STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MOTT	401 MILLIONAIRE AVE MOTT, ND 58646

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F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey, started on 07/09/12 and completed on 07/11/12, the sample included 2 residents for complete review, 7 residents for focused review, and 1 closed record for review. The sample included 4 additional residents to verify specific concerns during the survey.	F 000		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, procedure, and guidelines, review of professional reference, and staff interview, the facility failed to follow professional standards of practice or their policies and procedures related to monitoring and documentation of wounds for 1 of 2 sampled residents (Resident #6) with a pressure ulcer and 1 supplemental resident (Resident #13) with shingles, and failed to provide follow-up to an incident for 1 of 6 sampled resident (Resident #3) with a fall. Failure to complete wound flow sheets and incident reports has the potential to limit continuity of care and the development of effective interventions, and inhibits staff's ability to investigate the incident. Findings include: Review of the facility procedure titled "Pressure Ulcers: Skin Assessment and Prevention" occurred on 07/11/12. This procedure, dated	F 281	1) The corrective action accomplished for Residents #6 and #13 related to monitoring and documentation of wounds and Resident #3 related to follow-up to an incident is as follows: a) Resident # 6-Discharged to home on 7/24/12. b) Residents #13 and #3- Time has elapsed for staff to go back and fill out a wound assessment flow sheet or incident report. Therefore, nursing staff have been made aware of the oversight via verbal report to all nursing staff on 7/12,13/2012 by the DNS and by written communication in the nurses' communication book on 7/12/2012. 2) Other residents having the potential to be affected by the same practice have been identified on 8/6/2012 by the DNS/designee querying MDS 3.0 sections M0210; Resident having stage 1 or higher pressure ulcers and J1800-Any falls since admit/re-entry or prior assessment. Nursing staff is following up those residents identified to verify that the wound assessment flow sheet was completed on residents with wounds and that incident reports were filled out on residents with falls.	09/01/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Bruce O'Kelly	Administrator	8-13-2012

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

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F 281	Continued From page 1 January 2012, stated, "Purpose: . . . To accurately document observations and assessments of residents . . . Procedure: . . . 7. . . . The registered nurse should record the type of wound and the degree of tissue damage (i.e. [such as] for a pressure ulcer the stage). The licensed nurse records the location of the area, the measurements and the ulcer/wound characteristics. Document the information on the Wound Flow Sheet . . . 14. The pressure ulcer should be assessed/evaluated at least weekly and documented on the Wound Flow Sheet. . . . Observations of the ulcer's characteristics may be documented by a licensed nurse and should include at least the following: Measurements . . . Characteristics . . . Presence of pain . . . Current treatments . . . " Berman, Snyder, "Kozier & Erb's Fundamentals of Nursing: Concepts, Process, and Practice," Ninth Edition, 2012, Pearson Education, Inc., New Jersey, page 75, states, "An incident report . . . is an agency record of an accident or unusual occurrence. Incident reports are used to make all facts available to agency personnel, to contribute to statistical data about accidents or incidents, and to help health personnel prevent future incidents or accidents. . . ." and page 267 states, "Practice Guidelines Documentation: Do - Chart a change in a client's condition and show that follow-up actions were taken. . . ." Review of the facility guidelines titled "Prevention and Management of Falls: Practice Guidelines" occurred on 07/11/12. These guidelines, dated April 2011, stated, ". . . Tracking/Trending: A tracking mechanism should be utilized to assist in the evaluation of resident specific information and	F 281	3) Measures put into place to ensure the practice will not recur is that nursing staff will be educated by the DNS/designee on 8/16/2012. Education will focus on the proper procedure when filling out wound assessment flow sheets and incident reports. 4) The facility plans to monitor its performance to make sure solutions are sustained by assigning the QA coordinator or designee to monitor by using audits that wound assessment flow sheets have been completed for residents with pressure ulcers and incident reports have been completed for residents with falls. Audits will be done monthly x 3 then quarterly x 1 year. Results will be reported to the QA team with corrective action implemented.	

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F 281	Continued From page 2 center-wide performance. . . . A tracking tool, Resident Fall Log, is a recommended form that is used to track individual resident falls. Trending analysis should focus on prevention. . . . Falls Committee: The Interdisciplinary Team should perform an analysis of the precipitating events for individual resident falls and evaluate potential interventions aimed at prevention of future falls. . . . Quality Improvement: The Quality Improvement team should utilize the tools available, i.e. Incident Report, Resident Fall Log, and Incident Trending Chart to look for trends in Falls location, time and date, risk factor management and potential root cause. . . ." - Observation on all days of survey showed a pressure relieving boot on Resident #6's left foot and a quilted boot on the right foot. On 07/10/12 at 7:00 a.m., an administrative nurse (#1) replaced the Ultec Pro (sterile wound dressing) to Resident #6's left heel, stating the resident came with the ulcer and it is getting better. Observation showed an approximately one inch healed area with intact skin to the resident's left inner heel. Review of Resident #6's medical record occurred on all days of survey. Diagnoses included Alzheimer's dementia and right hip pinning prior to admission on 06/19/12. The admission Minimum Data Set (MDS), dated 06/25/12, indicated extensive assistance of two or more people for bed mobility and one stage 1 pressure ulcer. The current care plan for pressure ulcers showed an intervention to "turn and reposition Q [every] 2 hours WA [while awake] and Q 3-4 at night."	F 281		

