed to obtain a physician's order and complete a restraint assessment prior to initiating a physical restraint for 1 of 5 sampled residents (Resident #2) observed using a wedge cushion while in bed. Failure to obtain a physician's order for restraint use and complete a restraint assessment may result in the use of physical restraints not required to treat the resident's medical symptoms. Findings include: Review of the facility policy titled "Use of Physical Restraints" occurred on 08/29/13. This policy, dated May 2007, stated, "Policy Statement. Bethel Lutheran Home believes all residents have	F 221	F221 1. A physician order was obtained August 28, 2013, for the use of the wedge. A restraint assessment has been completed. The nurse manager met with the resident's wife on 08/29/13 to discuss the use of the restraint (wedge). Staff caring for resident #2 were re-educated 08/29/13 on restraint use and need for a restraint assessment as per policy. Resident #2 care plan was updated 08/28/13. 2. Any resident has the potential to be affected. 3. Mandatory education was held on 09/04/13, 09/05/13, 10/08/13, 10/09/13 and 10/10/13 for all nursing staff. The restraint policy and procedure will be reviewed and revised to reflect current restraint regulations.	

ORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	10/04/13 TP

deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that r safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days wing 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 following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ram participation.

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F 221	Continued From page 1 the right to be free from any physical restraint not required to treat the resident's medical symptoms. Policy Interpretation and Implementation. Procedure: 1. Evaluation for Restraint Use 1.1 Licensed staff will identify a need for restraint use or possible alternatives. 1.2 Nursing will obtain rehabilitative consult when appropriate. 1.3 Assistance Device Assessment will be initiated immediately upon application of restraint. 1.4 Completed Assistance Device Assessment will be routed to the Restraint Review Committee for completion/review. 1.5 Restraint use will be evaluated through Quarterly Nursing assessment or more often as needed. 1.6 Review restraint use monthly through Restraint Review committee as needed. 2. Documentation 2.1 Social Services shall receive written consent for restraint use from resident or representative when a restraint is deemed medically necessary. Consent will be updated at least annually. 2.2 Nursing will obtain physician order specifying type, duration, and reason for restraint use. 2.3 Physician will review restraint use at the regularly scheduled visit or as needed. 2.4 Restraint use will be included in the quarterly nursing assessment. 2.5 Resident's medical record will reflect: 2.5.1 Medical symptoms requiring restraint use. 2.5.2 Use of alternative restraints 2.5.3 Use of least restrictive device. 2.5.4 Devices considered restraints but utilized for positioning purposes do not require a physician's order. . . ." (This last statement is incorrect. If a device meets the definition of a	F 221	The facility policy on restraint use will include the use of wedges. A wedge must be considered as a physical restraint. The nursing quarterly assessment has been revised to identify restraint use. On the electronic medical record, triggers have been implemented (if appropriate) to complete restraint assessment, consult physical therapy, and for documentation of use of the physical restraint device. Rehab Vision (contract therapy services) will be involved in the assessment of the functional status of the resident. 4. The restraint review committee will meet weekly to review all residents with restraints, including the use of wedges, as well as resident falls. Nurse Manager (or designee) will monitor physical restraint use (compliance with policy and procedure) weekly for three months, then monthly for 9 months. DON will report results to the QA Committee monthly for 12 months. 5. 10/14/13	

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F 221	Continued From page 2 restraint, the regulations for restraints need to be followed.) Observations during the week of survey identified a wedge cushion in place on the exit side of the bed whenever Resident #2 laid in bed. On the morning of 08/28/13, two certified nursing assistants (CNAs) (#26 and #31) stated Resident #2 attempts to crawl out of his bed. Review of Resident #2's medical record occurred on all days of survey and diagnoses included Parkinson's disease, Alzheimer's disease, and left eye blindness. The annual Minimum Data Set (MDS), dated 08/10/13, identified the resident with short and long-term memory problems, inattention, physical and verbal behaviors, extensive assistance of two or more staff members for bed mobility, one fall since the previous assessment, and daily use of a wheelchair seatbelt restraint. The current care plan stated, "Focus: I have limited physical mobility r/t [related to] Disease Process (Parkinson's), Weakness, confusion . . . I am at risk for falls. I am unsteady and refuse help at times for ambulating. I wander at times. I am an elopement risk. I have a history of tipping my wheelchair backwards. I have a history of fracture on the right . . . Interventions: . . . I have a seatbelt in my wheelchair (physician's order obtained and restraint assessment completed for this restraint). . . ." Resident #2's care plan failed to identify the use of the wedge cushion when in bed. Resident #2's medical record lacked evidence the facility obtained a physician's order or completed	F 221		

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F 221	Continued From page 3 a restraint assessment for the wedge cushion restraint. During an interview on 08/29/13 at 8:15 a.m., an administrative nurse (#7) stated the wedge cushion acts as a restraint for Resident #2 and agreed the facility failed to obtain a physician's order, complete a restraint assessment, and care plan the physical restraint. The nurse (#7) identified she did not know how long the wedge cushion has been used.	F 221		
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 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 provide care for 3 of 24 sampled residents (Resident #5, #10, and #18) and 4 supplemental residents (Resident F, #27, #31, and #32) in a manner and environment that maintained, enhanced, and respected each resident's individual dignity and individuality. Failure to ensure Resident #10's slacks were not on backward, failure to knock before entering residents' rooms (Resident #5 and Resident #27), failure to address Resident #5 by her given name, and failure to provide privacy during blood glucose testing for Resident #18, #31, and #32 did not recognize the residents' individuality or provide care in a dignified manner.	F 241	F241 1. Staff caring for resident 5, resident 10, resident 18, resident 27, resident 31 and resident 32 have been re-educated on Resident Rights, Privacy, and Respect. Performance corrections will be noted for all staff involved. Resident F was assessed by the director of nursing at the time of her fall. The staff person involved was re-educated in the need to knock on the resident's door before entering. 2. All residents have the potential to be affected. 3. Mandatory education for all nursing staff was held on 09/04, 09/05, 10/08, 10/09 and 10/10.	

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F 241	Continued From page 4 Findings include: - During episodes of cares for Resident #5, on 08/27/13 at 8:40 a.m. and 12:20 p.m., observation showed a certified nursing assistant (CNA) (#3) addressed the resident as "dear" approximately 10 times. Review of Resident #5's medical record failed to identify this term as the resident's preference. - During an episode of care for Resident #5, on 08/27/13 at 8:40 a.m., observation showed a CNA (#2) entered the resident's room without knocking, announcing herself, or requesting permission to enter the room. - Observation from 11:20 a.m. to 11:35 a.m. on 08/27/13 showed a nursing staff member (#19) tested Resident #18, Resident #31, and Resident #32's blood glucose in the Wheatland lounge area within visual view of other staff, visitors, and residents in the same area. During an interview on 08/29/13 at 8:15 a.m., an administrative staff member (#7) stated she expected nursing staff to check resident's blood glucose in a private area without other people present. - An observation on 08/27/13 at 3:50 p.m., showed two CNAs (#9 and #10) assist Resident #10 to change her slacks. The CNAs put the slacks on backwards and after noticing this, failed to remove the slacks and place them on correctly. - During observations in the Harmony neighborhood on 08/27/13 at 5:37 p.m., an unidentified CNA entered Resident #27's room without first knocking, announcing herself, or	F 241	Paper education has been sent out to all neighborhoods. Nursing staff are to read the information and sign the form to indicate they have read and understand the content. Privacy screens are available in all neighborhoods. All the screens have been checked for proper functioning and repaired as needed. 4. House supervisors and/or nurse managers will monitor resident privacy, resident rights (use of proper name, knocking on doors before entering) weekly. Weekly walk-throughs are being done by department supervisors or designee and include monitoring staff not using terms of endearment such as dearie, honey, etc. and staff knocking on resident door before entering room. The Director of Nursing or designee will report results of the monitoring to the QA Committee monthly for three months, then quarterly for three months. 5. 10/14/13	

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F 241	Continued From page 5 requesting permission to enter the room. - During interview on 08/27/13 at 5:00 p.m., Resident F stated on one occasion while standing by her closet, a staff member opened the door and failed to wait for permission to enter. Resident F stated when the staff member opened the door; the door hit her and caused her to fall to the floor.	F 241		
F 244 SS=B	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, review of Monthly Resident Meeting Minutes, group, resident, and staff interview, and policy and procedure review, the facility failed to act upon resident grievances; specifically concerns about dirty dishes for 1 of 5 residents (Resident B) present at the group interview and failed to ensure prompt meal service for 5 of 21 sampled residents (Resident #10, #11, #27, #28, and #29) and 3 supplemental residents (Resident A, #30, and #33) observed receiving their meals on 3 of 5 resident care units (Wheatland, Harmony, and Legacy). Failure to act upon the grievances of the residents resulted in residents continuing to receive food and liquids in soiled dishes and glassware and resulted in a delay of meal service in the resident dining	F 244	F 244 Comment: correction page 9, 4th paragraph should read Wheatland dining room. 1. Dietary staff and nursing staff have been informed of the findings noted for F244. 2. All residents have the potential to be affected. 3. New dishes more easily cleanable and stain resistant were purchased April 2013. The procedure for dishwashing has been revised. All cups are now washed with "three scrubber" brushes to clean inside and outside of the cups. Dietary staff in-services were conducted on 09/05 and 09/24/13. Nursing staff in-services were held on09/04, 09/05, 10/08, 10/09 and 10/10. A meeting was held 10/01/13 with activity department supervisor, laundry/housekeeping supervisor,	

