STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355079	A. BUILDING _____ B. WING _____	C 04/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLA MARIA	**3102 S UNIVERSITY DR FARGO, ND 58103**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The standard Medicare/Medicaid and complaint survey began on 04/02/18 and was completed on 04/05/18.	F 000		
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal	F 550		5/10/18

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

Electronically Signed | 04/26/2018

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F 550	Continued From page 1 from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation and resident and staff interview, the facility failed to provide care and services in an environment and manner that enhanced dignity during 2 of 2 meals observed (04/02/18 and 04/03/18 evening meals). Failure to serve each resident seated at the same table at the same time and provide proper dishware for the resident does not preserve each resident's dignity or enhance their quality of life. Findings include: - Observation during the evening meal on 04/02/18 at 4:40 p.m. showed four residents seated at a table in the dining room. Staff served three of the residents their meal trays, but failed to serve the fourth resident until 4:51 p.m. (11 minutes later). Observation showed all residents received their desserts and fruits in a styrofoam bowls. - Observation during the evening meals on 04/02/18 and 04/03/18 showed staff used styrofoam dishes to serve food items such as desserts, grapes, and cottage cheese. - Observation on 04/03/18 at 4:31 p.m. showed two tables of six residents each in the dining	F 550	1. Corrective Action: It is the practice of the facility to serve meals to residents that sit at the same table in the main dining room at the same time to preserve dignity and enhance quality of life. It is also the practice of the facility to assure food service is efficient and organized. It is also the practice of the facility not to serve food items on/in Styrofoam containers, unless due to special circumstances, to assure food service is efficient and organized. It is also the practice of the facility that residents' meal choices are honored and delivered per that choice. Re-education was provided by the dietary manager to dietary staff during an in-service on 4/10/2018 which included a reminder not to use Styrofoam containers for meal service and that all residents at the same table will be served at the same time. In addition, re-education also included the importance of honoring choices, preserving dignity and enhancing quality of life. Re-education will also be provided to all staff at an all staff in-service to be held on 5/7/18, 5/8/18, and 5/9/18. Re-education will include the	

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F 550	Continued From page 2 room. Five of the residents at each table had their meals and were eating. Staff served the last residents at the tables at 4:38 p.m. and 4:41 p.m., and observation showed their tablemates were nearly done eating. - During the group interview on the afternoon of 04/03/18, residents stated the following: *Meal service is slow and not well organized *Residents at the same table don't all get served at the same time (even if all residents are at the table). Staff may take two of the four residents' orders, but not the other two *Sometimes the residents are the first people to order but the last to be served. *Residents do not get what they ordered; staff take orders but bring out something different. *One resident identified staff took her and her three tablemates' orders, and three of the residents received their food. The resident identified she had to alert one of the servers that the last resident had not received her food. This resident and her two tablemates were done eating. *It does not feel like a family atmosphere when people at the same table do not get to eat together. During an interview on 04/05/18 at 8:15 a.m., a dietary manager (#1) stated she would expect staff to serve food items on reusable dishware and serve all residents at one table together.	F 550	same as mentioned above. 2. Identify other residents: All residents that eat in the main dining room have potential to be affected by this deficient practice. 3. Measures put in place: All staff will been re-educated not to use Styrofoam containers with meal and snack service. All staff will re-educated to serve meals to residents that sit at the same table in the main dining room at the same time. All staff will be reminded of the importance of serving the resident's selected meal choice. 4. Monitoring: A quality audit will be conducted for residents that eat in the main dining room. The audit will be conducted three times a week for four weeks then one time a week for four months and continued auditing will be scheduled per discretion of the Quality Assurance Committee. The audits will include monitoring of meals not being served in/on Styrofoam containers, ensuring residents sitting at the same tables are being served at the same time, and honoring residents selected meal choices. These audits will be completed by the Dietary Manager and/or designee. Audits will be reviewed by the Quality Assurance Committee monthly to ensure continued compliance. 5. The facility will be in substantial compliance by May 10th, 2018.	

