STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355078	A. BUILDING _____ B. WING _____	01/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVENTIDE JAMESTOWN	1300 2ND PL NE JAMESTOWN, ND 58401

(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, started on 01/03/17 and completed on 01/05/17, the sample included 5 residents for complete review, 14 residents for focused review, and 3 closed records for review. The sample included 1 additional resident to verify specific concerns during the survey.	F 000		
F 241 SS=D	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat 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. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and record review, the facility failed to provide care in a manner that maintained or enhanced resident dignity for 2 of 19 sampled residents (Resident #12 and #13) and 1 supplemental resident (Resident #23). Failure to provide privacy during personal cares (Resident #12), provide feeding assistance in a dignified manner (Resident #13), and speak to a resident in a dignified manner (Resident #23) does not promote residents' dignity or enhance their quality of life. Findings include: Review of the facility policy titled "Standards of Care" occurred on 01/05/17. This policy, revised October 2016, stated, ". . . DIGNITY: 1. Privacy curtain/door to be closed anytime cares are being	F 241	1. The facility will ensure a dignified environment for resident 12, 13 and 23. Facility will care for residents in a manner which preserves and improves the resident's dignity and respect. 2. All residents of the facility have the potential to be affected. The facility will ensure staff promote dignity to all residents. This will be demonstrated by staff assisting with feeding residents appropriately, communicating to residents in a dignified manner and providing privacy residents in to a dignified manner. 3. All staff will be educated on promoting dignity and respect to residents prior to February 9th, 2017.	2/9/17

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

Electronically Signed | 01/28/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 241	Continued From page 1 completed. . . ." - Resident #12's medical record, reviewed on all days of survey, identified diagnoses of dementia. Resident #12's quarterly Minimum Data Set (MDS), dated 10/22/16, identified moderately impaired cognition, extensive assistance from one or more people for transfers, dressing, personal hygiene, and bathing. Observation on 01/04/17 at 8:15 a.m., showed a certified nursing assistant (CNA) (#3) and a staff nurse (#2) entered the tub room to assist the CNA (#4) with the transfer of Resident #12 from the bath chair to the wheelchair. Resident #12 sat in the bath chair facing the door, with no towel or clothing covering him, leaving him exposed from the waist to just below his knees. The staff failed to pull the privacy curtain, exposing Resident #12 unnecessarily to anyone entering the tub room or walking by while the door was open. - Resident #13's medical record, reviewed on all days of survey, identified diagnoses of dementia. Resident #13's quarterly MDS, dated 09/21/16, identified severely impaired mental status and extensive assistance of one to two for all ADLs. The current care plan stated, " . . . Interventions/Tasks . . . treat me in an adult and dignified manner . . ." Observation on 01/03/17 at 6:15 p.m., showed an unidentified CNA fed Resident #13 with a spoon, scraped the excess food from the resident's side of her mouth, mixed it with the food on her plate, and refed it to her.	F 241	4. The DON or designee will be responsible to monitor resident dignity and respect. QA monitoring was implemented on 1/30/17. The DON or designee will monitor weekly for a month, monthly for three months, and then random audits as needed per QA committee recommendations. Results will be immediately reported to the Executive Director. 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. 5. Date of Correction: 9th February 2017	

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F 241	Continued From page 2 - Observation during the evening meal on 01/03/17 at 6:19 p.m. showed a CNA (#15) conversed with Resident #23. The CNA stated, "you don't have to lie to me to be your friend, turns out they pay me to be yours." The CNA (#15) failed to speak to Resident #23 in a dignified manner.	F 241		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE (b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, and staff interview, the facility failed to complete a significant change in status assessment (SCSA) for 2 of 19 sampled residents (Resident #9 and #10) reviewed. Failure to determine the need for and complete a SCSA in response to each resident's decline limited the facility's ability to accurately assess the resident's status, and identify and implement appropriate interventions. Findings include:	F 274	1. Facility will reassess resident 9 and 10 and complete a significant change in status assessment. 2. All residents have the potential to be affected. The facility will ensure staff will complete a significant change in status assessment and MDS coded accordingly as indicated in the long-term care facility RAI 3.0 user□s manual. All MDS□s of current residents will reviewed to be sure a significant change in status assessment in not needed, if indicated the significant change in status assessment will be	2/9/17