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F 244	Continued From page 6 rooms. Findings include: The group interview occurred on 08/27/13 at 10:30 a.m. Resident B stated even though she complained about the dirty dishes, the facility has not resolved this problem. When asked if she told the facility staff about her concerns with dirty dishes, Resident B stated, "I quit bringing it up because they [referring to the facility staff] don't do anything about it." Review of the 01/21/13 Monthly Resident Meeting Minutes stated a "couple of residents mentioned that the cups and glasses at times don't seem to be cleaned or that they are stained. One resident commented that there was still lipstick on one of the cups at her table." The facility's response to these comments, as documented in the January minutes, stated "will do a QA [quality assurance] on this, and monitor this to see how the dishwasher is cleaning the glasses." The 02/25/13 Monthly Resident Meeting Minutes stated "One of the residents commented that they still feel that there are still times when the cups are still dirty. [name of director of food services] has done a QA on this and we continue to see some coffee cups that are still stained or even looked stained, They are able to clean them with a napkin according to a resident that brought it up. [name of director of food services] commented that they are looking at ordering extra cups so that they can alternate and allow the cups to soak overnight. She is hopeful that this will solve the problem." - During an interview on the afternoon of 08/26/13, Resident B stated she often observed	F 244	dietary manager and nursing management staff to discuss meal service in the neighborhood dining rooms. Restorative and activity aides (CNA's) will assist in the dining rooms at mealtimes. 4. Resident council meeting minutes will be reviewed at the Quality Assessment committee meetings monthly. Resident grievances will continue to be a part of the QA Committee agenda at least monthly. All written concerns are reviewed. Resident interviews (all interviewable residents) will be conducted during the month of October. Questions will include satisfaction with meal service, cleanliness of dishes, and any other concerns noted. The interviews will be conducted quarterly for the next year. Results of the interviews will be reported to the QA committee. All monthly department meeting will include QA monitoring being done for that specific department. All staff meetings will be held monthly with QA monitor reports as part of the agenda at each meeting. 5. 10/14/13	

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F 244	Continued From page 7 lipstick marks, cocoa residue, and black specks on clean dishes and brought it to the facility's attention, but continues to find unclean dishes. Observation on 08/27/13 at 8:10 a.m. identified black specks and coffee stains inside of Resident B's "clean" and empty coffee mug, not yet used for breakfast. - Review of the facility policy titled "Meal Times" occurred on 08/26/13. This policy, dated August 2013, stated, "Meals will be served in a timely manner that will meet established federal, state and local government guidelines. Procedure: 1. Meals will be served at the following locations at specified times: . . . b. . . . Legacy, and Wheatland i. Breakfast: 7:30 a.m. - 9:00 a.m. ii. Dinner: 11:30 a.m. -1:00 p.m. iii. Supper: 5:30 p.m. - 6:30 p.m. c. Harmony i . Breakfast: 7:50 a.m. - 9:00 a.m. ii. Dinner: 11:50 - 1:00 p.m. iii. Supper: 5:50 p.m. - 6:50 p.m. . . ." Observation of the noon meal on 08/27/13 in the Wheatland dining room identified staff in the process of meal service at 11:40 a.m. Staff served the last resident (Resident #33), present in the dining room since at least 11:40 a.m., at 12:30 p.m. (one hour past the scheduled start time of 11:30 a.m.). Observations in the Harmony dining room revealed the following: - On 08/27/13 at 8:26 a.m., Resident A received breakfast after a wait of 40 minutes. At 8:36 a.m., Resident #27 received breakfast after a wait of 30 minutes.	F 244		

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F 244	Continued From page 8 - At 12:20 p.m., Resident #27 received dinner after a wait of 27 minutes. At 12:24 p.m., Resident A received dinner after a wait of 32 minutes. - On 08/28/13 at 8:16 a.m., Resident #29 received breakfast after a wait of 26 minutes. At 8:24 a.m., Resident A received breakfast after a wait of 24 minutes. At 8:30 a.m., Resident #10 received breakfast after a wait of 29 minutes. - During an interview with Resident A on 08/27/13 at 5:06 p.m., the resident states it takes a long time for food service in the dining room. She usually waits about a half hour. - Observation of meal service in the Legacy Dining Room on 08/27/13 identified the following: *At 11:45 a.m. showed Resident #11 already present and seated at a table waiting for staff members to serve/deliver her meal. Observation showed Resident #11 received her meal at 12:10 p.m. (after waiting at least 25 minutes). *Dinner - last meal served at 12:20 p.m. (50 minutes after scheduled start of meal service) *Supper - first meal served at 5:50 p.m. (20 minutes after scheduled start of meal service) During interview on the morning of 08/29/13, an administrative dietary staff member (#8) stated she expected residents to receive their food within 15-20 minutes after staff collect and return the resident's meal ticket to the kitchen.	F 244		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with	F 248		

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F 248	Continued From page 9 the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to develop and implement an individualized activity program for 3 of 5 sampled residents (Resident #3, #11, and #18) dependent on staff for activities who reside on the Wheatland Unit. Failure to implement an individualized activity program to respond to the interests and current capabilities of the residents has the potential to affect their physical, cognitive, and emotional health. Findings include: The Activities Calendar for the week of survey identified the following: *August 26th - Monday - 9:30 a.m. Helping Hands, 10:30 a.m. Baking, 2:15 p.m. Coffee Hour, 3:00 p.m. Bingo, 6:45 p.m. 31 card game, 7:45 p.m. Coffee Hour *August 27th - Tuesday - 9:30 a.m. Helping Hands, 10:00 a.m. Communion, 11:00 a.m. Bible Trivia, 1:00 Spend time on patio, 2:15 p.m. Coffee Hour, 4:00 p.m. Devotions, 6:45 p.m. 6-5-4, 7:30 p.m. Coffee Hour *August 28th - Wednesday - 9:30 a.m. Helping Hands, 10:00 a.m. Gospel Sing-A-Long, 2:15 p.m. Coffee Hour, 3:30 p.m. Craft, 6:45 p.m. Yahtzee, 7:00 p.m. Bible Study, 7:30 p.m. Coffee Hour *August 29th - Thursday - 9:30 a.m. Helping Hands, 10:00 a.m. Mass, 10:30 a.m. Sharing Stories, 11:00 a.m. Bible Study, 1:00 p.m. Walk	F 248	F 248 1. Resident 3, resident 11, resident 18 activity care plans have been reviewed and updated as needed. Staff member attending to activities on Wheatland Neighborhood was re-educated on appropriate resident activity involvement. 2. All residents have the potential to be affected. 3. Resident participation in any activity/activity program is documented on the activity log. The activity record also notes whether or not the resident is an active or passive participant. A department meeting was conducted on 09/26/13 by the activity director and activity staff were re-educated on documentation on the activity log. The activity department supervisor met with the activity aides on 10/01/13. The activity aides are to have the resident activity performance list with them when out on the neighborhoods, providing activities for the residents. The activity director will maintain an activity list for all residents in the facility.	

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F 248	Continued From page 10 and wheelchair rides outside, 2:15 p.m. Coffee Hour, 4:00 p.m. Devotions, 7:00 p.m. Bingo, 7:45 p.m. Coffee Hour - Observations during the week of survey showed staff failed to provide meaningful, individualized activities on a consistent basis for Resident #3, #11, and #18. Observations at various times of the day showed between 10-15 residents seated in the TV area/lounge and surrounding the adjacent nurse's station on the Wheatland neighborhood, who were not actively engaged in any type of activity. - Review of Resident #11's medical record occurred on August 27-29, 2013. Medical diagnoses for Resident #11 include Alzheimer's disease, dementia without behavioral disturbances, depressive disorder, and seizures. Resident #11's current quarterly Minimum Data Set (MDS), dated 05/17/13, identified short and long term memory impairment, severely impaired daily decision making capability, moderate depression, and total assistance with transfers and locomotion on/off the unit. The admission MDS, dated 01/13/13, identified books, music, and religious activities were important to the resident. Resident #11's current activity care plan, dated 05/20/13, stated: "I will need to be offered and assisted to activities that give me comfort. I am mainly passive. My awake time varies from day to day, and at times I do not respond to staff . . . Goal of: I will passively watch my surroundings and be offered 1 to 1 visits such as holding my hand and hand massages 4 times a week . . . Interventions of: 1	F 248	The activity director will meet with all nursing staff 10/08, 10/09 and 10/10 to review activity participation documentation. Nursing staff will take credit for one to one visits, music therapy, etc. provided by the nursing staff. 4. Monitoring of the activity participation records (activity logs) will be done by the activity director or designee. Monitoring will include identifying the specific activity and whether the resident is an active or passive participant. Results of the monitors will be reported to the QA committee monthly times 3 months then quarterly thereafter. The monthly activity calendar is posted on all neighborhoods. The weekly walk-through by department supervisor (or designee) will be revised to include noting residents involved in activities in lounge areas, etc. 5. 10/14/13	

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	355070	A. BUILDING _____ B. WING _____	C 08/29/2013

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F 248	Continued From page 11 to 1 visits 4 times a week . . . Devotions 1 time a week in the lounge. I am out in the lounge around others 4 times a week. I watch my surrounds [sic] 4 times a week. Monitor for pain and report to the charge nurse. Music activity 3 times a week. TV in the lounge 3 times a week. " The June 2013 Activity Log identified Resident #11 attended activities on 10 of 30 days in June. This log identified facility staff failed to provide any type of scheduled activity on 20 separate days for Resident #11. Facility staff provided four separate "small group/individual" activities for Resident #11 during one week in June (June 02-08). The July 2013 Activity Log identified Resident #11 attended activities on 11 of 31 days in July. This log identified facility staff failed to provide any type of scheduled activity on 20 separate days for Resident #11. Facility staff provided four separate "small group/individual" activities for Resident #11 during one week in July (July 07-13). The August 2013 Activity Log identified Resident #11 attended 12 activities from August 01-26. During the days of the survey (August 26-29) this log identified facility staff failed to provide activities for Resident #11. During an interview on 08/29/13 at 9:20 a.m., an activity staff member (#32) stated she reads to Resident #11 and visits with her, but some days the resident doesn't want to be bothered. - Review of Resident #3's medical record occurred on August 27-29, 2013 and diagnoses included Alzheimer's dementia and depression. The quarterly MDS, dated 06/28/13, identified the	F 248		

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F 248	Continued From page 12 resident with severely impaired cognition, physical and verbal behaviors, and extensive assistance for transfers and locomotion. The annual MDS, dated 12/27/12, identified the resident enjoyed music, news, religion, and her favorite activities. The current care plan stated, "Focus: I need 1 to 1 interventions to help build trust and rapport and support leisure and social participation for short periods of time. I am more comfortable in the lounge and spend much of my day there . . . Interventions: 1 to 1 social visits 3 times a week, (farm, family) comb my hair and hand massages. Devotions in the lounge. Encourage with a variety of different phasings of invitations. Kid Therapy . . . Music Activity 3 times a week/Tape music, music video, live music. TV I watch as I choose. Watch others in the lounge. . . ." Review of activity participation logs for June-August 28, 2013 showed the following: *June 2013: participation in "social hour" 10 times, "small group/individual" 10 times, "group therapy" once, and "competitive game" once. The facility provided the resident with activities a total of 14 out of 30 days. *July 2013: participation in "social hour" 11 times, "small group/individual" 10 times, "competitive games" twice, "group therapy" once, and "special events" once. The facility provided the resident with activities a total of 13 out of 31 days. *August 2013: participation in "social hour" 13 times, "small group/individual" 12 times, and "musical activities" twice. The facility provided the resident with activities a total of 13 out of 28 days. The facility's activity participation logs failed to identify the specific activity performed and if the	F 248		