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F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and	F 584		5/10/18

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F 584	Continued From page 4 §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior on 3 of 4 resident living areas (Lovely Lane, Memory Lane, and Friendship Lane). Failure to maintain a clean and sanitary environment does not provide a comfortable living area for residents. Findings include: - Observation of the resident living area, Lovely Lane, occurred on all days of survey and showed the following: * Room 307: personal fan soiled with dust/debris * Room 310: tipped flower vase on the floor under the sink * Room 314-2: personal fan soiled with dust/debris * Room 318: torn wallpaper * Room 319-1: scuffed walls/wallpaper (Record review identified the residents residing in room 307 and 314-2 wear continuous oxygen) - Observation on 4/03/18 at 9:28 a.m. and 12:08 p.m. showed CNAs (certified nursing assistants) provided pericares for the resident in room 307 (Lovely Lane). After the CNAs washed their hands in the sink, observation showed the sink filled with water, splashed on the counter, and failed to drain.	F 584	1. Corrective Action: It is the practice of the facility for housekeeping and maintenance to provide services necessary to maintain a sanitary, orderly, and comfortable environment. On 4/4/18, housekeeping cleaned the personal fans in rooms 307 and 314-2. On 4/4/18, housekeeping removed the flower vase in room 310 and the floor was swept and mopped. On 4/6/18, maintenance cleaned the drains in the sinks of rooms 212, 307, and 409. On 4/5/18, maintenance repaired the torn wallpaper in room 318. On 4/5/18, maintenance repaired the scuffed walls and wallpaper in room 319-1. Re-education was provided on 4/16/18 and 4/20/18 by the Maintenance Director to floor care, housekeeping and maintenance staff. Re-education included the importance of cleaning under beds and chairs and the importance of moving resident's personal belonging to clean floors. Re-education also included review of the maintenance logs and reporting back to necessary staff, as well as reminders to check for new personal fans, slow draining sinks and needed repairs of walls, particularly paint and wallpaper. 2. Identify other residents: All residents residing in the facility have the potential to be affected by this deficient practice.	

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F 584	Continued From page 5 - Observation on the morning of 04/03/18 showed a CNA provided cares for the resident in room 212 (Friendship Lane). After the CNA dumped the basin of water down the drain and washed her hands in the sink, observation showed the sink remained full of water and drained slowly. - On the morning of 04/04/18, two CNAs provided care for the resident in room 409 (Memory Lane). After the CNAs washed their hands in the sink, observation showed the sink remained full of water and did not drain. One CNA stated they should let maintenance know. A tour of the resident living area, Lovely Lane, occurred on 04/05/18 at 11:05 a.m. with the environmental services manager (#8) and a unit manager (#9). The manager (#8) stated personal fans are cleaned on an as needed basis and he was not aware of the torn/scuffed walls and/or wallpaper and non-draining sinks on Lovely Lane, Memory Lane, and Friendship Lane. The manager (#8) stated he would expect facility staff to report these things to the environmental services department by submitting a work order.	F 584	3. Measure put in place: The facility will inspect monthly and as needed to address any needed repairs, cleaning or slow draining sinks in resident rooms. Staff will report any necessary repairs, cleaning or slow draining sinks to the Maintenance Director and/or designee. The facility will act on any needed repairs and/or cleaning observed or reported. The facility will clean all fans twice per month. Re-education was provided on 4/16/18 and 4/20/18 by the Maintenance Director to floor care, housekeeping and maintenance staff. Re-education included the importance of cleaning under beds and chairs, the importance of moving resident's personal belonging to clean floors, review of the maintenance logs and reporting back to necessary staff. Re-education also included reminders to check for new personal fans, slow draining sinks and needed repairs of walls, particularly paint and wallpaper. Re-education will also be provided to all staff on 5/7/18, 5/8/18 and 5/9/18 which will include processes for identifying and addressing needed repairs and cleaning and the importance of maintaining a clean and sanitary environment in efforts to provide a comfortable living area for residents. 4. Monitoring: Quality audits will be conducted by the Maintenance Director and/or designee. The audits will be conducted monthly for three months then quarterly thereafter. The audits will	

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F 584	Continued From page 6	F 584	include monitoring of dirty fans, slow draining sinks, dirty floors, torn/scuffed wallpaper and walls. Audits will be reviewed by the Quality Assurance Committee monthly to ensure continued compliance. 5. The facility will be in substantial compliance by May 10, 2018.	
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review, review of the North Dakota Provider Manual for Preadmission Screening and Resident Review (PASRR) and Level of Care Screening Procedures For Long	F 644	1. Corrective Action: It is the practice of the facility to complete a status change assessment with newly diagnosed mental illnesses. On 4/5/18, the Director of	5/10/18