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F 281	Continued From page 3 A daily skilled note, dated 06/27/12 at 11 a.m., identified Resident #6 "has a 2.1 cm [centimeter] x [by] 2.3 cm tan area inner aspect (L) [left] heel - area is dry with slight redness around . . . Ultec Pro applied et [and] will have [name of podiatrist] check next week. . . ." An interdisciplinary progress note, dated 07/03/12 at 7:45 a.m., stated, "[Name of podiatrist] here and debrided (L) heel ulcer. Ulcer almost healed. Ultec Pro applied. . . ." and on 07/10/12 at 7 a.m., stated, ". . . Removed area has dark pink skin where [name of podiatrist] debrided last week. No redness or drainage. Ultec Pro reapplied." The staff failed to complete a Wound Flow Sheet for the left heel pressure ulcer per their policy. During an interview on 07/10/12 at 2:30 p.m., an administrative nurse (#1) verified the nursing staff failed to complete a wound flow sheet for Resident #6's heel ulcer. Review of a policy titled "Notification of Condition Change and Observation" occurred 07/11/12. This policy, dated February 2005, stated ". . . The Condition Change and Observation (GSS [Good Samaritan Society] #241) is used to collect pertinent data on the resident and his or her current condition. . . . Document in Interdisciplinary Progress Notes (IDP) (GSS #239) an entry to 'See Condition Change and Observation' and document additional information in the IDP notes . . . Place the completed Condition Change and Observation (GSS #241) form behind the IDP Notes . . . Update care plan, CNA [certified nurse assistant] flow sheets and Medication Administration Record (MAR) (GSS #245), if appropriate. . . ."	F 281		

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F 281	Continued From page 4 - During the initial tour on the morning of 07/09/12, a nurse (#9) identified Resident #13 was on contact precautions for an active shingles infection. Review of Resident #13's medical record occurred on July 10-11, 2012. Diagnoses include cerebral palsy and a history of shingles. Review of a nurse's note, dated 07/02/12, identified blisters on her left hip and red, raised areas from her left middle back to left upper thigh. A nurse practitioner diagnosed shingles on 07/02/12. Resident #13's medical record lacked documentation of the area after the diagnosis. During an interview on 07/11/12 at 7:30 a.m., an administrative nurse (#1) stated the facility staff failed to fill out a monitoring form after the nurse practitioner diagnosed shingles on 07/02/12. This nurse confirmed Resident #13 showed no evidence of shingles, and the area lacked monitoring for 9 days. - Review of Resident #3's medical record occurred on all days of survey. Diagnoses included dementia. The quarterly MDS, dated 05/02/12, identified the resident with severely impaired cognition; required extensive assistance from two or more staff members for bed mobility, transfers, and toileting; and two falls without injury since the prior assessment. Review of Resident #3's IDP notes, dated 05/05/12, stated, "Res [resident] found in his BR [bathroom] on the floor by CNA. Res was self transferring to toilet. Res found on back, denies	F 281		

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F 281	Continued From page 5 hitting head. Denies pain anywhere. No injuries noted at this time . . . Resident brought out to solarium to recliner [after] finished on toilet [and] brief/pants [changed]." An Interdisciplinary Progress Note, dated 05/22/12, stated, "Pharmacy Review Committee reviewed res for frequent falls [and] res med [medication] list . . . Had 7 falls in April [and] none this month." During an interview on 07/10/12 at 3:00 p.m., an administrative nurse (#1) stated she was unaware Resident #3 fell on 05/05/12 and confirmed the facility fall log used to track and trend falls lacked this specific fall. This nurse (#1) stated a facility staff member failed to complete an incident report after the fall, as per facility policy, resulting in the lack of an investigation of the circumstances surrounding the fall and follow-up interventions.	F 281		
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 08/31/11. Based on record review, policy and procedure	F 309	1) The corrective action accomplished for Resident #12 related to providing appropriate consistency of food is that on 7/12/2012 the physician changed the Level 2 dysphasia diet to a Level 4 dysphasia/no restriction diet. Resident #10 is no longer in the facility. 2) Other residents having the potential to be affected by the same practice have been identified by querying MDS 3.0 section K0500C; Nutritional Approaches: mechanically altered diet. Dietary Manager reviewed all residents identified and confirmed on 8/8/2012 that all diets prescribed are appropriate and are being served as such.	09/01/12

