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 _____	01/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - DEVILS LAKE	302 7TH AVE NE DEVILS LAKE, ND 58301

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F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey started on January 13, 2013 and completed on January 16, 2013, the sample included two (2) residents for complete review, nine (9) residents for focused review, and one (1) closed record for review. The sample included eight (8) additional residents to verify specific concerns during the survey.	F 000	**General Disclaimer** Preparation and Execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. For the purposes of any allegations that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the State Operations Manual.	
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, review of facility procedure, and staff interview, the facility failed to perform an initial assessment, and develop a plan of care, for 1 of 1 sampled resident (Resident #4) placed in a geri chair to decrease the resident's risk of elopement from the facility. Failure to develop a plan of care which includes; timely assessments, alternatives to restraint use, and monitoring, placed the resident at risk for loss of mobility, increased agitation, loss of dignity, and reduced quality of life. Findings include: Review of facility policy titled "Physical Restraints" occurred on 01/16/13. This procedure, dated August 2008, stated, ". . . Definitions . . . Physical Restraints - . . . Placing a resident in a chair that	F 221	**F221 Physical Restraints** **This is what the facility will do to correct the specific problems, found related to the specific resident identified.** 1. The Physical Restraint Assessment for resident #4 was completed and the care plan	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Administrator | TITLE | (X6) DATE: 03/11/2013

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

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F 221	Continued From page 1 prevents rising, i.e., geri-chair may be a restraint . . . Non-Emergency Restraint Use 1. Prior to the application of a non-emergency physical restraint, the following must be completed: a. There must be documentation in the Interdisciplinary Progress Notes (GSS #239) of the observation that suggest a physical restraint is indicated and response to previous interventions attempted . . . c. The interdisciplinary care team . . . will then evaluate the environmental, physical, and psychosocial causes . . . d. The interdisciplinary care team . . . will review the attempted alternatives and explore further alternatives and interventions . . . 2. If the interventions are deemed unsuccessful and a restraint may be needed, the following must be completed . . . c. The interdisciplinary care team . . . will complete the designated portion of GSS #248 [Physical Restraint Assessment] . . . e. Obtain the physician order for the appropriate restraint, times to be used and the medical symptom for use . . . g. Update the resident care plan to include the reason for the restraint, the required monitoring and a measurable goal relating to the rationale for its use. . . ." Review of Resident #4's medical record occurred on all days of survey. Diagnoses include dementia, traumatic brain injury, cerebrovascular accident, and expressive aphasia. Observations during the initial tour of the facility, on the afternoon of 01/13/13, showed Resident	F 221	updated. Physician has reviewed use of restraint and a progress note has been written. **2. This is what the facility will do to identify and correct any problems found with other residents who also could be affected by the facility practice.** All residents who have any type of physical devices limiting movement were assessed with the Physical Restraint Assessment Form and care plans updated if needed. Residents with physical restraints will be assessed every three months and PRN. Physician will review use of restraints every two months. **3. This is what the facility will do or changes it will make to the systems that will prevent this problem from reoccurring in the future.** All staff were educated on the intent of restraint standards, assessment standards, and care planning standards using the facility Restraint Policy and Procedure.	2-28-13 2-28-13

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F 221	Continued From page 2 #4 in a geri chair. Further observations on January 14, 15, and 16 showed the resident sitting by the nurses station, at meals, or self propelling in the facility. During each observation the resident was seated in a geri chair with a wander guard attached to the back of the chair. A physician's order, dated 09/01/12, stated, "This is [Resident #4's name] chair [wheelchair]. We have placed it here to keep it away from [resident's name] due to multiple elopement attempts and acting out. We are going to replace it with a Geri chair." The physician's order failed to include when to use the geri chair or the medical diagnosis. A physician's progress note, dated 10/24/12, stated, ". . . PAST MEDICAL HISTORY . . . 14. Increasing psychotic and antisocial behaviors as manifested by resistance to care, oppositional defiant behavior, multiple attempts to leave the nursing home and physical aggression toward the staff. . . We do have him in a special chair and I have removed his wheelchair from his room to cut back on his attempted elopements. . . ." Review of a "Physical Restraint Assessment" form, dated 12/10/12, stated, ". . . 1. What device are you recommending . . . geri chair . . . Would the recommended device for this resident be a restraint? YES . . . 3. Why is a physical restraint being considered? Resident attempts to escape from building. When upset has put self on floor . . . 5. What is/are the specific medical symptom (s) that require (s) the use of restraints? Traumatic brain injury, stroke 6. Explain how the restraint will allow the resident to reach his/her highest level of independence. Resident still able to get	F 221	**4. This is how the facility will monitor to make sure the changes continue and the problem is prevented.** An audit on physical restraints will be completed monthly for three months by the Director of Nursing Services or her Designee to ensure all physical restraint assessments are completed appropriately and the restraint is care planned. An audit report will be provided to the QA Committee for further recommendations.	2-28-13

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F 221	Continued From page 3 around . . . 8. Explain what alternative (s) to a physical restraint have been tried and the date (s) of the trial. Wanderguard ineffective when in regular w/c [wheelchair] . . . " Review of the restraint assessment showed that the nursing portion of the assessment was completed 101 days after the date of the physician's order. The portion of the assessment that is to be completed by the interdisciplinary team was blank. Resident #4's current care plan, stated, ". . . PROBLEM high risk for elopement r/t [related to] dementia with behaviors, acute agitation, TBI [traumatic brain injury] m/b [manifested by] confusion, resistive to redirection LONG/SHORT TERM GOALS will not leave facility grounds unescorted . . . PLANS AND APPROACHES wanderguard check at NOC [night] obs [observe] for placement each shift . . . geri chair for mobility . . ." Resident #4's care plan lacked a problem, goal, plan or approach regarding the use of the geri chair as a restraint. During an interview on the afternoon of 1/15/13, a nurse (#8) reported staff code Resident #4's chair as a restraint on the Minimum Data Set and that the geri chair is used to prevent him from getting out the front door.	F 221	F225 Reporting allegations of Abuse **1. This is what the facility will do to correct the specific problems, found related to the specific resident identified.** The reports that were not sent timely were for allegations that were not substantiated so no resident were affected.	2-28-13
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide	F 225	**2. This is what the facility will do to identify and correct any problems found with other residents who also could be affected by the facility practice.** All residents have the potential to be affected in this area. There are currently no other abuse or neglect or financial exploitation	

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F 225	Continued From page 4 registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and review of facility policy and procedure, the facility failed to report 2 of 2 alleged incidents of neglect and/or abuse to the state survey and certification	F 225	investigations in progress. By changing our practice we will protect all residents. **3. This is what the facility will do or changes it will make to the systems that will prevent this problem from reoccurring in the future.** On 2-20-2013 All nursing staff will be educated on the procedure for Abuse and Neglect and instructed to report any concerns of abuse, neglect, mistreatment or misappropriation of property to their supervisor immediately. System Change: The Administrator, DNS, or Social Worker will be notified immediately when abuse is suspected. An e-mail report will be submitted by the Administrator, DNS or Social Services within 24 hours and a final report of the investigation will be sent within 5 working days. **4. This is how the facility will monitor to make sure the changes continue and the problem is prevented.** Social Service will be responsible to complete an audit on five staff members per month for three months to see if they know to	2-28-13 2-28-13 2-28-13

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F 225	Continued From page 5 agency immediately (within 24 hours) and failed to report the results of the investigations for two alleged incidents of neglect and/or abuse to the state survey and certification agency within five working days of the incident. Failure to report all alleged violations involving mistreatment, neglect, or abuse has the potential to place all residents at risk of possible neglect and abuse. Findings include: Review of the facility policy titled "Abuse and Neglect" occurred on 01/16/13. This policy, dated October 2009, stated, " . . . Policy . . . Alleged or suspected violations involving any mistreatment, neglect or abuse . . . will be reported immediately to the center administrator and to other officials in accordance with state law, including the state survey and certification agency . . . Results of all investigations will be reported to the administrator or designated representative and to other officials in accordance with state law, including to the state survey and certification agency within five working days of the incident . . ." Review of the facility procedure titled "Abuse and Neglect" occurred on 01/16/13. This procedure, dated June 2012, stated, ". . . Notification Procedures: a. Notify the center administrator immediately of any incidents of resident abuse, misappropriation of resident property, alleged or suspected abuse and injury of unknown origin, neglect . . . Record this notification on the Incident Report . . . 'Immediately,' in this procedure means "as soon as possible after discovery of the incident, and ought not to exceed the end of the shift, in the absence of a shorter state time frame requirement . . . c. Notify the	F 225	report any allegations of abuse, neglect, mistreatment or misappropriation of property to their supervisor immediately. A report of the audits will be submitted by Social Services to the Quality Assurance Committee for further recommendations.	2-28-13

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F 225	Continued From page 6 designated agencies in accordance with state law, including the state survey and certification agency . . ." Review of two alleged allegations occurred on 01/16/13 at 9:55 a.m. and identified the following: * Resident #19 lost a ruby and diamond ring with gold band on 02/11/12 (Saturday). An investigation report showed the facility notified the state survey certification agency on 02/14/12 (3 days later) and reported final results of the investigation to the state survey and certification agency on 02/21/12, 10 days after the incident occurred. * Resident #17 reported physical mistreatment by a staff member on 07/21/12 (Saturday). An investigation report showed the facility notified the state survey and certification agency on 07/23/12, 2 days after the incident, and reported final results of the investigation on 07/27/12, 6 days after the incident occurred. During an interview on 01/16/13 at 9:55 a.m., an administrative staff member (#19) and a licensed social worker (#2) stated staff fill out initial incident reports at the time of the occurrence and the social worker follows up and notifies the state agency as appropriate. The facility failed to identify a process to address who notifies the state agency if an incident occurs on the weekend.	F 225		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.	F 241	F241 Dignity **1. This is what the facility will do to correct the specific problems, found related to the specific resident identified.** Resident #8 is dressed and covered appropriately to prevent skin exposure in the view of the public during meals. Residents #3, #6, #16 and #19 can not make their needs be known but	

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F 241	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on observation, the facility staff failed to provide care in a manner and in an environment that maintained and enhanced each resident's dignity and respect during random observations in the dining room involving 1 of 1 sampled resident (Resident #8) observed with his abdomen exposed; 2 supplemental residents (Resident #16 and #19) observed having food scraped from their faces; and for 2 of 2 sampled residents (Resident #3 and #6) and 2 supplemental residents (Resident #17 and #21) seated at an assisted table with staff and the staff conversed amongst themselves during the noon meal on 01/14/13. Failure to ensure dignity and respect in the dining room did not recognize the individuality of each resident and enhance the quality of life for each resident. Findings include: Random observations on 01/14/13 showed the following: - 7:45 a.m.: Resident #8 seated in his geri chair in the dining room as staff fed the resident his breakfast. Observation showed staff members failed to pull the resident's pants securely up to his waist, thus exposing approximately 6-8 inches of the resident's abdomen. - 8:10 a.m.: A certified nurse aide (CNA) #3 used a spoon to scrape excess thicken juice off Resident #16's mouth and proceeded to re-feed this to the resident. - 8:40 a.m.: A certified medication aide (CMA) (#12) administered Resident #16's crushed	F 241	by fixing the process they will be protected in the future. Food will not be scarped from resident faces. **2. This is what the facility will do to identify and correct any problems found with other residents who also could be affected by the facility practice.** All resident have the potential to be affected in the area. By changing our practice we will protect all residents. **3. This is what the facility will do or changes it will make to the systems that will prevent this problem from reoccurring in the future.** On 2-20-2013 Nursing Staff were trained to CMS Standards for dignity. Nursing staff were educated on the need to keep conversations resident focused, use appropriate feeding technique that includes not scraping face and to make sure residents have no inappropriate exposed skin when in public areas. **4. This is how the facility will monitor to make sure the changes continue and the problem is prevented.** Social Services or designee will be responsible to complete an audit covering all three meals in a month	2-28-13 2-28-13 2-28-13