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F 644	Continued From page 7 Term Care Services, review of facility policy, and staff interview, the facility failed to complete a status change assessment for 2 of 5 sampled residents (Resident #42 and #100) with a newly diagnosed mental illness. Failure to complete a change in status assessment may result in the delivery of care and services that are inconsistent with residents' needs. Findings include: The North Dakota PASRR Provider Manual page 13 states, ". . . Change in Status Process . . . Whenever the following events occur, nursing facility staff must contact Ascend to update the Level I screen for determination of whether a first time or updated Level II evaluation must be performed. These situations suggest that a significant change in status has occurred: . . . If an individual with MI, ID, and/or RC (mental illness, intellectual disability, and conditions related to intellectual disability [referred to in regulatory language as related conditions or RC]) was not identified at the Level I screen process, and that condition later emerged or was discovered. . . ." Review of the facility policy titled "PASRR Screening" occurred on 04/05/18. This policy, dated October 2017, stated, ". . . 9. Any resident who exhibits a newly evident or possible serious mental disorder, intellectual disability, or a related condition will be [sic]for a level II resident review. Examples include: . . . b. A resident whose intellectual disability or related condition was not previously identified and evaluated through PASRR. . . ."	F 644	Resident Services completed a Level One Status Change on residents 42 and 100 and were approved. 2. Identify other residents: All residents with a diagnosis of neurocognitive disorder/dementia (F02.81), delusional disorder (F22), psychosis (F29), anxiety (F41.9) and major depressive disorder single (F32.9) have the potential to be affected by this deficient practice. 3. Measure put in place: Re-education was provided by the Director of Resident Services to the Director of Nursing, Quality and Learning Nurse, Clinical Support Nurses, MDS nurses, Nurse Managers and Care Managers. Re-education included a reminder to notify the Director of Resident Services with any new diagnosis or medications related to mental health, developmental disorder and/or dementia. On 4/19/18, Director of Resident Services provided re-education to the Care Managers at a meeting regarding the need to notify the Director of Resident Services with any new diagnosis and medications related to psych. Re-education will also be provided to direct care nurses and to all staff on 5/7/18, 5/8/18, and 5/9/18 which will include the importance of notifying the Director of Resident Services with any new diagnosis or medications related to mental illness, intellectual disability or related conditions. 4. Measure put in to place: A quality audit	

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F 644	Continued From page 8 - Review of Resident #42's medical record occurred on all days of survey. The record showed an initial PASRR completed on 12/04/14 and identified no mental illness. Current diagnoses included major depressive disorder, single episode, severe with psychotic features dated 09/07/17. A psychiatric progress note, dated 12/11/17, identified a diagnosis of major neurocognitive disorder with behavioral disturbances with psychotic symptoms. The record lacked evidence of an updated Level I screening/change in status assessment since the additional diagnoses. - Review of Resident #100's medical record occurred on all days of survey. The record showed an initial PASRR, completed on 04/18/13, identified anxiety disorder and no mental illness. Current diagnoses included major depressive disorder, single episode, dated 07/11/17, unspecified psychosis not due to substance or known physiological condition, and delusional disorder, dated 06/27/16. The medical record lacked evidence the facility completed an updated Level I screening/change in status assessment since the additional diagnoses. During an interview on the morning of 04/05/18, a social worker (#4) confirmed she failed to submit another PASRR for Resident #42 and Resident #100.	F 644	will be conducted for residents with the above diagnosis. This audit will be conducted monthly for three months and quarterly thereafter. These audits will be completed by the Director of Resident Services and/or designee. Audits will be reviewed by the Quality Assurance Committee monthly to ensure continued compliance. 5. The facility will be in substantial compliance by May 10th, 2018.	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive	F 684		5/10/18