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F 248	Continued From page 13 resident was an active or passive participant in the activity. Observations during the survey showed Resident #3 either in her wheelchair or recliner in the TV area/lounge and not actively participating in any activities. During an interview on 08/29/13 at 9:20 a.m., an activity staff member (#32) stated she attempts to provide activities to Resident #3, but stated she sleeps most of the day and likes to be left alone. - Review of Resident #18's medical record occurred on August 28-29, 2013 and diagnoses included Alzheimer's disease, depression, and anxiety. The quarterly MDS, dated 06/13/13, identified the resident with severely impaired cognition and extensive assistance for transfers. The significant change MDS, dated 03/13/13, identified the resident enjoyed music, religion, and her favorite activities. The current care plan stated, "Focus: I need 1 to 1 Visits and someone to sit with me. I repeat questions often . . . Interventions: 1 to 1 Visits 5 times a week; sit with me, offer me wheelchair rides, visit. Beauty Shop 1 time a week. Coffee Hour 5 times a week, Donuts, Popcorn. I am out in the lounge around others most days. Mass 1 time a week . . . Music in lounge. Visitors PRN [as needed] . . . Focus: I am/have potential to demonstrate verbally and physically abusive behavior r/t [related to] Dementia. I will hit or reach out to others. Occasionally I am weepy. At times will bang silverware on the table or throw it on the floor . . . Interventions: . . . Attempt to distract with food, drink, activity. Doll therapy. Give her baby doll to hold . . . Spend one-to-one	F 248		

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F 248	Continued From page 14 time with her or have her sit near staff in lounge or nurse station . . . Wheelchair rides three times daily. . . ." Review of activity participation logs for June-August 28, 2013 showed the following: *June 2013: participation in "social hour" eight times, "small group/individual" nine times, and "musical activities" once. The facility provided the resident with activities a total of 10 out of 30 days. *July 2013: participation in "social hour" 11 times, "small group/individual" eight times, and "special events" once. The facility provided the resident with activities a total of 11 out of 31 days. *August 2013: participation in "social hour" 10 times, "small group/individual" nine times, "group therapy" twice, "competitive games" once, "musical activities" three times, and "special events" once. The facility provided the resident with activities a total of 12 out of 28 days. The facility's activity participation logs failed to identify the specific activity performed and if the resident was an active or passive participant in the activity. Observations during the survey showed Resident #18 sitting in her wheelchair by the TV area/lounge or nurse's station. Observation showed the resident crying, sleeping, or reaching out to staff, visitors, and other residents. Failure to provide any activities to the resident, which may have resulted in increased behaviors. During an interview on 08/29/13 at 9:20 a.m., an activity staff member (#32) stated Resident #18 was "always aggravated," sleeps most of the morning, and self-propels after lunch. The staff member (#32) stated she "painted" Resident	F 248		

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F 248	Continued From page 15 #18's fingernails, holds her hand, and gives her wheelchair rides.	F 248		
F 253 SS=B	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed provide the housekeeping and maintenance services necessary to maintain a sanitary interior regarding soiled personal fans and bathroom vents on 3 of 5 resident care units (Horizon Towers, Wheatland, and Legacy), in the facility Laundry, and in the Rehabilitation Department for 1 of 4 days of survey (08/28/13). Failure to keep the fans and vents free from accumulated dust and debris and failure to maintain a cleaning schedule placed facility residents at risk of exposure to dust and debris in the environment, on linens, and on resident's personal clothing. Findings include: Observation during the facility environmental tour, on 08/28/13 at 2:30 p.m., identified the following in the Resident Care Units and facility departments: *Fans with accumulated lint and debris - Legacy - Dining Room - one fan, Resident Laundry - two fans Wheatland - Nurse's Station - one fan, Resident Laundry - two fans	F 253	F 253 1. Fans in Legacy dining room, Legacy resident laundry, Wheatland nurse's station, Wheatland resident laundry, Horizon Tower fourth floor lounge and hall, Horizon Tower second floor lounge, Horizon Tower tub room, Main laundry and Rehabilitation department have been cleaned. The bathroom vent in the Rehabilitation Department has been cleaned. 2. No residents were identified in this deficiency. 3. A cleaning schedule will be set up by the housekeeping supervisor and maintenance supervisor to assure all fans and vents are checked and cleaned at least monthly or as needed. A written policy and procedure with a cleaning checklist will be included in the housekeeping and maintenance department manuals. 4. The housekeeping supervisor or designee will monitor compliance monthly times three months and quarterly thereafter.	

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F 253	Continued From page 16 Horizon Towers - Fourth Floor Lounge - one fan, Hall - one fan - Second Floor Lounge - one fan, Tub Room - one fan Main Laundry - Fan in the dirty work room Rehabilitation Department - two fans *Bathroom vent - Rehabilitation Department - heavy accumulation of dust and debris. A maintenance management staff member (#14), present during the tour, confirmed the heavy accumulations of dust and debris on the fans and bathroom vent. This staff member reported the facility did not have a cleaning schedule for the fans and vents.	F 253	Results of the monitoring will be reported to the QA committee monthly times 3 months then quarterly thereafter. 5. 10/14/13	
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 observation, record review, review of professional reference, and staff interview, the facility failed to ensure 3 of 16 sampled residents dependent on staff for oral cares (Resident #2, #4, and #21) received the necessary care and services to maintain good oral hygiene. Failure to provide dependent residents with oral cares placed the residents at risk of oral infections, reduced appetite, and respiratory diseases.	F 312	F 312 1. Staff caring for resident 2, resident 4 and resident 21 were re-educated on the need for proper oral care for all residents. Performance correction for all staff involved will be completed by the nurse manager and/or director of nursing. The family of resident 4 has requested oral cares not be done and this will be care planned with alternatives for oral cares. 2. Any resident has the potential to be affected.	

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F 312	Continued From page 17 Findings include: Berman and Snyder, "Kozier & Erb's Fundamentals of Nursing: concepts, process, and practice", 9th edition, Pearson, Boston, page 774, states ". . . Certain clients are prone to oral problem because of an inability to maintain oral hygiene. Among these are clients who are seriously ill, confused, comatose, depressed, or dehydrated. . . . Mouth care should be performed every 2 hours on these clients. . . . people with nasogastric tubes or who are receiving oxygen are likely to develop dry oral mucous membranes, especially if they breathe through their mouths. . . ." - Review of Resident #4's medical record occurred on August 27-29, 2013. The facility admitted the resident in June 2010. Current diagnoses included paralysis agitans, hypoxemia, and cachexia. The significant change Minimum Data Set (MDS), dated 05/31/13, identified moderately impaired daily decision making and required total assistance of two or more persons for personal hygiene. Resident #4 received bolus gastrostomy tube feedings eight times each day, nothing by mouth (NPO), and continuous oxygen by nasal cannula at two liters per minute. Resident #4's Nutrition Care Area Assessment, dated 06/11/13, identified he was at risk of dry mouth and increased oral bacteria due to being NPO. The resident's care plan identified he was totally dependent on facility staff for personal cares and failed to include approaches for oral cares and secretions. Observation on 08/27/13 at 7:40 a.m. identified two certified nursing assistants (CNAs) (#2) and	F 312	3. Mandatory education on proper oral cares for all nursing staff was 10/09/13 and 10.10/13. The policy and procedure for oral care, including oral care for the resident with a gastrostomy tube, will be reviewed and revised as needed. Documentation of oral cares is included in the facility electronic medical record task manager program. 4. Monitoring of oral cares will/has been done by the nurse manager, house supervisor or designee. Monitoring will be done weekly for four weeks then monthly for eleven months. Results of the monitoring will be reported to the QA committee by the director of nursing at least monthly. 5. 10/14/13	

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F 312	Continued From page 18	F 312		

(#3) completing morning cares for Resident #4. The staff members positioned the resident on his right side in bed with oxygen and elevated the head of his bed approximately 60 degrees. During interview, CNA (#3) reported the staff members bathed, dressed, and provided oral cares with a "toothette" for Resident #4 before the observation.

Observations from 7:40 a.m. to 2:00 p.m. on 08/27/13 showed Resident #4 sleeping in bed, up in his chair, two CNAs (#2 and #3) transferring the resident to and from his bed and chair, and a licensed nurse (#4) providing feedings and medications via the gastrostomy tube. During these observations, Resident #4 demonstrated oral secretions and his mouth open as he slept. Facility staff wiped away the oral secretions and placed a cloth over his chest, but failed to provide oral cares. During interview, on 08/27/13 at 2:00 p.m., CNA (#3) reported the facility staff did not provide any additional oral cares for Resident #4 for the period from 7:40 a.m. to 2:00 p.m.

Observations from 2:10 p.m. to 5:00 p.m. showed CNAs (#5 and #6) transferring the resident to and from his bed and chair, and a licensed nurse (#4) providing feedings and medications via the gastrostomy tube. During these observations, Resident #4 demonstrated oral secretions and his mouth open. Facility staff wiped away the oral secretions and placed a cloth over his chest, but failed to provide oral cares.

