STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355100	A. BUILDING _____ B. WING _____	C 04/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVENTIDE DEVILS LAKE CARE CENTER	**302 7TH AVE NE DEVILS LAKE, ND 58301**

(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 The Standard Medicare/Medicaid recertification and complaint survey started on 03/31/19 and concluded 04/03/19.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal	F 550		5/8/19

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

Electronically Signed | 04/24/2019

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F 550	Continued From page 1 from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide care in a manner that maintained or enhanced dignity for 1 of 1 sampled resident observed being fed in the dining room. Failure to feed Resident #39 in a dignified manner did not promote her dignity/enhance her quality of life. Findings include: Review of the facility policy titled "Resident Dignity" occurred on 04/03/19. The policy, revised February 2017, stated, ". . . Promoting resident . . . dignity in dining. (Examples include avoidance of day-to-day use of . . . bibs [also known as clothing protectors] instead of napkins . . ." Review of Resident #39's medical record occurred on all days of survey. The Annual Minimum Data Set (MDS), dated 02/20/19, identified severely impaired cognition and extensive assistance required for eating. The current care plan identified, ". . . I have an ADL [Activities of Daily Living] self care performance deficit R/T [related to] dementia, osteoarthritis . . . EATING: Requires total	F 550	1. Resident # 39 is now being assisted with meals in a dignified manner. 2. The facility has identified that all residents who are assisted with meals in the facility have to potential to be affected by this practice. 3. The facility has implemented a systemic change. Dignity Audits will be performed on a quarterly basis and information gathered from these audits will result in quarterly mandatory all staff in-service training in addition to any monthly in-services provided. On 4/24/19 all staff received education on how to assist residents with meals in a dignified manner as well as the new quarterly audit changes. 4. An audit tool has been developed to ensure residents who require assistance with eating are being assisted in a dignified manner. Audit tool will be completed by Director of Nursing Services or designee 4 X week for one month, 2 X a week for two months, 1 X	

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F 550	Continued From page 2 assistance of 1 staff. . . ." Observation showed the following: * 04/01/19 at 8:16 a.m., Resident #39 sat at an assisted table with a certified nursing assistant (CNA) (#8) seated next to her. The CNA (#8) used a spoon to scrape residue from Resident #39 lips and the clothing protector to wipe residue from her lips/chin. * 04/01/19 at 12:30 p.m. Resident #39 sat at an assisted table with an unidentified CNA seated next to her. The unidentified CNA used a spoon to scrape residue from Resident #39 lips. * The morning of 04/02/19, Resident #39 sat at an assisted table with an unidentified CNA seated next to her. The unidentified CNA used a spoon to scrape residue from Resident #39 clothing protector. During an interview on the morning of 04/03/19, an administrative nurse (#2) confirmed staff are expected to use napkins to remove food residue from a resident's face/clothing protector.	F 550	week for 3 months and then quarterly for one year. A summary of all completed audits will be provided monthly to the quality assurance committee to ensure compliance is achieved and sustained. 5. Compliance will occur on or before May 8th 2019.	
F 567 SS=E	Protection/Management of Personal Funds CFR(s): 483.10(f)(10(i)(ii) §483.10(f)(10) The resident has a right to manage his or her financial affairs. This includes the right to know, in advance, what charges a facility may impose against a resident's personal funds. (i) The facility must not require residents to deposit their personal funds with the facility. If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the	F 567		5/8/19

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F 567	Continued From page 3 resident deposited with the facility, as specified in this section. (ii) Deposit of Funds. (A) In general: Except as set out in paragraph (f)(l0)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund. (B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed $50 in a noninterest bearing account, interest-bearing account, or petty cash fund. This REQUIREMENT is not met as evidenced by: Based on review of the facility's policy and resident/staff interviews, the facility failed to have a system in place to assure 1 of 21 sampled residents (Resident #41) had ready access to their personal funds in the evening and/or on the weekend. Failure to provide residents access to their personal funds during the evening and/or on the weekend limits the residents' rights to their money.	F 567	1. As of April 3rd, 2019 resident 41 has access to withdraw personal funds in the evenings and or weekends. 2. The facility has identified that all residents who have a resident trust account in the facility have to potential to be affected by this practice. 3. On 04/24/2019 Administrative staff and	

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F 567	Continued From page 4 Findings include: Review of the facility policy titled "Resident Trust Account" occurred on 04/03/19. The policy, revised December 2015, stated, ". . . By having a resident trust account, a resident can withdraw monies for personal spending or have the location pay for residents' personal items such as hair care, shopping needs or miscellaneous items from the trust account. . . ." During an interview on 03/31/19 at 5:13 p.m., when asked if she had access to her personal funds, Resident #41 stated, "Yeah, but you have to ask for it [funds] before the weekend - when the staff is here." During an interview on 04/02/19 at 1:10 p.m., a managerial staff member (#5) stated, "Residents have access to their personal funds every [week] day . . . until 5:00-5:30 . . . [except] on Sundays." The managerial staff member (#5) confirmed residents have no access to their funds after 5:30 p.m. and/or on Sundays.	F 567	charge nurses received education on RTA safe, process and regulations. On 04/24/2019 residents and or legal guardians were issued a letter explaining after hours and or weekends RTA withdraws. The facility has implemented a systemic change. The facility has implemented a resident trust account safe in the North nurse□s med room. The safe contains cash funds, listing of facility residents who have a resident trust account and cash withdraw sheet. The north charge nurse has been designated to assist all residents with available RTA funds with withdrawals after business hours and or on weekends. 4. An audit tool has been developed to ensure residents with RTAs are aware of the availability of their funds, RTA safe is in place and designated charge nurse is aware of the systemic change and procedure. Audit tool will be completed by Business Manager or designee 4 X week for one month, 2 X a week for two months, 1 X week for 3 months and 1X per quarter for a year. A summary of completed audits will be provided monthly to the quality assurance committee to ensure achieved and sustained compliance. 5. Compliance will occur on or before May 8th 2019.	
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7)	F 584		5/8/19

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F 584	Continued From page 5 §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and	F 584		

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F 584	Continued From page 6 §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, review of the facility's policy, and staff interview, the facility failed to provide maintenance services necessary to maintain a safe/comfortable environment for 2 of 4 units (Unit 2 and 4). Failure to maintain a safe/comfortable environment placed residents at risk for injury. Findings include: Review of the facility policy titled "Indoor Environmental Quality and Monitoring Overview" occurred on 04/03/19. The policy, revised March 2016, stated, ". . . The quality of the indoor environment is essential to the well-being of those exposed to the environment. The environmental services director or designee is responsible for the . . . sustainability of an indoor environmental quality program . . . that promotes the general comfort, health and well-being of our residents . . . by reducing or eliminating . . . exposures. . . ." - Observation of resident rooms on Units 2 and 4 occurred on all days of survey and showed the following: * 201, 203, 204, 205, 211, 213, 215, 217, 219, and 221: chipped/gouged doors with splintered wood * 204 and 217: chipped/gouged night stands with splintered wood * 402: chipped/gouged door with the bottom edge covered in duck tape Facility staff failed to repair the damaged wood	F 584	1. The doors have been repaired to be free of chips, gouges and splintered wood for rooms 201,203,204,205,211,213,215,217,219, 221 and 402. The night stands for 204 and 217 have been repaired to be free of chips, gouges and splintered wood. 2. The facility has identified that all residents have the potential to be affected by this practice. 3. On 04/24/2019 environmental staff and housekeeping staff received in-service education on indoor environmental quality & monitoring. The facility has implemented a systemic change. Upon resident room cleaning, housekeeping will complete a resident room inspection report. Each resident room will have a resident room inspection check list completed each quarter. This report will be given to the Director of Environmental Services and copied to Administrator. A calendar will be developed to ensure all rooms are inspected quarterly. 4. An audit tool has been developed and will be completed by the environmental service director or designee to ensure resident doors and night stands condition is and remain in acceptable and safe	