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F 241	Continued From page 8 medications mixed in thicken juice. The CMA (#12) used a spoon and placed an heaping spoonful of thicken juice into Resident #16's mouth. The excess thicken juice ran out of Resident #16's mouth and the CMA (#12) used a spoon to scrap the excess thicken juice from Resident #16's mouth. - 12:05 p.m.: Two CNAs (#3 and #9) conversed with each other about a fellow employee as they fed Resident #3 and #21; and while two other residents (Resident #17 and #6) also sat at this same assisted table in the dining room. The CNA's did not acknowledge the residents and failed to interact with them. - Observation on 01/16/13 at 8:47 a.m. showed a CNA (#5) assisted Resident #19 with her hot cereal. The cereal spilled onto the resident's face and the CNA scraped it off with a spoon.	F 241	for three months. The audit will check to make sure resident dignity is preserved during meals. A report of the audits will be submitted by Social Services to the Quality Assurance Committee for further recommendations.	2-28-13
F 246 SS=E	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, review of resident council minutes, and staff interview, the facility failed to provide reasonable accommodations of individual needs on 2 of 2 nursing units (North and West) and 3 of 4 days of	F 246	F246 Accommodation of Needs/Preferences **1. This is what the facility will do to correct the specific problems, found related to the specific resident identified.** Residents #9 and #13's call light is being answered on a timely basis. The DNS will attend resident council in March to follow up on resident concerns on call light times. Resident meeting minutes will be posted for all to review.	2-28-13

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F 246	Continued From page 9 survey. Failure to answer call lights in a timely manner may affect the quality of life and quality of care provided to all residents who reside in the facility. Findings include: - On 01/13/13 at 12:35 p.m., during the initial tour of the facility, Resident #9 voiced her concerns regarding how long it took for facility staff to respond to her call light. Resident #9 reported one incident of her call light unanswered for over 45 minutes which resulted in her being "incontinent of urine." - Observation on 01/14/12 from 4:34 p.m. to 4:47 p.m. (12-13 minutes) showed a bathroom call light flashing and alarming. At 4:47 p.m., a nurse (#6) entered the room and turned off the call light and exited the room. The nurse returned at 4:50 p.m. (16 minutes after call light initiated) and assisted the resident to transfer to and from the toilet. - On 01/14/13 at 4:55 p.m., observation showed an illuminated and audible call light activated in a resident room located on North Unit. Observation showed a staff nurse (#13) in the hallway with her medication cart. At 5:07 p.m. (after the call light sounded for 12 minutes), the resident opened her bathroom door and activated the tab alarm attached to the door. Upon hearing the tab alarm, a staff nurse (#13) entered the resident's room and transferred the resident onto the toilet. The staff nurse (#13) stated the resident's pad was "damp." - Observation on 01/15/13 from 8:44 a.m. to 8:57	F 246	**2. This is what the facility will do to identify and correct any problems found with other residents who also could be affected by the facility practice.** All residents have the potential to be affected in the area. By changing our practice we will protect all residents. **3. This is what the facility will do or changes it will make to the systems that will prevent this problem from reoccurring in the future.** On 2-20-2013 All nursing staff were educated on the call light expectations to be answered timely. Staff educated to answer call lights quickly (within 5-7- minutes) especially during meal time. **4. This is how the facility will monitor to make sure the changes continue and the problem is prevented.** A call light audit will be developed to ensure timely answering of call lights. The DNS or designee will be responsible for the completion of the audit. The audits will be completed on all three shifts. The audit will be done weekly for four	2-28-13 2-28-13

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F 246	Continued From page 10 a.m. (12-13 minutes) showed a call light flashing and alarming on the 200 hallway. - Review of the Resident Council minutes, dated 10/04/12, stated, ". . . [Resident's name] . . . concerns about having to wait for the call light to be answered. . . .Nursing staff will address the call light concern. . . . [a different Resident's name] . . . also had a concern about the call lights not being answered promptly. Resident reported that staff come in turn the call light off, leave, and then don't come back to assist her. . . ." During interview on 01/15/13 at 3:45 p.m., an administrative staff member stated her awareness of Resident #9's call light concern. This administrative staff member (#2) provided an internal communication form, dated 01/08/13 (seven days prior) which informed the Director of Nursing of Resident #9's call light concern. During an interview on 01/15/13 at 5:00 p.m., a social worker (#2) stated residents have approached her in the past about having to wait too long before call lights are answered. During an interview on 01/15/13 at 5:15 p.m., an administrative staff nurse (#1) described call lights on for 12 minutes would be "too long." During interview on 01/16/13 at 8:15 a.m., an administrative staff member (#1) stated she discussed Resident #9's call light concerns with facility staff during the facility's "morning stand-up meeting" however, failed to provide any evidence of additional follow-up or discussion with Resident #9.	F 246	weeks, then monthly for two months. The DNS will hold Nursing Staff accountable if the audit shows lights are not answered timely. If residents need follow up based on the audits, Social Service will make sure the follow up is completed. An audit of the resident council meeting will be developed and completed monthly for three months. The DNS or designee will be responsible for the completion of the audit.	2-28-13

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F 246	Continued From page 11 - During an interview on 01/16/13 at 10:00 a.m., a quality assurance staff member (#11), stated, "the last time an audit was done on call lights was in March of 2012." He stated, "the goal for that audit done in March was 3-5 minutes." He also indicated, since he started this position in May 2012 he has not received a request from the nursing department to monitor call lights.	F 246		
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 02/02/12.	F 280	F280 Care Plans **1. This is what the facility will do to correct the specific problems, found related to the specific resident identified.** Care Plans for residents #2 was updated to include toileting assistance and fall risk. Care plan for resident #6 was updated to include wondering, mobility, and discontinued use of finger foods. Care plan for resident #11 was updated to include fall risk and current resident needs. Resident #5 has been discharged. **2. This is what the facility will do to identify and correct any problems found with other residents who also could be affected by the facility practice.** All residents have the potential to be affected in this area. All resident care plans were reviewed for accuracy. Any problems were corrected as part of the review.	2-28-13 2-28-13

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F 280	Continued From page 12 Based on observation, record review, and review of facility policies, the facility failed to review and revise the comprehensive care plan to reflect the residents' current status for 4 of 11 sampled residents (Resident #2, #5, #6 and #11). Failure to revise the care plans limited staff's ability to communicate care needs and ensure continuity of care for each resident. Findings include: Review of the facility policy titled "Care Plan" occurred on 01/16/13. This policy, updated January 2009, stated, " . . . Care plans will also be reviewed, evaluated and update when there is a significant change in the resident's condition and/or in accordance with state guidelines. This plan of care will be modified to reflect the care currently required/provided for the resident . . ." Review of the facility policy titled "Comprehensive Care Plan and Care Conference" occurred on 01/16/13. This policy, updated January 2011, stated," . . . if a resident has specific behavioral approaches/interventions, the need to be reflected on the care plan and pulled to the Hands On Mood/Behavior Module. . . . Examples of the use of key words related to mood/behavior symptoms with individualized approaches. Agitated: Attempt to calm her by holding hand and talking with her. Crying: Redirect by talking about crocheting or other interest. Note: A default set of approaches display on the Mood/Behavior Module for all new residents. Mood/Behavior approaches must be individualized to the resident when mood/behavior symptoms are present. . . ." - Review of Resident #6's medical record	F 280	**3. This is what the facility will do or changes it will make to the systems that will prevent this problem from reoccurring in the future.** On 2-20-2013 the Care Plan Team members were educated using the Care Plan Policy and Procedure. Licensed Nurses were educated on the need to revise and review care plans to reflect any changes in resident conditions. CNA's were educated on the need to use information on the resident care plans. All nursing staff were educated on the "care plan needs review" button on the kiosk to inform the nursing staff that the care plan needs to be review and updated. Nursing Staff were educated to forward specifically what needs to be updated on the resident care plan to the DNS/MDS Crew so the care plan can be changed. **4. This is how the facility will monitor to make sure the changes continue and the problem is prevented.** The DNS/Designee will complete an audit of 5 % of the resident care plans per month for three months. A report of the audits will be submitted by the DNS to the	2-28-13

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F 280	Continued From page 13 occurred all days of survey and identified diagnoses of dementia, delirium, and impulse control disorder. Resident #3's quarterly Minimum Data Set (MDS), dated 11/17/12, identified the resident as usually capable of making herself understood and usually able to understand others, and displayed the following behavioral symptoms one to three days in the past week: physical and verbal behaviors directed towards others; other behaviors not directed towards others; rejection of care; and wandering. Review of the resident's progress notes identified the resident had a fall on 12/23/12 while ambulating independently in her room. Review of Resident #6's "Mood & Behavior Report" from 12/30/12 through 01/14/13, showed the resident's following behaviors: physical behavioral symptoms directed toward others on 12/30/12 and rejection of care on 01/02/13, 01/05/13, and 01/06/13. Observations during all days of survey showed Resident #6 required staff assistance in a wheelchair and did not walk independently. Review of the resident's activities of daily living (ADLs) charted from 12/27/12 through 01/02/13 identified the resident required extensive to total assistance for walking in corridor on 12/27/12 and this activity did not occur for the other seven days. The ADLs showed the resident required extensive to total assistance for locomotion on and off unit on all the days. Resident #6's current care plan identified the following problems and approaches: * alteration in nutrition "Supervision with eating"	F 280	Quality Assurance Committee for further recommendations.	2-28-13

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F 280	Continued From page 14 and "Offer finger food when wandering at meal time" * impaired mobility "Amb [ambulates] indep [independently] uses hand rails" * alteration in mood and behavior "Wanderguard check function every shift," "Obs [observe] for Elopement: Wandering, repeated request to Leave," and "obs whereabouts freq [frequently]" * alteration in thought process "Cue and remind prn [as needed]" Resident #6's care plan failed to address her physical and verbal behaviors and the resident's fall in December. The care plan failed to reflect her current capability related to mobility, and the facility failed to implement appropriate interventions for the resident's physical and verbal behaviors, rejection of care, and fall history. -Review of Resident #5's medical record occurred January 13-16, 2013. Current diagnoses included quadriplegia, cervical myelopathy, spinal stenosis, and mentally handicapped. A quarterly Minimum Data Set (MDS), dated 11/10/12, identified the resident with functional limitation in range of motion on both sides of the upper and lower extremities and the resident required total assistance of one to to staff for bed mobility, transfers, locomotion on and off unit, personal hygiene, and bathing; and identified the resident required total assistance for eating. Resident #5's medical record identified the resident had the G-tube discontinued on 12/17/12 and on 12/20/12, occupational therapy evaluated the resident due to him not being able to feed self and meal observations on all days of survey	F 280		

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F 280	Continued From page 15 showed Resident #5 required total assistance to eat. Resident #5's medical record identified a fall on 12/08/12 where the resident slid out of his wheelchair after being transported back to his room. A "Fax Communication to Physician" dated 12/08/12, stated a concern from a nurse regarding Resident #5 sliding out of his wheelchair with the physician response stating, "How could [resident's name] slide out of his chair? Please address this w/ [with] OT [occupational therapy] [and] DON [director of nursing] in AM [morning] to prevent further occurrence . . . " Resident #5's current care plan identified the following problems and approaches: * The care plan, dated 11/21/12 stated, ". . . Problem . . . Alt [alteration] in nutrition r/t [related to] quadriplegic . . . Approaches . . . Always put arm rest down so he leans forward . . . Sit at 90 degrees while eating no twist in body and buttocks all the way back in chair . . . " * Alteration in nutrition related to quadriplegia, "Always put arm rest down so he leans forward," "Use small rubber (toddler) spoon for meals with built up handles," "Change G-tube [gastrostomy tube] syringe and graduate daily," and "completely dependent on cues to take breaks between bites and to pull glass away so he only takes on drink at a time" * Ineffective management of therapeutic regime, "Meds [medications] per G-tube, flush tube before and after each med" The care plan failed to identify the resident's history of a fall and failed to implement care plan	F 280		

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F 280	Continued From page 16	F 280		

interventions to prevent further falls after the fall on 12/08/12. The resident's current care plan failed to reflect current feeding assistance needed at meals as well as having his feeding tube discontinued.