Resident #4 is dependent on facility staff for all personal cares and receives nothing by mouth. Observation showed oral secretions and facility staff placed a cloth on his chest to hold the secretions. Observation from 7:40 a.m. to 5:00

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F 312	Continued From page 19 p.m. on 08/27/13 (9 hours, 20 minutes) showed facility staff failed to provide oral cares for Resident #4. During interview, on 08/29/13 at 7:55 a.m., a nursing management staff member (#7) stated her expectation is that facility staff would provide Resident #4 with oral cares on a more frequent basis. - Review of Resident #2's medical record occurred on all days of survey and identified diagnoses of Parkinson's and Alzheimer's disease. The current care plan stated, ". . . ORAL CARE: I have upper and lower dentures. I require oral inspection BID [twice daily] . . . Clean dentures and put back into mouth. . . ." The annual MDS, dated 08/10/13, identified the resident required extensive assistance from staff for personal hygiene. Observation of morning cares occurred on 08/27/13 at 9:10 a.m. Two CNAs (#26 and #27) washed Resident #2's body, applied lotion, provided perineal cares, dressed the resident, transferred him to the wheelchair, placed his glasses and cap, attempted to put his top dentures in his mouth (bottom dentures already in his mouth), which the resident declined, and then transported him to the dining room for breakfast. Observation of Resident #2's mouth showed a brown material on his lips, on his bottom teeth, and inside his mouth. The staff members failed to provide oral cares. During an interview on 08/29/13 at 8:15 a.m., an administrative nurse (#7) stated she expected staff to provide oral cares on Resident #2.	F 312		

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F 312	Continued From page 20 - Review of Resident #21's medical record occurred on 08/29/13. The quarterly Minimum Data Set (MDS), dated 07/08/13 identified the resident required extensive assistance from staff for personal hygiene. Observation of morning cares occurred on 08/29/13 at 7:50 a.m. Two CNAs (#21 and #22) gave Resident #21 a partial bed bath, provided perineal cares, dressed the resident, transferred her to the wheelchair, brushed her hair, and then transported her to breakfast. The staff members did not provide oral cares. When asked what they would be doing with Resident #21 after breakfast, the staff members stated they would bring her to the lounge, as she likes sit in that area with other residents after breakfast.	F 312		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to provide services to treat urinary tract infections (UTIs) for 1 of 11 sampled residents (Resident #8) with a history of UTIs.	F 315	F 315 1. Staff caring for resident 8 have been re-educated on the importance of timely follow up with lab results. 2. Any resident has the potential to be affected. 3. The infection control nurse hours have increased to provide more coverage and accessibility in monitoring and surveillance. The system currently in place for monitoring results of laboratory tests being received in a timely manner has been reviewed by nursing management staff.	

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F 315	Continued From page 21 Failure to provide prompt treatment of UTIs may result in unresolved pain and discomfort, increased behaviors, and unsteady gait/falls. Findings include: Review of Resident #8's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease and unspecified urinary incontinence. A fax to the physician, dated 07/08/13, stated, ". . . [physician name] started [Resident #8] on Levaquin [an antibiotic] 7-4-13 for UTI and orders U/C [urine culture]. Order was sent to lab [laboratory] for U/C but didn't receive. Would you like us to send urine in for U/C today or when she completes Levaquin? Has two days left." The physician responded to the fax: "No repeat. UA [with] culture if [continued] symptoms of UTI." Nurses' notes stated the following: *07/04/13 at 1:29 a.m.: ". . . UA [urinalysis] results back . . . orders received for Levaquin . . ." *07/04/13 at 2:26 p.m.: ". . . Needs much encouragement to eat and take fluids. Just wants to lie in bed. Complains of back pain. . . ." *07/05/13 at 9:29 a.m.: ". . . gait very unsteady. Pushing walker with arms stretched out so walker too far away from her. Difficult to make her understand proper way to use walker due to confusion. Refused breakfast, stated 'Leave me alone, I just want to die.' . . ." *07/05/13 at 2:35 p.m.: ". . . Has spent majority of day in bed. Taking very little food or fluids. Gait remains unsteady . . ." *07/05/13 at 11:29 p.m.: ". . . Became very agitated after bedtime, was given Ativan [an anxiolytic] . . ."	F 315	An excel spreadsheet system will be used to record the laboratory tests ordered and date when results of the test were received by the facility. 4. Monitoring of laboratory testing and results of cultures/sensitivities will continue to be done by the infection control nurse. Results of the monitoring are reported to the director of nursing. The infection control nurse and/or director of nursing will report results to the QA committee monthly. 5. 10/14/13	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355070	A. BUILDING _____ B. WING _____	C 08/29/2013

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F 315	Continued From page 22 *07/08/13 at 2:07 p.m.: ". . . Has spent majority of shift in bed. Came willingly to dining room with staff but refused to eat anything. . . ." *07/09/13 at 9:23 a.m.: ". . . Very restless and agitated this a.m. Stated she wanted something to eat but refused to eat when cereal brought to her. In and out of room saying she wanted to lie down. PRN [as needed] Ativan given at [7:25 a.m.] . . ." *07/10/13 at 2:04 p.m.: ". . . Resident did not want to get out of bed today. . . ." *07/11/13 at 4:28 p.m.: ". . . resident has refused to eat breakfast and dinner . . . resident became agitated and combative when trying to take V/S [vital signs] . . ." *07/12/13 at 1:30 p.m.: ". . . UA obtained by straight cath [catheterization]. . . ." *07/12/13 at 9:53 p.m.: ". . . Ate only 25% for meal. . . . Has been very sleepy and only wants to stay in bed. . . ." *07/13/13 at 2:32 p.m.: ". . . Out of bed for meals only. . . ." *07/14/13 at 4:07 p.m.: ". . . In and out of bed several times this afternoon. Refused to come out to dining room. . . ." *07/17/13 at 10:57 a.m.: ". . . Resident was not wanting to get out of bed today . . ." *07/17/13 at 5:01 p.m.: ". . . Resident was found in the bathroom on the floor. . . . no injuries or pain at this time . . ." A final laboratory report, dated 07/14/13, identified Resident #8's urine was positive for Escherichia coli (i.e. E. coli, a bacteria commonly found in the gastrointestinal tract). The report also identified E. coli as resistant to the antibiotic Levaquin (prescribed on 07/04/13). Staff faxed the lab report to the physician on 07/15/13. A physician's order, dated 07/17/13, identified the	F 315		

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F 315	Continued From page 23 initiation of Augmentin (an antibiotic) to treat Resident #8's UTI (three days after the facility received the final culture report). During an interview on 08/29/13 at 8:45 a.m., an infection control nurse (#25) stated the lab faxes a copy of the culture report to the facility and also to the physician. The nurse (#25) was unsure why the physician did not initiate antibiotics sooner and agreed facility staff should follow up with laboratory reports. Failure to obtain a urine culture as ordered may have resulted in Resident #8 receiving an inappropriate antibiotic and delayed treatment of the UTI. Failure to ensure prompt treatment after receiving the final results of the urine culture on 07/14/13 further delayed treatment of Resident #8's UTI and may have resulted in unnecessary discomfort, behaviors, lack of appetite, and an unsteady gait which may have contribued to a fall.	F 315		
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. This REQUIREMENT is not met as evidenced by: 1. Based on observation, record review, review of professional preference, review of facility policy and procedure, and staff interview, the facility	F 323	F Tag 323A: 1. Certified Nursing Assistant's attending to Resident's #2, #3, #13, #9, and # 14 were re-educated on the use of the gait belt. Activity staff member attending to Resident #9 was re-educated to not propel any resident seated on the four wheeled walker. Resident #8 care plan was adjusted to reflect that foot rest of recliner is not to be placed in the up position. All care providers in the neighborhood were informed of the change in resident's care plan.	

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F 323	Continued From page 24 failed to provide adequate supervision and assistive devices necessary to prevent accidents for 8 of 17 sampled residents (Resident #2, #3, #6, #8, #9, #10, #13, and #14) who required assistance with transfers or positioning. Failure to use gait belts, or use them properly during transfers (Resident #2, #3, #9, #13, and #14); failure to properly use a mechanical lift (Resident #10); failure to ensure safe seating position (Resident #8); and failure to use a four wheeled walker as indicated (Resident #6) placed the residents at risk of accidents and injury and resulted in an episode of arm pain for Resident #13. Findings include: Review of the facility policy titled "Transfer/Gait Belts, Use of" occurred on 08/29/13. This policy, dated December 2012, stated, "PURPOSE: Ensure safety for residents and staff. PROCEDURE: 1. Criteria for Use: 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 belt with special care instructions (Ostomy, G-tube, etc.) 2. Guidelines 2.1 . . . Certified nursing assistants and licensed nursing staff shall carry/wear a transfer/gait belt at all times. . . . 2.3 Licensed nursing staff will observe for appropriate use of transfer/gait belts. Inappropriate gait use or failure to use the belt shall be promptly reported to the supervisor. . . . 3. Application of Gait Belt 3.1 Place gait belt snugly around resident's waist, beneath ribs, above pelvic bones. 3.2 Secure belt by going	F 323	Resident #10 was assessed on 08/30/2013 by the Consulting Physical Therapist and plan of care was adjusted for the Resident to be transferred with the full assist lift. Certified Nursing Assistant's attending to Resident #10 were educated on the change of care plan. Care plans and Certified Nursing Assistant Group sheets were up dated to reflect present care. Residents in the facility who utilized the partial assist lifts were reassessed for appropriate transfer. 2. Any Resident who requires assistance with transfers has the potential to be affected. 3. Staff were educated on September 4th and 5th, 2013 in regards to proper usage of the gait belt, use of the partial assist lift, transfer decision tree, adjustment of resident care plan, and that residents are not to be propelled while seated on the four wheel walker. Staff will be re-educated on October 8th, 9th, and 10th, 2013.	

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F 323	Continued From page 25 through complete buckle . . . 3.3 When resident is up in chair assure after standing gait belt is adjusted to fit snugly." - Review of Resident #13's medical record occurred on all days of survey. Medical diagnoses included lumbago, scoliosis, osteoarthrosis, and history of hip and knee joint replacement. Resident #13's quarterly Minimum Data Set (MDS), dated 05/04/13, identified she required limited assist of one person for transfers and walking. Resident #13's current care plan identified the following: "I have chronic pain r/t Arthritis in my shoulder and lower back. . . . Interventions: . . . Monitor/Document for probable cause of each pain episode. Remove/limit causes where possible. . . . My pain is aggravated by: an increase in movement. . . . I have had an actual fall that resulted in hematoma on back. This fall is r/t Unsteady gait, Poor balance. . . . I am High risk for falls r/t Unaware of safety needs, Deconditioning, Gait/balance problems. . . ." Observations on 08/27/13 at 8:30 a.m. and 11:10 a.m. showed a certified nursing assistant (CNA #18) assisted Resident #13 to transfer from her bed to a bedside commode and then back to the bed again with a front wheeled walker (FWW). Observation showed Resident #13 with an unsteady gait. The CNA failed to apply and utilize a gait belt during the transfers. Observation on 08/28/13 at 8:45 a.m. showed a CNA (#18) assisted Resident #13 to transfer from her bed to a bedside commode with a FWW. After the resident finished toileting, the CNA (#18) lifted under Resident #13's arm to assist her to a	F 323	On October 1st, 2nd, and 3rd, 2013 Consulting Occupational Therapist will provide education on the use/application of the gait belt and transfers. Policy and Procedures (Transfer Decision Tree, Transfers, and use of gait belts) were reviewed by DON and Consulting Physical and Occupational Therapists. 4. The nurse managers and house supervisors (or designee) will monitor gait belt usage, appropriateness of partial lift, safe seating, and assuring staff are not propelling residents seated in the four wheeled walker. This will be monitored weekly and reported to the QA Committee monthly for three months, then quarterly for three quarters. The DON will report the results of the monitoring to the QA committee monthly for two months, then quarterly thereafter. 5. October 14, 2013.	