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F 684	Continued From page 9 assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, record review, professional reference, and staff interview, the facility failed to provide care and services in a manner to maintain the highest practicable well-being for 1 of 1 sampled resident (Resident #111) observed. Failure to provide assistive devices to properly position Resident #111's head/neck put the resident at risk for discomfort/pain and unsafe swallowing which can result in aspirating. Findings include: Nancy B. Swigert, "The Source for Dysphagia: Third Edition", LinguiSystems, Inc, 2007, pages 15, 125, identified " . . . Stroke is the number one cause of dysphagia in patients with neurological disease. . . During the oral intake of . . . foods and/or liquids, it is optimal for a patient to be seated at a 90 degree angle, whether in bed or chair. . . for patients who exhibit hemiparesis . . . a lateral head tilt to the patient's intact side may help. . . . " Review of Resident #111's medical record on April 2-5, 2018. Diagnoses include hemiplegia, aphasia, abnormal posture, diabetes, arthritis, seizure, and a history of dysphagia. An occupational therapy note, dated 03/01/18, stated, ". . . Benefits from small towel roll or small	F 684	1. Corrective Action: It is the practice of the facility to provide assistive devices for proper positioning. On 4/5/18, an order was obtained for a soft cervical collar to be implemented for resident 111. On 4/5/18, re-education was provided to nursing staff caring for resident 111 on the importance of reviewing and implementing therapy recommendations by the Nurse Manager. On 4/11/18, re-education was provided to nursing staff by the Director of Nursing regarding the importance of reviewing and implementing therapy recommendations. 2. Identify other residents: All residents that are evaluated by therapy resulting in recommendations have the potential to be affected by this deficient practice. 3. Measure put in place: On 4/11/18, re-education was provided to nursing staff by the Director of Nursing regarding the importance reviewing and implementing therapy recommendations. Re-education will also be provided to all staff at an all staff in-service to be held on 5/7/18, 5/8/18, and 5/9/18 with review of the above. 4. Monitoring: A quality audit will be	

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F 684	Continued From page 10 stuffed animal behind L [left] neck in w/c [wheelchair]. . . . Resident experienced onset of severe . . . cervical flexion, which is resulting in pain, impaired line of sight to task at hand and potential for compromised swallow. . . ." Observation of Resident#111 on all days of survey showed her sitting in her wheelchair without a supportive device. Review of the current care plan, identified staff failed to address Resident #111's positioning needs. During an interview on 04/05/18 at 12 a.m., an administrative staff member #13 stated the occupational therapist has made several recommendations for Resident #111's positioning. She then handed this surveyor a doctors order for a soft cervical collar dated 04/05/18 (same day as the interview).	F 684	conducted to assure therapy recommendations are reviewed and implemented by nursing. The audit will be conducted by the Quality and Learning Nursing and/or designee. The audit will be conducted weekly for four weeks, then monthly for 3 months and continued auditing will be scheduled per discretion of the Quality Assurance Committee. Audits will be reviewed by the Quality Assurance Committee monthly to ensure continued compliance. 5. The facility will be in substantial compliance by May 10th, 2018.	
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the	F 690		5/10/18

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 11 resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review, information received from the complainant, and staff interview, the facility failed to provide appropriate services and assistance to maintain bowel/bladder continence for 1 of 12 sampled residents (Resident #65) observed during toileting/incontinence care. Failure to provide toileting assistance may result in unnecessary incontinence and a loss of dignity. Findings include: Information received from the complainant identified concerns with inadequate toileting assistance.	F 690	Corrective Action: It is the practice of the facility to provide toileting assistance per residents needs and/or requests. On 4/5/18, re-education was provided by the Nurse Manger to two resident assistants that were assisting resident 65 regarding the importance of honoring individual resident's request and following toileting schedules. On4/11/18, re-education was provided by the Director of Nursing to the nursing staff on the importance of offering toileting assistance and following toileting schedules. 2. Identify other residents: All residents that require assistance to toilet have the	

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	355079	A. BUILDING _____ B. WING _____	C 04/05/2018