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F 584	Continued From page 7 surfaces. During an interview on 04/02/19 at 2:00 p.m., an environmental services staff member (#6) stated, "We usually sand the doors and do touch-ups when we paint the rooms. I am behind on my doors. We haven't done anything to the doors in two years." The environmental services staff member (#6) agreed the damaged wood surfaces have the potential to cause injury to the residents who live on Unit 2.	F 584	condition. This audit will be completed 5X a week for one month, 4X a week for the second month, 2X week for the 3rd month and quarterly for one year. These audits will be in addition to resident room inspection check lists. A summary of all completed audits and resident room inspections will be provided to the quality assurance committee to ensure achieved and sustained compliance. 5. Compliance will occur on or before May 8th, 2019.	
F 609 SS=E	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.	F 609		5/8/19

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F 609	Continued From page 8 §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and review of facility policy, the facility failed to ensure the results of 6 of 21 final investigations of alleged abuse/neglect violations were reported to the State Survey Agency within five working days of each incident. Failure to report the results of each investigation to the State Survey Agency per the facility's policy placed all residents at risk for possible neglect and/or injury. Findings include: Review of the facility policy titled "Abuse and Neglect" occurred on 04/03/19. The policy, revised November 2016, stated, ". . . The social worker or designated employee will report the results of all investigations to the state survey and certification agency and other officials within five working days of the incident . . ." Review of the investigations of alleged abuse/neglect violations showed facility staff failed to report the results of each investigation to the State Survey Agency within five working days of each incident. * Major injury/possible neglect: initial report submitted 06/26/18 and final report submitted 07/09/18; 13 days later.	F 609	1. The residents involved in the 6 identified late conclusion reports had no adverse effects. 2. The facility has identified all residents of reportable incidents of allegations of abuse, neglect, exploitation; injuries of an unknown source and misappropriation of resident property have the potential to be affected by this practice. 3. On 04/24/2019 the Director of Nursing Serves, Director of Social Services, Nurse Manager West, Nurse Manger North and Administrator reviewed State Operations manual (F-609) reporting requirements, GSS Abuse & Neglect policy and procedure Social Service Manual and Abuse Definitions Social Service manual. The facility has implemented a systemic change. Initial reports of allegations of abuse, neglect, exploitation, injuries of an unknown source and misappropriation of resident property will be reported to required agencies by DNS, Nurse Managers, Director of Social Services and or Administrator. Upon initial report	

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F 609	Continued From page 9 * Major injury/possible neglect: initial report submitted 07/14/18 and final report submitted 07/23/18; nine days later. * Injury of unknown origin: initial report submitted 07/16/18 and final report submitted 07/23/18; seven days later. * Major injury of unknown origin: initial report submitted 08/17/18 and final report submitted 08/23/18; six days later. * Major injury/possible neglect: initial report submitted 02/05/19 and final report submitted 03/22/19; 45 days later * Possible verbal abuse: initial report submitted 02/13/19 and final report submitted 02/20/19; seven days later.	F 609	notifications, the reporter will include all the above disciplines in the initial reporting e-mail. At this time the Administrator or Director of Social Service will set-up an outlook email appointment on or before the 5th day of the initial report. On this designated day, the management team will meet to ensure investigation conclusion is reported to required agencies with-in the required 5 working days of the incident. 4. An audit tool has been developed to ensure all reportable incident investigation conclusions have been reported to required agencies with-in 5 days of the initial report. The audit tool will be completed by the Director of Social Services or designee weekly for first month, bi-weekly for the second month, 1X for third month and then quarterly for a year. If no reportable incidents occur during the audit calendar the management staff will be audited by having to describing the reporting procedure. A summary of completed audits will be provided monthly to the quality assurance committee to ensure achieved and sustained compliance. 5. Compliance will occur on or before May 8th, 2019.	
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)	F 657		5/8/19

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F 657	Continued From page 10 §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and resident and staff interviews, the facility failed to review/revise the comprehensive care plans to reflect the residents' current status for 5 of 21 sampled residents (Resident #5, #8, #30, #34, and #40). Failure to review/revise the care plans limited the staff's ability to communicate care needs and ensure continuity of care for each resident.	F 657	1. Residents #5s□ care plan has been updated to reflect check in/out system, use of facility walkie talkie while out front of building and designated safe smoking area. Resident #8s□ careplan has been updated to reflect the need of oxygen use.	

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F 657	Continued From page 11 Findings include: Review of the facility policy titled "Comprehensive Care Plan and Care Conferences" occurred on 04/03/19. This policy, revised October 2018, stated, ". . . To provide an ongoing method of assessing, implementing, evaluating and updating the resident's care plan to help maintain the resident's highest level of functioning . . . during a care plan review, care plans must be revised as the resident's needs/status changes . . . " Review of the facility policy titled "Smoke-free locations" occurred on 04/03/19. This policy, revised on March 2016, stated, " . . . must ensure precautions are taken for the resident's/clients individual safety . . . care plans are updated as needed . . ." - Review of Resident #5 medical record occurred on all days of the survey. Diagnoses included nicotine dependence, pain and spinal stenosis with impaired physical mobility. The current care plan identified the resident uses a motorized wheelchair for locomotion and is at risk for falls. A tobacco use assessment dated 02/01/19, stated ". . . the resident uses only his right hand to smoke with . . . uses an electric wheelchair to get around . . . has physical limitations that would interfere with his ability to get outside and back into the center independently . . ." The current care plan showed the resident is independent with tobacco use and is required to smoke off the facility grounds. Resident #5 stores	F 657	Resident #30s careplan has been updated to reflect current transfer status. Resident #34s careplan has been updated to reflect current toileting needs. Resident #40s careplan has been updated to accurately reflect location of knee pain. 2.Facility has identified that all residents with in facility have the potential to be affected by this practice. 3.On 4/24/19 the Care Plan IDT team received in depth education on policy and procedures related to care plan completion and updating. The facility has implemented a systemic change. a.The nursing management team will meet Monday-Friday to review resident 24 hour report. Residents care plans will be updated to reflect any change of status or conditions found in the 24 hour report during this meeting. b. All Care Plan IDT team members are required to sign the review care plan section in PCC prior to care plan and care conference date, acknowledging that all information in care plan is up to date and accurate. In care plan meetings all Care Plan IDT members will individually go over the section of the care plan they are	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355100	A. BUILDING _____ B. WING _____	C 04/03/2019

