DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES



PRINTED: 12/14/2011
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 355093 | A. BUILDING _____ B. WING _____ | 10/27/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| GOOD SAMARITAN SOCIETY - BOTTINEAU | 725 E 10TH ST BOTTINEAU, ND 58318 |

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| F 000 | INITIAL COMMENTS<br><br>For the standard Medicare/Medicaid recertification survey started on 10/24/11 and completed on 10/27/11, the sample included four residents for complete review, nine residents for focused review, and two closed records for review. The sample included one additional resident to verify specific concerns during the survey. | F 000 | | |
| F 253 SS=E | 483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES<br><br>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, review of the cleaning schedule, and staff interview, the facility failed to provide a clean and homelike environment regarding cleanliness of fans and bathroom exhaust vents on 3 of 4 resident care units (200, 300, and 400 wings), fans and vents in 1 of 1 restorative therapy room (300 wing), 1 of 1 beauty shop (300 wing), and holes in the walls on 2 of 4 resident care units (100 and 400 wings). Failure to clean the fans and vents creates a source of airborne material which places residents, staff, and visitors at risk of inhaling dust and debris. Failure to ensure holes in the walls were reported to the appropriate facility staff limited the facility's ability to repair these areas and maintain a homelike environment.<br><br>Findings include: | F 253 | The personal fans in rooms 201, 206, 407 and 303 have been cleaned along with the bathroom exhause vent in room 407. The circulating fams in the 300 wing tub room, 200 wing solarium, the 2 fans in restorative therapy and the beauty shop have been cleaned. The exhaust vents in the male and female rest rooms near the activity room have been cleaned. The walls in rooms 102 and 410 have been repaired.<br><br>The additional residents rooms were checked for personal fans and were cleaned. Exhaust vents and circulating fans not identified were checked and cleaned. Walls that needed repair were edentified and repaired.<br><br>The maintenance department will do a quarterly check on equipment cleaning schedules and repairs, and it will be monitored through the QA program. 11/25/11<br><br>Addendum: The staff was educated on the importance of filling out a work order. 12/01/11 | 12/1/11 |

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

Administrator 12-2-2011

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 253 | Continued From page 1<br>During the initial facility tour, on 10/24/11 at 11:30 a.m., observation identified the following:<br>*Personal fans with accumulated dust and debris on the blades and protective housing - Room 201, 206, 407, 303.<br>*Bathroom exhaust vent with accumulated dust and debris - Room 407.<br><br>During the environmental tour, on 10/26/11 at 10:00 a.m., observation with a maintenance management staff member (#14) confirmed the fans and vent with accumulated dust and debris from the initial tour. In addition, observation identified the following:<br>*Circulating fans with very heavy accumulated dust and debris - 300 wing tub room, 200 wing solarium, restorative therapy (2 fans), and beauty shop.<br>*Bathroom exhaust vents with accumulated dust and debris - male and female rest rooms near the activity room, used by residents, staff, and the public.<br>*Wall guard pulled out of the wall behind a bed, leaving a hole with rough edges, approximately four inches by six inches - Room 102.<br><br>Following the environmental tour, observation identified a wall guard pulled out of the wall behind a bed, leaving a hole with rough edges, approximately three inches in diameter - Room 410.<br><br>During interview, on 10/27/11 at 11:20 a.m., a maintenance management staff member (#14) provided a cleaning schedule, dated 10/07/11, which showed "Fan cleaning in all areas." This staff member also provided a "Maintenance - Near Miss Report." This form included the date, | F 253 | | |

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| F 253 | Continued From page 2<br>location of maintenance repairs requested, and maintenance department action. This staff member reported facility staff are to complete and submit this form for repairs such as the holes in the walls. This staff member was unaware of the holes in the walls and did not have a submitted "Maintenance - Near Miss Report." This staff member was uncertain why the fans and vents had accumulated dust and debris 17 days after cleaning.<br><br>The holes in the walls were at the foot ends of the beds and created potential hazards for residents to insert their feet or toes. Holes in the walls did not provide cleanable surfaces and did not provide the residents a homelike environment. Failure of facility staff to report these areas for repair limited the facility's ability to provide a homelike environment.<br><br>Failure to ensure the fans and vents are clean allowed circulation of dust and debris throughout the facility, placing residents, staff, and the public at risk of inhaling the dust and debris. | F 253 | | |
| F 280 SS=E | 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP<br><br>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.<br><br>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility | F 280 | Resident #6 was removed immediately when the incident occurred on 09/22/11. He was put in an area that is monitored more closely by staff. His belongings in his room were moved within 2 hours of the beahvior to another wing with a quieter roommate. Staff on the other wing was aware of his behaviors and made efforts to have him busy in a day room, which is located directly by the nurses station. His behavior was watched closely by staff and it did not happen again. He has been discharged from the facility. | 12/1/11 |