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F 690	Continued From page 12 Review of Resident #65's medical record occurred on all days of survey. Diagnoses included dementia. The resident's current Minimum Data Set (MDS), dated 02/09/18, identified extensive assistance from two or more people for toileting, frequently incontinent of bladder, and occasionally incontinent of bowel. Resident #65's current care plan stated, ". . . I am incontinent of bladder, I am incontinent of bowel. . . . TOILETING ROUTINE: Offer to take me to the toilet at: B1 [before 1st meal], A2 [after 2nd meal], B4 [before 4th meal] & HS [bedtime] as I can tolerate. . . . Check my product and provide incontinence care as needed when I am unable to tolerate getting up to the commode. . . . I may utilize a bedside commode. . . ." Observation on 04/03/18 at 9:17 a.m. showed two CNAs (certified nursing assistants) (#5 and #6) assisted Resident #65 with hygiene/dressing in bed. The resident stated, "I think I'm going to wet myself." One CNA (#5) stated, "We are going to clean you up and change you, so you can just go [meaning in her brief]." Observation showed the CNAs then provided incontinence cares and transferred the resident to the wheelchair. During an interview on 04/04/18 at 8:51 a.m., a CNA (#7) stated Resident #65 can use the commode, and the she/he would offer to toilet Resident #65. During an interview on 04/05/18 at 11:04 a.m., a supervisory nurse (#3) identified staff should toilet residents if they are able. Facility staff failed to provide toileting assistance consistent with Resident #65's needs/requests,	F 690	potential to be affected by this deficient practice. 3. Measure put in place: On 4/11/18, re-education was provided by the Director of Nursing to the nursing staff on the importance of offering toileting assistance and following toileting schedules. All staff will be educated at an all staff in-service to held on 5/7/18, 5/8/8, and 5/9/18 on the importance of following residents toileting schedules and their individual requests by the Quality and Learning Nurse and/or designee. 4. Monitoring: A quality audit will be conducted to assure any resident that requires assistance with toileting, those on a toileting schedule, and those who have individual requests for toileting. The audit will be conducted by the Quality and Learning Nurse and/or designee. The audit will be conducted weekly for four weeks,then monthly for three months and continued auditing will be scheduled per discretion of the Quality Assurance Committee. Audits will be reviewed by the Quality Assurance Committee monthly to ensure continued compliance. 5. The facility will be substantial compliance by May 10,2018.	

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F 690	Continued From page 13 which may have resulted in inappropriate toileting completed for staff convenience, decreased dignity, and avoidable incontinence.	F 690		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, facility staff failed to offer fluids to 2 of 12 sampled residents (Resident #67 and #100) who required staff assistance for fluid intake and are at risk for dehydration. Failure to provide assistance with fluid intake may result in dehydration, constipation, and urinary tract infections (UTIs).	F 692	1. Corrective Action: It is the practice of the facility to offer fluids to residents that require assistance with fluid intake. On 4/5/18, the Nurse Manager educated direct care staff on the importance of offering fluids between meals and snacks to residents 67 and 100. 2. Identify other residents: All residents	5/10/18

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F 692	Continued From page 14 Findings include: Review of the facility policy titled "Provision of Adequate Hydration Status" occurred on 04/05/18. This policy, revised March 2018, stated, ". . . POLICY: A Plan of care to promote intact hydrate will be implemented in a timely manner. PROCEDURE: . . . 10. For residents who require . . . Nectar thick . . . as assessed by Speech Therapist . . . correct fluid consistency will be offered between with [sic] meals and snacks. 11. Fluid will be provided for residents requiring altered consistencies with meals and snacks." - Review of Resident #67's medical record occurred on all days of survey. Diagnoses included constipation. The current care plan stated, "I am at risk for dehydration or potential for unstable fluid status . . . Offer and encourage me to drink 1500 cc [cubic centimeters] of fluids of choice in 24hrs [hours] as tolerated. Ensure I have access to cold water and other fluids of choice whenever possible. I need (assistance/encouragement/supervision) with fluid intake in order to meet daily requirements . . ." Observation 04/02/18 at 2:45 p.m. showed a certified nursing assistant (CNA) (#10) provided cares for Resident #67 and transported her from her room to the TV lounge area. Observation showed a mug of water on the resident's nightstand but not within reach. The CNA failed to offer fluids. Resident #67 did not receive fluids until her meal tray arrived at 4:15 p.m. Observation on 04/03/18 at 3:40 p.m. showed an	F 692	that require assistance with fluid intake have the potential to be affected by this deficient practice. 3. Measure put in place: On 4/11/18, re-education to nursing staff was provided on the importance of offering fluids between meals and snacks. Re-education was provided by the Director of Nursing. Further re-education will be provided to all staff at an all staff in-service to be held on 5/7/18, 5/8/8 and 5/9/18. 4. Monitoring: A quality audit will be conducted to assure residents are offered/encouraged fluids between meals and snacks and within reach. The audit will be conducted by the Quality and Learning Nursing and/or designee. The audit will be conducted weekly for four weeks, then monthly for 3 months and continued auditing will be scheduled per discretion of the Quality Assurance Committee. If concerns are noted, immediate corrective action will be taken by the Quality Assurance Committee and/or designee. 5. The facility will be in substantial compliance by May 10th, 2018.	

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F 692	Continued From page 15	F 692		

unidentified CNA provided cares for Resident #67. Observation showed a mug of water on Resident #67's nightstand, but not within reach. The CNA failed to offer fluids.

