STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355085	A. BUILDING _____ B. WING _____	C 08/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIM CARE CENTER	**3534 UNIVERSITY DR S FARGO, ND 58104**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey and complaint survey, started on 08/01/16 and completed on 08/04/16, the sample included 5 residents for complete review, 16 residents for focused review, and 3 closed records for review. The sample included 2 additional residents to verify specific concerns during the survey.	F 000		
F 278 SS=E	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a	F 278		9/8/16

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

Electronically Signed | 08/24/2016

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F 278	Continued From page 1 material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument 3.0 (RAI) User's Manual (Version 1.13), and staff interview, the facility failed to ensure accurate coding of Minimum Data Sets (MDSs) for 5 of 21 sampled residents (Resident #1, #2, #6, #12, and #19). Failure to accurately complete portions of the MDS, Section E (Behaviors) (Resident #2, #12, and #19), Section I (Active Diagnosis) (Resident #6), and Section H (Bladder and Bowel) (Resident #1 and #19) does not allow each resident's assessment to reflect the resident's current status/needs and has the potential to affect the accurate development of a comprehensive care plan and the care provided to these residents. Findings include: BLADDER APPLIANCES The Long-Term Care Facility RAI User's Manual, revised October 2015, page H-2 stated, ". . . H0100A, indwelling catheter (including suprapubic catheter and nephrostomy tube) . . ." - Review of Resident #1's medical record occurred on all days of survey. The resident returned to the facility from a hospital stay on 03/03/16 with an indwelling catheter in place. The significant change MDS, dated 03/08/16, failed to identify an indwelling catheter.	F 278	1. The dates of the MDS's for residents #1, #2, #6,#12,#19 that were identified in the summary statement were modified for the following specific sections delusions, hallucinations, catheter, UTI and constipation and submitted to the CMS QIES Assessment Submission and Processing system and to the North Dakota Department of Health. If the corrections affect payment the facility will do billing adjustments accordingly. 2. All residents coded under delusions, hallucinations, catheter, UTI and constipation on the MDS have the potential to be affected. 3. Current procedure related to coding MDSs is being reviewed and revised. All staff completing MDS's will be educated at a meeting on August 31st, 2016 at 1:30 pm regarding deficiency F278. Current policies will be reviewed 4. Date of Correction: 9/8/16 5. The DON or designee will monitor and audit 5 MDS's to assure accuracy of coding. These audits will be conducted weekly x 4 weeks, monthly x3 months and quarterly for one year. Results will be immediately reported to the DON if concerns are identified, immediate	

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F 278	Continued From page 2 During an interview on 08/02/16 at 11:28 a.m., a nurse (#1) confirmed Resident #1 did have an indwelling catheter and the MDS was coded incorrectly. BEHAVIORS The Long-Term Care Facility RAI User's Manual, revised October 2015, page E-2 states, "E0100: Potential Indicators of Psychosis . . . Coding Instructions . . . Code based on behaviors observed and/or thoughts expressed in the last 7 days rather than the presence of a medical diagnosis. Check all that apply. *Check E0100A hallucinations: if hallucinations were present in the last 7 days. A hallucination is the perception of the presence of something that is not actually there. It may be auditory or visual or involve smells, tastes or touch. *Check E0100B, delusions: if delusions were present in the last 7 days. A delusion is a fixed, false belief not shared by others that the Resident holds true even in the face of evidence to the contrary. *Check E0100Z, none of the above: if no hallucinations or delusions were present in the last 7 days. . . ." - Review of Resident #2's medical record occurred on all days of survey. Diagnosis included anxiety and dementia without behaviors. The quarterly MDS, dated 05/11/16, identified delusions during the seven day assessment period. The medical record lacked evidence to support the coding of delusions during the assessment period. During an interview on 08/02/16 at 2:15 p.m., a Case Manager (#3) confirmed Resident #2's medical record lacked documentation to	F 278	corrective action will be implemented. The Quality Assurance Nurse will submit a report of the monitoring results to the QA Committee at each scheduled meeting.	

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F 278	Continued From page 3 substantiate the coding of delusions. - Review of Resident #12's medical record occurred on all days of survey. Diagnoses included vascular dementia without behavioral disturbance. The quarterly MDS, dated 07/13/16, identified hallucinations. The medical record lacked evidence to support the coding of hallucinations during the seven-day look back period. During an interview on 08/03/16 at 11:55 a.m., a social services manager (#15) stated she believed hallucinations coded on a prior MDS carried over to the current MDS and staff failed to "uncheck" hallucinations. She verified Resident #12 did not have hallucinations in this assessment period. - Resident #19's medical record, reviewed August 3-4, 2016, identified diagnoses including dementia and anxiety. A quarterly MDS, dated 06/27/16, and significant change MDSs, dated 06/03/16 and 03/02/16, identified the resident as having delusions. Resident #19's medical record lacked evidence the resident experienced delusions during the above MDS assessment periods. During an interview on 08/04/16 at 7:53 a.m. a social worker (#15) confirmed staff should not have coded the resident as experiencing delusions during the assessment periods for the above MDSs. BOWEL PATTERNS The Long-Term Care Facility RAI User's Manual,	F 278		

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F 278	Continued From page 4	F 278		

revised October 2015, page H-12 defined constipation: "If the resident has two or fewer bowel movements during the the 7-day look-back period or if for most bowel movements their stool is hard and difficult for them to pass (no matter the frequency of the bowel movements). . . "

- Review of Resident #19's medical record occurred August 3-4, 2016. A significant change MDS, dated 03/02/16, identified the resident experienced constipation during the MDS assessment period. Review of the resident's bowel records from 02/23/16 to 03/02/16 identified the resident had a bowel movement each day except 03/02/16.