- Review of Resident #11's medical record occurred on January 15-16, 2013. Medical diagnoses for Resident #11 include cerebral vascular accident, hypothyroidism, congestive heart failure, and atrial fibrillation.

Resident #11's quarterly Minimum Data Set (MDS), dated 11/08/12, identified the resident required extensive one person physical assistance with transfers and toilet use.

The record identified the resident experienced eight falls from August-December 2012 related to self transfers (August 08, September 03, 12 and 29, October 02, November 16, and December 11 and 13).

An Interdisciplinary Progress Note (IPN), dated 12/13/12 at 6:15 a.m., identified a certified nurse aide (CNA) assisted the resident into the bathroom to use the toilet. Resident #11 told the CNA she wanted to sit awhile on the toilet. The record identified the CNA honored the resident's request, left the bathroom, and proceeded to make the resident's bed. Resident #11 stood up from the toilet unassisted and fell. Resident #11 sustained no injury.

Review of Resident #11's current care plan, stated, ". . . PROBLEM: Mobility, impairment et [and] pot [potential] for injury r/t [related to] falls LONG/SHORT TERM GOALS: Will increase

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strength and endurance. will have [no] avoidable falls. PLANS AND APPROACHES: RT [restorative therapy] Silver Sneaker Home Exercise Program . . . Transfer with asst [assist] of 1 . . . Tab system on when in bed."

Resident #11 exhibited numerous falls related to self transfers. On 12/13/12, Resident #11 sustained a fall in the bathroom when left unattended by facility staff. The facility failed to ensure staff remained with the resident during toileting to prevent further falls related to the resident self transferring in the bathroom.

- Review of Resident #2's medical record occurred on January 13-16, 2013. Medical diagnoses for Resident #2 include cerebral vascular accident, seizure disorder, Parkinson's disease, depression, anxiety disorder, and personality disorder.

Resident #2's quarterly MDS, dated 10/13/12, identified the resident as cognitively intact, and required extensive two person physical assistance with transfers and extensive one person physical assistance with bathing.

Resident #2 sustained a fall on 10/19/12 at 10:15 p.m. while in the shower/tub room. Review of the "Incident Details" from this fall identified one staff member transferred Resident #2 from the shower chair to her wheelchair and the resident "verbalized she was going to fall . . . then fell onto her bottom." Resident #2 sustained no injuries.

The facility informed the physician of Resident #2's fall in the shower room via fax on 10/20/12. The physician's written response stated, "D/W

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F 280	Continued From page 18 [discussed with] DON on 10/20/12. 1. This lady should not stand or be unobserved during bathing. Hx [history of] falls - often deliberate. Please be aware and use caution. 2. Continue to observe." Resident #2's current care plan, dated 10/25/12, identified the approach of "2 staff [members] present" during any cares involving the resident. Review of Resident #2's "PROBLEMS" titled "Self Care Deficit . . ., Mobility Impairment . . ., Alt [alteration] in Mood and Behavior" failed to identify and include the physician's comments of the resident's "deliberate" history of falls. During interview, on 01/16/13 at 8:15 a.m., an administrative nurse stated she recalled the incident of the fall in the shower room on 10/19/12 involving Resident #2. This administrative staff member stated she discussed the incident with Resident #2's physician and with facility staff during the facility's "morning stand-up meeting;" and failed to provide any evidence of any revisions to Resident #2's plan of care to identify her deliberate history of falls.	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, review of professional literature, policy and procedure review, record review, and staff interview, the facility failed to administer medication according to professional	F 281	F281 Professional Standards **1. This is what the facility will do to correct the specific problems, found related to the specific resident identified.** Resident #9 is receiving oral medications according to physician orders and professional standards. Resident #20 is receiving eye medication according to physician orders and professional standards.	2-28-13

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F 281	Continued From page 19 standards for 1 of 3 sampled residents (Resident #9) observed receiving an oral medication and for 1 supplemental resident (Resident #20) observed receiving an ophthalmic (eye) medication. Failure to administer the correct dosage of an ophthalmic medication and failure to administer an oral medication (Prilosec) before a meal as recommend may result in an ineffective or adverse response to the medication. Findings include: The Nursing 2013 Drug Handbook, 33rd edition, Lippincott, Williams, & Wilkins, Pennsylvania, page 1010, states regarding Prilosec, (a proton pump inhibitor medication used to treat symptomatic gastroesophageal reflux disease) ". . . Administration: P.O. [oral] . . . give at least 1 hour before meals." Review of the facility policy titled, "Administration of Medication" occurred on 01/15/13. This policy dated, 10/2009, stated, ". . . Procedure: . . . 4. Using the specific center's medication system, administer medications to the resident according to the 'Five Rights.' Right drug Right dose Right route Right time . . . ." Observation, on 01/14/13 at 2:40 p.m., of medication pass showed a certified medication aide (CMA) (#12) entered Resident #20's room, washed her hands, donned gloves, and placed one artificial tear eye drop into Resident #20's right and left eye.	F 281	**2. This is what the facility will do to identify and correct any problems found with other residents who also could be affected by the facility practice.** All residents that receive medications by the nurse have the potential to be affected in this area. By changing our practice we will protect all residents. **3. This is what the facility will do or changes it will make to the systems that will prevent this problem from reoccurring in the future.** On 2-20-2013 All Licensed Nurses and Medication Assistants will be educated on Medication Administration Policy and Procedures. The education will include how to avoid common errors, especially inappropriate times for medication administration and giving proper dosages of eye drop medication. **4. This is how the facility will monitor to make sure the changes continue and the problem is prevented.** An audit will be developed to monitor medication pass. The Workforce Development Coordinator and the DNS will each complete one observed medication pass of at least 10 residents per	2-28-13 2-28-13

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F 281	Continued From page 20 Review of Resident #20's January 2013 Medication Administration Record (MAR) stated, "Artificial tears 2 gtts [drops] ou [both] eyes TID [three times daily]." Review of Resident #20's medical record identified a physician order, dated 10/25/10 for artificial tears two drops to both eyes three times daily. Observation of medication pass, on 01/14/13 at 5:50 p.m., showed the CMA (#12) provided Resident #9 with Prilosec, along with three other medications (Senokot S, Lipitor, and Zoloft). The surveyor asked Resident #9 if she had eaten supper, and the resident replied "Yes." The administration times for the Prilosec, as printed on Resident #9's January 2013 MAR, stated, "7 a.m. and 5 p.m." During interview on 01/15/13 at 3:00 p.m., after being informed of the above observations, an administrative nurse (#1) stated she expected the CMA to administer Prilosec to Resident #9 before eating or if the resident had already eaten, the staff member should have held this scheduled dose and informed the charge nurse. During interview on 01/16/13, an administrative nurse (#1) confirmed Resident #20's physician's order stated to administer two artificial tear drops to each eye three times daily.	F 281	month for 3 months. A report of the audits will be submitted by the DNS to the Quality Assurance Committee for further recommendations.	2-28-13
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain	F 309	F309 Provide for Highest Well Being **1. This is what the facility will do to correct the specific problems, found related to the specific resident identified.** Resident #3's physician was contacted and the medication was decreased on 2-20-2013. Resident #3 did not have any permanent side effect from receiving the incorrect diet texture.	2-28-13

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F 309	Continued From page 21 or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and review of facility policy, the facility failed to provide the necessary care and services to manage behavioral and psychological symptoms of dementia for 1 of 4 sampled residents (Resident #3) identified with behaviors and receiving a scheduled antipsychotic medication. Failure to assess the reason/causative factor(s) for behaviors, implement appropriate individualized interventions (including non-pharmacological interventions) and establish accurate on-going monitoring of the behaviors has the potential to prevent Resident #3 from achieving her highest practicable physical, mental, and psychosocial well-being. Findings include: Review of the facility policy titled "Behavioral Causes and Interventions" occurred on 01/16/13. This policy dated October 2009, stated, ". . . Purpose: To aid in determining cause of behavior and appropriate intervention and strategies . . . A catastrophic reaction occurs when a situation is too overwhelming for a person with Alzheimers/dementia, causing the person to react inappropriately. In order to effectively deal with the catastrophic reaction, it is important to analyze and identify the catalyst or underlying	F 309	**2. This is what the facility will do to identify and correct any problems found with other residents who also could be affected by the facility practice.** All resident that receive antipsychotic medications have the potential to be affected in this area. A list of resident that receive antipsychotic medications will be generated and each resident will be reviewed by the behavior committee. Care plans and medication orders will be update as appropriate for any resident who lacks proper behavior documentation. All residents that have altered textured diets have the potential to be affected. The Dietician reviewed all resident diet orders including alternative texture diets, to ensure they match physician orders. The Dietician reviewed tray cards to make sure residents are served appropriate textures. **3. This is what the facility will do or changes it will make to the systems that will prevent this problem from reoccurring in the future.** Education was provided to all nursing staff on 2-20-2013 on the need to document resident	~~3/15/13~~ Spoke with Administrator 3-18-13, Change dates back to original Compliance date for all 4 Js except 309+329 JB ~~3/15/13~~

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	355100	A. BUILDING _____ B. WING _____	01/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - DEVILS LAKE	302 7TH AVE NE DEVILS LAKE, ND 58301