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F 657	Continued From page 12 cigarettes and lighter in a locked box in his room. The care plan failed to describe a check in/out system with safety measures when he leaves and re-enters the facility. - Review of Resident #8's medical record occurred on all days of survey. Diagnosis included congestive heart failure and chronic ischemic heart disease. Review of physician's orders identified, "Oxygen via nasal cannula 2 liters per minute continuous for dyspnea, hypoxia . . .". Observation on 03/31/19 at 2:06 p.m., showed Resident #8 sitting in her wheelchair wearing a nasal cannula with the oxygen tank attached to the wheelchair. The gauge on the tank identified it as empty. During an interview on 03/31/19 at 2:23 p.m. a managerial nurse (#15) stated the resident is on continuous oxygen, and his/her oxygen use should be on the care plan. Resident #8's current care plan failed to address his/her need for oxygen. - Review of Resident #30's medical record occurred on all days of survey. The current care plan identified, ". . . I have an ADL [activities of daily living] self care performance deficit R/T [related to] recent back surgery and pain. . . . TRANSFERS: I need Sit-to-Stand [mechanical lift] with 1 staff assist . . . I have potential nutritional problems related to . . . surgical incision to spine . . . I have to be careful when I eat because the brace makes it hard for me to move my chin. . . . "	F 657	responsible for to ensure accuracy. Any changes that are needed at that time can be implemented during care conference. 4.An audit tool has been developed to ensure that all care plans are accurate to resident□s current status. Audit tool will be completed by Director of Nursing Services or designee 4 x week for one month, 2 x a week for two months, 1 x week for 3 months and then quarterly for one year. A summary of completed audits will be provided monthly to the quality assurance committee to ensure achieved and sustained compliance. 5.Compliance will occur on or before May 8th, 2019.	

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F 657	Continued From page 13	F 657		

Observations 04/01/19 at 5:30 p.m., showed a CNA (#11) provided stand-by assistance as Resident #30 stood and pivoted into his wheelchair.

Observation showed Resident #30 failed to wear a brace.

During an interview on the morning of 04/03/19, an administrative nurse (#2) confirmed Resident #30's care plan did not accurately reflect his current transfer or nutritional needs.

- Review of Resident #34's medical record occurred on all days of survey. The current care plan identified, ". . . I am frequently incontinent of bladder R/T Dementia . . . Check and change q [every] 2-2.5 hours. . . ."

Observations 04/01/19 at 4:46 p.m., showed a CNA (#11) assisted Resident #34 to stand-pivot onto the toilet utilizing a gait belt.

During an interview on the morning of 04/03/19, an administrative nurse (#2) confirmed Resident #34's care plan did not accurately reflect her current toileting needs.

- Review of Resident #40's medical record occurred on all days of survey. Diagnoses included edema, muscle weakness, left knee pain, and difficulty walking. The current care plan stated, " . . . The resident has chronic/discomfort in right knee . . . "

During an interview on 3/31/19 at 3:16 p.m., Resident #40 reported having pain in his left

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F 657	Continued From page 14 knee when he moves his leg sideways. During an interview on 04/03/19 at 10:53 a.m., a managerial nurse (#4) confirmed the care plan should address Resident #40's left knee pain. The care plan failed to accurately reflect the location of Resident #40's pain.	F 657		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, record review, and staff interview, the facility failed to provide individualized, meaningful activities for 2 of 6 sampled residents (Resident #34 and #39) dependent on staff for activity participation. Failure to implement an individualized program to meet the interests/needs of dependent residents (Resident #34 and #39) may have a negative affect on their overall well-being. Findings include: Review of the facility policy titled "Activity	F 679	1. Resident #34 and Resident #39 are now receiving activities consistent with their individual care plan. 2. The facility has identified that all dependent residents have the potential to be affected by this practice. 3. On 04/24/2019 activities staff received in-service education regarding the requirements of providing activities for dependent residents based on their needs and all staff received in-service education regarding the importance of	5/8/19

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F 679	Continued From page 15 Program" occurred on 04/03/19. The policy, revised September 2017, stated, ". . . Based on the comprehensive assessment and care plan and the preferences of each resident, the location provides an ongoing program to support residents in their choices of activities. Both . . . group and individual activities . . . are designed to meet the interests and support the physical, mental and psychosocial well-being of each resident . . ." - Review of Resident #39's medical record occurred on all days of survey. Diagnoses include dementia and osteoarthritis. The current care plan identified, ". . . I have the potential activity deficit R/T [related to] Cognitive deficits . . . Engage me in simple, structured activities that avoid overly demanding tasks, such as mass, coffee time, and Rosaries, devotions. I like to look at the birds at times . . . . Reminisce with me using photos of family and friends . . ." During an interview 04/03/19 at 9:45 a.m., a managerial Activity staff member (#12) stated Resident #39 liked the birds and courtyard, and sleeps a lot. The staff member (#12) also explained one-on-one visits are typically 15 minutes in length. The Activity Participation Logs identified the following: * March 1-31, 2019 - 14 days with no activities and/or 19 days with less than 15 minutes of activities per day. Resident #39 participated in one-on-ones on five occasions and birds on 12 occasions. * April 1-3, 2019 - 3 days with no activities.	F 679	assisting dependent residents to and from activities for participation. The facility has implemented a systemic change. The activity director will review documentation daily to ensure that activities were provided to dependent residents and documented accordingly. 4. An audit tool has been developed to ensure that dependent residents are receiving activities per care plan and documented accordingly. The audit will be completed by the activities director or designee 4 X week for one month, 2 X a week for two months, 1 X week for 3 months and then quarterly for one year. A summary of completed audits will be provided monthly to the quality assurance committee to ensure compliance is achieved and sustained. 5. Compliance will occur on or before May 8, 2019.	