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F 274	Continued From page 3 The Long-Term Care Facility RAI 3.0 User's Manual (Version 1.13), dated October 2015, page 2-20 stated, ". . . A "significant change" is a decline or improvement in a resident's status that: 1. Will not normally resolve itself without staff intervention . . . 2. Impacts more than one area of the resident's health status; and 3. Requires interdisciplinary review and/or revision of the care plan. . . ." and page 2-23 stated, "A SCSA is appropriate if there are either two or more areas of decline or two or more areas of improvement. . . . [such as] increase in the number of areas where behavioral symptoms are coded as being present and/or frequency of a symptom increases . . . Any decline in an ADL [activity of daily living] physical functioning area where a resident is newly coded as Extensive assistance . . . Emergence of unplanned weight loss problem . . . " - Review of Resident #9's medical record occurred on all days of survey. The admission Minimum Data Set (MDS), dated 06/01/16, identified no physical or verbal behavioral symptoms, no wandering, and limited assistance with walking in room. The quarterly MDS, dated 07/13/16, identified physical behavioral symptoms (on 4-6 days of the 7-day look-back period), verbal behavioral symptoms (1-3 days), wandering (4-6 days), and extensive assistance (a decline) with walking in room. - Review of Resident #10's medical record occurred on all days of survey. The quarterly MDS, dated 08/08/16, identified no physical or "other" behavioral symptoms, wandering on 1-3 days of the 7-day look-back period, and a weight	F 274	completed. 3. Staff will be educated on completing the significant change in status assessment per the long-term care facility RAI 3.0 user□s manual prior to February 9th, 2017. 4. The DON or designee will be responsible to monitor the appropriate completion of the significant change in status assessment. QA monitoring was implemented on 1/30/17. The DON or designee will audit all MDS□s for a month, twenty MDS□s will be audited monthly for three months, and then random audits as needed per QA committee recommendations. Results will be immediately reported to the Executive Director. 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. 5. Date of Correction: 9th February 2017	

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F 274	Continued From page 4 of 149 pounds (#). The quarterly MDS, dated 11/01/16, identified physical behavioral symptoms (1-3 days), "other" behavioral symptoms (1-3 days), an increase in wandering (4-6 days), and a weight of 133# (a non-physician prescribed significant weight loss of 10.7 percent in three months). During an interview on 01/05/17 at 11:25 a.m., an administrative nurse (#1) agreed Resident #9's 07/13/16 MDS and Resident #10's 11/01/16 MDS should have been completed as significant changes.	F 274		
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a	F 278		2/9/17

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F 278	Continued From page 5 resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a 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 (RAI) 3.0 User's Manual, and staff interview, the facility failed to ensure accurate coding of Minimum Data Sets (MDSs) for 3 of 19 sampled residents (Resident #9, #10, and #17). Failure to accurately complete portions of the MDS does not allow each resident's assessment to reflect their current status/needs and may result in the inaccuracy of the facility's Resident Level Quality Measure Reports. Findings include: BEHAVIOR The Long-Term Care Facility RAI 3.0 User's Manual (Version 1.13), dated October 2015, pages E-4, E-5, and E-13, stated, "E0200: Behavioral Symptom - Presence and Frequency . . . C. Other behavioral symptoms not directed toward others (e.g. physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or	F 278	1. Resident 9, 10, and 17 MDS Assessments were modified to reflect the correct medication and behavior information. 2. All residents who receive antianxiety or antidepressant medications and those who exhibit behaviors have the potential to be affected. All recent MDS's completed for residents who have antianxiety/antidepressant medication and behaviors will be audited by nurse management staff. If coding is not accurate a correction will be made. 3. All staff who complete the MDS Assessments will be educated on proper coding of the MDS Assessment Tool from nursing documentation prior to February 9th, 2017. 4. The Director of Nursing or designee will be responsible to monitor the MDS Assessment Process to accurately reflect the condition of the resident. QA Monitoring was implemented on 1/30/17. The DON or designee will monitor each MDS prior to submission weekly for a	