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| F 280 | Continued From page 3<br>for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, review of facility policy and procedure, resident interview, and staff interview, the facility failed to ensure each resident's care plan was reviewed and revised for 3 of 13 sampled residents (Resident #2, #6, and #7) and 1 of 2 closed records (Resident #15) regarding elopement (Resident #2 and #15), resident to resident behaviors (Resident #6), resident safety (Resident #7), and bowel habits (Resident #7). Failure to review and revise each resident's care plan as the resident's status changes limited the staff's ability to provide care in a consistent coordinated manner.<br><br>Findings include:<br><br>Review of the facility policy "Care Plan" occurred on 10/27/11. This policy, revised January 2009, stated "PURPOSE, To develop a comprehensive care plan using an interdisciplinary team approach. POLICY, Residents will receive and be provided the necessary care and services to attain or maintain the highest practicable well-being in accordance with the comprehensive assessment. Each resident will have an | F 280 | REsident #15 has died.<br><br>Resident #2 care plan has been updated to include eloping from the facility. His condition has deteriorated and he is no longer wandering and has not eloped since 10/20/11.<br><br>Resident #7 care plan has been updated to include chair sensor to his recliner. Staff decided to keep alarms on his bed, wheelchair and recliner since he has a history of falls and has trouble remembering to ask for help. Alarms do not prevent falls but they notify staff if residents have transferred themselves.<br><br>Resident #7 care plan was also updated to give fleet enemas for bowel regularity. I visited with Resident #7 about the use of milk of magnesia and prune juice. He insists on using fleet enemas. This is the resident's choice for bowel regularity.<br><br>Every nurse will be assigned to review each care plan. They will check for approaches of elopement, resident to resident behaviors, resident safety and bowel habits. When they have finished reviewing the assigned care plans, they will initial at the bottom of the first page.<br><br>Each week, every nurse will review their assigned care plans and make updates. They will fill out the form "Care Plans to Check". These forms will then be given to the Social Worker so she can review them and add to the care plan if needed.<br><br>The nurses will have a meeting on 11/23/11 to receive instruction on this. The CNA's will have a meeting on 11/25/11 to go over bed and chair alarms, elopement, resident safety and resident to resident behavior. | |

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| F 280 | Continued From page 4<br>individualized comprehensive plan of care that will include measurable goals and timetables directed toward achieving and maintaining the resident's optimal medical, nursing, physical, functional, spiritual, emotional, psychosocial and educational needs. Through use of departmental assessments . . . any problems, needs and concerns identified will be addressed. . . . The care plan will emphasize the care and development of the whole person assuring that the resident will receive appropriate care and services. . . . Care plans will also be reviewed, evaluated and updated when there is a significant change in the resident's condition . . . This plan of care will be modified to reflect the care currently required/provided for the resident."<br><br>Review of the facility procedure "Comprehensive Care Plan and Care Conferences" occurred on 10/27/11. This procedure, revised in January 2009, stated "PURPOSE, To provide an ongoing method of implementing, reviewing and updating resident care. PROCEDURE, . . . 7. Reviews, Reassessments and Updates . . . b. Care plans are to be reviewed . . . whenever there is any significant change in the resident's condition . . ."<br><br>- Review of Resident #6's medical record occurred on October 24-27, 2011. The facility admitted the resident in September 2011. Current diagnoses included dementia and depression. The resident's admission Minimum Data Set (MDS), dated 09/12/11, identified the resident made himself understood and could understand others, had moderate cognitive impairment, did not demonstrate behaviors, and walked in his room by himself. | F 280 | The QA coordinator will pick a sample of 6 care plans each month for 6 months. She will fill out a form entitled "F Tag 280 QA". She will study these 6 care plans and answer these questions:<br>1) Are these itmes found on the care plan if they are a problem?<br>2) If not found, what action was taken?<br>3) Was the Social Worker made aware of the behavior problems?<br>4) Any needed follow up? | 12/01/11 |