During an interview on the afternoon of 08/03/16, an MDS nurse (#1) stated staff should not have coded constipation on Resident #19's 03/02/16 MDS.

ACTIVE DIAGNOSIS

The Long-Term Care Facility RAI Manual, revised October 2015, page I-8 stated, "Item I2300 Urinary Tract Infection (UTI): . . . Code only if all the following are met: 1. Physician . . . diagnosis of a UTI in last 30 days. 2. Sign or symptom attributed to UTI, which may or may not include but not be limited to: fever, urinary symptoms (e.g. peri-urethral site burning sensation, frequent urination of small amounts), pain or tenderness in flank, confusion or change in mental status, change in character of urine (e.g. pyuria), 3. 'Significant laboratory findings' (The attending physician should determine the level of significant laboratory findings and whether or not a culture should be obtained) and 4. Current

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F 278	Continued From page 5 medication or treatment for a UTI in the last 30 days. . ." - Review of Resident #6's medical record occurred on all days of survey. A quarterly MDS, dated 06/08/16 identified the resident as having a urinary tract infection in the past 30 days. Record review failed to identify the resident had signs and symptoms or was treated for a UTI in the 30 days preceding the MDS. During an interview on 08/03/16 at 10:39 a.m. an MDS nurse (#1) confirmed Resident did not have a UTI in the 30 days prior to the 06/08/16 MDS and stated the information must have been carried forward from a previous MDS.	F 278		
F 281 SS=E	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: TIMELY MEDICATION ADMINISTRATION 1. Based on observation, record review, policy review, and staff interview, the facility failed to ensure staff administered medication in a timely manner to 3 of 21 sampled residents (Resident #13, #19, and #20) and one supplemental resident (#25). Failure to administer medication as ordered within an acceptable time frame may result in reduced efficacy or in residents experiencing adverse health effects. Failure to develop a medication administration policy to ensure adequate spacing of doses may increase	F 281	1.For Resident #13's TID Gabapentin was changed to reflect the specific time range for our TID medication administration according to our policy. As well as for resident #25's TID Iron, Ascorbic acid, erythromycin ethylsuccinate, glycopyrrolate and midodrine were all changed to reflect the specific time range for our TID medication administration according to our policy. For resident #19's QID Gabapentin was changed to reflect the specific time range for our QID medication administration	9/8/16

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F 281	Continued From page 6 the risk of medication errors. Findings include: Review of the facility policy titled "Medication - Pass Times" occurred on 08/04/16. This policy, dated February 2016, stated, "Purpose: To dispense medications in a timely fashion while also complying with resident, family, and physician wishes. Procedure: . . . 4. Elim used a liberalized medication pass system as identified below: A.M. 07:00 [a.m.] - 10:00 [a.m.] Midday 11:00 [a.m.] - 14:00 [2:00 p.m.] P.M. 15:00 [3:00 p.m.] - 18:00 [6:00 p.m.] HS [bedtime] 19:00 [7:00 p.m. - 2300 [11:00 p.m.] * Daily medications will be given once a day at a time best suited for the resident. * Twice daily medications will be given at A.M. and P.M. (EXCEPT LASIX A.M. AND MIDDAY) (must be at least 6 hours apart) * Three times daily will be given at A.M., 2-4 P.M. and 8-11 P.M. (must be at least 4 hours apart) * Four times daily will [be] given at A.M., 12 Noon - 2 P.M., 4-6 P.M., and 8-11 P.M. 5. Medication administration times can be flexible as long as the Nurses [sic] IS AWARE of the last time a medication was given. The time is shown on the MAR [Medication Administration Record]." Review of the facility policy titled "Medication Administration" occurred on 08/04/16. This policy, dated February 2016, stated, ". . . Policy: . . . 2. Medications must be given within one hour of the designated administration time. When timely	F 281	according to our policy. For residents #13, #19, #20 and #25 all nurses and TMAs were re-educated on the "Medication - Pass time" policy and procedure. For resident #26 all nurses were re-educated on the "Medication-Gastrostomy Tube/GJ" Policy and Procedure. 2. All residents have the potential to be affected that receive medications and residents that receive their medication via gastrostomy tube. 3. The current Medication - Pass time policy was reviewed with no changes made. All Nurses and TMAs will be educated on the "Medication-Pass Time" policy and Procedure and provide education on appropriate documentation on late medication, hours needed between BID, TID and QID medications. All Nurses will be educated on "Medication-Gastrostomy Tube/GJ tube" policy and procedure at a meeting on August 31st, 2016 at 1:30pm. 4.Date of Correction: 9/8/16 5.The Nursing Unit Managers will audit medication pass times on residents eMAR and resident with gastrostomy tube medication administration to assure compliance with above policies. Audits will be completed weekly x 1 month, monthly x 3 months and quarterly thereafter for one year. Results will be immediately reported to the DON. If concerns are identified, immediate	