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F 679	Continued From page 16 Observations the week of March 31-April 3, 2019 showed staff failed to invite and/or Resident #39 failed to participate in any activities provided by the facility. - Review of Resident #34's medical record occurred on all days of survey. Diagnoses include dementia, cerebral infarction, and osteoarthritis. The Annual Minimal Data Set (MDS) (latest comprehensive assessment), dated 05/16/18, identified it is "very important" for Resident #34 to listen to her choice of music and participate in her favorite activities and "somewhat important" for her to keep up on the news, listen while books, newspapers, and magazines are read, participate in religious services, attend group activities, and to go outside. The current care plan identified, ". . . I have potential for activity deficit R/T Cognitive deficits. . . . Assist me to music, bingo, and special events. . . . I like to sing along with music. . . . Encourage me to participate in activities. I usually wander as I desire. Visit with me as long as I am interested in visiting." During an interview on 04/03/19 at 11:07 a.m., a managerial Activity staff member (#12) stated Resident #34 loves music/attending special events, but reported she often wanders off. The Activity Participation Logs identified the following: * March 1-31, 2019 - 16 days with no activities and/or 20 days with less than 15 minutes of	F 679		

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F 679	Continued From page 17 activities per day. Resident #34 participated in one-on-ones and/or coffee on 14 occasions and music, news, social and/or TV on one occasion. * April 1-3, 2019 - 1 day with no activities. Resident #34 participated in coffee and/or social on one occasion. Observations the week of March 31-April 3, 2019 showed staff failed to invite and/or Resident #34 failed to participate in any activities provided by the facility.	F 679		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)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 facility policy, and staff interview, the facility failed to provide sufficient supervision and/or assistive devices for 2 of 16 sampled residents (Resident #9 and #34) who required assistance with transfers. Failure to provide the sufficient level of assistance and/or assistive devices to safely transfer a resident placed Resident # 9 and #34 at risk for falls with/without injury. Findings include: The facility policy titled "Gait (Transfer) Belt," revised October 2017, stated, ". . . Gait belts are	F 689	Part 1 1. Resident #9 and #34 are now assisted with transfers and ambulation as per their care plan. 2.Facility has identified that all residents with in facility that are care planned to use a gait belt with transfers and ambulation have the potential to be affected by this practice. 3.The facility has implemented a systemic change. All staff who are responsible for	5/8/19

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F 689	Continued From page 18 used with assisted ambulation . . . When holding the belt, an underhand grasp should be used. The belt . . . is for support and stability only. . . . Transfer or ambulate resident and remove belt. . . ." - Review of Resident #9's medical record occurred on all days of survey. Diagnoses included Parkinson's disease, tremors, osteoarthritis, and osteoporosis. An annual Minimum Data Set (MDS), dated 12/31/18, identified extensive assistance of one person required for transfers and locomotion on the unit. The current care plan identified, ". . . I have an ADL [activities of daily living] self care performance deficit R/T [related to] Parkinson's Disease . . . TRANSFER: Assist of 1 with gait belt and wheeled walker . . ." Observation on 04/01/19 at 9:38 a.m. showed Resident #9 in the bathroom with the call light on. Resident #9 wiped herself, adjusted her clothing, and was in the process of exiting the bathroom when a CNA (#9) entered the room. The CNA (#9) watched from the bathroom doorway as Resident #9 walked across the room utilizing her front wheeled walker and sat down in her recliner. The CNA (#9) failed to utilize the gait belt as care-planned. - Review of Resident #34's medical record occurred on all days of survey. Diagnoses included dementia, dizziness, osteoarthritis, and osteoporosis. A quarterly MDS, dated 02/16/19, identified extensive assistance of one person required for transfers and supervision/physical assistance of one person for locomotion on the	F 689	assisting residents who are care planned to use a gait belt with transfers and ambulation have received education on 04/24/19 and will have additional education and instruction on proper use of gait belt on Annual Skills Fair day. They will be required to demonstrate 100% efficiency of gait belt use. 4.An audit tool has been developed to ensure that all staff assisting residents who require the use of gait belt with transfers and ambulation are properly using the gait belt. Audit tool will be completed by Director of Nursing Services or designee 4 x week for one month, 2 x a week for two months, 1 x week for 3 months and then quarterly for one year. A summary of completed audits will be provided monthly to the quality assurance committee to ensure achieved and sustained compliance. 5.Compliance will occur on or before May 8th, 2019. Part 2 1.As of 4/24/19 Resident #5 and staff have received education on the importance for his safety the need for signing in and out when he leaves the facility and to take a facility provided walkie to communicate with staff if he needs assistance when outside smoking. Facility has designated the north end of	

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F 689	Continued From page 19 unit. The current care plan identified, ". . . I have an ADL self care performance deficit R/T Dementia and osteoarthritis . . . TRANSFER: Pivot transfer assist of 1 with gait belt. I can bear weight on my legs. . . ." Observation on 04/01/19 at 4:46 p.m. showed a CNA (#11) transferred Resident #34 to the bathroom, assisted her to stand, and let go of the resident's gait belt when she turned towards the sink. Resident #34 attempted to sit down, falling backwards towards the toilet. The CNA (#11) quickly turned back towards Resident #34 and attempted to guide her onto the toilet by placing her hands on the resident's hips. A few minutes later the CNA (#11) assisted Resident #34 to stand, adjusted her brief/pants, and guided her into her wheelchair by placing her hands on the resident's hips. The CNA (#11) failed to utilize the gait belt as care-planned. During an interview on the morning of 04/03/19, an administrative nurse (#2) confirmed staff are expected to utilize a gait belt as care-planned. 2. Based on observation record review, review of facility policy, resident interview, and staff interview, the facility failed to ensure safety for 1 of 1 sampled resident (Resident #5) who was observed smoking outdoors without supervision. Failure of the facility to ensure safety while residents smoke placed them at risk for possible accidents and/or injury. Findings include:	F 689	sidewalks on either west or east side of front entrance. The resident□s care plan has been updated to reflect interventions to promote safety when out of the building smoking. Staff have completed a tobacco use evaluation to ensure accuracy of smoking ability and assistance needed to independently smoke. 2.Facility identified that residents who have physical limitations that would interfere with his/her ability to go outside and back into facility independently and smoke would have a potential to be affected by this practice. 3.On 4/24/19 Resident and staff have been educated of the designated safe area to smoke, use of walkie and sign in sign out sheet for resident safety. 4.An audit tool has been developed to ensure that resident is utilizing the sign in sign out sheet, smoking in safe designated area and taking walkie with him when he smokes. Audit tool will be completed by Director of Nursing Services or designee 4 x week for one month, 2 x a week for two months, 1 x week for 3 months and then quarterly for one year. A summary of completed audits will be provided monthly to the quality assurance committee to ensure achieved and sustained compliance. 5.Compliance will occur on or before May	

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F 689	Continued From page 20 Review of the facility policy titled "Smoke-free locations" occurred on 04/03/19. This policy, revised on March 2016, stated, " . . . must ensure precautions are taken for the resident's/clients individual safety . . . care plans are updated as needed . . ." Review of Resident #5 medical record occurred on all days of the survey. Diagnoses included nicotine dependence, pain and spinal stenosis with impaired physical mobility. A tobacco use assessment dated 02/01/19, stated ". . . the resident uses only his right hand to smoke with . . . uses an electric wheelchair to get around . . . has physical limitations that would interfere with his ability to get outside and back into the center independently . . ." The current care plan identified the resident as independent with tobacco use and is required to smoke off the facility grounds. Resident #5 stores cigarettes and lighter in a locked box in his room. The care plan lacked interventions related to safety measures when he/she leaves and re-enters the facility. During an interview on 04/02/19 at 3:34 p.m., an administrative nurse, (#2) stated Resident #5 goes out the front door to smoke in his scooter, and staff "basically know when he goes outside by different staff watching for him, but he does not have an official check in/out system and has no way to communicate with the facility." During an interview on 04/03/19 at 08:46 a.m., when asked how he would notify the facility if	F 689	8th, 2019.	

