North Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	8106	A. BUILDING _____ B. WING _____	03/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKES SUNRISE CARE CENTER	705 SE 4TH ST CROSBY, ND 58730

(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) COMPLETE DATE
B 000	INITIAL COMMENTS For the announced licensure survey, started on 03/01/2016 and completed on 03/02/16, the sample included a complete review of 5 current residents, and focused review of 1 closed record. The survey identified no Tier Ifindings and three Tier II deficiencies.	B 000		
B 926	33-03-24.1-09,2,f GOVERNING BODY f. A process for handling complaints made by residents or on behalf of residents. This state licensing rule is not met as evidenced by: Based on resident interview, review of facility grievance policies/procedures and staff interview, the facility failed to provide residents with their grievance policy/procedure, ensure residents had understanding of the grievance process, and ensure satisfactory resolution for 2 of 2 residents (Resident A and B) who expressed dissatisfaction with the facility's response to their grievance/complaints regarding a change in the facility's smoking policy. Failure to provide, educate and implement a process for submission and resolution of complaints/grievances does not allow residents the opportunity to voice their complaints with the assurance complaints are seriously considered and investigated by the facility, and are resolved to their satisfaction. Findings include: During interviews with Resident A and Resident B on the morning of 03/02/16, both expressed dissatisfaction with the recent change in policy regarding smoking and/or chewing tobacco on facility property. Both expressed they had voiced their complaints to facility administrative staff.	B926	1.) All residents will have the facility grievance procedure explained to them to ensure understanding of the process. 2.) All residents admitted to the facility have the potential to be affected by this deficient practice. 3.) The current policy/procedure for resident and family grievance is being reviewed and revised. All residents who are currently admitted will have the grievance procedures explained to them to assure understanding of the process. 4.) Date of Correction: April 15, 2016. 5.) The Social Services Director will monitor the resident's charts to assure bi-annual explanation and review of the grievance procedure. Audits will be completed on a monthly basis x 1, then quarterly x one year. If concerns are identified, immediate corrective action will be implemented.	

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B926	Continued From page 1	B926		

Both indicated they remained dissatisfied with the manner in which their complaints had been addressed by the facility.

Resident B indicated he/she had not been informed of the facility's grievance/complaint process, and did not believe he/she had been provided with a written copy of the procedure for submitting a complaint. Resident B stated he/she had been told repeatedly the change in facility policy resulted in a "law which prohibited smoking and tobacco use." Resident A had not been provided with the law on which the facility based their change in tobacco use on facility property.

During an interview with administrative/management staff members (#1, #2, and #3) the staff member indicated the residents receive a copy of the facility grievance procedure in their admission packet at the time of admission to the facility. An admission packet provided and reviewed at the time of this interview failed to include a copy of the facility's grievance procedure. The staff members concurred the change in tobacco use had taken effect on 03/01/2016, and they were aware of resident's complaints and unhappiness with the policy change. The admission packet reviewed did include a copy of the facility's "SMOKING AND TOBACCO POLICY " which stated the following:

"We are a tobacco free facility.

Tobacco free means that neither smoking nor chewing tobacco will be allowed inside our building.

Those residents who were using chewing tobacco prior to April 1, 2013 or under certain circumstances determined on an individual basis will be allowed to continue to use chewing tobacco until and unless it becomes a danger to

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B 926	Continued From page 2 themselves or others. Resident and their families will be notified if the tobacco use causes a danger to them or others and a solution will be found to lessen that danger up to and including the possibility of chewing tobacco not being allowed. For instance if someone who chews starts to spit on our floors, that would be a slip hazard to others. Those who were smoking outside prior to April 1, 2013 of under circumstances determined on an individual basis will be allowed to continue to smoke outside until and unless smoking becomes a danger to themselves or others. The smoking schedule set up for an individual resident MUST be followed. Residents who smoke must be at least 20 feet away from the building. Smoking outside will not be allowed in inclement weather...." Both Resident A and Resident B had been admitted to the facility after April 01, 2013, and had been allowed to smoke/chew outside, until the change in policy on 03/01/2016. Staff members (#1, #2, and #3) concurred the above policy had not been enforced for new admissions after April 1, 2013. The staff members provided no additional information to show the facility's attempts to resolve resident complaints regarding the banning of tobacco use on facility property.	B926		
'.0 33-03-24.1-12,2	RESIDENT ASSESSMENTS/CARE PLANS 2. The assessment must be completed in writing by an appropriately licensed professional. The assessment must include:	B1220		