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F 278	Continued From page 6 verbal/vocal symptoms like screaming, disruptive sounds) . . . Planning for Care: Identification of the frequency and the impact of behavioral symptoms on the resident and on others is critical to distinguish behaviors that constitute problems . . . Steps for Assessment: 1. Review the medical record for the 7-day look-back period. 2. Interview staff . . . 3. Observe the resident . . . E0800: Rejection of Care-Presence & Frequency . . . Did the resident reject evaluation or care (e.g. bloodwork, taking medications, ADL assistance) that is necessary to achieve the resident's goals for health and well-being? . . ." - Review of Resident #9's medical record occurred on all days of survey. The certified nurse aide (CNA) behavior flowsheet, dated July 7-13, 2016, identified Resident #9 exhibited "other behavioral symptoms not directed toward others" on five of the days. The quarterly MDS, dated 07/13/16, failed to identify Resident #9 exhibited "other" behavioral symptoms. The CNA behavior flowsheet, dated September 30-October 6, 2016, identified Resident #9 exhibited "other behavioral symptoms not directed toward others" on four of the days. The quarterly MDS, dated 10/06/16, identified "other" behavioral symptoms occurring on 1-3 days (not 4-6 days as listed above). - Review of Resident #10's medical record occurred on all days of survey. The CNA behavior flowsheets, dated August 2-8 and October 26-November 1, 2016, identified Resident #10 exhibited "other behavioral symptoms not directed toward others" on August	F 278	month, twenty MDS's will be audited monthly for three months and random audits as needed per QA committee recommendations. Results will be immediately reported to the Executive Director. If concerns are identified, immediate corrective action will be implemented. The DON or designee will submit a report of the monitoring results to the QA Committee at each scheduled meeting. 5. Date of Correction: 9th February 2017	

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F 278	Continued From page 7	F 278		

2 and "rejection of care" on October 29 and 31. The quarterly MDS, dated 08/08/16, failed to identify Resident #10 exhibited "other" behavioral symptoms. The quarterly MDS, dated 11/01/16, failed to identify rejection of care behavior.

- Review of Resident #17's medical record occurred on January 05, 2017. The CNA behavior flowsheet, dated October 12-18, 2016, identified Resident #17 exhibited "threatening behavior" on one day. The quarterly MDS, dated 10/18/16, failed to identify rejection of care behavior.

During an interview on 01/05/17 at 11:25 a.m., when asked how staff determine the presence and frequency of behaviors on each MDS, an administrative nurse (#1) stated the behavior section auto-populates from the CNA behavior flowsheet documentation, and did not know why "other behaviors" and "rejection of care" was not accurate.

MEDICATIONS

The Long-Term Care Facility RAI 3.0 User's Manual (Version 1.13), dated October 2015, pages N-4 and N-6, stated "N0410: Medications Received: Indicate the number of DAYS the resident received the following medications during the last 7 days . . . B. Antianxiety . . . C. Antidepressant . . . Coding Tips and Special Populations, Code medications in Item N0410 according to the medication's therapeutic category and/or pharmacological classification, not how it is used. . . ."

- Review of Resident #9's medical record

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F 278	Continued From page 8 occurred on all days of survey. The quarterly MDS, dated 10/06/16, identified the following: * N0410 B - antianxiety, coded received "0" days * N0410 C - antidepressant, coded received "7" days Resident #9's Medication Administration Record (MAR) showed the number of days the resident received the following during the 7-day look-back period from September 30-October 6, 2016: * lorazepam 1 milligram (mg) (antianxiety) - 7 days * antidepressant - none ordered or administered During an interview on 01/05/17 at 11:25 a.m., an administrative nurse (#1) stated Resident #9's MDS should have been coded for an antianxiety medication and not an antidepressant. - Review of Resident #17's medical record occurred on January 05, 2017. The quarterly MDS, dated 10/18/16, identified the following: * N0410 B - antianxiety, coded received "7" days The MAR showed Resident #17 did not receive any antianxiety medication during the MDS look-back period. During an interview on 01/05/17 at 2:10 p.m. an administrative nurse (#1) confirmed Resident #17's MDS, dated 10/18/16, should not have been coded for antianxiety medication.	F 278		
F 280 SS=E	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered	F 280		2/9/17

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F 280	Continued From page 9 plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans	F 280		

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F 280	Continued From page 10 (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to review and	F 280	1. Residents 7, 9, 10 and 11 care plans were assessed for accuracy and updated.	