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F 323	Continued From page 26	F 323		

standing position. Resident #13 stated "ow, I still have that sore arm" and sat back down on the commode. Resident #13 stood up again using the FWW and the CNA again lifted under the resident's arm to assist her to a standing position. The CNA failed to apply and utilize a gait belt during the transfer. Lifting under Resident #13's arm instead of using a gait belt resulted in the resident experiencing pain during the transfer.

- Review of Resident #14's medical record occurred on all days of survey. Medical diagnoses included hemiplegia due to cerebrovascular disease, lack of coordination, generalized muscle weakness, history of falls, and abnormality of gait. Resident #14's most recent significant change MDS, dated 07/08/13, identified the resident required extensive assistance for transfers.

Resident #14's current care plan for physical mobility, dated 07/19/13, identified the following: "I have limited physical mobility r/t [related to] unsteady gait, Parkinson's tremor, glaucoma, cataract, CVA [cerebral vascular accident] . . . Interventions: . . . I transfer with FWW [front wheeled walker], 1 assist with gait belt. At times I do refuse the gait belt and the assistance. . . ."

Observations on 08/27/13 at 9:05 a.m. and 11:20 a.m. and on 08/28/13 at 9:00 a.m. showed a CNA (#18) assisted Resident #14 with transfers and ambulation from her wheelchair to the bathroom and then back to the wheelchair, both with a FWW. Observations showed Resident #14 with an unsteady gait. The CNA (#18) failed to apply and utilize a gait belt during the transfers.

- Review of Resident #3's medical record occurred on all days of survey and included

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F 323	Continued From page 27 diagnoses of Alzheimer's dementia. The current care plan stated, ". . . MOBILITY: I require 1 staff participation, FWW [front-wheeled walker] and gait belt for mobility. . . ." Observation on 08/27/13 at 3:00 p.m. identified two CNAs (#29 and #31) pivoted Resident #3 to the toilet using a gait belt. When standing the resident to transfer her from her wheelchair to the toilet and back to her wheelchair, a CNA (#29) held on to the gait belt with one hand and lifted under the resident's arm with her other hand. - Review of Resident #2's medical record occurred on all days of survey and included diagnoses of Parkinson's and Alzheimer's disease. The current care plan stated, "Focus: I have limited physical mobility . . . I am at risk for falls. I am unsteady and refuse help at times for ambulating . . . Transfer: I require 1-2 staff participation with transfers. . . ." Observation on 08/27/13 at 3:20 p.m. showed two CNAs (#28 and #29) transferred Resident #2 from bed to his wheelchair using a gait belt. Both CNAs (#28 and #29) held on to the gait belt with one hand and lifted under the resident's arms with their other hand. Observation on 08/28/13 at 5:40 p.m. showed two CNAs (#26 and #30) failed to use a gait belt when transferring Resident #2 from a recliner to his wheelchair. They lifted under the resident's arms during the transfer. During an interview on 08/29/13 at 8:15 a.m., an administrative nurse (#7) stated staff should avoid lifting/pulling on residents' arms during transfers.	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 323	Continued From page 28 - Review of Resident #9's medical record occurred on all days of survey. Diagnoses included dementia without behavioral disturbance, adult failure to thrive, and macular degeneration. Resident #9's care plan, revised 06/17/13, stated, ". . . I have limited physical mobility r/t [related to] disease process. I am totally dependent on staff for ambulation/locomotion. AMBULATION: I require two assist with gait belt as desired/as tolerated. " Observation on 08/27/13 at 5:32 p.m. showed two CNAs (#9 and #12) assisted Resident #9 to transfer from her bed to her wheelchair, from her wheelchair to the toilet, and from the toilet to her wheelchair. The CNAs performed the transfers without the use of a gait belt. - Review of Resident #6's medical record occurred on all days of survey. Current diagnoses included recent stroke and dementia. The resident's annual MDS, dated 07/01/13, identified he required limited assistance of one person for locomotion on and off the unit. Observation on 08/27/13 at 10:55 a.m., showed Resident #6 seated on the seat of his four wheeled walker near the Legacy nurse's station. An activities staff member (#1) approached the resident to inquire if he would attend the morning's activity. Resident #6 responded he was sitting due to fatigue from ambulating. The staff member (#1) stated she would push him to the activity on the seat of his four wheeled walker. Resident #6 sat on the seat while the staff member (#1) pushed the resident backward as	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 323	Continued From page 29	F 323		

the resident held his feet off the floor. The transport occurred from the Legacy nurse's station to the Activities department, approximately 500 feet.

The brand of four wheeled walker used by Resident #6 is unknown. Invacare is a representative brand. The internet website, invacare.com, reviewed on 08/29/13, included the operating instructions for the Model 67100. These instructions, dated 2010, stated ". . . DO NOT use the Rollator as a wheelchair or transport device. The Rollator is NOT intended for propelling while seated. . . ."

- Review of Resident #8's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease and a history of falls, one of which resulted in a nasal fracture.

A fax to the physician, dated 08/16/13, stated, ". . . Trying to get out of recliner when foot rest was up. She was sliding out as recliner was tipping. Ended up on hands [and] knees on floor. No apparent injury. . . ."

Observation on 08/27/13 at 10:46 a.m. showed Resident #8 seated in a recliner with the foot rest up in the living room area. Observation showed Resident #8 swung her legs over the side of the foot rest and attempted to stand. The chair alarm sounded; however, observation showed no staff present in the living room or dining room areas. At 10:49 a.m., a CNA (#17) entered the living room area and stated, "[Resident #8] is trying to get up!" The CNA then assisted Resident #8 to stand and ambulate to the dining room.

During an interview on 08/29/13 at 9:04 a.m., a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355070	A. BUILDING _____ B. WING _____	C 08/29/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 323	Continued From page 30 supervisory nurse (#16) agreed staff should not leave Resident #8 unattended in the recliner with the foot rest up. - Review of Resident #10's medical record occurred on all days of survey. Diagnoses included falls with major injury, cerebral atherosclerosis, and profound intellectual disabilities. Resident #10's annual MDS, dated 07/31/13, identified she required physical assistance of two or more persons for transfers. Resident #10's care plan, revised 03/15/13, stated, ". . . TRANSFER: I require partial assist lift for toileting, hoyer for all other transfers." Observation on 08/27/13 at 3:50 p.m. showed two CNAs (#9 and #10) assisted Resident #10 to transfer from the toilet to her wheelchair using a mechanical sit to stand lift. While the resident was suspended in the lift, a CNA (#9) rolled the lift toward the resident's wheelchair. Resident #10 did not securely hold onto the handles of the lift and did not bear weight as she was suspended in the the lift. A CNA (#10) positioned the wheelchair toward the mechanical lift, tipped the wheelchair forward with the two rear wheels of the wheelchair off of the floor to position the wheelchair under the resident, and then lowered the resident into the wheelchair. During an interview on the morning of 08/29/13, an administrative nurse (#16) confirmed staff should use a gait belt for transfers with Resident #9 and the transfer of Resident #10 in the sit to stand lift placed the resident at risk of a fall. 2. Based on hot water temperatures, record review, and staff interview, the facility failed to	F 323		

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	355070	A. BUILDING _____ B. WING _____	C 08/29/2013

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F 323	Continued From page 31 ensure the resident environment remained as free of accident hazards as possible regarding water temperatures greater than 120 degrees Farenheit (F) for 2 of 5 resident care units (Pine View and Harmony) on 1 of 4 days (08/28/13) of survey. Water temperatures greater than 120 degrees F may cause third degree burns. Failure to monitor hot water temperatures placed all residents at risk of exposure to water temperatures high enough to cause third degree burns. Findings include: During observation of resident cares on the morning of 08/27/13 on the Pine View Resident Care Unit a certified nursing assistant (CNA) (#1) reported the water from the bathroom sink was very hot. On 08/28/13 at 8:45 a.m., random hot water temperatures in resident bathrooms on all resident care units showed the following units greater than 120 degrees F: *Harmony, Room 11 - 123 degrees F *Pine View, Room 4 - 127.5 degrees F On 08/28/13 at 9:30 a.m., repeat random hot water temperatures in resident bathrooms on all resident care units showed the following temperatures greater than 120 degrees F, confirmed by a maintenance management staff member (#14): *Pine View, Room 4 - 126 degrees F *Pine View, Room 9 - 129.2 degrees F Immediately after taking the temperatures on the Pine View unit, the staff member (#14) lowered the temperature at the hot water heater supplying that unit.	F 323	F 323B Hot Water temperatures 1. Hot water temperatures in room 11, harmony Neighborhood and room 4 on Pineview Neighborhood have been adjusted to temperatures less than 120 degrees. 2. Any resident has the potential to be affected. 3. The maintenance supervisor or designee will monitor the hot water temperatures in resident rooms on a weekly basis for four weeks then monthly thereafter. A policy and procedure with a monitoring tool will be developed for use by the maintenance staff. 4. Results of the monitoring will be reported to the QA Committee monthly time three and quarterly thereafter. 5. 10/14/13.	