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F 689	Continued From page 21 there was an emergency, Resident #5 stated, "nothing will happen," he would "take his chances," and "if the facility wants [him] to sign something, [he] will, but it has not been mentioned." Resident #5 reported he goes out the front door and sometimes goes down the alley where he is not always visible from the front offices. Observation on the morning of 04/03/19, showed Resident #5 in his motorized wheelchair smoking in the alley area, making it difficult to see the resident from the front door. The facility failed to ensure Resident #5 received the necessary safety measure while smoking outside to promote a safe environment.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one	F 690		5/8/19

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F 690	Continued From page 22 is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: 1. Based on record review, review of facility policy, and staff interview, the facility failed to provide timely services and treatment for 1 of 1 sampled resident (Resident #35) with a current urinary tract infection (UTI). Failure to ensure prompt diagnosis and treatment of a UTI may result in unnecessary discomfort, behaviors, and/or sepsis. Findings include: Review of the facility policy titled "Definitions of Infection - For Surveillance Purposes Only" occurred on 04/03/19. This policy, revised November 2016, stated, " . . . Urinary Tract Infections (Symptomatic) Resident without indwelling catheter have at least one of the following signs or symptoms from this sub-criteria . . . Acute Dysuria or acute pain . . . leukocytosis and at least one of the following localizing urinary	F 690	Part 1 1.As of 4/8/19, Resident #35 has completed a course of antibiotics for UTI and no longer presents with UTI symptoms. 2.Facility has identified that all residents with in facility that have symptoms of UTI have the potential to be affected by this practice. 3.The facility has implemented a systemic change. All staff that are responsible for monitoring and evaluating residents with symptoms of UTIS, notification and interpretation of lab values will contact physician within 24 hours of receiving lab values that are symptomatic of UTI and resident□s physical symptoms justify	

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F 690	Continued From page 23 tract sub-criteria . . . New or marked increase in urgency . . . New or marked increase in frequency. . . ." Review of the facility policy titled " . . . CARE PATH - Symptoms of Urinary Tract infection (UTI) (in residents without an indwelling catheter)" occurred on 04/03/19. This policy, revised August 2015, stated, "Evaluate [lab] Results . . . Notify MD/NP/PA . . . " Review of Resident #35's medical record occurred on all days of survey. Diagnoses included history of UTI. A quarterly Minimum Data Set, dated 02/17/19, identified occasionally incontinent and an extensive assist of one for toileting. A physician's order, dated 03/26/19 at 3:58 p.m., stated, "Urinalysis - Diagnosis: Urgency." Review of Resident #35's Urinary Analysis with Reflex Microscopic lab results, collected and completed on 03/27/19, identified " abnormal clarity (slightly cloudy) . . . abnormal leukocytes (moderate) . . . abnormal protein . . . " During an interview on 03/31/19 at 1:30 p.m., staff nurse (#7) stated,"they had called the doctor's office on Friday [03/29/19] about a UTI and did not get a response back." During an interview on 04/01/19 at 1:25 p.m., Resident (#35) stated she has a UTI but hasn't started medication yet. During an interview on 04/01/19 at 4:44 p.m., staff nurse (#7) stated, "no orders for antibiotic	F 690	notifying physician in regards to UTI symptoms. If Primary MD is not available staff will contact on call physician for follow up. 4.An audit tool has been developed to monitor timely notification of physician of residents with physical symptoms and positive labs values indicating UTI. Audit tool will be completed by Director of Nursing Services or designee 4 x week for one month, 2 x a week for two months, 1 x week for 3 months and then quarterly for one year. A summary of completed audits will be provided monthly to the quality assurance committee to ensure achieved and sustained compliance. 5.Compliance will occur on or before May 8th, 2019. Part 2 1. Resident #39 is now receiving proper perineal cares with each episode of incontinence. 2.Facility has identified that all residents with in facility that are incontinent of bowel/bladder and require staff to assist with perineal cares have the potential to be affected by this practice. 3.All staff that are responsible for performing perineal cares on residents have received in-service education as of 4/24/19 regarding proper perineal care	

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F 690	Continued From page 24 yet, but [doctor name] will be doing rounds at 6:00 p.m., and the pharmacy is open till 8:00 p.m., so she should start medication today." A physician's order, dated 04/01/19 at 6:38 p.m., stated, ". . . Rocephin Solution Reconstituted 1 GM [gram] (CefTRIAXone Sodium) (antibiotic) Use 1 gram intravenously at bedtime for UTI for 6 Days and 04/01/19 at 6:41 p.m., stated Rocephin Solution Reconstituted 1GM (CefTRIAXone Sodium) Inject 1 gram intramuscularly one time only for UTI for 1 Day . . . " During an interview on 04/03/19 at 10:20 a.m., a nurse manager (#2) confirmed staff should assess the resident, get vital, push fluids, follow Care Path for UTI's, review labs, and if staff can't reach the doctor, they should keep trying or call the on-call doctor. The record showed the facility initiated antibiotics on 04/01/19 (six days after the record identified the resident had UTI symptoms). Failure to ensure a prompt physician response resulted in delayed diagnosis, treatment, and unnecessary discomfort/pain. 2. Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide perineal care in a manner consistent with practices used to prevent urinary tract infections (UTIs) for 1 of 1 sampled resident (Resident #39) observed receiving inappropriate perineal care. Failure to provide perineal care according to acceptable standards of practice placed Resident #39 at risk of developing a UTI. Findings include:	F 690	and will be required to attend annual Skills Fair and score 100% on perineal care check off. 4.An audit tool has been developed to monitor staff when performing perineal cares to ensure proper procedures are followed. Audit tool will be completed by Director of Nursing Services or designee 4 x week for one month, 2 x a week for two months, 1 x week for 3 months and then quarterly for one year. A summary of completed audits will be provided monthly to the quality assurance committee to ensure achieved and sustained compliance. 5.Compliance will occur on or before May 8th, 2019.	

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F 690	Continued From page 25 Review of the facility policy titled "Perineal Care" occurred on 04/03/19. The policy, revised October 2017, stated, ". . . Have resident flex and separate knees if able. If resident is unable to spread legs and flex knees, turn the resident on the side with legs flexed. . . . For females . . . Separate the labia with one hand and wash with the other, using gentle downward strokes from the front to the back of the perineum. Avoid the area around the anus . . ." Review of Resident #39's medical record occurred on all days of survey. Diagnoses include a personal history of urinary tract infections. The annual Minimum Data Set (MDS), dated 02/20/19, identified severely impaired cognition, always incontinent of urine/bowel, and total dependence on two or more persons for toileting/personal hygiene. The current care plan identified, ". . . I have bowel and bladder incontinence R/T [related to] dementia . . . Check for incontinence every 2-2.5 hours and change as needed. . . . Monitor for s/s [signs/symptoms] UTI . . ." Observation on 04/02/19 at 9:15 a.m. showed two certified nursing assistants (CNAs) (#9 and #10) lowered Resident #39's pants before rolling her onto her right side; with her legs closed/knees touching. Observation showed the resident's brief heavily soiled with loose stool. While providing toileting cares, the CNA (#9) used fifteen wipes to cleanse the resident's buttocks. The CNA (#9) then applied a new brief and adjusted Resident #39's clothing without rolling her onto her back/side with legs flexed and	F 690		