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F 281	Continued From page 7 medication administration is not possible, it must be documented and the medication given as soon as possible. When medication has been administered beyond the one hour time frame: . . . If using the eMAR [electronic Medication Administration Record]: choose the reason for the late administration and make additional comments if needed. . . . 5. Narcotics, antibiotics, Parkinson's mediations, thyroid medications, and other time sensitive medications will be given per MD [medical doctor] orders which may include more specific time frames. Medication times may be adjusted to accommodate individual resident needs. . . . Procedure: . . . 1. Use the 5 R's [rights] to ensure safe drug administration. . . . e. The right time: All routine medications should be given within one hour of the scheduled time. - The facility's liberalized medication pass system, along with their policy to give medication within one hour of the designated administration time, allowed staff to administer the medication at the following times: * BID [twice daily]: 6-11 a.m. and 2-7 p.m. This policy potentially allowed two consecutive doses to be administered three hours apart (11 a.m. to 2 p.m.). * TID [three times daily]: 6-11 a.m., 1-6 p.m., and 7-12 midnight. This policy potentially allowed two consecutive doses to be administered an hour apart (6 p.m. to 7 p.m.) or up to 12 hours apart (6 a.m. to 6 p.m.). * QID [four times daily]: 6-11 a.m., 11 a.m.-3 p.m., 3-7 p.m., and 7-12 midnight. This policy potentially allowed two consecutive doses to be administered at the same time (11 a.m., 3 p.m., or 7 p.m.) or up to 9 hours apart (6 a.m. to 3 p.m.	F 281	corrective action will be implemented. The DON will submit a report of the monitoring results to the QA Committee at each scheduled meeting.	

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F 281	Continued From page 8 or 3 p.m. to 12 midnight). The liberalized medication pass system does not ensure staff administer BID medications at least six hours apart and TID medications at least four hours apart, as per facility policy. The facility policies allowed medication doses to be delivered in four to five hour time spans. Failure to establish a policy of medication administration to ensure appropriate spacing of medication doses may increase the risk of medication errors and adversely affect the residents. - Observation on 08/02/16 at 5:15 p.m. showed a nurse (#2) prepared and administered Resident #25's Pro-Stat, Gas-X, famotidine, Iron, ascorbic acid, erythromycin ethylsuccinate (antibiotic), glycopyrrolate (anticholinergic medication used to treat stomach ulcers), and midodrine (treats low blood pressure). The medication administration record (MAR) identified the following medications as administered late: Iron, ascorbic acid, erythromycin ethylsuccinate, glycopyrrolate, and midodrine. The physician's orders identified Iron and ascorbic acid scheduled three times a day between 7-10 a.m., 2-4:30 p.m., and 8:30-11 p.m. and erythromycin ethylsuccinate, glycopyrrolate, and midodrine scheduled three times a day between 7-10 a.m., 3-4:30 p.m., and 8:30-11 p.m. (The times of the second and third doses conflict with the scheduling times identified on the facility policy.) The MAR documentation showed the nurse (#2)	F 281		

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F 281	Continued From page 9 administered Resident #25's medications at 5:40 p.m. (one hour and ten minutes late). The nurse (#2) failed to administer Resident #25's Iron, ascorbic acid, erythromycin ethylsuccinate, glycopyrrolate, and midodrine at the time ordered. - Resident #19's record, reviewed August 3-4, 2016, identified diagnoses including rheumatoid arthritis and spinal stenosis (narrowing of the spinal column). The resident's 07/02/16 MAR showed the following: * Lortab 10-325 (a narcotic analgesic) scheduled for: 12 a.m., 6 a.m., 12 p.m., and 6 p.m. The MAR identified staff administered the 12 p.m. dose at 2:30 p.m. (2 1/2 hours late) and documented the reason as "assisting another resident." * Ativan 0.5 milligrams (mg) (for anxiety) scheduled for: 12 a.m., 6 a.m., 12 p.m., and 6 p.m. The MAR identified staff administered the 12 p.m. dose at 2:30 p.m. (2 1/2 hours late) and documented the reason as "assisting another resident." * Gabapentin 400 mg (for nerve pain) scheduled for: AM: 7-9 a.m., MIDDAY: 11 a.m.-1:00 p.m., PM: 4-6 p.m. and HS: 8-11 p.m. (These times conflict with the scheduling times identified on the facility policy.) The MAR identified staff administered the midday dose at 2:30 p.m. (1 1/2 hours late) and documented the reason as "assisting another resident." The MAR further identified staff administered the PM dose at 3:52 p.m. (one hour and 22 minutes after the midday dose) and stated the reason as "Early Administration: Due to condition." The medical record lacked any documentation regarding the resident's condition on 07/02/16.	F 281		