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F 309	Continued From page 22 cause. Planning and programming should include attention to a resident as soon as there are signs that a catastrophic reaction may occur such as agitation, increased restlessness, facial or body cues of fear or disorientation or distraught moods. . . ." Review of the facility policy titled "Comprehensive Care Plan and Care Conference" occurred on 01/16/13. This policy dated January 2011, stated," . . . if a resident has specific behavioral approaches/interventions, they need to be reflected on the care plan and pulled to the Hands On Mood/Behavior Module. . . . Examples of the use of key words related to mood/behavior symptoms with individualized approaches. Agitated: Attempt to calm her by holding hand and talking with her. Crying: Redirect by talking about crocheting or other interest. Note: A default set of approaches display on the Mood/Behavior Module for all new residents. Mood/Behavior approaches must be individualized to the resident when mood/behavior symptoms are present. . . ." - Review of Resident #3's medical record occurred on January 13-16, 2013. The facility admitted Resident #3 in May 2012. Medical diagnoses for Resident #3 included dementia with behavioral disturbances and impulsive control disorder (ICD). Resident #3's significant change Minimum Data Set (MDS), dated 11/01/12, identified the resident exhibited long-term memory impairment; and the following mood and behaviors: little interest/pleasure in doing things, trouble falling/staying asleep/sleeping too much, feeling tired/having little energy present nearly every day.	F 309	behaviors and the need for staff to follow the diet card. Education provided to dietary staff on the need to follow physician order diet. The Dietician will reviewed tray cards monthly to ensure residents are served appropriate textured diets. This will continue on an on-going basis. **4. This is how the facility will monitor to make sure the changes continue and the problem is prevented.** Social Service will audit resident behavior notes weekly for four weeks, then monthly for two months to make sure any resident receiving antipsychotic mediation has appropriate behavior documentation in place. A report of the audits will be submitted by Social Service to the Quality Assurance Committee for further recommendations. The dietician will audit speech therapy notes every two weeks for one month, then monthly for two months to check for any changes in diet texture. A report of the audits will be submitted by the Dietician to the Quality Assurance Committee for further recommendations.	3/15/13 Adm: Changed per phone conver. 3-21-13 JB 3-28-13 3/15/13

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F 309	Continued From page 23 Resident #3's current behavioral care plan, dated 11/21/12, stated, "PROBLEM: Pot [potential] for alt [alteration] in mood status/behavior r/t [related to] dementia with behaviors, ICD m/b [manifested by] SNF [skilled nursing facility] placement. LONG/SHORT TERM GOALS: Will be accepting of nursing home placement. PLANS AND APPROACHES: 1:1 visits with SS [social service] addressing psychosocial adjustment. Remind resident that sexual remarks are inappropriate. Meds [medications] as ordered, obs [observe] for effectiveness, side effects, and adverse consequences. PROBLEM: Pot for alt in thought process r/t dementia, ICD m/b confusion. LONG/SHORT TERM GOALS: Will accept assist and redirection. PLANS AND APPROACHES: Segment tasks into simple steps." Random observations on 01/14/13 showed facility staff transported Resident #3 by wheelchair to the dining room for all meals. Between meals Resident #3 remained in his room, and asleep in bed. Observations on January 14-16, 2013 showed facility staff members failed to arouse/awake Resident #3 or encourage him to attend or participate in the facility's activity programs. Moods exhibited by Resident #3 in September 2012 included being short tempered/easily annoyed (on 05, 15 and 27). Behaviors exhibited by Resident #3 in September 2012 included physical and verbal behavioral symptoms directed toward others (on 05, 15 and 27); other behavioral symptoms not directed towards others (on 15); and rejection of care (on 05).	F 309		

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F 309	Continued From page 24 Resident #3 exhibited being short tempered/easily annoyed and verbal behavioral symptoms directed towards others on 11/25/12. Resident #3's record lacked any documented moods or behaviors for the months of October and December 2012 and January 2013. Review of Resident #3's Interdisciplinary Progress Notes (IPNs) from September 2012 thru January 15, 2013 identified licensed nursing staff members assessed and documented two "behaviors" by Resident #3 in September 2012 (the 15 and 25). Resident #3's medical record identified a psychiatrist seen/examined the resident on four occasions in 2012 (on June 20, August 15, October 17, and December 19). The psychiatrist prescribed Risperdal (an antipsychotic medication) to help manage Resident #3's behaviors of grabbing female caregivers and expressing verbal sexual comments to females. Review of Resident #3's "Initial Antipsychotic Medication Assessment" dated 07/09/12, stated, ". . . Symptoms/behaviors being treated . . . grabbing female caregivers peri areas, sexual comments to females . . . What 'Behavioral Interventions' have been tried and what success was achieved? Distraction, reapproach, redirection, different staff, family involvement-none of the above worked . . . ." Resident #3's physician ordered Risperdal usage included: Risperdal 0.5 milligrams (mg) twice daily (BID) started on 07/16/12.	F 309		

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F 309	Continued From page 25 Increased to 0.5 mg in the a.m. and 1.0 mg at bedtime on 08/15/12. Decreased to 0.5 mg BID on 10/17/12. Review of a Psychiatric Progress Note, dated 10/17/12, identified facility staff noted Resident #3's moods to be "stable and his behavior has been good." In addition, facility staff reported "sedation" to the psychiatrist. The psychiatrist decreased Resident #3's Risperdal dosage and recommended a follow-up appointment in two months. Review of a Psychiatric Progress Note, dated 12/19/12, stated, "Notes . . . Staff reports that his moods have been stable and his behavior has been tolerable. There has been some reported sedation according to staff but it reported as tolerable. His medical medications were reviewed . . . Assessment: He is doing okay on his present dose of medications in regards to his Impulse Control Disorder and his Dementia with behavioral disturbances. I do not want to reduce the medications at this time. Plan: 1. Reduce the Risperdal to 0.5 mg po [orally] bid. 2. Return to see me in two months." At the time of the December psychiatric visit, Resident #3's current Risperdal dosage was 0.5 mg BID. The psychiatrist noted "some reported sedation" by staff members. The psychiatrist's plan of treatment indicated to "reduce" Resident #3's Risperdal to 0.5 mg BID which was his current dosage. Facility staff failed to contact and clarify Resident #3's Risperdal dose with the psychiatrist following receipt of this signed dictated note.	F 309		

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F 309	Continued From page 26 Resident #3's medical record lacked evidence facility staff identified and assessed the reason/causative factor(s) for the mood and behaviors documented by the direct care staff beginning in July 2012, and implemented individualize interventions to prevent or reduce these behaviors prior to the initiation of an antipsychotic medication. 2. Based on observation, record review, and staff interview, the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with a comprehensive assessment and plan of care for 1 of 1 sampled resident (Resident #3) observed receiving the incorrect diet texture of food in the dining room. Failure to provide Resident #3 with the correct food texture (as recommended by the occupational therapist [OT]) placed this resident at risk of swallowing difficulties, increased coughing, potential blockage, and choking. Findings include: A IPN, dated 12/22/12, identified the facility noted Resident #3 displayed increased coughing with fluids. On 12/24/12, the facility initiated a referral to an occupational therapist (OT). Review of the form titled "Dysphagia Evaluation and Plan of Treatment," identified a "SOC [Start of Care]" date of 12/26/12 for "Treatment Dx: [diagnosis] Dysphagia." The OT's initial assessment identified Resident #3's diet as "Level 3 [with] nectar thick liquids [with] sippy cup [and] [assistance] for self feeding. The OT's initial observation of Resident #3 showed the resident	F 309		

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F 309	Continued From page 27 coughed three times during the meal while consuming a Level 3 diet and drinking nectar thick liquids. The OT documented the inability to distinguish if the cough "was the result of food or liquids" with a plan to "[change] diet to Level 3 [with] honey thick liquids for trial for pt [patient] safety." On 01/14/13 at 8:24 a.m. observation of Resident #3's dietary card identified the following: "Please trial Level 3 foods [and] ground meats [with] honey thick liquids, effective 12/27/12 . . . Bkft [breakfast] fortified cereal - no toast . . . ." Observation on 01/14/13 of the food items and beverages served to Resident #3 at the breakfast included: a poached egg, cream of wheat, bread with butter, and honey-thickened orange juice to the resident. The OT (#23) arrived in the dining room at 12:15 p.m. on 01/14/13 and observed Resident #3 during the dinner meal. The OT inquired from facility staff how much and what Resident #3 consumed for breakfast. A staff member (#21) stated and informed the OT (#23) of the food items and beverages provided to Resident #3 at breakfast included "bread." The OT (#23) stated the facility should not provide "any bread" to Resident #3. During interview on 01/14/13 at 12:45 p.m., the OT (#23) stated Resident #3 exhibited difficulty with swallowing pancakes in late December and changed Resident #3's diet to eliminate all bread products. The OT (#23) stated he expected the dietary staff members not to provide bread to Resident #3.	F 309		

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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, policy review, and staff interview, the facility failed to provide the necessary care and services for 1 of 6 sampled residents (Resident #6) who required assistance with eating and 2 of 10 sampled residents (Resident #1 and #5) who required extensive to total assistance with personal hygiene. Failure to provide assistance at meals placed Resident #6 at risk for nutritional decline and failure to provide shaving to Resident #1 and #5 limited the residents' ability to maintain personal grooming. Findings include: Review of the facility policy titled "Comprehensive Care Plan and Care conferences" occurred on 01/16/13. This policy dated January 2011, stated, ". . . Formulating the Care Plan: The care plan is driven by identified resident issues/conditions . . . When implemented in accordance with standards of good clinical practice the care plan becomes a powerful, practical tool representing the best approach to providing quality of care and quality of life. . . Note: if a problem statement is a "potential for," you may need a m/b [manifested by] statement . . . Example (with m/b): Self-care	F 312	F312 ADL Care Provided **1. This is what the facility will do to correct the specific problems, found related to the specific resident identified.** Resident #6 is being cued and encouraged to eat her food and the care plan was updated as needed. Resident # 1 was shaved and staff instructed to document when they offer to shave resident. Resident #5 was discharged. **2. This is what the facility will do to identify and correct any problems found with other residents who also could be affected by the facility practice.** All residents have the potential to be affected in this area. By changing our practice we will protect all residents. **3. This is what the facility will do or changes it will make to the systems that will prevent this problem from reoccurring in the future.** System Change: The DNS and Dietician reviewed the seating arrangement and serving order to ensure residents are served timely. The Charge Nurses were educated	2-28-13 2-28-13

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F 312	Continued From page 29 deficit r/t [related to] extreme weakness m/b inability to bathe, dress/undress, groom self . . ." - Review of Resident #6's medical record occurred January 13-16, 2013 and identified diagnoses of dementia, delirium, and impulse control disorder. Resident #3's quarterly MDS, dated 11/17/12, identified the resident as independent with eating. Review of the level of assistance needed for activities of daily living (ADLs) for 12/27/12 through 01/15/13 (20 days) showed the resident needed limited or extensive assistance to eat one meal during 15 days and required only supervision assistance at meals on four days. - Resident #6's current care plan stated, "Problem . . . alt [alteration] in nutrition r/t dementia, Vit [vitamin] B-12 def [deficiency] m/b wanders from table at mela [meal] time . . . Plan and Approaches . . . Level 4 NAS [no added salt] diet . . . Supervision with eating . . . Offer finger food when wandering at meal time . . ." Observation on 01/14/13 at 8:10 a.m. showed Resident #6 seated in her wheelchair at the breakfast table along with three other residents (Resident #3, #17, and #21). All of the resident's had plates of food in front of them. Two staff members (#5 and #21) provided physical assistance to Resident #1 and #21. Observation showed the staff members seated at this same table, failed to verbally cue, encourage, or assist Resident #6 to eat her breakfast. At 8:34 a.m. a licensed nurse (#20) brought Resident #6's medications to the table and encouraged the resident to drink her milk and swallow her medication. At 8:50 a.m. observation showed	F 312	on the requirement to be present in the dining room during meal service. Residents that require assistance with meals will be served first to free up staff at the end to toilet resident and to answer call lights more timely. Charge Nurse duties include ensuring residents receive the correct diet and assistance with eating from staff. On 2-20-2013 nursing staff were educated on the need to shave residents and offer meal cueing and assistance with dining and this will be documented on the electronic kiosks. Staff was educated on the need to keep the conversation oriented to the resident, not to discuss other employees during resident dining time. **4. This is how the facility will monitor to make sure the changes continue and the problem is prevented.** Social Services or designee will be responsible for the completion on an audit on all three meals weekly for four weeks, then monthly for two months. The audit will check to make sure residents receive appropriate meal assistance, diet	2-28-13 2-28-13