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F 323	Continued From page 32 On 08/28/13 the staff member (#14) provided temperatures as follows: - at 3:30 p.m., Pine View,Room 4- 99.9 degrees F - at 5:45 p.m., Pine View,Room 4- 100 degrees F Pine View,Room 9- 98 degrees F During interview, on 08/28/13 at 9:30 a.m., the staff member (#14) reported the facility had not monitored the hot water temperatures since September 2012 when this staff member began his position.	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, review of facility policy and procedure, review of professional reference, family interview, and staff interview, the facility failed to ensure residents are free of significant medication errors for 1 of 1 sampled resident receiving medications via gastrostomy tube (Resident #4). Failure to provide medications on a timely basis and failure to investigate the cause of the delayed medication pass placed the resident at risk of reduced therapeutic effect of the medications prescribed and placed all facility residents at risk of delayed medication pass. Findings include: "Nursing 2013 Drug Handbook," 33rd edition, Lippincott, Williams & Wilkins, Philadelphia,	F 333	F tag 333 1. Licensed Nursing member, who is an Agency Nurse, attending to Resident #4 is no longer working at the facility. 2. Any resident who requires medication has the potential to be affected. 3. Staff were educated on September 4th and 5th, 2013 in regards to time line for medication administration and when to report a medication discrepancy form. Mandatory Licensed Nursing meetings will be held on October 8th, 9th, and 10th to review medication administration, time line for medication administration,	

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	355070	A. BUILDING _____ B. WING _____	C 08/29/2013

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F 333	Continued From page 33 pages 811-813, identified Stalevo as an "Antiparkinsonian" medication and states "PATIENT TEACHING . . . Tell patient to report a "wearing off" effect, which may occur at the end of the dosing interval. . . .;" and, pages 901-903, identified Metoclopramide as an "antiemetic" to be given before meals to reduce nausea and vomiting. Review of the facility policy and procedure, "Medication Errors," occurred on 08/29/13. This document, dated August 2012, stated "Policy Statement, Medication errors and adverse drug reactions must be reported to the resident's attending physician. Policy Interpretation and Implementation . . . 2. A detailed account of the incident must be recorded on an incident report and filed with the Director of Nursing. Clinically relevant information about follow up of the resident should be recorded in the chart . . . 4. The attending physician and director of nursing services are informed of all medication errors." Review of Resident #4's medical record occurred on August 27-29, 2013. The facility admitted the resident in June 2010. Current diagnoses included paralysis agitans (Parkinson's disease) and cachexia. The resident receives all nutrition, fluids, and medications via gastrostomy tube and nothing by mouth. Current physician orders included the following: *Stalevo 50, 150 milligrams (mg), four times each day and at bedtime, ordered 02/11/13. *Metoclopramide HCL, 5 mg per 5 milliliter (ml), 5 ml, four times each day, ordered 02/09/13. *Nutren 1.5 formula (high calorie liquid nutrition), 200 ml bolus, eight times each day, ordered	F 333	reporting/reviewing of delay in medication administration, gastrostomy feeding, and implementing a plan of action if required. Policy and Procedure for medication administration was reviewed by DON and Consulting Pharmacist. The medication error form was reviewed by DON and Consulting Pharmacist. 4. DON (or designee) and Consulting Pharmacist will audit (through Point Click Care) "Physician order audit report for scheduled medications" on a weekly basis for 3 months, then quarterly for 3 quarters. The DON will report to the QA committee. DON (or designee) and Consulting Pharmacist will audit medication discrepancies on a weekly basis for 3 months, then quarterly for 3 quarters. The DON will report results of the monitoring to the QA committee meeting monthly for two months, then quarterly thereafter. 5. October 14, 2013.	

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F 333	Continued From page 34 05/19/13. Resident #4's Medication Administration Record (MAR) for the physician orders previously identified, showed scheduled administration times as follows: *Stalevo 50 - 1:00 a.m., 4:00 a.m., 10:00 a.m., 4:00 p.m., and 9:00 p.m. *Metoclopramide HCL - 3:00 a.m., 9:00 a.m., 2:00 p.m., and 6:15 p.m. *Nutren 1.5 formula - 1:00 a.m., 4:00 a.m., 7:00 a.m., 10:00 a.m., 1:00 p.m., 4:00 p.m., 7:00 p.m., and 10:00 p.m. Resident #4's Nursing Progress Notes, dated 07/02/13 at 2:24 a.m., stated "Resident's family extremely upset with cares this night. Resident's medications were two hours late d/t [due to] full stomach with first attempt and feedings as well as extended med [medication] pass for facility. . . . Family stated medications and tube feedings cannot be given together or this late and instructed to give medications and wait an hour to do late tube feeding. Per family only 150 ml given with late tube feed. . . . Family was upset that this seems to happen frequently. . . ." Resident #4's Physician Orders Audit Report for the scheduled medications between 6:15 p.m. on July 01, 2013 to 4:00 a.m. on July 02, 2013 showed the following: *Metoclopramide HCL - 07/01/13, scheduled at 6:15 p.m., administered at 11:19 p.m. - more than five hours late and more than four hours after the 7:00 p.m. gastrostomy feeding. *Stalevo 50 - 07/01/13, scheduled at 9:00 p.m., administered at 11:18 p.m., more than two hours late. *Nutren 1.5 formula - 07/01/13, scheduled at	F 333		

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F 333	Continued From page 35 10:00 p.m., administered at 11:56 p.m., approximately two hours late. *Nutren 1.5 formula - 07/02/13, scheduled at 1:00 a.m., administered at 12:49 a.m., 200 ml. The Nursing Progress Notes identified Resident #4's family members requested and the facility staff administered 150 ml at this time. The Audit Report failed to identify the reduced amount of Nutren provided. During interview, on 08/28/13 at 5:20 p.m., Resident #4's Family Members A and B reported the medications and gastrostomy feedings for Resident #4 had been delayed for several hours on 07/01/13. Family Member A reported contacting the nurse on duty who was unfamiliar with the residents on the unit. After a second contact by Family Member A and insisting Resident #4 receive his medication and gastrostomy feeding, the nurse on duty did provide them. Family Member A reported the gastrostomy feedings had to be adjusted to reduce the risk of aspiration and expressed concern regarding the delay in receiving the Stalevo and effectiveness of the medication. Family Members A and B reported similar delays in medications and gastrostomy feedings have occurred, but this was the "worst." On 08/29/13 at 7:55 a.m., review of the delayed medication and gastrostomy feedings for Resident #4 on July 01-02, 2013 occurred with a nursing management staff member (#7). This staff member reported being aware of this episode. Additional information including an investigation or incident report regarding this episode was requested. Later in the morning, this staff member (#7) reported the facility had no additional information including an investigation or	F 333		

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F 333	Continued From page 36 incident report regarding this episode. Resident #4's physician orders included gastrostomy tube feedings every three hours, Metoclopramide HCL to reduce nausea and vomiting, and Stalevo for Parkinson's disease with precaution regarding potential "wearing off" at the end of the dosing interval. The facility staff delayed the medication pass by more than five hours and delayed the gastrostomy tube feeding on July 01-02, 2013 as documented in the Nurses Progress Notes and the MAR. These delays may have limited the therapeutic benefits of the medications and placed Resident #4 at risk of adverse effects. The Nurses Progress Notes and interviews with Family Members A and B indicate similar episodes have occurred before. The Nurses Progress Notes also identified an "extended med pass for facility." It is unknown what is meant by this statement or the nature of this "extended med pass." Failure to investigate and complete an incident report regarding the delays on July 01-02, 2013 and the "extended med pass" limited the facility's ability to determine the cause of the delay, track and trend similar medication pass delays, and placed all residents at risk of reduced medication effectiveness due to delayed medications and treatment.	F 333		
F 363 SS=E	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance;	F 363	F 363 1. There were no specific residents identified. Dietary staff serving meals on Wheatland, Legacy and Horizon Tower at any mealtime were re-educated on correct portion sizes.	

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F 363	Continued From page 37 and be followed. This REQUIREMENT is not met as evidenced by: Based on observation and review of daily menus, the facility failed to meet the nutritional needs of the residents by serving incorrect portion sizes during 4 of 4 observations of tray line (noon meal on the Wheatland and Legacy units on 08/27/13, evening meal on the Wheatland unit on 08/27/13, and evening meal on the Towers unit on 08/28/13). Failure to follow recommended portion sizes as outlined in the facility's menus may result in weight loss and inadequate nutritional intake. Findings include: Observation of tray line occurred on 08/27/13 at 11:40 a.m. in the Wheatland dining room. Observation showed the following inconsistencies between portion sizes listed on the facility's menus and the actual amount served to residents: *Barbecued shredded chicken served with a 3 ounce (oz) scoop (the menu identified 2 oz) *Potato salad served with a 2 oz scoop (the menu identified 4 oz) *Cucumber salad served with a 2 oz scoop (the menu identified 4 oz) *Pureed meatloaf served with a 4 oz scoop (the menu identified 6 oz) *Pureed barbecued chicken served with a 3 oz scoop (the menu identified 2/3 cup) Observation of tray line occurred on 08/27/13 at 11:57 a.m. in the Legacy dining room. Observation showed the following inconsistencies	F 363	2. Any resident has the potential to be affected. 3. The dietary manager has developed a new policy regarding scoops and spoodles. Cooks will make a list of all foods being served and the appropriate serving utensils needed for those foods for all portion sizes. Cooks will have the utensils and lists ready for each neighborhood. All dietary staff have been re-educated on the importance of portion control. 4. The director of food services or designee will monitor each neighborhood three times a week for one month then weekly to ensure neighborhood staff is using the utensils correctly. Results of the monitoring will be reported to the QA committee monthly times 3 months then quarterly times three months. 5. 10/14/13	

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F 363	Continued From page 38 between portion sizes listed on the facility's menus and the actual amount served to residents: *Mashed potatoes served with a 6 oz scoop (the menu identified 4 oz) *Mechanical soft meatloaf served with a 6 oz scoop (the menu identified 3 oz) *Pureed meatloaf served with a 4 oz scoop (the menu identified 6 oz) *Pureed chicken served with a 4 oz scoop (the menu identified 2/3 cup) *Cucumber salad served with a 3 oz scoop (the menu identified 4 oz) *Potato salad served with a 3 oz scoop (the menu identified 4 oz) Observation of tray line occurred on 08/27/13 at 5:49 p.m. in the Wheatland dining room. Observation showed the following inconsistencies between portion sizes listed on the facility's menus and the actual amount served to residents: *Rice and chicken hotdish served with a 4 oz scoop (the menu identified 6 oz) *Mechanical soft hotdish served with a 2 oz scoop (the menu identified 6 oz) *Pureed chicken served with a 3 oz scoop (the menu identified 2/3 cup) *Pureed hotdish served with a 4 oz scoop (the menu identified 6 oz) *Mashed potatoes served with a 3 oz scoop (the menu identified 4 oz) Observation of tray line occurred on 08/28/13 at 5:48 p.m. in the Towers dining room. Observation showed the following inconsistencies between portion sizes listed on the facility's menus and the	F 363		