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F 281	Continued From page 10 Failure to administer Resident #19's medications at the frequency ordered by the physician may result in poor pain control and increased anxiety. Staff administering the gabapentin doses an hour and 22 minutes apart could result in the resident experiencing adverse effects from the medication. - Resident #20's medical record, reviewed August 3-4, 2016, identified diagnoses including anxiety disorder and dementia with behaviors. The resident's July 2016 MAR showed the following: * 07/03/16: Risperdal (an antipsychotic) 0.25 mg scheduled for AM: 7-10 a.m. and PM: 3-6 p.m. The MAR identified staff administered the AM dose at 11:11 a.m. (one hour and 11 minutes late) and documented the reason as "given when awake." * The record showed, on 07/21/16, the physician increased the Risperdal dose which resulted in the schedule changing to include a midday dose scheduled for 2-4 p.m. * 07/26/16: Risperdal 0.25 mg midday dose administered at 5:12 p.m. (one hour and 12 minutes late) and documented the reason as "assisting other residents." - Review of Resident #13's medical record occurred on all days of survey. The MAR, dated 07/04/16 to 08/03/16, showed the following: * Enoxaparin (an anticoagulant) 40 mg subcutaneous [SQ] once a day [QD] scheduled for 6 a.m. On July 9, staff administered it at 7:06 a.m. (one hour and 6 minutes late) with a comment, "Assisting other residents." The facility failed to administer Resident #13's enoxaparin	F 281		

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F 281	Continued From page 11 timely per facility policy. * On July 10, the MAR showed the facility changed the administration time of enoxaparin to 7-10 a.m. On July 11, staff administered it at 11:38 a.m. (one hour and 38 minutes late). The facility failed to administer Resident #13's enoxaparin in a timely manner or document the reason it was administered late. The facility administered the enoxaparin outside the 7-10 a.m. range on five occasions during the 21 days scheduled at this time. * Gabapentin 200 mg TID scheduled for AM: 7-10 a.m., midday: 2-5 p.m., and HS: 8-11 p.m. (The midday time conflicts with the scheduling times identified on the facility policy). On July 11, staff administered the midday dose at 6:04 p.m. (one hour and 4 minutes late). On July 12, staff administered the midday dose at 6:05 p.m. (one hour and 5 minutes late). The facility failed to administer Resident #13's gabapentin in a timely manner (with a gap of eight to 11 hours after the AM dose) or document the reason it was administered late. The facility administered the gabapentin outside the actual range times on 13 occasions during the 29 days reviewed. Failure to administer Resident #13's medication in a timely manner has the potential to reduce the effectiveness of the medication or increase the potential for adverse reactions/pain due to too long or short of a time span between doses. During an interview on the morning of 08/04/16, an administrative nurse (#12) stated the nurses are busy and sometimes get medications passed late. The nurse stated the facility policy allows staff to administer medications one hour before	F 281		

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F 281	Continued From page 12 or after the scheduled time frames identified on the MAR. MEDICATION ADMINISTRATION GASTROSTOMY TUBE 2. Based on observation, record review, and review of facility policy, the facility failed to ensure staff properly administered medications through a gastrostomy tube (G-Tube) to 1 of 2 residents (Resident #26) observed during medication pass. Failure to flush the tubing before and between medications may increase the potential of occlusion and tube replacement. Findings include: Review of the facility policy titled, "Medication-Gastrostomy Tube/GJ Tube" occurred on 08/04/16. This policy, with a review date of March 2016, stated, ". . . 11. If the tube feeding is infusing, you must stop the feeding and flush the tubing with 30cc [cubic centimeter] preferably warm water, normal saline, or sterile water. . . 13. Flush with 15cc water between each medication. . . ." Observation of medication administration on 08/02/16 at 5:15 p.m., showed a nurse (#4) prepared Resident #26's medications. The nurse disconnected the enteral feeding from the resident's G-tube and administered four separate medications. The nurse (#4) failed to flush the resident's G-Tube prior to administration of the medications and failed to flush with water between each administration of medication.	F 281		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309		9/8/16

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F 309	Continued From page 13 Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, information submitted by the complainant, record review, and staff interview, the facility failed to provide necessary care and services to maintain physical well-being for 2 of 7 sampled residents (Resident #3 and #4) with fractures. Failure to ensure proper turning and wheelchair positioning (Resident #3) and failure to implement a shoulder immobilizer as ordered (Resident #4) resulted in Resident #3 experiencing unnecessary pain and placed Resident #3 and #4 at risk for improper healing of the fractures and decreased physical functioning. Findings include: - Review of Resident #3's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease, osteoporosis, unspecified pain, and a right femur fracture. The current care plan stated, ". . . R) [right] femur fracture on 6/18/16. . . . Approach . . . Uses broda wheelchair with legs elevate [sic] to maintain R) leg straight due to immbolizer [sic], assist of 1 to destinations. . . . TRANSFERS: Assist x 2 using hoyer lift [a full body mechanical lift]. Both legs must be supported in sling during	F 309	1. For resident #3, C.N.As were instructed and re-educated on proper positioning for resident, indicated in resident plan of care. For resident #4, nurses were re-educated on documenting in residents progress notes when physician DME orders are faxed to a DME supplier. 2. All residents who utilize an immobilizer for positioning and all residents who have a physician ordered DME have the potential to be affected. 3.The current "CNA - Standards of Care" policy and procedure, "New Employee Orientation Checklist" and "CNA Yearly Competency Checklist" were reviewed. The current "Physician's orders-transcribing" policy and procedure was reviewed and revised. All nursing staff will be re-educated at the meeting on August 31st, 2016 regarding the "CNA Standards of Care" policy and procedure regarding following resident plan of care. All nurses at this meeting will be educated on the	