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F 312	Continued From page 30 Resident #6 placed her toast into a glass of cranberry juice. Observation on 01/14/13 at 8:57 a.m. showed a CNA (#21) wheeled Resident #6 out of the dining room and stated the resident ate a couple bites. The CNA stated the resident usually doesn't eat much in the morning. The daily food intake report showed staff documented the resident ate 25 percent of her breakfast meal on 01/14/13. Observation on 01/15/13 at 8:15 a.m. showed Resident #6 seated in her wheelchair at the breakfast table along with three other residents (Resident #3, #17, and #21). At 8:40 a.m. observation showed a staff member (#21) served Resident #6 her breakfast consisting of a hard boiled egg, toast, and cream of wheat. At 8:45 a.m., a staff member (#21) provided physical assistance to two other residents (Resident #3 and #21) seated at the same table. At 8:47 a.m., Resident #6 picked up her fork but was unable to get any of the egg on her fork and put the fork down. The staff member (#21) (seated at the same table as Resident #6) failed to encourage or cue Resident #6 to eat her food. Record showed the resident consumed 25% of her breakfast meal. The facility failed to cue and encourage Resident #6 to eat her food and failed to address the increased need for assistance on her plan of care limiting the facility's ability to maintain necessary services to meet the resident's nutritional needs. - Observations on all days of survey showed Resident #1 and Resident #5, two male residents, with unshaved facial hair.	F 312	texture and staff is talking to residents appropriately at meals. A report of the audits will be submitted by Social Services to the Quality Assurance Committee for further recommendations. Social Services will be responsible to complete audits checking for appropriate shaving. Audits will be completed two times per week for four weeks than monthly for two months. A report of the audits will be submitted by Social Services to the Quality Assurance Committee for further recommendations	2-28-13 ~~3-11-13~~ 2-28-13

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F 312	Continued From page 31 - Review of Resident #5's medical record occurred on all days of survey. Current diagnoses included quadriplegia and mentally handicapped. The resident's quarterly MDS, dated 11/10/12, identified the resident with severe cognitive impairment, required total assistance for personal hygiene, had functional limitation in range of motion in upper extremities, and failed to identify any behavioral symptoms including rejection of care. Review of Resident #5's current care plan identified the following, ". . . Problem . . . Self care deficit r/t quadriplegic, mild MR [mental retardation] m/b assist of 1 with ADL's . . . Plans and Approaches . . . Shave daily asst of 1 . . ." Review of Resident #5's "Mood & Behavior Report" from 11/01/12 through 01/14/13 showed no behaviors documented including rejection of care. - Review of Resident #1's medical record occurred on all days of survey. Current diagnoses included agitation, dementia, psychosis with reactive confusion, and aphasia. The resident's quarterly Minimum Data Set (MDS), dated 01/05/13, identified the resident with severe cognitive impairment, required extensive assistance of one person for personal hygiene, and failed to identify behaviors including rejection of care. Review of Resident #1's current care plan identified the following, ". . . Problem . . .Self care deficit r/t Alzheimer's, agitation m/b needs assist of 1 with ADL's may resist care . . . Plans and Approaches . . . Shave daily asst of 1 may refuse	F 312		

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F 312	Continued From page 32 . . . Encourage to have beuatician [sic] cut hair/shave . . ." Review of Resident #1's "Mood & Behavior Report" from 10/27/12 through 01/14/13 showed no documentation of refusal of cares. The facility failed to offer shaving to Resident #5 during observations of personal cares on 01/14/13 at 11:18 a.m. and 5:24 p.m. The facility staff failed to offer shaving to Resident #1 during observations of personal cares on 01/14/13 at 5:05 p.m., and 01/15/13 at 9:14 a.m. and 2:47 p.m. During an interview on 01/14/13 at 5:40 p.m., a two certified nursing assistant (#25 and #27) assisting Resident #5 identified if a resident refused to be shaved, staff would document the rejection of care. During an interviews on 01/15/13 8:45 a.m., the CNA (#21) who assisted Resident #1 with morning cares stated she doesn't document anywhere if a resident refuses to shave, and she would tell the nurse. During an interview on 01/15/13 at 9:40 a.m., the CNA (#26) who assisted Resident #5 with morning cares stated Resident #5 was not shaved today because she ran out of time. This CNA stated the resident's shaver is kept at the nurses station and if the resident refused to be shaved the CNAs would document it. The CNA stated Resident #5 doesn't typically refuse cares. The facility staff failed to shave Resident #1 and Resident #5's facial hair on all days of survey as identified on plan of care.	F 312	F314 Prevention of Pressure Ulcers **1. This is what the facility will do to correct the specific problems, found related to the specific resident identified.** Resident # 3 has a pressure relief wheel chair cushion and pressure relief mattress. The resident is being turned and repositioned every two hours to relieve pressure off the coccyx area.	2-28-13
F 314	483.25(c) TREATMENT/SVCS TO	F 314		

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	355100	A. BUILDING _____ B. WING _____	01/16/2013

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F 314 SS=D	Continued From page 33 PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy and procedure review, and staff interview, the facility failed to ensure that 1 of 1 sampled resident (Resident #3) with a facility acquired pressure ulcer (PU) received the necessary treatment and services to promote healing. Failure to implement pressure relieving interventions for Resident #3 may result in delayed healing of his coccyx PUs, cause unnecessary pain, and additional development of PUs. Findings include: Review of the facility policy titled, "Pressure Ulcer Practice Guidelines" occurred on 01/15/13. This policy dated, 09/2010, stated, "PURPOSE: To provide current information on prevention and management for pressure ulcers . . . MOVEMENT OR MANAGEMENT OF TISSUE LOAD: Staff should implement resident specific turning and positioning programs based upon an individualized assessment. This includes a consistent program for changing the resident's	F 314	**2. This is what the facility will do to identify and correct any problems found with other residents who also could be affected by the facility practice.** All residents that require assistance with transfer and ambulation have the potential to be affected in this area. All residents will have a weekly documented skin inspection. **3. This is what the facility will do or changes it will make to the systems that will prevent this problem from reoccurring in the future.** On 2-20-2013 nursing staff were educated on Pressure Ulcer Practice guidelines. The Education included repositioning residents to relieve coccyx pressure, the need for daily documentation on all residents with pressure ulcers and the requirement of completing weekly skin audits on all residents. Licensed Nurses are responsible to check for proper repositioning as required by the care plan. Any new concerns noted will be followed up by the Charge Nurse and reported to the DNS via an incident report. Nursing Staff were educated on Pressure Ulcer Management Process. This includes	~~2-28-13~~ 2-28-13 2-28-13 ~~3/15/13~~

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F 314	Continued From page 34 position and realigning the body. Review of the facility policy titled, "Pressure Ulcer: Skin Assessment and Prevention" occurred on 01/15/13. This policy dated, 01/2012, stated, "PURPOSE: . . . To appropriately use prevention techniques and pressure redistribution surfaces on those residents at risk for pressure ulcers. PROCEDURE: . . . 6. Residents who are unable to reposition themselves independently should be repositioned as often as directed by the care plan approaches. Developing an individualized repositioning schedule is recommended based on observation of the resident's skin over a period of time. Individual pressure points are observed for redness or discomfort (tissue tolerance) . . . The positioning schedule should be communicated to the nursing assistants . . . ." Review of Resident #3's medical record occurred on January 13-16, 2013. The facility admitted Resident #3 in May 2012. Medical diagnoses for Resident #3 included dementia with behavioral disturbances and impulsive control disorder (ICD). Resident #3's significant change Minimum Data Set (MDS), dated 11/01/12, identified the resident exhibited long-term memory impairment; mood and behaviors of little interest/pleasure in doing things, trouble falling/staying asleep/sleeping too much, feeling tired/having little energy present nearly every day during the look-back period; required extensive two person physical assistance with bed mobility and transfers; at risk for the development of PUs; and the utilization of pressure reducing devices in the chair and bed.	F 314	repositioning residents, skin monitoring and providing additional nutritional intake for residents with pressure ulcers. This Pressure Ulcer Management Process will be included in the resident's care plan and documented as needed. This will continue on an ongoing basis. 3/15/13 2-28-13 **4. This is how the facility will monitor to make sure the changes continue and the problem is prevented.** DNS or designee will complete an audit weekly for four weeks, then monthly for two months. The audit will focus on wound care documentation of pressure ulcers on a daily, weekly, and monthly skin inspection documentation. CNAs will inspect resident skin daily with routine cares. A report of the audits will be submitted by the DNS to the Quality Assurance Committee for further recommendations. 3/15/13 2-24-13	

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F 314	Continued From page 35	F 314		

Resident #3's current care plan, dated 11/21/12, stated, "PROBLEM: Pot [potential] for skin integrity impairment r/t [related to] ICD, dementia with behaviors, m/b [manifested by] hx [history of] skin tears. Stage II pressure ulcers to bil [bilateral] heels, lt [left] [and] rt [right] buttocks [dated 01/2013]. . . . PLANS AND APPROACHES: Pressure relieving concave mattress-bed, cushion -chair . . . Blue heel boots on at all times."

Resident #3's "Wound Flow Sheets" identified a left coccyx ulcer measuring 2.5 centimeters (cm) (length) by 2.1 cm (width) on 01/05/13 and a right coccyx ulcer measuring 1.5 cm by 1.0 cm on 01/10/13.

The facility identified the implementation of a repositioning/turning schedule for Resident #3 on 01/10/13, but failed how often staff should reposition the resident.

Resident #3's December 2012 and January 2013 Treatment Administration Records showed facility staff completed the following treatments and interventions to Resident #3's PUs:

12/22/12 - "Booties while in bed to bilateral feet for protection."

12/24/12 - "Hydrocolloid to lt heel. [change] q [every] 3-5 days [and] PRN." On 01/04/13, the facility added the same treatment to the right heel.

12/25/12 - "Triad cream to coccyx TID [three times daily] until healed. If no improvement in 3-4 days, please get a wound care evaluation."