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F 363	Continued From page 39 actual amount served to residents: *Pureed French toast served with a 4 oz scoop (the menu identified 6 oz) *Crab salad served with a 4 oz scoop (the menu identified 2 oz)	F 363		
F 364 SS=D	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview, group interview, staff interview, and surveyors' sampling of a scheduled hotdish meal tray the facility failed to prepare palatable food for 2 of 5 residents (Resident A and B) who attended the group interview and 1 supplemental resident (Resident G). Failure to address the residents' concerns regarding the palatability of the hotdishes served and failure to monitor the hotdishes at the evening meals limited the facility's ability to ensure the residents receive a nutritive balanced diet, an enhanced dining experience, and may have placed the residents at risk of unintended weight loss. Findings include: - During an interview on the afternoon of 08/26/13, Resident B stated the hotdishes are bland and unpalatable.	F 364	F 364 1. There were no specific residents identified in this deficiency. 2. All residents have the potential to be affected. 3. All cooks are required to taste, check temperature and survey all food before serving. A resident menu and recipe committee has been formed to facilitate resident involvement in the quality of the dining experience. The chairperson of this committee will report to the resident council at their monthly meeting. 4. The director of food services or designee will monitor taste and quality of the food at least three times per week. Monitoring results will be reported to the QA committee quarterly by the director of food services. 5. 10/14/13	

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F 364	Continued From page 40 - Five residents (Resident A, B, C, D, and E) attended the group interview on 08/27/13 at 10:30 a.m. Resident A and B stated the food served is "bland" especially the hot dishes. - During interview on 08/27/13, Resident G reported the facility's meals are not warm, noon meals usually have "pasta or rice", which the resident does not like, and the alternatives are not appealing. Resident G has fruit and popcorn available for noon meals. The resident reported discussing this with the facility staff, however there has not been a resolution to the resident's concerns. Review of Resident G's medical record on August 26-29, 2013, showed the facility staff discussed food concerns with the resident. The medical record failed to identify any alternatives or resolution to Resident G's concerns. - During an interview with Resident A on 08/27/13 at 5:06 p.m., she stated the food is not very warm and bland, especially the hot dishes. She further commented the hot dishes have very little meat. - On 08/27/13 at 5:50 p.m., the survey team requested a test tray from the evening meal. The meal included a rice and chicken hotdish. The survey team verified the hotdish tasted bland. During interview on the morning of 08/29/13, an administrative dietary staff member (#8) stated most of the hot dishes are served during the evening meal. This staff member stated she currently conducts quality monitoring of food palatability at the noon meal, but does not conduct any monitoring of the evening meal .	F 364		

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F 371	Continued From page 41	F 371	F 371	
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, review of manufacturer's recommendations, review of facility policy, review of dishwashing machine temperature logs, resident interview, and staff interview, the facility failed to serve, store, and prepare food under sanitary conditions in 1 of 1 facility kitchen. Failure to properly wash dishes and cool cooked meat appropriately does not inhibit microbial growth and may result in foodborne illness. Findings include: Review of the facility policy titled "Food Temperatures" occurred on 08/29/13. This undated policy stated, ". . . Anything that is cooked must be cooled properly . . . Cooling temps [temperatures] should be done for all cooked foods i.e.; Beef, pork, & turkey roasts. Cooked roasts should be placed on a sheet pan, a space between each, cover with wax paper, place in freezer. . . . Stage 1 = when food is finished cooking . . . Stage 2 = temp after food has cooled for 2 hours (< = [less than or equal to]	F 371	1. There were no residents identified in this deficiency. 2. All residents have the potential to be affected. 3. A policy has been developed and implemented regarding cooling of foods and proper storage of foods. Roasts will be prepared/cooked and served with no cooling time needed when possible. If roasts are prepared and cooled the following procedure will be followed. Roasts will be cut into smaller pieces prior to cooking when possible, or after the roast is cooked. The roast will be placed on a flat cookies sheet with space between each piece; it will be covered with parchment paper and placed in the freezer. Temperatures will be recorded when the roast is done then in 2 hour intervals with the first 2 hour check temp to be 70 degrees or less and the next 2 hour temp to be 41 degrees or less.	

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F 371	Continued From page 42 70 F [degrees Fahrenheit] . . . Stage 3 = temp after food has cooled for 4 hours (< = 41 F) . . . Any foods not meeting these critical control temps will need corrective action & supervisor notification . . ." - Observation during the main dietary tour on 08/28/13 at 2:30 p.m. showed the following items cooling the walk-in cooler: *A plastic container approximately six inches deep with a tight plastic cover in place. The container held two cooked beef roasts. *A plastic container approximately six inches deep with a tight plastic cover in place. The container held five cooked corned beef roasts. *A plastic container approximately six inches deep with a tight plastic cover in place. The container held four cooked turkey roasts. *The container holding the corned beef roasts was stacked on top of the container holding the turkey roasts. Observation showed a build-up of condensation (i.e. steam) under the covers of all three plastic containers. A dietary staff member (#24) present during the dietary tour stated the following: *Staff cooked the roasts that morning and placed them in the walk-in cooler between noon and 1:00 p.m. (two to three hours prior). *Staff usually cut the roasts in half prior to cooling them, and they should have cut them in half this time, so the roasts would cool faster. *Staff do not record a second temperature (i.e. after two hours of cooling), only a final cooking temperature when they remove the roasts from the oven. *Staff used to monitor cooling temperatures; however, this is no longer done.	F 371	At that time the roast will be transferred to a covered container and placed in the cooler. Dietary staff has been educated in cooling guidelines for all foods on 09/05/13 and 09/24/13. 4. QA monitoring will be done daily by the director of food services or designee as need for one month then weekly times two weeks to ensure the policy is being followed. Results of the monitoring will be reported by the dietary food service manager to the QA committee monthly times three months and quarterly thereafter. 5. 10/14/13	

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F 371	Continued From page 43 As a result, cooling logs for the roasts were not available. Per surveyor request, the staff member took temperatures of the roasts with the following results: *Roast beef: 120 and 128 degrees F at 3:18 p.m. *Corned beef: 100, 90, 90, 82, and 72 degrees F at 3:20 p.m. *Turkey roasts: 110, 115, 119, and 119 degrees F at 3:22 p.m. On 08/28/13 at 4:43 p.m., a dietary staff member (#23) again obtained temperatures of the roasts with the following results: *Roast beef: 105 and 110 degrees F *Corned beef: 90, 88, 80, 74, and 80 degrees F *Roast turkeys: 100, 100, 100, and 100 degrees F On 08/28/13 at 5:30 p.m., the survey team determined the roasts did not reach appropriate cooling temperatures in a timely manner (i.e. 135 degrees F to 70 degrees F within 2 hours). The survey team requested that facility staff reheat and recool the roast beef, discard the corned beef, and discard the turkey roasts. At 5:38 p.m., a dietary staff member (#23) stated she discarded the corned beef and turkey roasts, and the roast beef was reheating in the oven. She also stated she was unaware of cooling guidelines. On 08/28/13 at 5:48 p.m., temperature monitoring of tray line items in the Towers dining room and main kitchen showed the following: *Crab salad at 68 degrees F *Pureed crab salad at 69 degrees F *Crab salad at 59 degrees F During an interview on 08/28/13 at 6:21 p.m., a	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355070	A. BUILDING _____ B. WING _____	C 08/29/2013

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 371	Continued From page 44 dietary staff member (#24) stated the staff cooked the crab between 2:00 and 2:30 p.m. to use for crab salad that evening (four hours prior). Staff then mixed the crab with mayonnaise and placed it in the walk-in cooler, but failed to monitor cooling temperatures. The staff member (#24) stated they would make sandwiches with the leftover crab salad. Per surveyor request, the staff discarded the leftover crab salad, as it was improperly cooled and subjected to temperature abuse during cold holding. The dietary staff member (#24) confirmed they failed to cool the crab salad appropriately. - Review of manufacturer's recommendations for the facility's dishwashing machine (Hobart CCS-66A) occurred on 08/29/13. The recommendations for this model identified a minimum wash temperature of 160 degrees F and a minimum final rinse temperature of 180 degrees F. Review of the facility policy titled "Dish Machine Temperature Log" occurred on 08/29/13. This undated policy stated, ". . . Policy: Dishwashing staff will monitor and record dish machine temperatures to assure proper sanitizing of dishes. . . . 3. Staff will be trained to record dish machine temperatures for the wash and rinse cycles at each meal. 4. The director of food services will spot check this log to assure temperatures are appropriate and staff is actually monitoring dish machine temperatures. 5. Dishwashing staff will be trained to report any problem with the dish machine to the food service manager as soon as they occur. . . ." The facility form titled "Dishmachine-Temperature Sheet" (used by staff to document	F 371	Dishwasher temperature 1. There were no residents identified in this deficiency. Dietary staff responsible for documentation on the temperature sheet re-educated on documentation of the temperatures and corrective action to take if the temperature of the dishwashing machine falls below acceptable range. 2. All residents have the potential to be affected.	

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	355070	A. BUILDING _____ B. WING _____	C 08/29/2013

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F 371	Continued From page 45 temperatures of the dishwashing machine in the morning and afternoon) stated the following: "If the heat temperature does not turn the appropriate temperature, stop washing dishes and notify your supervisor. *Your supervisor needs to initial when the reading is not within normal limits to verify they were notified. . . ." Observation of the facility's dishwashing machine occurred on 08/27/13 at 9:30 a.m. Observation showed the machine (a heat sanitizing dishwasher) reached a maximum temperature of 146 degrees F during the wash cycle. The face plate on the machine identified the minimum washing temperature should be 160 degrees F, and the minimum rinse temperature should be 180 degrees F. A dietary staff member (#23) stated the wash temperature should reach 160 degrees. She also stated staff monitor dishwashing machine temperatures twice a day, once in the morning and once in the afternoon. Observation of the facility's dishwashing machine occurred on 08/28/13 at 8:55 a.m. Observation showed the machine reached a maximum temperature of 150 degrees F during the wash cycle. The facility's Dishmachine Temperature Sheets for the months of January - August 2013 showed the following: *January 2013: Staff failed to monitor dishwashing machine temperatures in the morning and/or afternoon on 25 days. The dishmachine failed to meet required temperatures for the wash and/or rinse cycles on 12 occasions. *February 2013: Staff failed to monitor dishwashing machine temperatures in the morning and/or afternoon on 23 days. The	F 371	3. Dishwashing machine temperatures are recorded twice a day at the beginning of each shift. At any time during the shift if the temperature falls below 160 degrees or the rinse temperature falls below 180 degrees the dishwashing process is to be stopped and the dietary supervisor notified. Dishwashing in the dish machine can be continued if the wash temperature is less than 160 degrees only when all dishes are pre-washed in the sink and then sent through the machine to sanitize. If the rinse temperature is below 180 degrees the machine may not be used at all and all dishes have to be washed using the three sink method. Dietary staff was educated on the policy/procedure 09/05/13 and 09/24/13. 4. QA monitoring will be done by the director of food services or designee. Monitoring will be done to check documentation of the temperatures and corrective action taken if the temperature does not fall into acceptable range. Monitoring will done at least three times	