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F 309	Continued From page 14 transfer. Resident has fractured R) femur (leg) as of 06/18/2016 and wears an immobilizer brace to that broken leg (metal part of brace is to be behind her leg per therapy), pillow under R) leg while in bed/wheelchair with blue boots to both feet. . . . Edited: 08/01/2016 . . ." A physical therapy (PT) note, dated 08/01/16, stated, "PT order request sent to eval [evaluate] and treat. Will begin ROM [range of motion] and work out of brace when order is signed. . . ." Observation on 08/01/16 at 4:10 p.m. and 5:22 p.m. showed Resident #3 in a Broda wheelchair without her legs elevated and with a pillow under her calves and both knees bent. Observation on 08/02/16 at 8:15 a.m. showed two certified nursing assistants (CNAs) (#18 and #19) placed an immobilizer on Resident #3's right leg and assisted her out of bed using a hoyer lift. The CNAs positioned Resident #3 in a broda chair with both knees bent and placed a pillow under the resident's calves. Observation throughout the morning showed Resident #3 remained in her wheelchair without her legs elevated and both knees bent. Observation at 08/02/16 at 12:17 p.m. showed two CNAs (#18 and #19) assisted Resident #3 to lie down using a hoyer lift. The CNAs checked the resident's incontinence brief in bed. As the CNA (#19) rolled Resident #3 to her left side, the resident's right leg flopped/fell over the edge of the bed. The resident stated, "Oh! Oh!" and the CNA stated, "I'm sorry, [Resident #3]." The CNAs then positioned Resident #3 on her (fractured) right side with a pillow between her knees and along her back. When asked about the resident's	F 309	revised "Physician's Orders-Transcribing" policy and procedure which now includes under "Transcribing the Orders" e)Any physician order for DME will be faxed to appropriate DME supplier and noted in resident progress notes that the order was faxed with date and time. 4.Date of Correction: 9/8/16 5. The Unit Nursing Managers will monitor to assure for residents with immobilizers have proper positioning according to residents plan of care and monitor for physician orders for DME ordered supplies. Audits will be completed weekly x 1 month, monthly x 3 months and quarterly thereafter for one year. Results will be immediately reported to the DON. If concerns are identified, immediate corrective action will be implemented. The DON will submit a report of the monitoring results to the QA Committee at each scheduled meeting.	

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F 309	Continued From page 15 immoblizer, a CNA (#19) stated, "I'm not sure why she has that brace." Observation throughout the morning of 08/03/16, the evening meal on 08/03/16, and the morning of 08/04/16 showed Resident #3 in a broda wheelchair without her legs elevated, both knees bent, and no pillow under her legs. During an interview on 08/04/16 at 10:51 a.m., a supervisory nurse (#7) stated Resident #3 will be working with therapy to wean out of the immobilizer, but staff should be following the care plan regarding positioning for the resident's right leg (until further direction from PT). Failure to ensure proper repositioning and handling of Resident #3's fractured femur resulted in unnecessary pain and failure to ensure appropriate wheelchair positioning may have caused further discomfort and improper healing. - Information received from the complainant identified Resident #4 received an order for shoulder/arm sling on 04/28/16 after consultation with an orthopedic provider. The complainant identified the order was conveyed to three different facility staff members upon return from the orthopedic appointment; however, the sling was still not in place at the resident's care conference on 05/12/16 (two weeks after the orthopedic appointment). Review of Resident #4's medical record occurred on all days of survey. Diagnoses included dementia, fracture of upper end of the right humerus, and pain.	F 309		

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F 309	Continued From page 16	F 309		

Nurses' notes identified Resident #4 complained of right shoulder pain on 04/23/16, and the facility transferred the resident to the emergency room for evaluation. The resident returned with a diagnosis of a right humerus fracture and a right arm sling in place. Nurses' notes further identified the following:
*04/26/16 at 5:26 p.m.: ". . . This writer visited with [Resident #4's daughters] at approx. [approximately] 1600 [4:00 p.m.] regarding several concerns they expressed. . . . Informed them that Therapy had screened her use of the sling to be sure [the] arm is in correct placement and education provided to staff. New sling ordered today with waist strap to hold arm more securely as any movement will cause the arm to slid [sic] in the sling. . . ."
*04/28/16 at 7:43 p.m.: ". . . New orders received. See physician notes for details. . . ." The record identified Resident #4 had an appointment with an orthopedic provider on this day. Upon return, the referral form sent with the resident identified the orders: "1. Wear sling next 3 weeks - Velpeau immobilizer [a type of device that immoblizes the arm/shoulder after surgery or injury]. . . ." The referral form identified a nursing staff member observed the order on that date; however, the form and medical record lacked evidence of any action taken to obtain the immobilizer.
*05/10/16 at 2:10 p.m.: ". . . Spoke with [the orthopedic provider's nurse] regarding immobilizer for resident. She stated she would have him sign a prescription and she will fax it to [healthcare accessories agency]. . . ."
*05/11/16 at 3:28 p.m.: ". . . Spoke to [healthcare accessories agency] about Velpeau sling order. [Healthcare accessories agency] said it would be