- Review of Resident #100's medical record occurred on all days of survey. Diagnoses included constipation and dysphagia (difficulty swallowing). The current care plan stated, "I am at risk for, dehydration or potential for unstable fluid status . . . Offer and encourage me to drink 2000 cc NT [nectar thick] fluids of choice as tolerated whenever possible. I need encouragement with fluid intake in order to meet daily requirements. . . ."

Observation on 04/02/18 at approximately 1:15 p.m. showed Resident #100 in bed watching TV and no fluids available.

Observation on 04/03/18 at 9:28 a.m. showed no fluids available in Resident #100's room. A CNA (#11) provided cares for the resident for approximately 80 minutes and failed to offer fluids during or after cares.

Observation on 04/03/18 at 11:58 p.m. showed no fluids available in Resident #100's room. Two CNAs (#11 and #12) provided personal cares for the resident and exited the room. The CNAs failed to offer the resident fluids.

Observation on 04/04/18 at 8:45 a.m. showed a bottle of Pepsi on Resident #100's bedside table, but not within reach.

During an interview on the morning of 04/05/18, the unit manager (#9) stated she expected facility

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F 692	Continued From page 16 staff to provide fluids during cares.	F 692		
F 698 SS=E	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of professional reference, and staff interview, the facility failed to ensure residents received the care and services consistent with professional standards of practice for 3 of 3 sampled residents (Resident #28, #90, #238) receiving hemodialysis outside the facility. Failure to assess/monitor hemodialysis vascular access sites (arterial-venous fistulas) on a regular basis can result in complications with access function and possible loss of the access site. Findings include: The Centers for Medicare and Medicaid Services (CMS) has outlined standards of practice regarding dialysis which states, ". . . The nursing home staff must provide immediate monitoring and documentation of the status of the resident's access site(s) upon return from the dialysis treatment to observe for bleeding or other complications. . . ." - Review of Resident #90's medical record occurred on all days of survey. Diagnoses included end-stage renal disease. The resident's	F 698	1. Corrective Action: It is the practice of the facility to ensure professional standards of practice for residents receiving hemodialysis outside the facility are met by monitoring and documenting the status of a resident's access site upon return from the dialysis treatment facility. On 4/11/18, the facility implemented monitoring and documenting of any resident with a hemodialysis access site including residents 28, 90 and 238. The facility's Dialysis Care policy was updated to reflect this change as well. On 4/11/18, re-education was provided by the Director of Nursing to nursing staff regarding the need to monitor and document access sites for patency and/or complications of any resident that is receiving hemodialysis outside the facility. 2. Identify other residents: All residents receiving hemodialysis at an outside facility have the potential to be affected by this deficient practice. 3. Measure put in place: On 4/11/18, the	5/10/18

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F 698	Continued From page 17 current care plan stated, ". . . I need hemo-dialysis 3 x week related to: End stage disease . . ." Observation on the morning of 04/03/18 showed a fistula site to Resident #90's right arm. The resident identified she goes to dialysis on Monday, Wednesday, and Friday. The medical record lacked evidence the facility monitored Resident #90's fistula site. - Review of Resident #238's medical record occurred on all days of survey. Diagnoses included end stage renal disease and dependence on renal dialysis. The current care plan stated, "I need, dialysis, hemo [hemodialysis], related to: end stage renal disease . . . Monitor changes in my mental status Lethargy, Somnolence, Fatigue, Tremors, seizures. Do not draw blood or take B/P [blood pressure] in my arm with graft. Blood draws in (specify) Right/Left arm . . . Monitor/document/report to MD PRN [as needed] any s/sx [signs and symptoms] of infection to access site Redness, Swelling, warmth or drainage. . . ." The medical record lacked evidence the facility monitored Resident #238's fistula site. - Review of Resident #28's medical record occurred on all days of survey. Diagnoses included end stage renal disease and dependence on renal dialysis. The current care plan stated, ". . . I have a need	F 698	facility implemented monitoring and documenting of any resident with a hemodialysis access site. The facility's Dialysis Care policy was updated to reflect this change as well. On 4/11/18, re-education was provided by the Director of Nursing to nursing staff regarding the need to monitor and document access sites for patency and/or complications of any resident that is receiving hemodialysis outside the facility. 4. Monitoring: A quality audit will be conducted for residents that have a dialysis access site to assure there is monitoring and documentation in place. This audit will be conducted monthly for three months and then quarterly thereafter. This is will be conducted by the Quality and Learning Nurse and/or designee. Audits will be reviewed by the Quality Assurance Committee monthly to ensure continued compliance. 5. The facility will be in substantial compliance by May 10th, 2018.	