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F 309	Continued From page 6 review, and staff interview, the facility failed to provide the appropriate consistency of food for 1 of 1 closed record resident (Resident #10) and for 1 supplemental resident (Resident #12) with physician's orders for a mechanically altered diet. Failure to provide the appropriate consistency resulted in Resident #10 experiencing a choking episode resulting in hospitalization. Findings include: Review of a facility policy titled, "Nutrition Care Choking Prevention" occurred on 07/11/12. This policy, dated March 2009, stated, " . . . Procedure . . . 9. The current diet roster will be compared to the resident diet cards by the dietary manager or the registered dietitian to ensure the diet ordered by the physician matches the diet card. Resident diet cards will be compared to the diet roster on a periodic basis to ensure accuracy. . . . " Review of a policy titled, "Nutrition Care Dysphagia" occurred on 07/11/12. This policy, dated September 2009, stated, ". . . National Dysphagia Diet terminology guidelines for solid foods are as follows: . . . b. Level 2 - Dysphagia Mechanically Altered characteristics Description: . . . foods are moist, soft-textured and easily formed into a bolus. Meats are ground or minced no larger than one-quarter-inch pieces . . . c. Level 3 - Dysphagia Advanced Description: This level consists of food of nearly regular textures with the exception of very hard, sticky, or crunchy foods. Foods still need to be moist and should be in "bite-size" pieces at the oral phase of the swallow. . . ." - Review of Resident #10's medical record	F 309	3) Measures put into place to ensure the practice will not recur is that dietary staff will be educated by the facility's consultant LRD on 8/23/2012 on proper food consistency for all dysphasia levels. In addition, meals will be observed at various times that the food served is the proper consistency and reflects that which is listed on the tray card. 4) The facility plans to monitor its performance to make sure solutions are sustained by assigning the Dietary Manager/ designee to use audits to monitor meals served by dietary staff that food is the proper consistency. Audits will be done weekly x 2 months then monthly x 1 year. Results will be reported to the QA team with corrective action implemented.	

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F 309	Continued From page 7 occurred on 07/11/12. Diagnoses included history of cerebral vascular accident, behavioral disorder, and chronic obstructive pulmonary disorder. The resident's Minimum Data Sets, dated 03/04/11, 03/04/12, 06/04/12, identified the resident needed supervision with eating, coughed or choked during meals or when swallowing medications, and required a mechanically altered diet. Resident #10's care plan dated 06/11/12, stated, ". . . Plans and approaches . . . Eating: Supervision of 1 per. [person] . . . Problems/needs/concerns . . . [Resident's name] has potential for coughing or choking with meals or meds [medications] . . . Goals: Will not choke . . . Plans and approaches . . . remind to take small bites & chew food up. Offer sips between bites . . . report frequent coughing with liquids . . . Problems/needs/concerns . . . He doesn't chew his food well. He often sneezes with mouthful of food . . . Plans and Approaches . . . #2 dysphagia ground meat consistency . . . Resident #10's physician orders, dated 03/09/10, stated the resident's diet to be a mechanically altered diet (Level 2 per diet manual). The physician last reviewed and signed this order on 05/24/12. Resident #10's meal tray card from 07/08/12 stated, ". . . dysphagia Iii [sic] [3] ground meat. . . ." The food listed on the menu to be served for the supper meal on 07/08/12 included whole wheat toast, whole wheat bread, half baked potato, and cut-up chicken nuggets. The resident's tray card indicated a Level 3 diet, a dysphagia advanced diet, not mechanically altered as the physician had ordered.	F 309		

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F 309	Continued From page 8 Resident #10's nurses note on 07/08/12 at 6:00 p.m. stated, "Notified by RN [registered nurse] working that Resident was choking and staff was bringing resident out of dining room where he had been eating supper to provide needed medical attention. Resident non responsive when brought out of dining room . . . Heimlich maneuver done [with] several attempts . . . not successful so resident positioned on floor and abdominal thrust preformed [sic] nurse went into mouth to check . . . (1) chicken nugget removed whole . . . nurse went to call for emergency transfer to hospital . . . [oxygen] applied to resident after removing chicken nugget . . . " Review of a investigation report completed by the facility on 07/11/12 for Resident #10's incident, stated, ". . . 7/9/2012, 2:00 pm - . . . Cook stated she couldn't find any unbreaded chicken to use as ground meat for the residents whose diet called for ground meat. Since tray card said chicken nuggets could be cut up, she decided the chicken nuggets were soft enough to serve by having them cut into smaller pieces. The resident sits in supervised area. A CNA [certified nurse assistant] place [sic] the resident's food on the table and then took tray back to the kitchen window. Before the CNA could return to the table, the resident put several pieces of chicken in his mouth, causing him to choke. Residents' primary need for nursing care is a brain injury, which causes compulsive behaviors. . . ." Review of a hospital note, dated 07/08/12, stated, ". . . he had been eating . . . some chicken nuggets and . . . choked . . . Heimlich maneuver was done by staff. EMS [emergency medical	F 309		

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F 309	Continued From page 9	F 309		

services] was notified. They arrived and started CPR [cardiopulmonary resuscitation]. The nursing home was unable to find documentation of his code status, so they went ahead and attempted to resuscitate him with CPR and artificial respirations with bag valve mask. They did do that for about 20 minutes. They stated he had no spontaneous respirations for approximately 20 minutes in route. When he started to cough, he did cough up more food particles and woke up. He was breathing on his own, but he was still in a fair amount of respiratory distress. When he arrived here, he was sitting up. He was awake . . . His wife was contacted . . . stated that she did not want anything done other than to keep him comfortable. . . ."