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F 309	Continued From page 17 received in a week. . . ." *05/12/16 at 12:00 p.m. (recorded as a late entry written on 05/13/16 at 8:56 a.m.): ". . . Message left for [healthcare accessories agency staff] regarding multiple attempts to order Velpeau immobilizer since 4/28 . . ." *05/12/16 at 7:26 p.m.: ". . . Quarterly care conference held. . . . [Resident #4's daughter] noted various complaints and questions - all addressed and resolved. . . ." *The nurses' notes lacked evidence of facility communication with the healthcare accessories agency between 04/28/16 and 05/11/16. On the afternoon of 08/03/16, an administrative staff member (#20) obtained a copy of a fax which the facility sent to the healthcare accessories agency on 05/03/16 (five days after the orthopedic provider ordered the immobilizer). The fax contained the referral form from the resident's orthopedic appointment with the order for the immobilizer. The staff member also provided a fax sent from the orthopedic provider to the healthcare accessories agency on 05/10/16. The fax contained the orthopedic provider's dictation note from the appointment on 04/28/16. The dictation stated, ". . . Patient will be treated conservatively with use of Velpeau sling, just passive use 2 weeks. . . ." Resident #4's medical record lacked evidence of communication with the healthcare accessories agency and/or the orthopedic provider except on May 3, 2016 and May 10, 2016 (five and 12 days after orthopedic provider ordered the immobilizer). During a phone interview on 08/04/16 at 9:12 a.m., a representative from the healthcare	F 309		

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F 309	Continued From page 18 agency stated they did not receive communication from the facility prior to 05/03/16 regarding an immobilizer for Resident #4 (including the dates of 04/26/16 and 04/28/16). The representative identified the agency received an order for the shoulder immobilizer on 05/11/16 from the orthopedic healthcare provider. The agency ordered the immobilizer at that time, and the facility received it on 05/20/16. The facility failed to ensure access of the Velpeau immoblizer ordered by the orthopedic provider on 04/28/16.	F 309		
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 prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to provide assistive devices necessary to prevent accidents for 1 of 7 sampled residents (Resident #4) who transferred with one staff assist and a gait belt. Failure to ensure staff used the correct assistive device (a walker) during transfers placed residents at risk for falls and injury. Findings include:	F 323	1. For resident #4 all CNAs were re-educated on using correct assistive device. 2. All residents who need assistance with a device have the potential to be affected. 3. The current policy the "CNA Standards of Care" was reviewed as well as the CNA Orientation Checklist and the Annual Competency Checklist. All nursing staff	9/8/16

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F 323	Continued From page 19 Review of Resident #4's medical record occurred on all days of survey. Diagnoses included dementia, generalized muscle weakness, and difficulty in walking. The current care plan identified ". . . Mobility: Needs assist with ambulation due to dementia and forgetfulness. Resident is high risk for falls due to poor safety awareness and self transferring. . . . TRANSFERS: Assist of A x 1 [assist of one] to transfer/ambulate with staff using Fww [front wheeled walker] . . ." Observation on 08/01/16 at 4:30 p.m. showed a certified nursing assistant (CNA) (#6) took Resident #4 to her room in a wheelchair. Once inside the room, the CNA put a gait belt around Resident #4's waist and gave her a three-point cane. The CNA then assisted the resident to stand and instructed her to walk to the bathroom. The CNA stated, "Stand up tall," as the resident leaned forward during ambulation. Upon completion of toileting, the CNA assisted Resident #4 to stand. The resident stated, "I can't stand," and was unable to ambulate. The CNA assisted Resident #4 to sit back down, and brought a wheelchair to the bathroom. The CNA then assisted Resident #4 to stand and pivot to the wheelchair. During an interview on the morning of 08/04/16, a supervisory nurse (#7) verified staff should have used a walker to transfer/ambulate Resident #4.	F 323	will be re-educated at the meeting August 31st, 2016 regarding policy and checklists. 4. Date of correction: 9/8/16 5. The QA nurse will monitor and audit to assure for correct transfer/ambulation assist device according to residents plan of care. Audits will be completed weekly x 1 month, monthly x 3 months and quarterly thereafter for one year. Results will be immediately reported to the DON. If concerns are identified, immediate corrective action will be implemented. The DON will submit a report of the monitoring results to the QA Committee at each scheduled meeting.	
F 327 SS=D	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health.	F 327		9/8/16