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F 698	Continued From page 18 for dialysis treatment 3x/week . . . has a fistula on my left upper arm. . . ." The current physician orders stated, " Remove bandage to fistula site. Cleanse area and dry well. Leave area open to air at bed time every Sunday, Wednesday, Friday for skin alteration." The medical record lacked evidence the facility monitored Resident #28's fistula. During an interview at 3:37 p.m. on 04/04/18, an administrative nurse (#3) identified the facility does not have a consistent process for monitoring the residents' fistulas after dialysis treatments.	F 698		
F 804 SS=D	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, and group interview, the facility failed to serve foods at palatable temperatures in 1 of 1 meal observed. Failure to serve foods at a temperature acceptable to residents may result in decreased intake, weight loss, and inadequate nutrition. Findings include:	F 804	1. Corrective Action: It is the practice of the facility to serve foods at palatable temperatures. It is the practice of the facility to offer a new meal tray to resident if there are concerns related to food temperature. Re-education was provided by the dietary manager to dietary staff during an in-service on 4/10/2018	5/10/18

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F 804	Continued From page 19 During the group interview on the afternoon of 04/03/18, six of the eight residents stated the food is sometimes cold, usually during the evening meal. Observation during the evening meal on 04/03/18 showed Resident A and another residents' food dished at 4:24 p.m. and placed on the serving line counter. Facility staff delivered the trays at 4:31 p.m. (7 minutes later). When asked about the meal, Resident A stated, "It's not warm. It's not even lukewarm." Another resident in the dining room, Resident B, stated she "waited a long time" to receive her food from the time she ordered it and when the food arrived, it was cold. During an interview on 04/03/18 at 4:50 p.m., Resident A further stated her potatoes were cold and she thinks the food is cold due to sitting on serving line counter for long periods of time before staff deliver it. Failure to serve foods at palatable temperatures may negatively impact residents' meal consumption.	F 804	regarding a new process for temping food, the importance of dishing up meals when dietary staff are available to serve it and importance of teamwork. Re-education will also be provided to all staff at an all staff in-service to be held on 5/7/18, 5/8/18 and 5/9/18. Re-education will include the same as mentioned above. 2. Identify other residents: All residents that eat meals in the main dining room have the potential to be affected by this deficient practice. 3. Measure put in place: Dietary manager or designee will monitor food temps at the beginning and middle of meal service to assure palatable temperatures. A log will be kept to assist in tracking. Dietary staff have been educated on a new process for temping food, the importance of not dishing up meals until dietary staff are available to serve it and importance of teamwork. The facility will educate all staff at an in-service to be held on 5/7/18, 5/8/18 and 5/9/18 as mentioned above. 4. Monitoring: A quality audit will be conducted by the dietary manager and/or designee. The audit will include testing of meal tray temps. The audit will be conducted three times a week for four weeks then one time a week for four months and continued auditing will be scheduled per discretion of the Quality	

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F 804	Continued From page 20	F 804	Assurance Committee. Audits will be reviewed by the Quality Assurance Committee monthly to ensure continued compliance. 5. The facility will be in substantial compliance by May 10, 2018.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify	F 880		5/10/18

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F 880	Continued From page 21 possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which 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; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced	F 880		