Review of a hospital transfer form, dated 07/09/12, identified Resident #10 was discharged from the hospital with a diagnosis of respiratory distress related to aspiration and hypoxia. The resident was placed on comfort cares.

Review of Resident #10's progress notes on 07/09/12 at 10:55 a.m. identified the resident returned to the facility on comfort cares and on 07/10/12 at 3:15 a.m. "resp (respirations) ceased, no HR (heart rate) . . . "

Failure to provide the appropriate diet consistency contributed to Resident #10's choking episode and hospitalization.

- Review of Resident #12's medical record occurred on July 11, 2012. Diagnoses included a cerebrovascular accident with expressive aphasia and dementia with behaviors. The quarterly MDS, dated 05/11/12, identified the resident with intact

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F 309	Continued From page 10 cognition, independent with eating, no swallowing problems, and on a mechanically altered and therapeutic diet. A physician's order, dated 05/12/09, stated, "Diet: Regular Mechanical altered diet with no salt at the table." (Level 2 per facility's diet manual). The current care plan stated, "Problem: [Resident #12] is on a NAS [no added sodium] diet . . . Serve NAS diet with #3 dysphagia regular consistancy [sic] . . . refuses ground meat . . ." Resident #12's meal tray card, dated 07/08/12 identified the resident received a Dysphagia - III (3), NAS diet with small portions. The Level 3 dysphagia diet identified on the meal tray card indicated a dysphagia advanced diet, not a mechanically altered diet (Level 2 dysphagia diet) as ordered by the resident's physician. During an interview on 07/11/12 at 10:30 a.m., a dietary staff member (#2) confirmed the dietary department incorrectly served Resident #12 a Level 3 dysphagia diet (dysphagia advanced) and should have provided a Level 2 dysphagia diet (mechanically altered), as prescribed by the resident's physician. Failure to provide the appropriate diet consistency may cause harm to Resident #12.	F 309		
F 315 SS=E	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an	F 315	1) The corrective action accomplished for Residents #2, 3, 7, 8 & 9 related to bowel/bladder assessments and comprehensive assessments is that on 7/12/2012, three day	09/01/12

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F 315	Continued From page 11 indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy/procedure, and staff interview, the facility failed to provide the appropriate treatment and services to restore as much normal bladder function as possible for 7 of 9 sampled residents (#2, #3, #4, #6, #7, #8, and #9) with urinary incontinence. Failure to complete initial and ongoing bladder assessments limited staff's ability to establish individualized toileting plans and related interventions and does not allow residents to achieve their highest level of continence. Findings include: Review of the facility procedure titled "Toileting Programs" occurred on 07/11/12. This procedure, dated January 2011, stated, "Purpose: To assist in the selection of an appropriate toileting program for the resident; To regain continence and bladder function dignity. Procedure: 1. The probable type of incontinence should be identified based on information obtained and evaluated through the use of the Bladder Assessment . . . and the Care Area Assessment (CAA). 2. An appropriate toileting program should be implemented based on the type of incontinence	F 315	bowel/bladder assessments and comprehensive assessments have been initiated which determines a toileting plan that is then care planned. These assessments are completed by nursing staff. Resident #6 was discharged to home on 7/24/2012 and Resident #4 expired on 8/5/2012. 2) Other residents having the potential to be affected by the same practice have been identified on 8/6/2012 by the DNS/designee, querying MDS 3.0 section H0300; Urinary incontinence and section H0400; Bowel Continence. A three day Bowel and bladder assessment along with a care planned toileting plan will be completed by nursing staff prior to the resident's next care conference. 3) Measures put into place to ensure the practice will not recur is that nursing staff will be educated by the DNS/designee on 8/16/2012 on following proper policy/procedure for bowel/bladder assessments and comprehensive assessments. The MDS coordinator or designee will assign the nursing staff to complete bowel and bladder assessments with seven day observation schedules. 4) The facility plans to monitor its performance to make sure solutions are sustained by assigning the QA coordinator/ designee to monitor by using audits that comprehensive assessments along with care planned toileting scheduled have been completed for residents identified as	

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F 315	Continued From page 12 and information obtained and evaluated through use of the Bladder Assessment . . . and completion of the Care Area Assessment . . . 4. The care plan should utilize continence terms and include measurable goals to maintain or restore the highest level of continence possible . . .9. Residents should be re-evaluated whenever there is a change in condition, physical ability, . . ." - Review of Resident #6's medical record occurred on all days of survey. Diagnoses included Alzheimer's dementia and history of urinary tract infection (UTI). The admission Minimum Data Set (MDS), dated 06/25/12, indicated extensive assistance of two or more people for toileting, a trial of a toileting program had not been attempted, and frequently incontinent of urine. The current care plan for activities of daily living (ADLs) identified the intervention: "Toileting: Extensive assist of 2," but lacked a specific toileting plan. The Care Area Assessment (CAA) for Urinary Incontinence, dated 07/02/12, stated, ". . . staff toilet routinely." Observations of Resident #6 showed the following: * 07/09/12 at 1:07 p.m. - refused to use toilet, check and changed wet brief * 07/09/12 at 3:18 p.m. - incontinent in brief and voided in toilet * 07/10/12 at 7:13 a.m. - incontinent in brief and voided in toilet * 07/10/12 at 9:55 a.m. - stated "no," when asked if needed to use the bathroom * 07/10/12 at 11:45 a.m. - refused to use toilet before lunch, check and changed wet brief * 07/10/12 at 12:48 p.m. - refused to use toilet, check and changed wet brief	F 315	incontinent. Audits will be done monthly x 1 year. Results will be reported to the QA team with corrective action implemented.	