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F 690	Continued From page 26 failed to cleanse her perineal area. During an interview on the morning of 04/03/19, an administrative nurse (#2) confirmed the above technique placed Resident #39 at risk of developing a UTI.	F 690		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to offer fluids to 2 of 6 sampled residents (Resident #34 and #39) dependent on staff for fluid intake. Failure to provide assistance with fluid intake may result in dehydration,	F 692	1. Resident #34 and #39 are being offered fluids with cares. 2.Facility has identified that all residents that are dependent on staff for fluid intake have the potential to be affected by this	5/8/19

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F 692	Continued From page 27 constipation, and urinary tract infections (UTIs). Findings include: Review of the facility policy titled "Nutrition and Hydration" occurred on 04/03/19. The policy, revised October 2017, stated, ". . . Offer sufficient fluid intake to maintain proper hydration and health . . ." - Review of Resident #39's medical record occurred on all days of survey. Diagnoses include dementia, constipation, and a personal history of urinary tract infections. The annual Minimum Data Set (MDS), dated 02/20/19, identified severely impaired cognition, extensive assistance from one person required for eating, and at risk of dehydration. The current care plan identified, ". . . I have an ADL [Activities of Daily Living] self care performance deficit R/T [related to] dementia, osteoarthritis . . . EATING: Requires total assistance of 1 staff. . . . I have the potential for dehydration or potential fluid deficit R/T inability to take fluids by myself. . . . Offer fluids between meals." Observations on 04/01/19 at 9:45 a.m. and 04/02/19 at 9:15 a.m. showed two certified nursing assistants (CNAs) (#9 and #10) toileted Resident #39. The CNAs (#9 and #10) failed to offer Resident #39 fluids following cares. - Review of Resident #34's medical record occurred on all days of survey. Diagnoses include dementia and constipation. The Quarterly MDS, dated 02/16/19, identified	F 692	practice. 3.All staff who are responsible for offering/providing fluids, to residents who are dependent on staff for fluid intake have received in-service education as of 4/24/19. These staff members will also be required to attend Annual Skills Fair and achieve 100% compliance on the importance of offering/providing adequate fluid intake to maintain proper hydration. 4.An audit tool has been developed to monitor staff for offering/providing adequate fluids to residents who are dependent on staff for hydration. Audit tool will be completed by Director of Nursing Services or designee 4 x week for one month, 2 x a week for two months, 1 x week for 3 months and then quarterly for one year. A summary of completed audits will be provided monthly to the quality assurance committee to ensure achieved and sustained compliance. 5.Compliance will occur on or before May 8th, 2019.	

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F 692	Continued From page 28 supervision/assistance from one person required for eating. The current care plan identified, ". . . I have an ADL self care performance deficit R/T Dementia and osteoarthritis . . . EATING . . . staff to set up tray . . . I have a potential nutritional problem R/T dementia E/B [exhibited by] poor meal intake . . . offer . . . beverages of choice to encourage intake. . . ." Observations showed the following: * 04/01/19 at 3:18 p.m., a CNA (#11) offered to toilet Resident #34. The CNA (#11) failed to offer Resident #34 fluids before exiting the room. * 04/02/19 at 12:45 p.m., a CNA (#9) transferred Resident #34 into bed. The CNA (#9) failed to offer Resident #34 fluids following cares. During an interview on the morning of 04/03/19, an administrative nurse (#2) confirmed staff are expected to offer water with cares.	F 692		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview, and policy review, the facility failed to	F 695	1.As of 3/31/19 Resident #8 had oxygen tank replaced, a full respiratory	5/8/19

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F 695	Continued From page 29 provide the necessary care and services for 1 of 3 sampled residents (Resident #8) with orders for continuous oxygen. Failure to provide oxygen as ordered has the potential for residents to experience complications related to inadequate oxygen saturation levels. Findings include: Review of the Procedure titled "Oxygen Administration" occurred on 04/03/19. This policy, revised October 2017, stated, ". . . A licensed nurse or other employee trained according to state regulations in the use of oxygen will be on duty and is responsible for the proper administration of oxygen to the resident . . . " Review of Residents #8's medical record occurred on all days of survey. Diagnoses included congestive heart failure and chronic ischemic heart disease. Current physician's orders included continuous oxygen via nasal cannula 2 liters per minute (LPM) for dyspnea, hypoxia. Observation on 03/31/19 at 2:04 p.m., showed Resident #8 seated in his/her wheelchair and wearing a nasal cannula attached to an oxygen tank on the back of her wheelchair. The oxygen tank meter registered empty. During an interview on 03/31/19 at 2:23 p.m., an administrative nurse (#15) stated, "yes, the resident is to be on 2 liters of continuous oxygen to keep oxygen saturations above 89%, and staff make sure his/her oxygen tank is on at all times."	F 695	assessment was performed on resident and oxygen saturation was 92% and no signs of respiratory distress were noted. Staff responsible for #8 on 3/31/19 received verbal on site education from Unit Manager of importance of maintaining oxygen tank levels adequately. 2.The facility has identified that all residents that require the continuous use of oxygen have the potential to be affected by this practice. 3.As of 4/24/19 all staff that are responsible for monitoring and administering oxygen have been educated on the importance of maintaining continuous oxygen supply for residents who require continuous oxygen supply. All staff responsible for monitoring and administering oxygen are required to attend Annual Skills Fair and achieve 100% compliance check off with regards to oxygen administration and safety. 4.An audit tool has been developed to ensure residents who require continuous oxygen are being monitored, oxygen is being administered as ordered and oxygen tank levels are maintained adequately. Audit tool will be completed by Director of Nursing Services or designee 4 X week for one month, 2 X a week for two months, 1 X week for 3 months and then quarterly for one year. A summary of completed audits will be	

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F 695	Continued From page 30 The facility failed to consistently provide Resident #8's oxygen at the ordered continuous flow per nasal cannula.	F 695	provided monthly to the quality assurance committee to ensure compliance is achieved and sustained. 5.Compliance will occur on or before May 8th 2019.	
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by:	F 725		5/8/19