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	355070	A. BUILDING _____ B. WING _____	C 08/29/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 371	Continued From page 46 dishmachine failed to meet required temperatures for the wash and/or rinse cycles on 8 occasions. *March 2013: Staff failed to monitor dishwashing machine temperatures in the morning and/or afternoon on 23 days. The dishmachine failed to meet required temperatures for the wash and/or rinse cycles on 9 occasions. *April 2013: Staff failed to monitor dishwashing machine temperatures in the morning and/or afternoon on 19 days. The dishmachine failed to meet required temperatures for the wash and/or rinse cycles on 9 occasions. *May 2013: Staff failed to monitor dishwashing machine temperatures in the morning and/or afternoon on 21 days. The dishmachine failed to meet required temperatures for the wash and/or rinse cycles on 9 occasions. *June 2013: Staff failed to monitor dishwashing machine temperatures in the morning and/or afternoon on 24 days. The dishmachine failed to meet required temperatures for the wash and/or rinse cycles on 5 occasions. *July 2013: Staff failed to monitor dishwashing machine temperatures in the morning and/or afternoon on 28 days. The dishmachine failed to meet required temperatures for the wash and/or rinse cycles on 20 occasions. *August 1-26, 2013: Staff failed to monitor dishwashing machine temperatures in the morning and/or afternoon on 19 days. The dishmachine failed to meet required temperatures for the wash and/or rinse cycles on 23 occasions. *The logs lacked evidence (i.e. supervisor's initials) to indicate staff notified the supervisor on any of the above occasions in which the dishwashing machine did not meet the required temperatures. During an interview on the morning of 08/28/13, a	F 371	per week indefinitely. Results will be reported to the QA committee monthly times three months then quarterly times three months. 5. 10/14/13	

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	355070	A. BUILDING _____ B. WING _____	C 08/29/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 371	Continued From page 47 contracted maintenance services representative (#20) stated he checked the dishwashing machine "a couple weeks ago." He stated he completes an inspection report after each visit; however, he did not have a report for the August visit. Previous inspection reports identified the following regarding the dishwashing machine: *01/30/13: A final rinse temperature of 170 degrees F *02/27/13: A final wash temperature of 156 degrees F *03/14/13: A final rinse temperature of 160 degrees F and a final wash temperature of 150 degrees F *04/29/13: A final wash temperature of 152 degrees F *06/12/13: A final wash temperature of 156 degrees F The facility failed to provide evidence of corrective maintenance after the above inspections identified the dishwashing machine did not meet required temperatures. During an interview on 08/29/13 at 8:33 a.m., a supervisory dietary staff member (#8) agreed the dishwashing machine should reach 160 degrees F during the wash cycle and 180 degrees F during the rinse cycle.	F 371		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.	F 441	F 441 1. Staff caring for residents 2, 9 and 10 have been re-educated in proper hand washing/hand hygiene and proper perineal care procedure. Performance corrections will be done for all staff involved. 2. Any resident has the potential to be affected.	

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	355070	A. BUILDING _____ B. WING _____	C 08/29/2013

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F 441	Continued From page 48 (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy and procedure, and staff interview, the facility failed to follow standard infection control practices for 3 of 16 residents (Resident #2, #9, and #10) observed during toileting/perineal care. Failure to follow infection control practices related to glove	F 441	3. Mandatory in-services were held for all nursing staff on 09/04, 09/05, 10/08, 10/09, and 10/10/13. Topics included proper hand washing, hand hygiene, and perineal care The monitoring tool used for observation of perineal care has been revised to include specific steps to perineal care and removal of gloves. The policy and procedure for perineal care and hand hygiene will be reviewed and revised as needed. 4. The nurse managers, house supervisors or designee will monitor staff performance of perineal cares, and hand hygiene at least weekly times three months. Results of the monitoring will be reported to the QA committee at least monthly for three months, then quarterly for three quarters. 5. 10/14/13	

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F 441	Continued From page 49	F 441		

usage and hand hygiene has the potential to cause or spread infection within the facility.

Findings include:

Review of the facility policy titled "Hand Hygiene" occurred on 08/29/13. This policy, dated May 2012, stated, "Policy Statement. Hand hygiene shall be regarded by this organization as the single most important means of preventing the spread of infections. . . . 1. All personnel shall follow our established hand hygiene procedure to prevent the spread of infection and disease to other personnel, patients, and visitors. Appropriate fifteen (15) second handwashing must be performed under the following conditions: . . . g. after contact with . . . body fluids, excretions . . . . h. After handling items potentially contaminated with . . . body fluids, excretions, . . . i. After personal body function (e.g., use of toilet, . . . k. After removing gloves . . . 3. The use of gloves does not replace hand washing. . . ."

- Observation on 08/27/13 at 9:10 a.m. showed two certified nursing assistants (CNAs) (#26 and #27) assisted Resident #2 with morning cares while the resident lay in bed. One CNA (#27) wore gloves, removed the brief (wet with urine), completed perineal cares, placed a new brief, and removed her gloves. Without performing hand hygiene after perineal cares, the CNA (#27) sat the resident up in bed and offered him a drink of water, touching the tip of the straw with her bare hand (the resident declined a drink). The CNAs (#26 and #27) dressed Resident #2, transferred him from the bed to his wheelchair, and placed his foot pedals, seatbelt, cap, and glasses. The CNA (#27) then washed her hands (for the first

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F 441	Continued From page 50	F 441		

time since completing perineal cares) prior to putting the resident's dentures in his mouth and assisted him to the dining room.

- Observation on 08/27/13 at 9:37 a.m. showed two CNAs (#9 and #11) assisted Resident #10 with toileting in the resident's bathroom. Both CNAs (#9 and #11) wore gloves and together, lowered the resident's slacks and removed a soiled brief. A CNA (#9) provided perineal care after the resident voided and had a bowel movement, removed her soiled gloves and donned another pair of gloves from her pocket, and without performing hand hygiene before applying a clean brief to the resident.

- Observation on 08/27/13 at 3:20 p.m. showed two CNAs (#28 and #29) assisted Resident #2 to transfer onto the toilet. One CNA (#29) removed his brief (wet with urine) and the resident voided and had a small bowel movement in the toilet. The CNA (#29) performed perineal cares, removed her gloves, and without completing hand hygiene, exited the resident's room to obtain some barrier cream for the resident's perineal area. The CNA (#29) returned to the resident's bathroom, donned gloves, applied the cream to the resident's perineal area, removed her gloves, and without performing hand hygiene, assisted the other CNA (#28) to transfer the resident from the toilet back to his wheelchair. The CNA (#29) applied foot pedals to the resident's wheelchair, placed his cap, and then washed her hands prior to exiting the resident's room.

- Observation on 08/27/13 at 3:50 p.m. showed a CNA (#9) provided perineal care to Resident #10 after she voided and had a bowel movement. Without changing her gloves, the CNA (#9)

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 _____	C 08/29/2013

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F 441	Continued From page 51 applied a clean brief to the resident and pulled up her slacks. - Observation on 08/27/13 at 5:32 p.m. showed two CNAs (#9 and #12) assisted Resident #9 with toileting. Both CNAs (#9 and #12) donned new gloves after providing perineal cares to the resident without first completing hand hygiene. During an interview on 08/29/13 at 11:20 a.m., an administrative nurse (#13) stated she expected staff to perform hand hygiene immediately after completing perineal care and removing their gloves.	F 441		
F 454 SS=E	483.70 LIFE SAFETY FROM FIRE The facility must be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel and the public. This REQUIREMENT is not met as evidenced by: Based on observation, review of professional reference, and staff interview, the facility failed to store oxygen according to current Life Safety Code requirements in 1 of 1 oxygen storage area (garage). Placement of oxygen tanks horizontally across the top and between oxygen tanks stored vertically placed the facility's residents, visitors, and staff at risk of injury in the event of the tanks falling off and becoming projectiles. Findings include: Life Safety Code requirements state, "Nonflammable medical gas systems and equipment used for the administration of	F 454	F 454 1. There were no residents identified in this deficiency. 2. Any resident, staff or visitors have the potential to be affected. All areas of oxygen storage were checked for proper placement of oxygen tanks by the maintenance supervisor, or designee. 3. Maintenance staff was educated in proper storage of the oxygen cylinders and risk of improper storage on 09/03/13. Nursing staff were educated on proper oxygen storage during in-services held 10/08/2013, 10/09/2013 and 10/10/2013.	

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

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F 454	Continued From page 52 inhalation therapy and for resuscitative purposes comply with NFPA 99, 13-5.1, 7-1.2, NFPA 70." Standard for the Storage, Use, and Handling of Compressed Gases and Cryogenic Fluids in Portable and Stationary Containers, Cylinders, and Tanks, NFPA 55, 7.1.4.4 states "Securing Compressed Gas Containers Cylinders, and Tanks. Compressed gas containers, cylinders, and tanks in use or in storage shall be secured to prevent them from falling or being knocked over by corralling (collect/gather) them and securing them to a cart, framework, or fixed object by use of a restraint, unless otherwise permitted by 7.1.4.4.1 and 7.1.4.2.7." During the environmental tour, on 08/28/13 at 2:45 p.m., observation in the facility garage showed a cart rack with oxygen tanks stored vertically. Placed on top and between the rows of vertical tanks were six, unsecured, "D, E, and M" size oxygen tanks in a horizontal position. A maintenance management staff member (#14), present at the time of the observation, confirmed the facility staff should not have stored the oxygen tanks in an unsecured horizontal position. This staff member (#14) obtained another cart rack to store the unsecured tanks in a secure manner.	F 454	4. The maintenance supervisor will monitor oxygen storage weekly for four weeks. This will also be included in the monthly preventative maintenance program. The maintenance supervisor will report results of the monitoring of correct oxygen storage to the QA committee monthly times three months. 5. 10/14/13	
F9999	FINAL OBSERVATIONS Based on observation, record review, and staff interview, the complaint investigated in conjunction with the standard Medicare/Medicaid survey was not substantiated.	F9999		