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F 315	Continued From page 13 * 07/10/12 at 3:40 p.m. - incontinent in brief and voided in toilet The facility failed to complete a bladder assessment and develop individualized interventions to maintain as much bladder continence as possible for Resident #6. - Review of Resident #8's medical record occurred on 07/11/12. Diagnoses included urinary retention, bladder cancer, and history of UTI. The significant change MDS, dated 06/26/12 and the quarterly MDS, dated 03/26/12, indicated extensive assistance of two or more people for toileting, a trial of a toileting program had not been attempted and not on a current toilet plan, and frequently incontinent of urine. The current care plan identified a history of urinary frequency with the intervention ". . . toilet before and after meals, 10 p.m. and 2 a.m. . . ." The CAA for Urinary Incontinence, dated 07/05/12, stated, ". . . toileted upon request . . ." A Nursing Documentation form, dated 06/26/12, section "Continence/Incontinence" stated, "Incontinent of bladder and wears incontinent brief - this et [and] checked and changed q [every] 2 [hours] & [and] PRN [as needed]." The care plan, CAA, and Nursing Documentation form failed to show a consistent plan for toileting. On 07/11/12 at 7:15 a.m., observation showed a certified nurse aide (CNA) (#5) removed Resident #8's wet brief and assisted him onto the toilet. The resident voided and also dribbled urine as he stood up from the toilet. When asked how staff know when residents are to be toileted, this CNA stated, "I ask residents if they need to go to the	F 315		

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F 315	Continued From page 14 bathroom if they are able to tell me, otherwise we take residents every two hours." The facility failed to complete a bladder assessment and develop individualized interventions to maintain as much bladder continence as possible for Resident #8. - Review of Resident #2's medical record occurred on July 9-11, 2012. Diagnoses included diabetes and edema. The quarterly MDS, dated 05/24/12, indicated extensive assistance of two or more people for toileting and frequent urinary incontinence. The CAA for Urinary Incontinence, dated 12/01/11, stated, ". . . After resident recuperates hopefully she will once again be able to get herself to the bathroom . . . She is able to make her needs known and calls for help when needed. . . . The resident is continent and needs help with toileting . . ." The current care plan stated, "Problem: . . . weak [and] needs help with cares . . . Approaches: . . . Toileting: Ext. [extensive] assist of 2 . . . Uses a commode at bedside for toileting . . . Ask every 2-3 hours if need to void. . . ." The most recent "Bladder Assessment," dated 06/28/11, identified, "No problems identified." The facility failed to re-assess Resident #2's bladder function, including her voiding patterns and toileting abilities. The "Voided Report," dated 06/24/12-07/11/12, showed Resident #2 as incontinent one-to-five times per day on 10 of the 18 days identified on	F 315		

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F 315	Continued From page 15 the report. Observations of Resident #2 showed the following: * On 07/09/12 at 12:40 p.m. - incontinent in brief and voided in toilet * On 07/10/12 at 10:34 a.m. - incontinent in brief and voided in toilet - Review of Resident #7's medical record occurred on July 11, 2012. Diagnoses included Alzheimer's dementia, incontinence, and history of UTIs. The annual MDS, dated 06/28/12, indicated extensive assistance of one person for toileting and frequent urinary incontinence. The CAA for Urinary Incontinence, dated 06/28/12, stated, ". . . [Resident #7] is incontinent of urine frequently . . . Resident can no longer make her needs kown [sic] all the time and she requires assistance with toileting. . . . Residents needs have to be anticipated now . . ." The current care plan stated, "Problem: . . . [Resident #7] is frequently incontinent of urine . . . Approaches: . . . Wears a brief, check [and] change prn, Take to bathroom every 2 hours during the day, needs strong encouragement to go to the bathroom. . . ." Observations of Resident #7 showed the following: * On 07/11/12 at 10:00 a.m. - brief dry, voided in toilet The facility failed to assess Resident #7's bladder function, including her voiding patterns and toileting abilities.	F 315		