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F 725	Continued From page 31 Based on observation, review of facility policy, and resident, family, and staff interviews, the facility failed to ensure sufficient staffing was available to promptly respond to resident's call lights for 12 of 21 sampled residents (Residents A, B, C, D, E, F, G, H, I, #8, #24, #34) and residents' family members (Residents D and F). Failure to provide sufficient staffing for assistance may result in residents experiencing falls and/or incontinence and may negatively affect the residents physical, mental and psychosocial well-being. Findings include: Review of the facility policy titled "Call Light" occurred on 04/03/19. The policy, dated September 2012, stated, ". . . When resident's call light is observed/heard, go to resident's room promptly . . . When leaving the room, place call light within easy reach of resident if in bed . . . For residents unable to use call light, staff need to make frequent visits or provide an adaptive call light. . . ." - Random resident interviews on 03/31/19 identified the following information: * 12:30 p.m., Resident C stated, "I think they need more aides . . . They don't do a good job of coming in and checking on you . . . Sometimes it's hard. They say hold on, I'll be right there . . . Some of [the staff] are so lazy they never show back up again . . . I peed and pooped my pants waiting." When asked how long she waited for staff to respond to the call light, she stated, "About a half hour. An hour. Maybe longer. They come in, turn the light off, say they will come back, and don't. Then you have to get up on your	F 725	1. All staff responsible for answering call lights have been educated and informed of residents and families concerns of call light response times and placement call cords. Residents #8 #24 and #34 now have call cord placed with in their reach. All call cords have had clips added to cord. 2.The facility has identified that all residents in the facility have the potential to be affected by this practice. 3.As of 4/18/19 all call lights in resident□s rooms have had broken/missing clips replaced to ensure ability to clip call light within reach for resident at all times. This will prevent call lights from falling on the floor or being tied to turn bars making them out of reach of resident. All staff have received in-service education on 4/24/19 regarding call light use and placement and systemic change. The facility has implemented a systemic change. During evening meals; a CNA will deliver the meal trays and then stay on the floor to specifically answer call lights to cover the floor. During resident council Social Worker will address concerns in-regards to timeliness of call light answering and discuss concerns with resident. Social worker or designee will do call light audits and discuss with resident□s and families concerns related to promptness of call lights being answered.	

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F 725	Continued From page 32 own . . . I get depressed when they don't come." * 1:19 p.m., Resident H stated, "Sometimes it takes a half hour [for staff to answer my call light]." * 2:32 p.m., Resident C reported having to take a diuretic for the swelling in her legs, and stated, "Then I have to pee at night." When asked if staff ensure the call light is within reach, she stated, "Sometimes I drop [the call light] and can't reach it. It's loose, not hooked to anything." * 3:16 p.m., Resident F stated, "Some staff at night don't want to be bothered. I'm cold when I go to bed and then warm up, and need help taking off my covers." * 4:55 p.m., Resident E stated, "The longest I've waited [for staff to answer my call light] was for 35 minutes." When asked if staff ensure the call light is within reach, he stated, "Yeah I sat off the chair the other day here. I couldn't reach the button. I was sitting too far over." * 5:09 p.m., Resident A stated, "I think [the facility is] short staffed." * 5:14 p.m., Resident H stated, "I kinda think we need more staff, cause they answer [the call lights] late." When asked how long she waited for staff to respond to her call light, she stated, "About a half hour. I have been incontinent because I've had to wait. That's why they give us briefs. In case they don't get there in time." - Random family interviews on 03/31/19 identified the following information: * 2:27 p.m., Residents D's family member reported the facility is short staffed and stated, "Its hard to get help." * 5:40 p.m., Resident F's family member stated, "I do know they have others to take care of too, but I don't like that he has to wait. He pushes his	F 725	Social worker will adjust call light audits based off of information obtained from resident and family concerns. These audits will address areas of concern specifically, to improve satisfaction of call light response time. 4.An audit tool has been developed to ensure resident□s call lights are answered in a timely manner to ensure resident and family satisfaction. An audit tool has also been developed to ensure proper placement of call lights for resident access. Audit tool will be completed by Social Worker or designee 4 X week for one month, 2 X a week for two months, 1 X week for 3 months and then quarterly for one year. Any audits developed by the Social Worker based on resident and family concerns will also be completed in the same manner. A summary of completed audits will be provided monthly to the quality assurance committee to ensure compliance is achieved and sustained. Compliance will occur on or before May 8th, 2019.	

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	355100	A. BUILDING _____ B. WING _____	C 04/03/2019

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EVENTIDE DEVILS LAKE CARE CENTER	302 7TH AVE NE DEVILS LAKE, ND 58301

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F 725	Continued From page 33	F 725		

button and has to wait. 25 minutes he's been waiting."

- Random resident interviews on 04/01/19 at 10:15 a.m. identified the following information:
* Resident B stated, "I had to wait up to one hour and a half for staff to address my call light." The resident stated a few weeks ago on a weekday, shortly before lunch, she put her call light on requesting water and to empty her urine bag. A certified nursing assistant [CNA] entered her room, turned off the call light, told her she was very busy, and walked out. The resident put her call light on approximately 20 minutes later; staff delivered her lunch tray with no water and failed to empty her urine bag. Resident B then stated she spoke with the administrator about these incidences and he stated he would talk with the staff involved. Resident B reported she has had to wait [for her call light to be answered] too many times.
* Resident I stated he has had to wait up to an hour for his call light to be answered. The resident reported the facility has call pendants for the residents to use when not in their rooms, but he/she unsure if they are still available.
* Resident G stated she has waited up to half and hour for her call light to be answered. On one occasion, a CNA entered her room, turned the call light off, stated she would be back, and failed to return. The resident reported she is incapable of self-transfering, and finds it very frustrating to be told to wait when she needs toileting assistance and staff do not return.
* Resident H reported after waiting up to 30-45 minutes, staff entered her room, told her they would be right back, and did not return. Resident H turned on her call light and had to wait for

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F 725	Continued From page 34 assistance a second time. * Resident I cannot self ambulate and is an assist of one with a gait belt and walker. The resident stated there have been times staff have left her in the chapel 10-20 minutes or longer after services, explaining they will be right back as they are assisting the other residents. On a couple of occasions, Resident I had to "yell out" for assistance as she did not have a call light. Observations showed the following: * 03/31/19 at 2:06 p.m. Resident #8 was sitting in her wheelchair that was pushed up against the bedside table, leaning forward attempting to reach her call light. Her call light was clipped to the head of her bed, approximately three feet out of reach of the resident. * 03/31/19 at 2:09 p.m. Resident #24 was lying in bed. Her call light hung from the bedside table, outside of her reach. * 03/31/19 at 3:01 p.m., 04/01/19 at 2:00 p.m. and 3:18 p.m., and 04/02/19 at 12:45 p.m., Resident #34 laid in bed on her left side. Her call light hung from the right side rail, behind the resident and out of her line of vision. During an interview on 03/31/19 at 2:23 p.m., an administrative nurse, (#15) stated, "Yes , the call lights need to be in reach for the residents."	F 725		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when	F 761		5/8/19

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F 761	Continued From page 35 applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to ensure accurate labeling of medications reflected the current physician's order for 1 of 6 residents (Resident #28) observed during medication pass. Failure to relabel an insulin (NovoLog) box and vial following an order change may result in Resident #28 receiving too much/little insulin and /or having a negative reaction. Findings include: Review of the facility's policy and procedure titled, "Medication - Change of Direction Stickers" occurred on 04/03/19. This policy, dated December 2015, stated, " . . . If the prescriber's directions for use change, the nurse may place a	F 761	1.As of 4/3/19 Resident #28□s insulin bottle and box was labeled with sticker indicating dosage change check MAR. 2.The facility identified that all residents in facility that receive medications and changes are made have the potential to be affected by this practice. 3.As of 4/24/19 all Nursing staff responsible for administering medications have been educated on the importance of proper medication labeling and change of sticker directions. This included performing the 5 rights of medication administration. Stickers have been placed in all medication carts for easy access.	