01/08/13 - Wound care evaluation of the bilateral heel PUs. "Clean [and] dress [with] Aquacel [and] hydrogel dressing twice a week- q

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F 314	Continued From page 36 Tues [Tuesday] [and] Fri [Friday]." 01/10/13 - "Triad cream to bilateral buttocks q 4 [hours]." Observations on 01/14/13 of Resident #3 showed: 7:40 a.m.- Resident #3 sitting in a wheelchair (w/c) in the hallway. Noted a pressure relieving cushion to the seat of the w/c and pressure relieving bilateral blue booties on feet. 9:16 a.m.- Two certified nurse aides (CNAs) (#21 and #9) transported Resident #3 in his w/c from the dining room (DR) to his room and transferred the resident to bed using a full body mechanical lift. The CNAs positioned Resident #3 on his back, placed his feet upon a pillow, and elevated his bilateral heels off the bed. 10:45 a.m. and 11:15 a.m.- Observation showed Resident #3 remained in bed, laying on his back. 11:45 a.m. - Observation showed Resident #3 lying on his back in bed. Two CNAs (#21 and #9) and transferred the resident out of bed into his w/c using a total full body mechanical lift and transported the resident to the DR. The resident remained on his back with direct pressure to his coccyx area for two and one-half hours. 1:25 p.m. - Resident #3 laying supine in bed, with his eyes closed, bilateral pressure relieving booties on feet, and his heels elevated off the bed. 3:00 p.m. and 4:12 p.m.- Observation showed Resident #3 remained in bed, laying on his back with direct pressure to his coccyx area. The resident remained in this position for two hours and forty-five minutes. Observation on 01/15/13 showed Resident #3	F 314		

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F 314	Continued From page 37 sitting in his w/c in the dining room from 7:45 a.m. - 9:30 a.m. At 9:35 a.m. two CNAs (#26 and #9) transported Resident #3 in his w/c from the DR to his room and transferred the resident to bed using a full body mechanical lift. The CNAs positioned Resident #3 on his back, placed his feet upon a pillow, and elevated his bilateral heels off the bed. Observation showed staff members failed to turn/position Resident #3 off of his coccyx area. At 01/15/13 at 9:55 a.m., a licensed nurse (#20) completed the dressing change to Resident #3's bilateral heels. Upon the completion of the dressing change, the nurse (#20) repositioned Resident #3 on his left side. During interview on 01/15/13 at 3:00 p.m., an administrative nurse (#1) stated the facility does not document individual turning/repositioning of residents and stated she expected her staff to turn/reposition residents as part of the resident's routine plan of care. This administrative nurse stated she expected staff members to position Resident #3 off of his coccyx area to promote pressure relief and healing of his PUs. Facility staff failed to consistently prompt/encourage and provide Resident #3 with pressure relieving interventions to his coccyx area while in bed.	F 314		
F 323 SS=D	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	F 323	F323 Free of Accidents **1. This is what the facility will do to correct the specific problems, found related to the specific resident identified** Resident #4 room was searched and no knives were found. No other dangerous items were found. Resident #4 no longer expresses a desire to do harm to himself. Resident #6 was assessed with the Mobilization Support data collection tool, the transfer method was reviewed and care plan updated.	2-28-13

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F 323	Continued From page 38 prevent accidents. This REQUIREMENT is not met as evidenced by: 1. Based on observation, record review, and staff interview, the facility failed to make a reasonable effort to identify hazard and/or risk factors, provide specific interventions and/or monitoring and adequately assess for specific self injurious behaviors for 1 of 1 sampled resident (Resident #4) who expressed a desire to hurt himself. Findings include: Review of Resident #4's medical record occurred on all days of survey. Diagnoses include dementia, traumatic brain injury, cerebrovascular accident, and expressive aphasia. Resident #4's quarterly Minimum Data Set (MDS), dated 12/15/12, identified the resident with moderate cognitive impairment and severe depression. Review of Resident #4's Interdisciplinary Assessments and Summary Review note, dated 12/14/12, stated, ". . . When the resident was asked the question 'Have you been bothered by thoughts that you would be better of [sic] dead or hurting yourself in some way ?' Resident replied 'yes' Writer asked him further about this & [and] he told writer that he would hurt himself [with] a knife. The resident's physician will be notified as well as the D.O.N. [director of nursing] Resident also expressed having a poor appetite due to not	F 323	**2. This is what the facility will do to identify and correct any problems found with other residents who also could be affected by the facility practice.** All resident that require assistance with a mechanical lift have the potential to be involved in an accident. Any resident with prior ideas of suicide will be reviewed to ensure the care plan addresses suicidal statements. **3. This is what the facility will do or changes it will make to the systems that will prevent this problem from reoccurring in the future.** Nursing staff were educated on 2-20-2013 on the need to follow the plan of care for mobility and transfers. This training included proper use of gait belts. The facility is part of the No Lift program to prevent staff and resident injuries and all new staff will be educated as part of this on-going program. Social Service was educated on the procedure for suicide precautions and to report any residents who express suicidal thought/ideation to the DNS and Administrator immediately. Social Service Policy	2-28-13 2-28-13

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F 323	Continued From page 39 liking the food served here. Resident reported having trouble sleeping. He told writer he lays in bed thinking a lot. The resident's Guardian was notified of this concern. Will continue to monitor & offer support. The D.O.N. plans to visit [with] the resident's physician re: [regarding] medications." Review of Resident #4's Interdisciplinary Progress notes lacked any documentation to indicate staff had followed up on the resident's expression of harming himself. The resident's care plan also lacked any problem, goal or interventions related to the above documentation. Review of a physician's progress note, with a date of service as December 22, 2012, but not received by the facility until 1/16/13 (34 days after the interview with the Social Worker), stated, ". . . It should be noted that there is a note from Social Worker dated 12/14/2012 regarding answers to questions she posed during a BIMS [Brief Interview for Mental Status] Assessment. She states that [Resident's name] stated he would hurt himself. There are several issues with this. I do not think [Resident's name] is able to fully comprehend the type and length of question that was given to him. I believe his ability to comprehend is limited by his traumatic brain injury, as well [sic] his cerebrovascular disease, cognitive impairment and dementia. I do not feel that [Resident's name] is suicidal or has expressed any idea of self-harm. I do not feel he presents a threat to himself or others . . . " Observations during the survey showed Resident #4 self propelling in his geri chair throughout the facility and in his room.	F 323	II.S.6, titled Suicide Precautions, and II.S.6a, titled Understanding and Helping the Suicidal Resident, were used for the education. The policies include initiating monitoring, removing all items that could cause self injury. Licensed Nurses and CNA's were educated on the need to report any resident who expresses any suicidal thought/ideation. **4. This is how the facility will monitor to make sure the changes continue and the problem is prevented.** On 2-20-2013 Nursing or designee will audit all residents that make statements of suicide or suicidal ideations, a room search will be completed for sharp objects, and care plan will be updated. The audit will be completed monthly for three months. A report of the audit will be reported to the QA committee for further recommendations. The Restorative Nurse and Restorative Aide will watch three resident transfers per week for four weeks, then monthly for two months checking to make sure the proper method was safely used. A	2-28-13 2-28-13

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F 323	Continued From page 40 During an interview on 01/15/13 at 10:30 a.m., a social service staff member (#2) stated, "she did not check [Resident #4's] room for a knife" and failed to identify and address potential risks and/or develop a plan to monitor the resident for potential self harm. During an interview on 01/15/13 at 12:30 p.m., an administrative nurse (#1) stated, she had called the physician regarding Resident #4's statement, but failed to document the conversation in the medical record. 2. Based on observation, record review, review of facility procedures, and staff interview, the facility failed to ensure a safe environment with adequate staff assistance and/or appropriate assistive devices during personal cares for 1 of 3 sampled residents (Resident #6) requiring asistance with transfers. Failure to utilize assistive devices (a stand lift) safely for Resident #6 during transfers increased the risk of falls and has the potential to cause injury and pain to the resident. Findings include: Review of the facility policy titled "Fallen or Injured Resident" occurred on 01/16/13. This policy, dated October 2012, stated ". . . Purpose - To give prompt treatment - To prevent further injury - To make staff aware of required and optional documentation related to falls . . . Procedure . . . 19. Update the Comprehensive Care plan and Documentation Record and GSS [Good Samaritan Society] Resident Services with any changes/new interventions and/or initiate a Post-Fall Short-Term Care Plan. . . ."	F 323	report of the audits will be submitted by the Restorative Nurse to the Quality Assurance Committee for further recommendations.	2-28-13

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F 323	Continued From page 41 Review of the facility policy titled "Comprehensive Care Plan and Care Conference" occurred on 01/16/13. This policy, dated February 2005, states, ". . . the care plan is driven by identified resident issues/conditions and their unique characteristics, strengths, and needs. . . . Plans/approaches are what staff do to help the residents reach their goals and should be: 1) individualized, realistic . . . 2.) specific and concise by saying what we plan to do . . . 3) Written with key words and numbered to cue staff of the approach . . . Examples of the use of key words related to care plan approaches with individualized approaches. Transfer: two person assist, total lift, medium sling . . ." - Review of Resident #6's medical record occurred on all days of survey. Current diagnoses included impulse control disorder, dementia, and delirium. The resident's "ADLs [activities of daily living] Report" from 12/27/12 to 01/16/12 identified the resident required extensive assistance of one to two people for transfers and toilet use on all shifts except the night shift of 12/31/12 where the resident was coded as independent. The resident experienced a fall in her room on 12/23/12. Resident #6's current care plan identified the following problems and approaches, ". . . Self care deficit r/t dementia m/b [manifested by] supervision of 1 subtask [sic] with ADL's . . . Assist of 1 with ADL's . . ." The resident's care plan failed to identified fall risk or transfer assistance required. A "Mobilization Support Data Collection Tool"	F 323		

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F 323	Continued From page 42 completed on 01/07/13, identified Resident #6 required assistance of 1 person using the electronic "Sit to Stand" lift with a medium sized sling for transfers. Observation on 01/14/13 at 9:24 a.m. showed a certified nurse assistant (CNA #3) assisted Resident #6 to the bathroom with an electric stand lift. During the transfer, the sling slid up around the resident's chest as the resident's shoulders raised causing her right ear to touch her right shoulder. The CNA transferred the resident off the toilet, failing to tighten or adjust the strap, and the resident's shoulders again raised up. Observation on 01/14/13 at 3:25 p.m. showed a CNA (#4) assisted Resident #6 from wheelchair to toilet and back to a wheelchair without the use of any assistive device, including a gait belt or stand lift. During the transfer from the wheelchair to the toilet, the CNA counted "one, two, three" two times to cue the resident to stand after the resident failed to stand after the first count. The resident stood, leaned forward, and held the grab bars next to the toilet while the CNA lowered the resident's pants. The CNA encouraged the resident to pivot, the resident made confused comments, and tried to sit back down onto the wheelchair. The CNA lifted under the resident's right armpit to assist the resident onto the toilet. After voiding, the resident stood and leaned forward to hold onto the arms of the wheelchair while the CNA completed pericares. The resident moved her feet and sat down in the wheelchair without the CNA holding onto the resident and without the use of a gait belt.	F 323		