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F 315	Continued From page 16 - Review of Resident #3's medical record occurred on all days of survey. Diagnoses included dementia, urinary retention secondary to prostate cancer, and a history of urinary tract infections. The quarterly MDS, dated 05/02/12, identified the resident required extensive assistance of two or more staff members for transfers and toileting, not on a current toileting plan or trial, and frequently incontinent of urine. A significant change MDS, dated 04/05/12, identified occasional bladder incontinence. The care plan failed to address the resident's incontinence and lacked interventions to maintain or increase Resident #3 continence. Observations of Resident #3 on July 09-10, 2012 showed the following: * 07/09/12 at 1:20 p.m. - brief incontinent of urine, voided in the toilet * 07/09/12 at 4:05 p.m. - brief clean and dry, did not void in the toilet * 07/10/12 at 10:30 a.m. - a CNA (#10) stated the resident declined to toilet earlier on in the morning * 07/10/12 at 1:35 p.m. - brief incontinent of urine and stool, voided and had a bowel movement in the toilet During an interview on 07/10/12 at 10:30 a.m., a CNA (#10) stated Resident #3 tells staff when he needs to use the bathroom and staff also encourage him to toilet. On 07/11/12 at 10:30 a.m., a licensed nurse (#9) stated bladder assessments should be completed upon admission and when residents experienced a decline in bladder continence.	F 315		

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F 315	Continued From page 17 The staff failed to complete a bladder assessment after the resident experienced a decline in bladder continence, as evidenced by the 05/02/12 MDS. - Review of Resident #4's medical record occurred on all days of survey. Diagnoses included Alzheimer's dementia, uterine cancer, and a history of urinary tract infections. The quarterly MDS, dated 05/07/12, identified the resident required extensive assistance of two or more staff members for transfers and toileting, not on a current toileting program or trial, frequently incontinent of urine, and had two stage II pressure ulcers. The admission MDS, dated 11/14/11, identified occasional bladder incontinence. The care plan failed to address the resident's incontinence and lacked interventions to maintain or increase Resident #3 continence. The medical record lacked evidence staff completed a bladder assessment. Observations of Resident #4 on July 09-10, 2012 showed the following: * 07/09/12 at 1:40 p.m. - brief checked, dry - not toileted * 07/09/12 at 4:15 p.m. - brief checked, dry - not toileted * 07/10/12 at 8:50 a.m. - brief checked, dry - not toileted * 07/10/12 at 12:55 p.m. - brief incontinent with urine and stool, new brief placed on resident - not toileted During an interview on 07/10/12 at 10:30 a.m., a CNA (#10) stated staff check and change (if needed) Resident #4's brief before and after	F 315		

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F 315	Continued From page 18 meals and at bedtime and stated staff transfer the resident onto the toilet when she asks to "drain the radiator." The staff failed to complete a bladder assessment upon admission to the facility and after she experienced a decline in bladder continence, per facility policy. - Review of Resident #9's record occurred on July 11, 2012. The resident was admitted in August 2011 and diagnoses included dementia and a history of urinary tract infections. The quarterly MDS, dated 05/22/12, identified the resident required extensive assistance of one staff member for toileting, not on a current toileting program or trial, and frequently incontinent of bladder. The care plan, dated 05/24/12, stated, ". . . [Resident #9] is incontinent of urine, has potential for skin breakdown . . . Take to toilet every 2 hours & [and] PRN [as needed] while awake, 10 PM, 12 MN [midnight], & 4 AM . . ." The staff completed bladder and bowel flow sheets on September 02-07, 2011, but failed to complete a comprehensive bladder assessment. Observation of Resident #9 on July 11, 2012 showed the following: * 07/11/12 at 8:00 a.m. - brief incontinent of urine, did not void in the toilet * 07/11/12 at 10:30 a.m. - resident declined toileting * 07/11/12 at 1:10 p.m. - brief dry, voided in toilet During an interview on the morning of 07/11/12, an administrative nurse (#1) stated bladder and bowel assessments have not been completed on any resident since last year, along with	F 315		

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F 315	Continued From page 19 developing individual toileting plans. The facility failed to evaluate Resident #2, #3, #4, #6, #7, #8, and #9's voiding patterns and failed to complete bladder assessments which limited the facility's ability to implement the most effective interventions for the residents and may have contributed to an increased level of incontinence, increased the risk for UTIs, and has the potential to compromise the residents' dignity.	F 315		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, policy and procedure review, and staff interview, the facility failed to ensure the preparation, distribution, and serving of food to facility residents under safe conditions regarding saving leftovers after 1 of 1 tray line observations (noon meal on 07/10/12), and failed to monitor storage of foods regarding outdated, undated, or wrongly dated food items in 1 of 1 kitchen (Main kitchen). Failure to implement facility policy to cool leftover foods after meal service and failing to throw away expired food items and/or ensure proper dating of food items,	F 371	1) F371-The corrective action accomplished related to serving food under safe conditions and monitoring the storage of food is that all food identified as a) not cooled properly and b) out dated was discarded immediately on 7/10/2012 by the Dietary Manager. 2) The facility recognizes that all residents have the potential to be affected by the same practice and have been identified as such. As of 7/11/2012, a food temperature log is being used to verify that food is properly cooled and all food expiration dates have been verified. 3) Measures put into place to ensure the practice will not recur is that dietary staff will be educated on 8/23/2012 by the Dietary Manager on proper cooling of food and using the food temperature log, as well as the proper checking of expiration dates. The Dietary Manager will use the facility's policy and procedures on how to properly store, prepare, distribute and serve food under sanitary conditions.	09/01/12