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81220	Continued From page 3 a. A review of health, psychosocial, functional, nutritional, and activity status. b. Personal care and other needs. c. Health needs. d. The capability of self-preservation. e. Specific social and activity interests. This state licensing rule is not met as evidenced by: Based on observation, record review, review of Resident Council meeting minutes, review of facility policy/procedure, resident interview, and staff interview, the facility failed to conduct individualized assessments of incontinence, including assessment of resident voiding patterns/habits, factors contributing to the incontinence, and continence/incontinence history for 2 of 2 residents (Resident #1, #2) identified by the facility as incontinent. Failure to conduct adequate assessments of incontinence placed residents at risk for avoidable incontinence, increased potential for avoidable infections, skin breakdown, increased risk for falls, and negative impact on their overall dignity. Lack of adequate management of resident incontinence resulted in all facility residents being subjected to wet chairs and chair pads in common lounge/living room spaces. Findings include: Review, on 03/02/16, of the facility's "Incontinence Care" procedure stated: ". . .	81220	1.) All residents admitted to the basic facility will have their continence pattern charted Q shift by the nursing staff. 2.) All resident incontinent of bowel and/or bladder have the potential to be affected by this deficient practice. 3.) The current electronic documentation system is being updated to require Q shift documentation. A formal incontinence assessment will be added to the quarterly assessments completed on all basic residents. 4.) Date of Correction: April 15, 2016 5.) The Director of Nursing will do a weekly audit x 4 weeks, then bi-weekly audit x 2 months, then monthly audit x 9 months to assure correct assessments and documentation are in place. If concerns are identified, immediate corrective action will be implemented.	

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81220	Continued From page 4 Purpose: To keep skin clean, dry, free of irritation and color. To identify skin problems as soon as possible so treatment can be started. To prevent skin breakdown. To prevent infection. Assessment Guidelines: May include, but are not limited to: Color, consistency and amount of urine and feces. Pain or discomfort. Dehydration and fluid balance. Condition of skin and perineum. Potential for participation in a bowel and/or bladder management program. Need for a regular toileting plan." The procedure lacked a specific process for assessment of the resident's individual voiding habits/patterns, history of continence/incontinence, evaluation of clinical/medical conditions and factors contributing to incontinence, and evaluation of assessment data to determine management program to improve/maintain continence. Review of Resident Council monthly meeting minutes occurred on 03/01/16, and showed the following concerns identified by the residents in attendance: 01/25/16 - "Wet chairs and pads in living room." 02/22/16 - "Wet chairs - has improved." During an interview on the morning of 03/02/16, Resident B indicated he/she had encountered eight instances of sitting on a wet chair in the living room. The resident said the most recent instance of finding a wet chair in living room had occurred "last week." Resident B stated, "I got smart and feel the chair before I sit down." - Review of Resident #1's medical record occurred on 03/01/16. The resident's admission nursing assessment, completed on 02/05/16,	81220		

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81220	Continued From page 5 identified Resident #1 as "Incontinent of bladder and occasionally of bowel." Resident #1's vulnerability assessment completed 02/01/16 identified the resident as "confused and forgetful," and a nurses' note, dated 02/12/16 stated, "Needing much direction from staff with ADLs [activities of daily living]." Observation on 03/02/16 at 7:45 a.m., showed Resident #1 alone in the bathroom with both a licensed nurse and a nursing assistant entering in the room during this time. Neither monitored the status of Resident #1's continence/incontinence, and need for personal care during this observation. Resident #1's plan of care identified a need for AOL assistance, and an intervention of, "Able to toilet self. Wears a panty liner during day and a pull up at night. May need help with changing." The plan of care included no approaches/interventions to promote increased continence and maintain Resident #1's individual dignity. Resident #1's record lacked assessment of the resident's incontinence, including frequency of incontinence, voiding patterns/habits, factors contributing to the incontinence, and evaluation of the assessment data to determine the appropriate interventions/approaches to allow the resident to attain/maintain maximum bowel and bladder continence. The record lacked evidence a panty liner provided Resident #1 with sufficient protection to prevent leakage and soiling of clothing during the daytime hours. During an interview on the morning of 03/02/16, a management staff member (#3) indicated the facility had not conducted an assessment of	81220		