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F 280	Continued From page 11 revise the comprehensive care plan to reflect the residents' status for 4 of 19 sampled residents (Resident #7, #9, #10, and #11). Failure to review and revise the care plan limited staff's ability to communicate care needs and ensure continuity of care for each resident. Findings include: Review of the facility policy titled "CARE PLANS" occurred on 01/05/17. This policy, revised May 2013, stated, ". . . C. Documentation . . . 2. Care plans will be updated and changes will be made as they occur to ensure the most current plan for the resident. . . ." - Review of Resident #7's medical record occurred on all days of survey. A progress note, dated 10/17/16, stated Resident #7 slid off of her low bed onto the floor. The care plan failed to identify Resident #7's low bed as a fall intervention. During an interview on the afternoon of 01/05/17 an administrative nurse (#11) confirmed Resident #7 currently has a low bed. - Review of Resident #9's medical record occurred on all days of survey. Diagnoses included dementia with behavioral disturbance and anxiety disorder. The quarterly Minimum Data Set (MDS), dated 10/06/16, identified severely impaired decision making ability and the presence of physical, verbal, and other behavioral symptoms, and wandering. The CNA behavior flowsheet, for the 7-day look-back period ending 10/06/16, identified	F 280	2. All residents have the potential to be affected. Care plans are reviewed to ensure accuracy and updated as appropriate to individual resident needs. 3. Care Plans are Initiated on admission and reviewed and revised as needed for each resident with every change of condition and MDS assessment by a nurse or nurse manager. Changes to the care plan will to be communicated to staff and will be done immediately and appropriately. Nursing will ensure the care plan accurately reflects the resident's current condition through assessment and by communicating all changes in condition to staff providing care. Education will be completed for staff completing care plans prior to February 9th, 2017. 4. The DON or designee will be responsible to monitor the Care Plan Process to accurately reflect the current condition of the residents. QA monitoring was implemented on 1/30/17. The DON or designee will monitor thirty care plans weekly for a month, forty care plans monthly for three months, and then random audits as needed per QA committee recommendations. Results will be immediately reported to the Executive Director. 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. 5. Date of Correction: 9th February 2017	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVENTIDE JAMESTOWN	1300 2ND PL NE JAMESTOWN, ND 58401

(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 280	Continued From page 12 Resident #9 exhibited the following behaviors: * "Kicking/Hitting" toward others - one day * "Abusive Language" toward others - one day * "Wandering" - daily * "Other behavioral symptoms not directed toward others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds)" - four days. A follow-up question report to the "Other Behaviors" listed "Voiding/Defecating in Inappropriate Areas" on one day. The CNA behavior flowsheet listed the interventions staff employed with the above behaviors as "provide redirection," "provide distraction," and "provide diversional activities (toilet, walk, wheelchair ride, snack)." Resident #9's care plan included the problem, "Resident can be resistive with cares and have other behaviors r/t to dementia. . . . I will get restless and take my brief off or take it apart. I will also dig in my brief and smear feces [other behavioral symptom not directed toward others]. . . . Interventions: . . . Give meds . . . If being resistant with cares, provide distraction, offer different caregiver . . . one piece outfit as needed. 30 min [minute] visual checks . . . reside in the SCU [special care unit] . . . " The facility failed to include the behaviors of kicking/hitting, abusive language, and wandering, specific goals and/or interventions to manage these behaviors. - Review of Resident #10's medical record occurred on all days of survey. Diagnoses	F 280		

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included vascular dementia with behavioral disturbance. The quarterly MDS, dated 11/01/16, identified severely impaired cognition, physical and other behavioral symptoms, and wandering.

The CNA behavior flowsheet, for the 7-day look-back period ending 11/01/16, identified Resident #10 exhibited the following behaviors:
* "Grabbing" - one day
* "Repeats movement" - one day
* "Rejection of care" - two days
* "Wandering" - five days
* "Other behavioral symptoms not directed toward others" - two days

The CNA behavior flowsheet listed the interventions staff employed with the above behaviors as "provide redirection," "provide 1:1 contact or reassurance," "check for pain, fear, illness or other physical reason," and "provide diversional activities (toilet, walk, wheelchair ride, snack)."

Resident #10's care plan included the problem, "Potential for safety concerns due to Dementia * wandered into another res.[resident's] room . . ." and included interventions. The facility failed to include in the care plan the behaviors of grabbing, repeats movement, rejection of care, and other behavioral symptoms not directed toward others, along with specific goals and/or interventions to manage these behaviors.

During an interview on 01/05/17 at 3:00 p.m., an administrative nurse (#11) agreed issues identified on the MDS should be care planned.