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| F 280 | Continued From page 5<br>Resident #6's Cognitive Care Area Assessment (CAA), dated 09/17/11, stated ". . . he is exhibiting confusion, lack of s/t [short term] memory . . . mood seems stable . . ." The resident's social services Interdisciplinary Assessment note, dated 09/17/11, stated ". . . There are no Behavioral issues noted to date . . . will monitor cognitive status as well as Mood/Beh. [Behavior] . . ." The resident's current care plan, dated 09/20/11, stated "Problems . . . Alteration in Mood/Behaviors . . . Plans . . . Observe/report changes in mood/behavior . . . [revised 09/23/11] H/O [History of] striking out when angry. . . ."<br><br>Resident #6's Interdisciplinary Progress Notes (IDPN), dated 09/22/11 at 1:25 p.m., stated ". . . based on report by CNA [certified nursing assistant] . . . she [CNA] had heard resident's roommate hollering . . . upon entering resident's room she learned that resident had hit roommate . . . resident reported having been threatened by roommate . . . it is unclear as to exactly what occurred. . . . Resident's spouse is positive & [and] supportive of resident changing rooms . . ."; dated 09/23/11 at 11:55 a.m., "[Resident #6] admits having punched his rm [room] mate in the mouth [due to] 'he wouldn't shut up.' . . ."; and, dated 09/23/11 at 2:00 p.m., "Resident and belongings moved to . . ." The remainder of Resident #6's medical record, including behavior documentation, did not identify any other behaviors by Resident #6 towards other residents.<br><br>Review of the facility's Incident Report for the incident on 09/22/11 identified the facility staff notified both families involved, notified the administrative staff, notified the physicians, and | F 280 | | |

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| F 280 | Continued From page 6<br>identified no injuries occurred.<br><br>The facility staff identified Resident #6's behavior towards his roommate and took action to separate them. The revision to Resident #6's care plan did not provide the facility staff with information regarding possible causative factors and appropriate approaches if similar behaviors occurred again. During interview, on 10/27/11 at 10:00 a.m., a supervisory nursing staff member (#4) confirmed Resident #6's care plan had not been revised to include Resident #6's aggression toward another resident and interventions to prevent a reoccurrence.<br><br>- Review of Resident #7's medical record occurred on October 24-27, 2011. The facility admitted the resident in August 2008. Current diagnoses included Alzheimer's disease, depression, history of left femur fracture and right total hip replacement, and constipation. The resident's significant change MDS, dated 08/30/11, identified he made himself understood and understood others, was cognitively intact, transferred, and walked in his room, and used the toilet with extensive assistance of one or two persons. The MDS also identified two falls with injuries since the prior assessment on 06/01/11.<br><br>Resident #7's Falls CAA, dated 08/31/11, stated ". . . Resident is at risk for falls. He had recent fall in which he substained [sic] rib fx's [fractures]. . . . He pivot transfers with assistance of 2 or sit to stand lift. . . . Resident has a sensor mat to his bed and chair to alert staff of potential self transfers as he does need assistance and is forgetful at times. . . ." | F 280 | | |

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| F 280 | Continued From page 7<br>Resident #7's current care plan, dated 09/06/11, stated "Problems . . . Impaired mobility, potential for falls . . . Plans . . . Trasnfers [sic] with assist of 1-2 w/ [with] walker or stand pivot; sit-stand lift assist of 2, prn [as needed]. . . . Sensor mat to bed and chair. . . ."<br><br>Resident #7's IDPN, dated 07/27/11, identified a facility staff member found the resident laying on the floor after he attempted to transfer himself. X-rays taken showed left rib fractures. The resident experienced pain and limited mobility after the fall. The IDPN, dated 08/15/11, identified the staff found the resident in his room on the floor after he attempted to transfer himself.<br><br>Observation throughout the survey showed Resident in his wheelchair or recliner. The recliner lacked a sensor mat or other chair alarm device. Observation did show a tab alarm device attached to the wheelchair and the cord and clip for attachment to the resident's clothing wrapped around the frame of the wheelchair.<br><br>During interview, on 10/25/11 at 9:00 a.m., when asked about self toileting, self transfers, and lack of the chair and wheelchair alarms, Resident #7 stated "Got to do something yourself."<br><br>During interview, on 10/25/11 at 9:50 a.m., a certified nursing assistant (CNA) (#6) reported the resident's mobility is improved, he is independent in toileting, and the alarms are no longer used.<br><br>Resident #7's mobility status has improved per staff reports. Failure to review his status and revise his care plan limited the staff's ability to | F 280 | | |