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F 371	Continued From page 20 placed all residents, visitors, and staff at risk of illness related to consuming contaminated food items. Findings include: Review of the facility policy titled "Food/Food Preparation Leftovers" occurred on 07/11/12. This policy, dated March 2009, stated, ". . . Refrigerated leftovers will be utilized within 72 hours . . . Leftover hot food will be cooled to 41 [degrees] F [Fahrenheit] per state regulations: First two hours - 135 [degrees] to 70 [degrees] F . . . Second four hours - 70 [degrees] to 41 [degrees] F . . . hot food should be placed uncovered on the top shelf of the cooler near the fans allowing for air circulation. Cover loosely, label and date. Once the food has reached 41 [degrees] F., it must be covered tightly. . . . Leftover food will be reheated to the appropriate temperature before using. Meat and meat products need to be reheated to 165 [degrees] F . . ." Review of the facility policy titled "Food/Food Preparation Food Storage" occurred on 07/11/12. This policy, dated November 2010, stated, ". . . Expiration dates will be checked on a regular basis and foods/fluids which have expired will be discarded. . ." Observation on 07/10/12 at 11:50 a.m., showed chicken spaetzel and green beans served to residents. During trayline, a supervisory dietary staff member (#2) obtained a previously cooked chicken fried steak from a plastic container in the walk-in refrigerator, ground it in a blender, reheated the steak, and served the meat to a	F 371	4) The facility plans to monitor its performance to make sure solutions are sustained by assigning the Dietary Manager or designee to monitor by using audits that food is properly cooled and expiration dates are regularly checked. These audits will be done monthly x 3 months then quarterly x 1 year. Results will be reported to the QA team with corrective action implemented.	

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F 371	Continued From page 21 resident prior to taking the temperature of the food. After the surveyor requested a temperature, the staff member obtained a reading of greater than 170 degrees F. Staff removed food from tray line for lunch on 07/10/12 at 12:10 p.m., and observation at 2:10 p.m. (2 hours after tray line), showed the following temperature readings of leftovers stored in tightly covered plastic containers in the walk-in refrigerator showing: * one container of chicken spaetzel at 99 degrees F * a second container of chicken spaetzel at 84.5 degrees F * a third container of chicken spaetzel at 85.1 degrees F * a container of green beans at 74.1 degrees F Observation on 07/10/12 at 2:10 p.m., also showed French toast with a temperature of 42.6 degrees F (approximately 6 hours after breakfast trayline). During a kitchen tour on 07/09/12 at 9:05 a.m., observation showed the following food items outdated and stored in the kitchen: * 4 cans of diced chicken dated 04/09/12 * 34 cans of evaporated milk with a best by dated of 05/17/12 * 2 cans of vanilla frosting with a best by date of 01/10/11 * 3 boxes of butterscotch pudding with the best by dates of 05/12/12; 01/22/12; and 06/19/12 * 2 chocolate Mighty Shake supplements thawed and undated in a refrigerator with a manufacturer's label stating to use product within 14 days after thawing. The supervisory dietary	F 371		

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F 371	Continued From page 22 staff member (#2) was unable to identify the length of time the Mighty Shakes had been thawed. During a kitchen tour on 07/10/12 at 12:30 p.m., observation showed: * 1 peach yogurt dated 02/09/12 * a jar of cinnamon cookie spread, dated 03/07/12 During an interview on 07/10/12 at 12:50 p.m., a dietary staff member (#2) reported staff remove food from the tray line around 12:10 p.m. following lunch and around 8:10 a.m. following breakfast and the facility does not monitor the temperatures of leftovers prior to storing in the walk-in or during the cool down process. During an interview on 07/10/12 at 2:10 p.m., two dietary staff members (#3 and #4) stated staff do not monitor the temperatures of cooling leftovers, and these staff members were unaware of what temperature foods should cool down to in 2 hours (chicken spaetzel and green beans) or in 6 hours (French toast) after trayline. On the tours, the supervisory staff member (#2) disposed of the outdated and undated food products. On 07/10/12 at 3:40 p.m., the staff member disposed of the leftovers in the walk-in refrigerator.	F 371		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.	F 441	1) The corrective action accomplished for Residents #5 & #7 related to infection control procedures and managing and tracking infections is that the Infection Control Nurse has been made aware of the findings by the DNS on 7/12/2012. The Infection Control Log has been updated.	09/01/12