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F 880	Continued From page 22 by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to ensure staff followed appropriate infection control practices for 1 of 1 sampled resident (Resident #100) on isolation precautions and 1 of 2 sampled residents (Resident #67) observed during sit to stand transfers. Failure to follow appropriate infection control practice related to isolations precautions (Resident #100) and sanitizing equipment (Resident #67) may result in the spread of infection to all residents, staff, and visitors. Findings include: Review of the facility policy titled "Management of Residents with C-Diff [Clostridium Difficle]" occurred on 04/05/18. This policy, dated December 2017, stated, ". . . Clean room surfaces with bleach or another EPA [Environmental Protection Agency] approved, spore killing disinfectant while a resident with C. diff is being treated . . . Remember spores are most difficulty [sic] to kill and are what allow bacteria to reproduce. . . . Practice and follow infection control recommendations . . . This includes . . . good cleaning practices, appropriate handling of linens . . ." Review of the facility policy titled "Standard Precautions" occurred on 04/05/18. This policy, dated January 2018, stated, ". . . Resident care equipment that is to be re-used will be: 1. Handled in a manner that prevents skin and mucus membrane exposure or contamination of clothing. 2. Cleaned and disinfected before re-use, as appropriate. . . ."	F 880	1. Corrective Action: It is the practice of the facility to follow appropriate infection control practices for isolation precautions and sanitizing of mechanical lifts. On 4/5/18, re-education was provided to the resident assistant that was taking care of resident 100. re-education included the importance of following isolation precautions policy/procedure. Re-education was provided to Lovely Lane staff on isolation precaution policy/procedure and importance of sanitizing mechanical lifts between use by the Nurse Manager. 2. Identify other residents: All residents in isolation precautions and residents that require a mechanical lift for transfers have the potential to be affected by this deficient practice. 3. Measures put into place: On 4/11/18, re-education was provided to nursing staff by the Director of Nursing on the importance of following facility policy/practice related to isolation precautions and sanitizing of mechanical lifts between resident use. Re-education will also be provided to all staff on 5/7/18, 5/8/18 and 5/9/18 regarding infection control practices. 4. Monitoring: Quality audits will be conducted to ensure staff are following isolation precautions and sanitizing mechanical lifts between resident use. The audits will be conducted by the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355079	A. BUILDING _____ B. WING _____	C 04/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 23 - Review of Resident #100's medical record occurred on all days of survey and identified a diagnosis of C. diff on 03/29/18. The current care plan stated, "I have C. Difficile indicated by positive stool sample . . . Interventions: Disinfect all equipment used before it leaves the room. . . ." Observation on 04/02/18 at approximately 1:15 p.m. showed a sign on Resident #100's door alerting staff/visitors to check with the nurse before entering the room. Observation showed, inside the room, a stack of yellow disposable isolation gowns on the sink counter. Observation on 04/03/18 at 9:28 a.m. showed a certified nursing assistant (CNA) (#11) entered Resident #100's room with a portable laundry/garbage cart. The cart held two large cloth bags. The CNA donned a gown (located on the sink counter) and gloves, obtained a basin of water, and provided incontinence (bowel movement (BM)) cares. After completing cares, the CNA poured the basin of water into the handwashing sink. The CNA failed to remove the clean gowns located on the sink counter before pouring the contaminated water into the sink. The CNA then removed her gloves, and washed her hands. Observation showed the contaminated water drained slowly from the sink while the CNA washed her hands. The CNA (#11) applied new gloves, disinfected the plastic frame of the laundry/garbage cart with Clorox Wipes, removed her gown and gloves, and washed her hands. Observation showed contaminated water still remained in the sink. The CNA (#11) failed to pour the contaminated basin water into the toilet,	F 880	Quality and Learning Nurse and/or designee. The audits will be conducted weekly for 4 weeks then monthly for three months and continued auditing will be scheduled per discretion of the Quality Assurance Committee. Audits will be reviewed by the Quality Assurance Committee monthly to ensure continued compliance. 5. The facility will be in substantial compliance by May 10th, 2018.	

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F 880	Continued From page 24 failed to disinfect the sink counter, and failed to remove the clean gowns from the counter and place them in the personal protection equipment (PPE) box hanging on the door before exiting the room with the laundry/garbage cart. Observation on 04/03/18 at 12:08 p.m. showed two CNAs (#11 and #12) entered Resident #100's room, donned gowns (located on the sink counter) and gloves, and provided incontinence (BM) cares for the resident. After completing cares, the CNAs removed their gowns and gloves and washed their hands while the water drained slowly from the sink. The CNAs (#11 and #12) failed to disinfect the sink counter or remove the clean gowns from the counter and place them in the PPE box. - Observation on 04/02/18 at 2:45 p.m. and on 04/03/18 at 8:47 a.m. and at 3:40 p.m. showed a CNA (#10) utilized a sit to stand mechanical lift to transfer Resident #67 from one surface to another. The CNA failed to disinfect the lift after removing it from the resident's room. During an interview on 04/03/18 at 5:19 p.m., a CNA (#15) stated all mechanical lifts are sanitized between residents. During an interview on 04/05/18 at 10:28 a.m., an infection control nurse (#14) stated she expected: * Facility staff to dispose of basin water in the toilet and not the handwashing sink * Gowns to be stored in the PPE storage box on the back on the resident's door and not on the counter * All equipment used for multiple residents is disinfected between use	F 880		

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F 880	Continued From page 25 * Not to take laundry/garbage carts into an isolation room	F 880		