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| F 280 | Continued From page 8<br>provide a consistent approach for care and ensure the resident's highest functional level.<br><br>- Resident #7's physician orders included the following medications or treatments related to bowel function:<br>*Senna S, one tablet, three times each day (laxative and stool softener)<br>*Dulcolax, orally, 10 milligrams (mg.), PRN (as needed) (laxative)<br>*Milk of magnesia, 30 cubic centimeters (cc), PRN (laxative)<br>*Fleets enema, daily, PRN<br><br>Resident #7's current care plan, dated 09/06/11, stated "Problems . . . Potential altered bowel elimination r/t [related to] constipation . . . Plans . . . Medicate as ordered. Monitor for adverse consequences. Encourage fluids. Offer high fiber foods, fruits, and juices in diet. . . ."<br><br>Resident #7's PRN Medication Administration Records (MARs) for the period June through September 2011 identified bowel medications or treatments administered on the following dates:<br>*June 2011<br>Dulcolax - 2, 6, 10, 15, 30 - five times<br>Milk of magnesia - none<br>Fleets enema - 19, 26 - two times<br>*July 2011<br>Dulcolax - 29 - one time<br>Milk of magnesia - none<br>Fleets enema - 3, 14, 17, 22, 30 - five times<br>*August 2011<br>Dulcolax - 6, 11, 24, 26, 28 - five times<br>Milk of magnesia - 10, 30 - two times<br>Fleets enema - 13, 17, 28 - three times<br>*September 2011 | F 280 | | |

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| F 280 | Continued From page 9<br>Dulcolax - 7, 14, 19 - three times<br>Milk of magnesia - none<br>Fleets enema - 3, 9, 11, 17, 19, 21, 24, 26, 30 - nine times<br><br>On 10/26/11 at 1:55 p.m., at the surveyor's request, an administrative nursing staff member (#8) provided a handwritten protocol for bowel medications. This protocol identified the facility staff should administer milk of magnesia or prune juice first; if no bowel movement, administer Dulcolax; and, if no bowel movement, then a Fleets enema.<br><br>During interview regarding Resident #7's bowel program, on 10/27/11 at 10:00 a.m., a supervisory nursing staff member (#4) reported the resident prefers the use of enemas instead of attempting milk of magnesia or Dulcolax for bowel movements. The medical record lacked evidence the staff educated Resident #7 of the risks and benefits of the enemas and the care plan lacked information the resident preferred enemas as his preferred approach for bowel management. Staff member (#4) agreed this information should be included on the resident's care plan.<br><br>Failure to include the Resident #7's preference for enemas as a bowel management program on the resident's care plan limited the staff's ability to provide consistent care.<br><br>- Review of Resident #2's medical record occurred on October 24-27, 2011. A quarterly Minimum Data Set, dated 08/15/11, identified Resident #2 wanders daily, is independent walking in the room, and the corridor, and with | F 280 | | |

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| F 280 | Continued From page 10<br>locomotion on/off the unit.<br><br>Review of the care plan, dated 08/23/11, identified Resident #2 wore a wanderguard bracelet but failed to identify the resident's successful elopements. The care plan identified ". . . walking of the halls, restlessness has [history of] attempts to get outside (elopement) . . ." and " . . . There is also a high risk for elopement."<br><br>During an interview on 10/25/11 at 3:00 p.m., an administrative nurse (#5) stated facility staff are to keep residents in a central area, monitor their location, and provide an activity to minimize restlessness. Resident #2's care plan included none of the above interventions and did not identify actual elopements.<br><br>- Review of Resident #15's medical record occurred on October 26-27, 2011. Medical diagnoses included dementia and Alzheimer's disease. The current MDS, dated 09/02/11, identified the resident wandered daily.<br><br>Review of an "Incident Details" report identified Resident #15 eloped from the facility on 08/03/11 at 9:30 a.m. The report stated, "Resident was in maintence [sic] office. Had come in through back door - do not know how he got out of building - he has a secure care braclet [sic] on ankle and on on walker." Another "Incident Details" report identified Resident #15 eloped from the facility on 08/03/11 at 4:00 p.m. The report stated, "Eloped through NW door. Took 3 CNAs [certified nursing assistants] to get him to come in."<br><br>During an interview on 10/26/11 at 3:30 p.m., an administrative nurse (#8) stated facility staff | F 280 | | |