- Review of Resident #11's medical record

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F 280	Continued From page 14 occurred on all days of survey. The physician orders identified a "Liberal Geriatric diet CAT [consistencies as tolerated] diet." The current care plan stated, "Focus: Allergy to gluten and avoids seeds. Requests small portions. . . . Interventions/Tasks . . . Provide Gluten restricted diet, small portions (per resident request); no seeds as tolerated . . . Focus: I have an ADL [activities of daily living] Self Care Performance Deficit r/t weakness . . . Interventions/Tasks . . . EATING: Assist of 1 soft foods ground meat . . ." During an interview on 01/04/17 at 4:10 p.m. the dietician (#16) confirmed Resident #11 receives a regular consistency diet.	F 280		
F 315 SS=D	483.25(e)(1)-(3) NO CATHETER, PREVENT UTI, RESTORE BLADDER (e) Incontinence. (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. (2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon	F 315		2/9/17

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F 315	Continued From page 15 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. (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, and staff interview, the facility failed to provide toileting cares in a timely manner for 1 of 8 sampled residents (Resident #13) observed during toileting. Failure to provide toileting in a timely manner did not allow Resident #13 to attain/maintain her highest practicable physical and psychosocial well-being and may result in avoidable incontinence. Findings include: - Review of Resident #13's medical record occurred on all days of survey. Diagnoses included dementia, diabetes mellitus, edema, and history of falls. The resident's quarterly Minimum Data Set (MDS), dated 09/21/16, identified frequently incontinent of urine and stool, and extensive assistance of two or more persons for toileting and transfers.	F 315	1. Resident 13 was assessed for appropriate toileting and daily monitoring of toileting schedule was implemented and communicated to assure the toileting schedule is followed. 2. All residents who are on a toileting schedule have the potential to be affected. 3. All staff will be educated prior to February 9th, 2017 on providing toileting to residents in a timely manner to a maintain residents highest practicable physical and psychosocial well-being. 4. The DON or designee will be responsible to monitor toileting schedules to ensure residents are toileted in a timely fashion. QA monitoring was implemented on 1/30/17. The DON or designee will monitor weekly for a month, monthly for three months, and then random audits as needed per QA committee	

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F 315	Continued From page 16 The current care plan identified, " . . . Focus: Potential for skin breakdown related to incontinence . . . Focus: Potential for changes to bowel and bladder function r/t [related to] incontinence. . . . Focus: Potential for falls r/t dementia . . . Interventions . . . Toilet prior to rest times . . . Focus: Self deficit related to disease process secondary to dementia . . . Interventions/Tasks . . . Offer and assist with toileting q [every] 3 hrs [hours] and prn [as needed] if restless or verbalizes need. . . ." Observation on 01/04/17 identified the following: * From 8:00 a.m. to 9:35 a.m., Staff transported Resident #13 from the dining room to the resident lounge, where she remained in her wheelchair. * At 9:35 a.m., Two certified nursing assistants (CNAs) (#13 and #14) transferred Resident #13 from her wheel chair to one of the recliners in the resident lounge using a stand lift. The staff failed to toilet Resident #13 prior to her "rest time" as care planned. * From 9:40 a.m. to 11:25 a.m., Resident #13 remained in the recliner in the resident lounge. * At 11:25 a.m., Two CNAs (#3 and #13) transferred Resident #13 from the recliner back into her wheelchair using a stand lift, and then transported her to an area near the nurses station. The staff failed to toilet Resident #13 every three hours as care planned.. * From 11:30 a.m. to 12:35 p.m., Resident #13 remained in her wheel chair in the area near the nurses station. (Later in the day, the CNA #13 reported a Speech Therapist fed Resident #13 during this time period.) * 12:35 p.m., Two CNAs (#3 and #13) transported Resident #13 to her room and	F 315	recommendations. Results will be immediately reported to the Executive Director. 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. 5. Date of Correction: 9th February 2017	

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assisted her with toileting cares. The CNAs (#3 & #13) utilized a stand lift to transfer Resident #13 to the bathroom. The CNAs (#3 and #13) removed Resident 13's dry brief before lowering her onto the toilet, where she voided. When asked, the CNA (#13) reported, "The last time [Resident #13] was toileted was at 7:15 a.m. today."
* From 1:40 p.m. to 3:15 p.m., Resident #13 remained in her low bed in her room.
* 3:15 p.m., Resident #13 sat on the edge of her low bed. Two CNAs (#3 and #13) transferred her from her bed to her wheel chair using a stand lift. Resident #13 was combative throughout the transfer. After safely transferring her into her wheelchair, the CNAs (#3 and #13) transported her to the resident lounge. The staff failed to toilet Resident #13 every three hours as care planned.
*From 3:30 p.m. to 6:00 p.m., Resident remained in her wheel chair in the resident lounge.