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F 323	Continued From page 43 The staff failed to utilize and appropriately use a stand lift sling placing the resident at risk for falls and pain.	F 323	F329 Free from Unnecessary Drugs **1. This is what the facility will do to correct the specific problems, found related to the specific resident identified.** Resident #7's physician was contacted to review this medication dose and current behaviors. Care plan will be updated as needed. Social Services provided Resident #7's family information related to the use of anti-anxiety medication. ~~This was completed on 3-13-13~~ 3/15-13 **2. This is what the facility will do to identify and correct any problems found with other residents who also could be affected by the facility practice.** All residents receiving anti-anxiety drugs have the potential to be affected in this area. All identified residents will be reviewed for appropriate behavior documentation to warrant ongoing usage of the medication. Care plans reviewed and updated as needed. 3-15-13 3. This **is what the facility will do or changes it will make to the systems that will prevent this problem from reoccurring in the future.**	
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review, professional reference, and staff interview, the facility failed to ensure an adequate indication for an increased dosage of Ativan (an antianxiety medication) for 1 of 1	F 329		

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	355100	A. BUILDING _____ B. WING _____	01/16/2013

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F 329	Continued From page 44 sampled resident (Resident #7) without documented anxiety and/or behaviors. Failure to adequately assess Resident #7's need for an increased dose of an antianxiety medication without first assessing his anxiety and/or behaviors resulted in Resident #7 receiving an unnecessary medication. This practice did not allow Resident #7 to reach his highest practicable mental, physical, and psychosocial well-being. Findings include: The 2013 Nursing Drug Handbook, page 843-844, identified adverse reactions to Ativan (lorazepam) as drowsiness, sedation, amnesia, insomnia, agitation, dizziness, weakness, unsteadiness, disorientation, depression, and headache. Use cautiously in elderly, acutely ill, or debilitated patients. Review of Resident #7's medical record occurred on all days of survey. Diagnoses include progressive dementia of the Alzheimer's type, depression, and anxiety. Review of Resident #7's medical record identified the following dose changes of Ativan since April 2012: *A physician's progress note, dated April 19, 2012, stated, . . ." Ativan 0.5 mg [milligrams] in the evening and 0.5 mg at 11 in the morning and then at 3 in the afternoon along with additional 0.5 mg b.i.d. [twice a day] p.r.n. [as needed]" *A physician's progress note, dated May 8, 2012, stated, . . ." He is less alert, we did cut the Ativan to 0.5 mg b.i.d.; his wife and daughter do not feel that he can manage with further reduction at this time. We did, however, cut the Zoloft [an	F 329	A Licensed Staff and Social Service meeting was held on 2-20-2013 to educated the staff on the Chemical Restraint policy and procedure. At the time the medication is ordered, all residents and families who have Psychopharmacological medication ordered will be offered education regarding medications by Nursing Staff. This will continue on an ongoing basis. The Chemical Restraint policy requires that residents must have documented behaviors to warrant on going usage of medication. **4. This is how the facility will monitor to make sure the changes continue and the problem is prevented.** Social Services or designee will audit behavior notes weekly for four weeks, then monthly for two months to make sure any resident receiving anti-anxiety mediation has appropriate behavior documentation and all assessment are completed. A report of the audits will be submitted by Social Service to the Quality Assurance Committee for further recommendations.	~~3-15-13~~ 3-13-13 ~~3-15-13~~ per discussion with adm. 3-20-13 changed date back to 3-13-13 ~~3-15-13~~

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F 329	Continued From page 45 antidepressant medication] to 25 mg daily. . . " *An Interdisciplinary Progress Note, dated 08/15/12, indicated the resident's wife was concerned regarding the resident's restlessness in the afternoon, "wanting to go home/pay bill, family feels ativan is effective but req [request] ativan be [arrow up] to t.i.d. . . ." *A physician's order, dated 08/16/12, stated, "Ativan 0.5 mg tablet three times daily at 1300 [1:00 p.m.] 1500 [3:00 p.m.] and 2100 [9:00 p.m.]." *A physician's progress note, dated August 21, 2012, stated, . . ."He has no other complaints, and he denies any pain, The nurses have no other concerns." *A physician's progress note, dated October 24, 2012, stated, . . . "He is gradually being less alert. Some behavioral problems are noted at times, but overall things are going fairly well for him. He's had steady progression of his dementia. The nurses report no new major problems . . . Ativan 0.5 mg 1 t.i.d. . . ." *An Interdisciplinary Progress Note, dated 12/18/12 at 6:00 p.m., "Res [resident] restless & [and] looking for the front door . . . states he [sic] have a train to catch & refused to eat supper in the drm [dining room] . . . 2030 [8:30 p.m.] [wife's name] states res still restless & packing the picture frames in his room . . . gave res pudding snack. CNA [certified nursing aide] will do hs [hours of sleep] cares & put him to bed. 2130 [9:30 p.m.] noted res sleeping soundly. . . ." *A physician's progress note, dated December 20, 2012, stated, . . . "is getting perhaps a little more restless and confused at times. He seems to be somewhat more prominent when his family members are around. He has had gradually increasing dementia . . . The nurses state that	F 329		

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F 329	Continued From page 46 overall he had been much the same otherwise . . ." *A physician order, dated 12/20/2012 increased the Ativan 0.5 mg to four times a day. Resident #7's Minimum Data Sets (MDSs) dated, 01/06/12, 04/06/12, 07/06/12, and 10/06/12 failed to show any behavioral symptoms or wandering. The MDS, dated 07/06/12, indicated rejection of cares occurred on 1 to 3 days during the assessment period. A mood and behavior report for the time period of 04/01/12 to 01/15/13 showed the following days which staff documented mood or behavioral symptoms, 05/02/12 verbal behavior, 07/03/12 rejection of cares, 07/29/12 rejections of cares, and 08/04/12 verbal behaviors and wandering. Review of Resident #7's care plan stated, . . . "PROBLEM: ALT [alteration] in thought process r/t [related to] anxiety, Alzheimer's m/b [manifested by] BIMS [Brief Interview for Mental Status] score of 4, Hx [history] of elopement risk . . . PLANS AND APPROACHES: segment tasks into simple steps, RO [reality orientation] PRN [as needed], allow time to respond, wanderguard, check for function/placement every shift, bed/chair/bathroom alarm/fall mat . . . " During an interview on 01/15/13 at 10:45 a.m., a nurse (#8) stated, "the family calls the doctor when they observe him [Resident #7] agitated, they direct the dose." Failure of the facility to educate the family may have resulted in the resident receiving an unnecessary medication.	F 329		

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F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, policy and procedure review, and staff interview, the facility failed to prominently post the actual hours worked per shift	F 356	F356 Posted Nurse Staffing Information **1, This is what the facility will do to correct the specific problems, found related to the specific resident identified.** The Daily Nursing Hours are posted according to facility procedure. **2. This is what the facility will do to identify and correct any problems found with other residents who also could be affected by the facility practice.** All residents have the potential to be affected by this practice By changing our practice we will protect all residents. **3. This is what the facility will do or changes it will make to the systems that will prevent this problem from reoccurring in the future.** On 2-20-2013 The Licensed Nurses will be educated on the need to properly post and update the daily staffing form. The posted form must be updated at the end of every shift. The form will be posted in the view of the public on the West Nurses station. **4. This is how the facility will monitor to make sure the changes continue and the problem is prevented.**	2-28-13 2-28-13 2-28-13

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F 356	Continued From page 48 by registered nurses (RNs), licensed practical nurses (LPNs), and certified nurse aides (CNAs) for 3 of 4 days of survey. Findings include: Review of the facility policy titled, "Communication- Staff to Staff. occurred on 01/16/13." This policy, dated 02/2012, stated, ". . . PURPOSE: To post the center's daily staffing and resident census . . . WHERE FILED: Post the report where it will be visible for the public . . . INSTRUCTIONS: . . . post at the beginning of each shift and update as appropriate (for each shift) resident census, the number of licensed and unlicensed nursing staff directly responsible for resident care, actual hours worked, and total hours worked . . . This information must include the actual number and hours of licensed and unlicensed nursing staff responsible for the care of residents for the particular day on each shift . . . " Observation of the bulletin board located in the West hallway on 01/13/13 at 12:15 p.m. showed a facility form titled "Daily Nursing Staffing" with a date of 01/10/13, filled out for all shifts, and posted for public view. Random observations on 01/13/13 at 5:30 p.m. and on 01/14/13 at 7:30 a.m. and 6:00 p.m., showed the same Daily Nursing Staffing form, dated 01/10/13, remained posted for public view. On 01/15/13, the surveyor removed the Daily Nursing Staffing form from the bulletin board and discovered the Daily Nursing Staffing forms dated January 11-15, 2013 located behind the January	F 356	The Workforce Development Coordinator will audit the daily posting of nursing hours for placement of posting and for accuracy. The audit will be completed weekly for four weeks, then monthly for two months. A report of the audits will be submitted by the Workforce Development Coordinator to the Quality Assurance Committee for further recommendations.	2-28-13

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F 356	Continued From page 49 10th form. During interview on 01/15/13 at 3:00 p.m., an administrative nurse (#1) stated she completes a Daily Nursing Staffing form for the next day, for all shifts prior to leaving each day using the facility's bi-weekly staffing schedule and leaves the form at the nurses station. This administrative nurse (#1) stated if the number of hours delegated to each shift or resident census change, the charge nurse documents these changes on the facility form titled "Daily Assignment Sheet," and the facility does not update the posted Daily Nursing Staffing form located on the bulletin board in the West hallway. The facility failed to post staff information at the beginning of each shift, update the information as needed, and ensure the current form is prominently displayed for public view.	F 356	F371 Food Procedure Store/Prep/ Serve in Sanitary Manner **1. This is what the facility will do to correct the specific problems, found related to the specific resident identified.** The sanitizing dispenser was replaced by 1-16-13. Staff have been testing the new dispenser and it has worked without error.	2-28-13
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local 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 facility policy, review of manufacturer's recommendations, and	F 371	**2. This is what the facility will do to identify and correct any problems found with other residents who also could be affected by the facility practice.** All residents have the potential to be affected in this area. By changing our practice we will protect all residents. **3. This is what the facility will do or changes it will make to the systems that will prevent this problem from reoccurring in the future.** Dietary Staff have been educated on the proper use of the sanitizer dispenser. Staff were also educated to use the appropriate testing form.	2-28-31 2-28-13

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F 371	Continued From page 50 staff interview, the facility failed to sanitize dishware in 1 of 2 kitchens. The facility failed to follow the manufacturer's guidelines for mixing the sanitizing solution for a three compartment sink and a bucket used to clean surfaces. Failing to properly sanitize dishes used to prepare food and failing to use appropriate concentration for cleaning food contact surfaces placed residents at risk for foodborne illness. Findings include: Review of the manufacturer's recommendations for the sanitizers used by the the facility occurred on 01/16/13. These recommendations stated, ". . . usage notes: Recommend dilution levels for food service sanitizing applications . . . 3 - comp [compartment] sink 250 ppm [parts per million]. . . sanitizer pail w/ [with] cloths 350 ppm . . ." The manufacturer's recommendations noted stated a concentration of 200 to 400 ppm protected against salmonella and an additional 8 organisms. Review of the dietary policy titled "Sanitizing Solutions" occurred on 01/16/13. This policy, dated November 2012, stated, ". . . Procedure: 1. Employees need to be properly trained in handling different cleaning agents. 2. Mix chemicals used in the recommended concentration of levels for maximum efficiency. (High concentrations can be unsafe and may leave an odor or bad taste on the objects and corrode metals.) . . . 6. Check solution concentrations frequently with a test kit since they may become depleted when they kill microorganisms and bind with food . . ."	F 371	**4. This is how the facility will monitor to make sure the changes continue and the problem is prevented.** The Dietitian/Designee will audit the testing strip form on a monthly for three months. The Dietitian/Designee will audit four dietary staff per month to make sure they properly use the sanitizer dispenser and test strips. A report of the audits will be submitted by the Dietitian/Designee to the Quality Assurance Committee for further recommendations.	2-28-13