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F 441	Continued From page 23 (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to follow infection control procedures to manage infections for 1 of 1 sampled resident (Resident	F 441	2) Other residents having the potential to be affected by the same practice have been identified on 8/6/2012 by the DNS/designee querying MDS 3.0 section N0400F; Medications: antibiotics. The Infection Control Nurse/designee is tracking the infections on the Infection Control Log. 3) Measures put into place to ensure the practice will not recur is that nursing staff will be educated on 8/16/2012 by DNS or designee on appropriate tracking of infections. 4) The facility plans to monitor its performance to make sure solutions are sustained by assigning the QA coordinator or designee to monitor by using audits that nursing staff are properly tracking infections. These audits will be done monthly x 3 then quarterly x 1 year. Results will be reported to the QA team with corrective action implemented.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355099	A. BUILDING _____ B. WING _____	07/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 441	Continued From page 24 #5) receiving an inappropriate antibiotic and failed to maintain an accurate infection control log to track infections within the facility for 2 of 7 sampled residents (Resident #5 and #7) with an infection. Failure to treat infections with an antibiotic susceptible to the organism may lead to continued infection, pain, and the potential to spread the infection to other residents, staff or visitors. Failure to track all infections has the potential to affect the health of all residents residing in the facility. Findings include: Review of the facility policy titled "Infection Control Plan" occurred on 07/11/12. This policy, dated November 2011, stated, ". . . The center will maintain an infection control plan/program to provide a safe, sanitary and comfortable environment for residents, families, visitors and employees; and to help prevent the development and transmission of disease and infection. . . . " - Review of Resident #5's medical record occurred on all days of survey. Diagnoses included dementia, urinary retention, history of urinary tract infection (UTI) and conjunctivitis. Medications included Cipro (ciprofloxacin) 500 milligrams twice daily for 10 days, starting 05/16/12 for a diagnosis of UTI. Resident #5's final urine culture, dated 5/13/12, showed "Escherichia Coli > [greater than] 100,000 CFU/ml [colony-forming units per milliliter]" and "Group D enterococcus 50,000 - 60,000 CFU/ml" with the Escherichia Coli [E.coli] resistant to ciprofloxacin.	F 441		

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F 441	Continued From page 25 During an interview on the morning of 07/11/12, when asked about follow-up to the resident's UTI and why the Cipro continued despite resistance to E.coli, an administrative nurse (#1) stated the doctor doesn't order repeat urine tests unless the resident is symptomatic, and does not know why the Cipro was continued. A physician progress note, dated 06/14/12, stated, "Subjective: [Name of Resident #5] yesterday was noted to have a swollen left eye and have periorbital cellulitis. He was given a shot of Rocephin and Duricef . . . He also had a UTI that was symptomatic and he was treated and recovered from that . . . does have an indwelling catheter which predisposes to recurrent infection and it is really hard to know prospectively when he is starting to get sick. . . . Plan: . . . continue the Duricef for a total of ten days . . ." Review of the Monthly Infection Control Log for June, 2012 failed to indicate Resident #5's periorbital cellulitis. During an interview the morning of 07/11/12, when asked why the periorbital cellulitis was not on the Infection Control log for June, an administrative nurse (#1) stated "It just got missed." - Review of Resident #7's medical record occurred on July 11, 2012. Diagnoses included incontinence and history of UTIs. Resident #7's "Lab Reports" identified the following: * The final urine culture, dated 03/03/12, showed "Group D enterococcus > 100,000 CFU/ml".	F 441		

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F 441	Continued From page 26 * The final urine culture, dated 03/15/12, showed "Proteus mirabilis > 100,000 CFU/ml". Review of the "Quarterly Report for Infections," dated March, 2012, failed to identify either of Resident #7's UTIs. During an interview on 07/11/12 at 12:30 p.m., when asked why the Resident #7's UTIs were not identified on the Infection Control Log, an administrative nurse (#1) stated, "I don't know. They should be on the tracking form."	F 441		
F 520 SS=C	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as	F 520	1) The corrective action accomplished related to a physician actively participating as a member of the QA committee is that the facility's Medical Director has been made aware of this requirement on 7/12/2012 by the DNS per phone conversation. 2) The facility recognizes that all residents have the potential to be affected by the same practice and have been identified as such. 3) Measures put into place to ensure the practice will not recur is that the facility's Medical Director has made a verbal commitment to attend the facility's quarterly QA meetings. The quarterly QA meeting will be scheduled by the QA coordinator or designee on the same day he is scheduled to do physician rounds for the residents. The QA coordinator/designee will fax QA meeting minutes to the physician for approval and signature if unable to attend, which will be returned to the facility.	09/01/12

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F 520	Continued From page 27 a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on review of the facility's Quality Assessment and Assurance (QA) program and staff interview, the facility failed to ensure a physician actively participated as a member of the QA committee for 4 of 4 quarters (April 2011 through June 2012). Failure to have a physician participate in the facility's quality assurance activities deprives the committee of the unique contribution a physician provides for analysis of quality concerns and assistance with decision making based on identified concerns. Findings include: During an interview on 07/11/12 at 2:30 p.m., an administrative nurse (#1) identified the physician failed to attend quarterly meetings. Review of the facility QA meeting's minutes identified the medical director/physician failed to attend the QA meetings since April 2011.	F 520	4) The facility plans to monitor its performance to make sure solutions are sustained by assigning the QA coordinator or designee to monitor by using audits that the physician has been in attendance at the quarterly QA meetings. Audits will be done quarterly x 1 year. Results will be reported to the QA team with corrective action implemented.	