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F 761	Continued From page 36 direction change . . . on the container indicating there is a change in directions for use . . . When the sticker is applied the new order must be sent to the pharmacy so that it is correctly logged and dispensed with the next official refill . . . " Review of Resident #28's medical record occurred on 04/02/19. The current physician orders included an order in March of 2019, for NovoLog 70/30: inject 5 units subcutaneously at lunch and 8 units with supper. -Observation on 04/02/19 at 05:33 p.m., showed Resident #28's NovoLog 70/30 vial and box with labels that read "inject 5 units subcutaneously two times a day, lunch and supper meals." A staff nurse (#7) administered 8 units subcutaneously with the supper meal along with sliding scale insulin. The facility failed to obtain new labels from pharmacy for the NovoLog 70/30 insulin vial and box with the current physician orders. During an interview on 04/02/19, at 5:35 p.m., a staff nurse (#7) stated the insulin orders can change frequently, and the nurses followed the electronic medication administration record (MAR) for the correct dosage and not the label on the vial or box.	F 761	All staff responsible for administering medications are required to attend Annual Skills Fair and obtain 100% compliance with Safe Medication Administration, labeling, and change of sticker directions. 4.An audit tool has been developed to ensure staff responsible for administering medications are compliant with Safe Medication Administration, labeling, and change of sticker directions.. Audit tool will be completed by Director of Nursing Services or designee 4 X week for one month, 2 X a week for two months, 1 X week for 3 months and then quarterly for one year. A summary of completed audits will be provided monthly to the quality assurance committee to ensure compliance is achieved and sustained. 5. Compliance will occur on or before May 8th 2019.	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal,	F 812		5/8/19

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F 812	Continued From page 37 state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, review of the facility policy, and staff interview, the facility failed to prepare and serve food in accordance with professional standards for food service safety in 1 of 1 kitchenette. Failure to ensure proper sanitization of kitchen surfaces has the potential to result in foodborne illnesses to resident, staff, and visitors. Findings include: Review of the facility policy titled, "Sanitizing Food Contact Surfaces" occurred on 04/03/19. This policy, revised December 2017, stated, " . . . Wash surfaces with hot soap and water . . . Apply sanitizer to surface and allow to air dry . . . " An initial tour of the main floor kitchenette occurred on 03/31/19 at 12:20 p.m. Observation showed an unidentified dietary staff member (#1) cleaning kitchen surfaces with a spray bottle	F 812	1. Food and Nutrition staff are now using hot water and soap to clean surfaces and follow-up by applying sanitizer to surface to and allowing it to air dry in accordance with GSS Procedure Sanitizing Food Contact Surfaces. 2. The facility had identified that all residents have the potential to be affected by this practice. 3. On 04/24/2019 Food & Nutrition employees received in-service training on sanitizing food contact surfaces. The facility has implemented a systemic change. All food and nutrition employees will be assessed and complete a food & nutrition competency checklist (Sanitizing food and contact surfaces) on or before May 8th, 2019 and these will continue on	

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F 812	Continued From page 38 solution and cleaning towel. When asked for clarification, the dietary staff (#1) stated the spray bottle contained a mixture of dishwashing detergent and vinegar. An unidentified kitchen staff (#2) walked up to staff member (#1) and said, "you need to throw that away." Observation showed no filled sanitizer buckets or sanitizer spray bottles in the kitchen. During an interview on 04/03/19 at 10:15 a.m., the dietary manager (#3) confirmed staff should use soap and water to wipe off counters, let dry and use sanitizer bucket with rag or sanitizer in spray bottle.	F 812	a quarterly basis. 4. An audit tool has been developed to ensure food and nutrition employees are sanitizing food contact surfaces in accordance with GSS procedure Sanitizing Food and Nutrition Surfaces. The audit tool will be completed by the Director of Food and Nutrition or designee 5X weekly for one month, 3X weekly for the second month, 2X weekly for the third month and 2X quarterly for a year. 5. Compliance will occur on before May 8th, 2019.	
F 868 SS=D	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i) §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; §483.75(g)(2) The quality assessment and assurance committee must: (i) Meet at least quarterly and as needed to identifying issues with respect to which quality assessment and assurance activities are necessary. This REQUIREMENT is not met as evidenced by: Based on review of the facility's Quality	F 868	1. The Medical Director will attend	5/8/19

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F 868	Continued From page 39 Assurance and Performance Improvement (QAPI) program and staff interview, the facility failed to ensure the Medical Director (physician) was an active participant on the QA committee for 1 of 4 quarters (April-June 2018). Failure to ensure the medical director participates in the facility's quality assurance activities deprived the committee of the physician's unique contributions for analyzing and correcting problems with identified resident care areas. Findings include: Review of the facility QAPI program titled "Quality Assurance and Performance Improvement (QAPI) Plan" occurred on 04/03/19. The plan, dated 11/28/17, stated, ". . . Our center has a QAPI committee that meets monthly which consists of the administrator, director of nursing [DON], QAPI coordinator, infection preventionist (the DON at this time), safety chairperson, medical director, consulting pharmacist, and a representative from each department. . . . The medical director will attend meetings monthly if possible and at least quarterly as required by regulation. . . ." The facility provided documentation showing the QA committee met on a monthly basis between January 2018 and March 2019. The documentation showed the Medical Director failed to attend meetings on 04/24/18, 05/22/18, and 06/27/18. During an interview on 04/03/19 at 10:53 a.m., a managerial nurse (#4) confirmed the Medical Director failed to attend for one of the four required quarterly QA committee meetings.	F 868	Quality Assurance Committee at least quarterly moving forward. 2. The facility has identified that the Quality Assurance Committee serves all the residents of the facility and has they all have the potential to be affected by this practice. 3. On 04/24/2019, all members of the Quality Assurance Committee reviewed and received in-service education on the requirements of Quality Assurance Committee meeting frequency and minimum member requirements. The facility has implemented a systemic change. Moving forward the Quality Assurance Coordinator will develop a schedule for all monthly quality assurance meetings and the coordinator will also set meeting as an outlook appointment which will be sent to all members of the quality assurance committee. This will ensure timely meeting notification to all QA members. The QA Coordinator will follow-up with members who haven□t accepted meeting prior to monthly meeting. The Quality Coordinator will facilitate locations Medical Director to attend the first meeting of each quarter moving forward. 4. An audit tool has been developed to ensure monthly dates have been set for QA meetings, an outlook appointment has been sent to all members, follow-up has occurred for those who have not accepted	

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F 868	Continued From page 40	F 868	appointment and Medical Director has attended meetings at a minimum of quarterly. This audit tool will be completed monthly for 1 year. A summary of the audit results will be provided to the Quality Assurance Committee to ensure achieved and sustained compliance. 5.Compliance will occur on or before May 8th, 2019.	