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F 371	Continued From page 51 Review of the facilities "Pot/Pan Chemical Sanitizing Log" occurred on 01/16/13. This log failed to identify the minimum ppm strength needed for sanitation in the three compartment sink. Observation on 01/13/13 at 12:18 p.m. showed a three compartment sink with water in all the compartments. Cleaned items next to the sanitizer compartment included two pans, a whisk, and parts for a blender used to make pureed foods. The sanitizer compartment lacked a booster heater to maintain a high temperature to sanitize dishes, therefore, required the need for a chemical sanitizer. When requested to test the concentration of the sanitation in the three compartment sink, a dietary staff member (#14) telephoned another staff member who helped her locate testing strips, tested the sanitizer, and obtained a reading of less than 150 ppm. The dietary staff member emptied the sanitizer compartment and refilled the sink but noticed no sanitizer dispensed. The dietary staff member and an administrative maintenance staff member (#16) mixed a solution by hand and the dietary staff member (#14) rewashed the dishes. During an interview on 01/13/13 12:45 p.m. a dietary staff member (#15) stated she tested the solution that morning and noticed the dispenser did not work right. Review of the three compartment sink log showed a measurement of 200 ppm documented that morning. Observation on 01/14/13 at 12:18 p.m., showed a dietary staff member (#24) tested the	F 371		

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F 371	Continued From page 52 concentration of the sanitizer in a bucket in the main kitchen and when the strip turned dark green the dietary staff member stated the strip read "500 ppm," indicating too high of a concentration. Observation on 01/15/13 at 10:15 a.m. showed a dietary staff member (#18) tested the concentration of a sanitizer in a bucket in the main kitchen and stated the strip read "180 ppm." The strip turned green which identified the concentration between 200-400 ppm. The staff member stated she always read the strip as 180 ppm even if it turned green, indicating the staff member unable to accurately test the concentration of the sanitizer in the bucket. During an interview on 01/15/13 at 4:00 p.m. an administrative maintenance staff member (#16) stated the mechanism for the water into the sanitizer system broke last week. The staff member stated he instructed the dietary staff to mix sanitizing solution by hand, effective 01/10/13. During an interview on 01/15/13 at 4:15 p.m. an administrative dietary staff member (#17) stated she made the sign for the three compartment sink in the afternoon on 01/13/13 with instructions on how to hand mix the sanitizer and failed to educate the dietary staff on how to mix the sanitizer by hand for the three compartment sink after maintenance informed her it was broke on 01/10/13. Failure to educate staff about the broken dispenser system for sanitizer in the three compartment sink resulted in the improper	F 371		

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F 371	Continued From page 53 sanitation of dishware.	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. (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.	F 441	F441 Infection Control **1.This is what the facility will do to correct the specific problems, found related to the specific resident identified.** No residents show any signs or symptoms of an infection related to the unclean blood glucose testing monitor. No residents were identified in this deficiency. **2. This is what the facility will do to identify and correct any problems found with other residents who also could be affected by the facility practice.** All residents that receive blood glucose testing have the potential to be affected in this area. All residents that receive assistance with peri-care have the potential to be affected in this area. **3. This is what the facility will do or changes it will make to the systems that will prevent this problem from reoccurring in the future.**	~~2-28-13~~ 2-28-13 2-28-13

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F 441	Continued From page 54 This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy and procedure review, and staff interview, the facility failed to follow standards of practice to prevent the transmission of infections during 1 of 4 days of survey (January 14, 2013) involving 1 of 3 sampled residents (Resident #5) observed during personal cares, and 1 of 1 observations where staff failed to sanitize the glucometer (a device used to obtain a resident's blood glucose reading) between resident use. Failure to follow infection control practices has the potential to spread infection within the facility. Findings include: Review of the facility policy titled "Perineal Care" occurred on 01/16/13. This policy, dated November 2009, stated, ". . . 2. Wash hands and put on gloves. (If additional supplies are needed during perineal care, remember to remove soiled gloves, wash hands or use hand sanitizer before touching objects in environment. Re-glove to resume perineal care.) . . . 7. Turn resident on side to wash, rinse and dry anal area. After removing soiled gloves, use hand sanitizer or wash with soap and water to cleanse hands. Put on clean gloves to put on clean pad and/or clothing. Review of the facility policy titled, "Procedure for Taking Glucometer into a Resident's Room" occurred on 01/16/13. This policy, dated March 2010, stated, ". . . Purpose: To ensure that	F 441	On 2-20-2013 All Licensed Nurses were educated on the procedure for taking a glucometer into a resident's room. All Licensed Nurses were educated on the procedure titled Perineal Care. **4. This is how the facility will monitor to make sure the changes continue and the problem is prevented.** The Workforce Development Coordinator or designee will complete five audits per month for three months to check for proper cleaning of the glucose monitor. The Workforce Development Coordinator or designee will audit three residents per week for appropriate pericare and proper hand washing and gloving for four weeks, then monthly for two months. A report of the audits will be submitted by the Workforce Development Coordinator to the Quality Assurance Committee for further recommendations.	2-28-13 2-28-13

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 _____	01/16/2013

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F 441	Continued From page 55 Standard Precautions are carried out appropriately to reduce the risk of transmission of infection. Procedure: 1. Upon completion of the Blood Sugar Monitoring: . . . e. Wearing gloves, use a disinfectant towelette to wipe down the entire glucometer . . . ." Review of Resident #5's medical record occurred on January 13-16, 2013. Diagnoses included quadriplegia and suprapubic catheter. The quarterly Minimum Data Set, dated 11/10/12, identified the resident as cognitively impaired and required extensive assistance of two with toilet use and personal hygiene. Observation on 01/14/13 at 11:18 a.m., showed two certified nursing assistants (CNAs #9 and #10) assisted the resident, who was in bed, after an incontinent bowel movement. A CNA (#9) wearing gloves provided pericares, and without removing her gloves, pulled up the resident's pants, attached a full body sling onto a lift, removed boots which the resident wears in bed, and put on the resident's shoes, and then removed her gloves. Another CNA (#10) assisted the CNA (#9) to transfer the resident into a wheelchair, and the CNA (#9) unhooked the sling hooks from the lift, adjusted the residents feet on the foot pedals, moved the resident's catheter bag into a pouch, put on the resident's glasses, folded blankets on the bed, donned new gloves, drained the catheter bag into a graduate cylinder, disposed of the urine in the toilet, removed her gloves, and then washed her hands. During an interview on 01/15/13 at 5:15 p.m., an administrative staff nurse stated she expects staff to remove gloves after perineal cares and	F 441		

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F 441	Continued From page 56 complete hand hygiene as long the resident is safe. Observation on 01/14/13 at 4:55 p.m. showed a licensed nurse (#13) exited an unidentified resident room located on the North nursing unit, holding the facility's glucometer device and placed the glucometer into the medication cart. Continuous observation of this licensed nurse (#13) from 4:55 p.m.- 5:15 p.m. showed the nurse failed to clean and disinfect the glucometer device. At 5:15 p.m., the licensed nurse (#12) used the above mentioned glucometer machine and obtained a blood glucose reading from Resident #10. Continuous observation from 5:15 p.m.-5:27 p.m. showed this nurse failed to clean and disinfect the glucometer machine. During interview on 01/15/13 at 3:00 p.m., an administrative licensed nurse (#1) stated the facility supplies a glucometer for each of the two nursing units (West and North). This administrative nurse (#1) stated she expected staff to clean and disinfect the glucometer between resident use using a disinfectant Cavi wipe.	F 441		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and	F 514	F514 Accurate Records **1. This is what the facility will do to correct the specific problems, found related to the specific resident identified.** Resident #5's was discharged **2. This is what the facility will do to identify and correct any problems found with other residents who also could be affected by the facility practice.** All residents that require Tracheostomy care have the potential to be affected in this area. Currently there are no other residents with a tracheotomy. All residents that receive nursing treatments have the potential to be affected in this area. **3. This is what the facility will do or changes it will make to the systems that will prevent this problem from reoccurring in the future.**	2-28-13 2-28-13

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F 514	Continued From page 57 services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy/procedure review, and staff interview, the facility failed to maintain clinical records in accordance with accepted professional standards and practices for 1 of 1 sampled residents (Resident #5) with a tracheostomy. Failure to ensure the medical record is complete and accurate limited the facility's ability to ensure the provision of appropriate resident care and services. Findings include: Review of the facility policy titled "Legal Documentation Standards" occurred on 01/16/13. This policy dated January 2011, stated, ". . . Pre-dating and Back-dating . . . Documentation is NOT to be altered or falsified. . . . Backdating may be defined as dating any document prior to completing the required information . . ." Review of Resident #5's medical record occurred on all days of survey. Review of the physician orders identified tracheostomy cares every eight hours which included the following: to remove, clean and rinse inner cannula; clean face plate and around stoma; wash, rinse and dry neck area; and place new sterile dressing and tracheostomy ties when soiled. The treatment record (TAR) noted the tracheostomy cares to be completed at 6:00 a.m., 3:00 p.m., and 10:00	F 514	**The nurse who made this error was re-educated on the need to accurately document cares.** On 2-20-2013 All Licensed Nurse were educated on the procedure titled Legal Documentation Standards will a focus on the need to accuracy complete documentation of treatments. **4. This is how the facility will monitor to make sure the changes continue and the problem is prevented.** The DNS will observe five residents who receive treatment from Licensed Nurses to make sure treatment is being completed as ordered and as documented. The DNS will choose different residents and will make sure different Licensed Nurses documentation is reviewed each time the DNS completes the audit. This will include making sure all bandages are dated and initialed, tube feeding solutions is dated when opened and the feeding is started, and all steps are completed on sterile bandages changes.	2/28/13 2-28-13 ~~3/15/13~~

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F 514	Continued From page 58 p.m. The TAR identified tracheostomy cares signed off on 01/14/13 at 3:00 p.m. Observation on 01/14/13 at 1:38 p.m., 2:58 p.m., 3:18 p.m. showed Resident #6 lying in bed. During an interview on 01/14/13 at 3:20 p.m., a nurse (#6) reported the nurse (#7) signed off the TAR for providing the tracheostomy cares at 3:00 p.m. prior to leaving her shift today. An interview with the nurse (#7) who signed Resident #5's TAR on 01/14/13 occurred on 01/15/13 at 8:45 a.m. The nurse (#7) stated she changed Resident #5's tracheostomy dressing in the morning when he woke up, but did not provide tracheostomy cares at 3:00 p.m. The facility failed to ensure the resident's medical record remained accurate by signing off on the treatment record without completing the tracheostomy care.	F 514	A report of the audits will be submitted by the DNS/Designee to the Quality Assurance Committee. This will continue on an ongoing basis as part of the DNS job duties. Date of completion: 2-28-2013	~~3/15/13~~