Review of the CNA toileting documentation identified the following:
* 12/31/16 at 10:52 p.m., incontinent.
* 01/01/17 at 6:05 a.m., incontinent (over 7 hours since last toileted).
* 01/01/17 at 2:22 p.m., incontinent (over 8 hours since last toileted).
* 01/01/17 at 9:28 p.m., incontinent (over 7 hours since last toileted).
* 01/02/17 at 5:57 a.m., incontinent (over 8 hours since last toileted).
* 01/02/17 at 2:55 p.m., incontinent (over 8 hours since last toileted).
* 01/02/17 at 9:42 p.m., incontinent (over 6 hours since last toileted).
* 01/03/17 at 6:53 a.m., incontinent (over 9 hours since last toileted).

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F 315	Continued From page 18 * 01/03/17 at 10:12 a.m., incontinent (over 4 hours since last toileted). * 01/03/17 at 9:19 p.m., incontinent (over 11 hours since last toileted). * 01/04/17 at 6:11 a.m., incontinent (over 8 hours since last toileted). * 01/04/17 at 2:28 p.m., continent (over 8 hours since last toileted). * 01/04/17 at 10:28 p.m., incontinent (8 hours since last toileted). * 01/05/17 at 6:06 a.m., incontinent (over 7 hours since last toileted). During an interview on 01/05/17 at 12:30 p.m., an administrative nurse (#11) confirmed Resident #13's care plan may need to be updated to reflect her current needs regarding toileting. The facility's lack of implementing the scheduled toileting plan per the current care plan does not allow Resident #13 the opportunity to maintain maximum bladder function/control.	F 315		
F 323 SS=E	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and	F 323		2/9/17

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F 323	Continued From page 19 maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: TRANSFERS 1. Based on observation, record review, staff interview, review of facility policy, and review of professional literature, the facility failed to properly use assistive devices during transfers for 3 of 10 sampled residents (#4, #6, and #7). Failure of staff to ensure proper use of a stand lift (Resident #4 and #6) and gaitbelt (Resident #7) placed residents at risk for possible accident and/or injury. Findings include: Review of facility policy titled "Lifts - Hoyer and Standing" occurred on 01/05/17. This policy, revised September 2016, stated, "STANDING LIFT: . . . Have the resident grasp the lift handles. . . . instruct the resident to stand up as the lift comes up. Tighten the belt on the sling as the resident is raised so the support will be provided behind the back rather than the arms. . . ." Review of the "MEDCARE Stand Products Operations Manual" occurred on 01/05/17. The	F 323	1. Resident 4, 6 and 7 were reassessed for proper transfer device and technique. Gait belts will be used with all transfers and when using lifts, harness will be tightened to prevent sling from slipping. Chemicals in bath and other areas will be locked. 2. All residents who are required to use a lift or transfer with a gait belt have the potential to be affected. All residents have the potential to be affected by improper chemical storage. 3. All Nursing staff will be educated prior to February 9th, 2017 on appropriate transfers with gait belts and lifts as well as proper chemical storage to make ensure residents and staff are safe. 4. The DON or designee will be responsible to monitor transfers with gait belts and standing lifts along with appropriate chemical storage to ensure	

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F 323	Continued From page 20 manual stated, " . . . position the patient's/resident's arms on the outside of the belt and place their hands on the padded handles . . . As you raise the patient, their abdomen will elongate. Retighten the belt strap to ensure it doesn't move up. . . ." - Review of Resident #6's medical record occurred on all days of survey. Diagnoses included right sided hemiplegia (loss of muscle function), hemiparesis (weakness on one side of the body), and cerebral infarction (stroke). The annual Minimum Data Set (MDS), dated 11/20/16, identified moderately impaired cognition, and extensive assistance of two for transfers. Resident #6's care plan stated, " . . . Focus: The resident has an ADL [activities of daily living] Self Care Performance Deficit r/t [related to] weakness. . . . Interventions/Tasks . . . TRANSFER: the resident requires medistand . . ." Observation on 01/03/17 at 4:30 p.m., showed a Certified Nurse Aide (CNA) (#5) transported Resident #6 from the toilet to his wheelchair using the stand lift. The CNA (#5) placed the harness straps loosely around Resident #6's torso, instructed the resident to hold onto the lift handle bars, and raised the resident to a standing position. As staff raised Resident #6 they failed to tighten the harness straps around the resident's waist as it pulled upward into his armpits, raising his shoulder to ear level. The resident stated, "ouch it hurts." The CNA (#5) lowered Resident #6 into the wheelchair and removed the harness strap. Resident #6 stated,	F 323	the safety of the residents. QA monitoring was implemented on 1/30/17. The DON or designee will monitor weekly for a month, monthly for three months, and then random audits as needed per QA committee recommendations. Results will be immediately reported to the Executive Director. 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. 5. Date of Correction: 9th February 2017	

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"it's painful under my arms when they lift me up with that lift machine."