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81220	Continued From page 6 Resident #1's incontinence and incontinent needs, and provided no additional information. - The facility identified Resident #2 as "incontinent" on the "Resident Roster" completed for the survey. Review of Resident #2's medical record on 03/01/16, identified the resident as "incontinent of bladder" on the "Resident Service Plan/Care Plan" completed 11/02/13 following admission on 11/01/13. Information provided by the facility nursing staff on forms used for physician follow-up visits identified Resident #2 as experiencing "stress incontinence" during the last three physician follow-up visits dated 10/01/15, 7/02/15, and 6/04/15. Resident #2's record lacked evidence of assessment of the resident's incontinence of both bowel and bladder, including the resident's voiding habits/patterns, factors contributing to the resident's incontinence, i.e., the resident's identified chronic constipation. The record lacked evidence, based on the assessment, of a responsive plan to assist Resident #2 with attaining/maintaining maximum continence and preserving the resident's dignity. During an interview on the morning of 03/02/16, a management staff member (#3) concurred the facility had not assessed Resident #2's incontinence and had not developed a responsive plan of care with measureable goals to address the resident's incontinence needs/problems.	81220		
81230	33-03-24.1-12,3 RESIDENT ASSESSMENTS/CARE PLANS	81230		

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3. A care plan, based on the assessment and input from the resident or person with legal status to act on behalf of the resident, must be developed within twenty-one days of the admission date and consistently implemented in response to individual resident needs and strengths.

This state licensing rule is not met as evidenced by:
Based on observation, record review, review of Resident Council meeting minutes, review of facility policy/procedure, resident interview, and staff interview, the facility failed to develop and implement individualized plans of care to address the incontinence needs/problems for 2 of 2 sampled residents (Resident #1, and #2) who experience incontinence. Failure to develop and implement individualized plans of care placed residents at risk for experiencing avoidable/unnecessary incontinence, skin breakdown and urinary tract infections, avoidable falls, and a lack of preservation of the resident's individual dignity.

Findings include:

Review, on 03/02/16, of the facility's "Incontinence Care" procedure stated: ". . . Purpose: To keep skin clean, dry, free of irritation and color. To identify skin problems as soon as possible so treatment can be started. To prevent skin breakdown. To prevent infection. Assessment Guidelines: May include, but are not limited to: Color, consistency and amount of urine and feces. Pain or discomfort. Dehydration and fluid balance. Condition of skin and perineum. Potential for participation in a bowel and/or bladder management program. Need for a regular toileting plan. Care Plan Documentation

1) Care plans for resident # 1 and # 2 will be revised to include appropriate interventions to promote increased continence and maintain his/her dignity.
2) All residents incontinent of bowel and/or bladder have the potential to be affected by this deficient practice.
3) All care plans for residents admitted to the basic unit with incontinence will be reviewed at monthly staff meetings to assure appropriate individualized care plan interventions are in place and goals are routinely being met.
4) Date of Correction: April 15, 2016
5) The Director of Nursing will do a monthly audit x 12 months to assure individualized interventions care planned for all incontinent residents. If concerns are identified, immediate corrective action will be implemented.

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81230	Continued From page 8 Guidelines: Problem: Identify the appropriate problem under which to list incontinence care as an approach. Consider listing possible risks and complications. Goal: List MEASURABLE goal(s) to be accomplished. List target date. Approaches: List responsible discipline for each approach. List instructions unique to this resident. List necessary monitoring and observation of the incontinence for changes in pattern and urinary tract infection. List appropriate preventative skin care. List approaches for toileting per resident ' s customary routine." - Refer to 81220. Review of Resident #1's record occurred on 03/01/16, and identified Resident #1 as incontinent of bowel and bladder. The record lacked evidence of an assessment of Resident #1's incontinence and the plan of care included no approaches/interventions to promote increased continence and maintain Resident #1's individual dignity. - Refer to 81220. Review of Resident #2's record occurred on 03/01/16, and identified the resident as incontinent of bladder. The record lacked evidence, based on the assessment, of a responsive plan to assist Resident #2 with attaining/maintaining maximum continence and preserving the resident's dignity.	81230		