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F 327	Continued From page 20 This REQUIREMENT is not met as evidenced by: Based on observation, information submitted by the complainant, record review, review of facility policy, and staff interview, the facility failed to provide fluids to maintain proper hydration for 1 of 8 sampled residents (Resident #4) who required staff assistance for fluid intake. Failure to ensure adequate fluid intake at and between meals placed Resident #4 at risk for dehydration, constipation, and urinary tract infections (UTIs). Findings include: Information received from the complainant identified staff failed to offer fluids between meals, and residents only received fluids during meals and medication passes. Review of the facility policy titled "Standards of Care" occurred on 08/04/16. This policy, dated July 2016, stated, ". . . Encourage fluids with each interaction and monitor for dehydration. . . ." Review of Resident #4's medical record occurred on all days of survey. Diagnoses included dementia, constipation, and a history of UTIs. The current Minimum Data Set (MDS), dated 05/09/16, identified severe cognitive impairment and limited assistance from one person for eating. The resident's current care plan stated, ". . . Nutritional Status . . . Difficulty swallowing, requiring a modified diet. . . . Approach . . . Nectar liquids . . . Offer fluids with each encounter in room. . . ."	F 327	1. For resident #4, all CNAs were re-educated on encouraging fluid intake between meals. 2. All residents who require staff assistance for fluid intake have the potential to be affected. 3. The current "Food Fluid Intake" policy and procedure for hydration was reviewed and revised and the current policy the "CNA Standards of Care" was reviewed as well as the CNA Orientation Checklist and the Annual Competency Checklist. All nursing staff will be re-educated at the meeting August 31st, 2016 regarding policy and checklists. 4. Date of Correction: 9/8/16 5. The QA nurse will monitor and audit to assure resident's receive one eight ounce glass of water and one eight ounce glass of milk and/or juice at meals unless documented differently in resident's plan of care. Resident's that need assist with fluid intake will be monitored for fluid intake between meals and including during cares. Audits will be completed weekly x 1 month, monthly x 3 monthly and quarterly thereafter for one year. Results will be immediately reported to the DON. If concerns are identified, immediate corrective action will be	

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F 327	Continued From page 21 Resident #4's current dietary assessment, dated 05/09/16, identified, ". . . Nutritional Needs: Describe Total Calories, Total Protein, and Total Fluids required to meet needs. . . . Fluids 1600 ml's [milliliters]. . . . Fluid intake as recorded at meals alone not adequate to meet needs. Encourage fluid consumption between meals. Hydration status fair. . . ." Observation on 08/01/16 at 4:30 p.m. showed a certified nursing assistant (CNA) (#6) assisted Resident #4 to the bathroom and then took the resident to the TV area. Observation showed a mug of thickened juice available in the resident's room; however, the CNA failed to offer fluids with cares. Observation during the evening meal at 5:30 p.m. showed Resident #4 received only a four ounce (120 ml) glass of juice. The resident consumed all of the juice and no other fluids were available. Observation on 08/02/16 at 8:44 a.m. showed Resident #4 received only a four ounce glass of juice at breakfast, along with cereal with milk. Observation showed Resident #4 consumed all of her juice and cereal, and no other fluids were available. Observation of cares on 08/02/16 at 11:03 a.m. showed a CNA (#18) assisted Resident #4 to the bathroom and then took the resident to the TV area. Observation showed a glass of thickened water available in the room; however, the CNA failed to offer fluids with cares. Observation during the noon meal showed only a four ounce glass of juice and a bowl of ice cream available at the resident's place setting. Observation showed the resident consumed all of the juice	F 327	implemented. The DON will submit a report of the monitoring results to the QA Committee at each scheduled meeting.	

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F 327	Continued From page 22 and ice cream, and no other fluids were available. Observation during the evening meal on 08/02/16 showed only a four ounce glass of juice available for Resident #4. Observations of all three meals on 08/03/16 showed only an eight ounce (240 ml) glass of juice available at each meal for Resident #4. During an interview on 08/04/16 at 9:03 a.m., a dietary supervisor (#17) stated staff should provide more fluids at meals for Resident #4. During an interview on 08/04/16 at 9:51 a.m., a supervisory nurse (#7) states staff are expected to offer fluids with cares. Failure to offer adequate fluids at and between meals in an effort to meet fluid goals placed Resident #4 at risk for dehydration, constipation, and UTIs.	F 327		
F 441 SS=E	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,	F 441		9/8/16

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F 441	Continued From page 23 should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: PERINEAL CARES/HAND HYGIENE 1. Based on observation, record review, and policy review, the facility failed to provide services in a manner that prevents the spread of infectious organisms for 3 of 13 sampled residents (Resident #1, #4, and #13) observed during perineal cares. Failure to follow proper procedure with cleansing the perineum, and perform hand hygiene after perineal cares has the potential to cause or spread infection within	F 441	1. For resident #1 and #13, all C.N.As caring for these residents were re-educated on the "Hand Hygiene" policy and Procedure. For resident #4, all C.N.As providing pericare for this resident were re-educated on the "Perineal Care" policy and procedure. All nursing staff were re-educated on cleaning and disinfecting the whirlpool baths and where to find the step-by-step instructions.	