Observation on 01/04/17 at 3:45 p.m., showed two CNAs (#6 and #7) transported Resident #6 from his wheelchair to the toilet using the stand lift. The CNA (#7) placed the harness straps loosely around Resident #6's torso, instructed the resident to hold onto the lift handle bars, and raised the resident to a standing position. As staff raised Resident #6 they failed to tighten the harness straps around the resident's waist as it pulled upward into his armpits, raising his shoulder to ear level. The resident stated "ouch, ouch." A CNA (#6) removed Resident #6's brief and another CNA (#7) lowered Resident #6 onto the toilet.

- Review of Resident #4's medical record occurred on all days of survey. An annual MDS, dated 09/26/16, identified severely impaired cognition and extensive assist of two persons for transfer.

Resident #4's care plan stated, ". . . Focus: I have an ADL Self Care Performance Deficit r/t Dementia . . . Interventions/Tasks: TOILET USE: Requires assist of 1 and medistand to use toilet . . . TRANSFERS: I require assist X [times] 1 w/ [with] medistand; I am unable to ambulate . . ."

Observation on 01/04/17 at 7:50 a.m. showed a CNA (#9) transferred Resident #4 from the bed into the wheelchair with a stand lift. The CNA failed to place Resident #4's hands on the handles or direct her to hold onto the handles as staff raised the lift. As staff raised Resident #4, they failed to tighten the harness straps around

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the resident's waist as it pulled upward into her armpits, raising her shoulders to ear level.

Observation on 01/04/17 at 9:45 a.m. showed a CNA (#9) transferred Resident #4 from the wheelchair onto the toilet and back to the wheelchair with a stand lift. During the observation, the CNA failed to place or cue Resident #4 to hold on to the handles of the lift. As staff raised the lift, the harness pulled up raising her shoulders to ear level as her arms hung by her side.

During an interview on 01/05/17 at 1:00 p.m., regarding Resident #4's transfers, a physical therapist (#17) stated, "it's best if they can hold on" during the transfers.

Review of the facility policy titled "Standards of Care" occurred on 01/05/17. This policy, revised October 2016, stated, ". . . Procedure: SAFETY: 1. A gait belt will be used for assisted transfers . . ."

- Review of Resident #7's medical record occurred on all days of survey. The current care plan stated, "Focus: Self care deficit related to weakness Interventions/Tasks . . . Transfers: assist of 1 . . ."

Observation on 01/03/17 at 5:51 p.m. showed a CNA (#18) transferred Resident #7 from her bed to her wheelchair and failed to use a gaitbelt.

Observation on 01/04/17 at 2:33 p.m. showed a CNA (#15) transferred Resident #7 from the toilet to the wheelchair. The CNA held onto the back of Resident #7's pants instead of the gaitbelt. The

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F 323	Continued From page 23 CNA (#15) failed to use the gaitbelt. Observation on 01/04/17 at 3:24 p.m. showed a CNA (#18) transferred Resident #7 from her bed to her wheelchair and failed to use a gaitbelt. During an interview on the afternoon of 01/05/17, an administrative nurse (#11) stated she expected staff to use a gaitbelt with transfers. UNSECURED CHEMICALS 2. Based on observation, review of facility policy, review of chemical label information, and staff interview, the facility failed to maintain an environment free from accident hazards in 1 of 4 bathing rooms (the 100 unit). Failure to ensure chemicals are inaccessible placed wandering and cognitively impaired residents at risk for injuries. Findings include: Review of the facility policy titled "Chemicals" occurred on 01/05/17. This policy, revised 04/11/14, stated, ". . . All chemicals will be stored in a locked environment. . . ." Observation on 01/04/17 at 10:00 a.m. showed an unlocked bathing room in the 100 hall. The bathing room contained a cupboard with keys hanging from the lock (i.e., unsecured). Inside the cupboard were the following chemicals: *One bottle of TurboClean Pre-Disinfectant Detergent *Two bottles of Cid-A-L II Disinfectant with the following warning on the label, "Causes irreversible eye damage and skin burns."	F 323		