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	355085	A. BUILDING _____ B. WING _____	C 08/04/2016

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F 441	Continued From page 24 the facility. Findings include: Review of the facility policy titled "Perineal Care" occurred on 08/04/16. This policy, dated October 2015, stated, ". . . Cleanse using disposable wipes/washcloth and perineal cleanser/moisture barrier. . . . Each wipe/washcloth can be used 3 times using the "taco fold" maintaining a clean side of the wipe/washcloth each time. . . . Make sure to turn the wipe/washcloth and use a clean area with each stroke. . . ." Review of the facility policy titled "Hand Hygiene" occurred on 08/04/16. This policy, dated August 2013, stated, ". . . PROCEDURE . . . 4. When to perform hand hygiene . . . m. Before and after assisting a resident with toileting . . . p. After contact with a resident's mucous membranes and body fluids or excretions . . ." - Review of Resident #4's medical record occurred on all days of survey. Diagnoses included dementia and a history of urinary tract infections (UTIs). The current Minimum Data Set (MDS), dated 05/09/16, identified frequent urinary and bowel incontinence and extensive assistance from two or more people for toilet use. Observation on 08/01/16 at 4:30 p.m. showed a certified nursing assistant (CNA) (#6) assisted Resident #4 to the bathroom. Observation showed the resident was incontinent of bowel movement (BM). The CNA assisted Resident #4 with perineal care, wiping the resident from the front perineal area to the back. Observation showed BM on the cloth, and the CNA used the	F 441	2. All residents who are incontinent, need assist with pericare and those resident who use the whirlpool bath have the potential to be affected. 3. The current policy and procedure for "Hand Hygiene", "Perineal Care" were reviewed with no changes and the "Bath, Tub/Whirlpool" policy and procedure was reviewed and revised to include where the step by step instructions were located on cleaning and disinfecting the whirlpool tub. All new CNAs are educated at new employee orientation on hand hygiene, perineal care, tub cleaning and disinfection; are trained with their mentor on hand hygiene, perineal care, tub cleaning and disinfection and has yearly competency completed on hand hygiene, perineal care, tub cleaning and disinfection. All nursing staff will be re-educated at the meeting August 31st, 2016 regarding the above policies and New Employee Checklist and the CNA annual competency checklist. 4. Date of Correction: 9/8/16 5. The Unit Nursing Managers will monitor to assure proper hand hygiene when removal of gloves, pericare on incontinent residents for maintaining clean side of wipe each time and proper disinfecting of the whirlpool after each use. Audits will be completed weekly x 1 month, monthly x 3 months and quarterly thereafter for one year. Results will be immediately reported to the DON. If	

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F 441	Continued From page 25 same area of the cloth to again wipe the resident from the front to the back. The CNA then took a new cloth and repeated this process. - On 08/02/16 at 5:55 p.m., observation showed two CNAs (#13 and #14) checked Resident #13's brief and noted incontinence of urine and BM. One CNA (#13) performed perineal cares to the resident's posterior side, removed her gloves, washed her hands, and donned new gloves. Both CNAs repositioned Resident #13 on her back, and one CNA (#13) completed frontal perineal cares and removed her gloves. The CNA (#13) failed to perform hand hygiene after completing perineal cares. The CNAs then placed a new brief, pulled Resident #13's pants up, placed a mechanical lift sling under the resident, and transferred her to the wheelchair. One CNA (#14) washed her hands. The other CNA (#13) applied the resident's glasses, held a cup while she drank from a straw, brushed her hair, and assisted her to apply chapstick. The CNA (#13) then left the room without washing her hands. - Observation on 08/02/16 at 8:02 a.m. showed one CNA (#5) assisted Resident #1 with morning cares. Observation showed the resident incontinent of urine. The CNA provided perineal cares and removed her gloves. Without performing hand hygiene, the CNA applied the resident's TED stockings and clothes, lotioned the resident's back, applied her glasses, and combed her hair. The CNA (#5) applied gloves, performed denture care, and removed her gloves. She gave Resident #5 a drink of water and then washed her hands. The CNA (#5) failed to perform hand hygiene after providing perineal cares and before completing other tasks.	F 441	concerns are identified, immediate corrective action will be implemented. The DON will submit a report of the monitoring results to the QA Committee at each scheduled meeting.	

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F 441	Continued From page 26 WHIRLPOOL BATHTUB CLEANING 2. Based on staff interview and review of facility policy, the facility failed to follow accepted infection control practices for 2 of 2 units (300 and 400 Street) observed with whirlpool bathtub areas. Failure to follow accepted infection control practices when disinfecting the whirlpool bathtub between residents has the potential to spread infection within the facility. Findings include: Review of the facility instruction sheet titled "Bath Disinfecting Process" occurred on 08/04/16. This undated instruction sheet stated, " . . . Use the soapy solution to scrub the tub and chair. Leave wet for 10 minutes. . ." During an interview on 08/04/16 at 7:50 a.m. a CNA (#16) in the 300 unit explained she cleans the whirlpool tub using the sanitizing spray, scrubbing the bathtub and rinsing the tub with water. The CNA stated she rinses the solution off right away. During an interview on 08/04/16 at 8:10 a.m. in the 400 bathing area a CNA (#6) explained she disinfects the whirlpool bathtub using the disinfecting button, runs the jets, scrubs the tub, and rinses with water. The CNA (#6) explained she leaves the disinfectant on for five to ten minutes. During an interview on the morning of 08/04/16 an administrative nurse (#12) stated she would expect staff to follow the bath disinfecting	F 441		

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F 441	Continued From page 27 process as stated on the instruction sheet.	F 441		