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F 323	Continued From page 24 Observation on 01/04/17 at 11:13 a.m. in the 100 hall bathing room showed the chemical cupboard remained unlocked. At 12:19 a.m., a CNA (#9) stated, "That's supposed to be locked," and locked the cupboard door. During the environmental tour on 01/04/17 at 4:00 p.m., a maintenance supervisor (#12) confirmed staff should keep the cupboard locked.	F 323		
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (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: (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 (facility assessment implementation is Phase 2); (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 possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of	F 441		2/9/17

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	355078	A. BUILDING _____ B. WING _____	01/05/2017

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F 441	Continued From page 25	F 441		

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.

(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

(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

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F 441	Continued From page 26 by: Based on observation. record review, facility policy review, and staff interview, the facility failed to follow infection control practices for 1 of 12 sampled residents (Resident #6) observed during personal cares. Failure to follow infection control practices related to hand hygiene has the potential to spread infection. Findings include: Review of the facility policy titled "Hand Hygiene" occurred on 01/05/17. This policy revised November 2013, stated, " . . . Hand hygiene will be done: Before and after resident contact (before you leave the room) . . . before every clean procedure . . . PURPOSE: Hand Hygiene . . . The purpose is to prevent the spread of infection . . ." Review of Resident #6's medical record occurred on all days of survey. Diagnoses included right sided hemiplegia (loss of muscle function), and cerebral infarction (stroke). The annual Minimum Data Set (MDS), dated 11/20/16, identified moderately impaired cognition, and extensive assistance of one to two required for Activities of Daily Living (ADLs). Observation on 01/03/17 at 4:30 p.m., showed a CNA (#5) assisted Resident #6 with perineal cares following a bowel movement. The CNA (#5) removed his gloves, transferred Resident #6 into his wheel chair using a stand lift, removed the belt strap from around his torso, and adjusted his clothing. The CNA failed to perform hand hygiene after completing perineal cares and prior to completing other cares.	F 441	1. Resident 6 was assessed for proper infection control practices. Proper hand washing and glove usage will be utilized when performing peri-cares, handling of linens and other resident items. 2. All residents have the potential to be affected by improper hand washing and glove use. 3. All nursing staff will be educated prior to February 9th, 2017 on the proper infection control process related to hand hygiene and glove use. 4. The Director of Nursing or designee will be responsible to monitor hand hygiene and proper glove use. QA auditing was implemented on 1/30/17. The DON or designee will monitor weekly for one month, monthly for three months, and random audits as needed. Information will be immediately reported to the Executive Director. If concerns are brought forward, immediate corrective action will be implemented. The DON or designee will submit a report of the monitoring results to the QA Committee at each scheduled meeting. 5. Date of Correction: 9th February 2017	

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F 441	Continued From page 27 Observation on 01/04/17 at 8:30 a.m., showed two CNAs (#8 and #9) performed perineal cares for Resident #6 who was incontinent of urine. Without removing her gloves, the CNA (#9) placed a clean brief on, pulled the resident's pants up to his knees, raised the head of the bed, placed Resident #6's legs over the edge of the bed, applied the transfer belt strap around his torso, and transferred him to the bathroom using a stand lift. The CNA (#9) removed her gloves and without sanitizing her hands applied a new pair of gloves. The CNA (#9) then removed the bottom sheet from Resident #6's bed, placed it in a bag and stated, "the bottom sheet had a wet stain on it," removed her gloves and exited the room without sanitizing her hands. The CNA (#9) walked down the hallway to the clean linen cart, removed clean sheets from cart and entered Resident #6's room, made the bed, placed the call light, and exited the room. The CNA (#9) failed to perform hand hygiene after completing perineal cares, prior to completing other cares, and prior to exiting the resident's room. Observation on 01/04/17 at 9:10 a.m., showed a CNA (#9) performed perineal cares for Resident #6. Without performing hand hygiene, the CNA applied tooth paste on the resident's tooth brush, turned the water on, gave the resident a towel, closed the door, and left the room. The CNA (#9) failed to perform hand hygiene after providing perineal cares, prior to completing other cares, and prior to exiting the room. During an interview on 01/05/17 at 12:30 p.m., an administrative nursing staff (#11) stated she expected staff to wash/sanitize their hands after	F 441		

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F 441	Continued From page 28 assisting with toileting and providing cares.	F 441		