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| F 280 | Continued From page 11<br>figured out Resident #15 read the code fixed to the wall, entered the code on the code pad, and exited the facility. Facility staff changed the numbers on the wall to Roman numerals and Resident #15 did not exit the facility again.<br><br>Review of the care plan, dated 09/13/11, identified Resident #15 wore a wanderguard bracelet but failed to identify a history of elopement. | F 280 | | |
| F 309 SS=D | 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, and staff interview, the facility failed to provide the necessary care and services to attain the highest practicable physical, mental, and psychosocial well-being regarding pain management for 1 of 1 sampled resident (Resident #4) who sustained a fracture in the facility and experienced pain during cares. Failure to report a resident's symptoms of pain, assess the pain, and implement pain management interventions for Resident #4 resulted in the resident experiencing unnecessary pain.<br><br>Findings include: | F 309 | Staff will do a pain assessment of Resident #4. After the assessment is done, staff will review the findings with the DON. Non-pharmocological interventions will also be reviewed and tried on REsident #4 to see if pain episodes decrease. The care plan will be updated. The summary of the findings and review will be faxed to the physician by the DON.<br><br>A list will be made of residents receiving pain meds and those not receing pain meds. The DON will meet with respective nursing staff, who know the residents well, to evaluate pain management of each resident. Pain meds and non-pharmalogical intervention will be discussed. If they feel any changes should be made, the physician will be notified.<br><br>A new form entitled "Medication Notes" has been made. It will show non-pharmacological interventions used and if the pain med is effective one hour after it is given. So the medication, non-pharmacological interventions and follow up will now be on one page and will be easier to visualize any problems. The nurses will have a meeting on 11/23/11 to get instruction on the | 12/1/11 |

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| F 309 | Continued From page 12<br><br>Review of Resident #4's medical record occurred on all days of survey. Medical diagnoses included Alzheimer's disease, dementia, a fall on 09/24/11, and a hip fracture identified on 09/27/11. Medications included Vicodin (a narcotic pain reliever initiated on 09/27/11) 1 or 2 tablets every 4 to 6 hours as needed (PRN), and Tylenol (initiated on 09/26/11) three times a day.<br><br>Resident #4's current Minimum Data Set (MDS), dated 09/18/11 (prior to the fracture), identified a problem with short and long term memory and experienced pain daily. The resident's pain indicators included non-verbal, vocal, expression, and body/posture. Resident #4's Care Area Assessment (CAA) regarding pain, dated 09/18/11, stated, "appears to have pain by body language. Taken off oxycodone [a narcotic pain medication] due to decline in condition. c/o [complaints of] leg pain per history. weeps frequently for unknown etiology."<br><br>Resident #4's current care plan stated, "Problem: Impaired Mobility, potential for Falls . . . Rt [right] hip fx [fracture] [problem initiated 09/29/11], forgets not to bear wt [weight] on RLE [right lower extremity] NWB [non-weight bearing] to RLE. Goals: . . . will have pain controlled/relief of pain as evidenced by relaxed facial expression & body positioning Approaches: . . . Pain assessment quarterly & PRN. Provide non-drug pain relief one time each pain episode when appropriate . . . Report pain to nurse. Transfer [with] total mechanical lift assist of 2."<br><br>The most recent "Pain Review," dated 09/16/11, stated, "She [Resident #4] was given Tylenol on | F 309 | use of the form. CNA's will be inserviced on 11/25/11 on the importance of reporting pain and being careful with residents during cares.<br><br>The QA coordinator will do a QA on this two times per month for one month and then monthly x5. She will check to see if residents are receiving the pain control they need. If they are not, she will give unit managers a note so there is follow up with the providing physician. | 12/01/11 |

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| F 309 | Continued From page 13<br>09/13/11 for leg pain et [and] on 09/16/11 for preventative pain. Pain management review unchanged from 09/12/11. She shakes her head 'no' re: [regarding] pain today or last 5 days. She is unable to accurately recall this . . ." Staff failed to complete a pain assessment/review after Resident #4's fall and hip fracture in September.<br><br>Observation on 10/25/11 from 7:40 a.m. to 11:55 a.m. showed Resident #4 seated in her wheelchair. An "Incident Details" report, dated 10/25/11 at 1:20 p.m., stated, "Resident [#4] was trying to transfer self . . . nurse tried to reach her before she fell . . . Immediate Interventions: . . . Remind CNA [certified nursing assistant] to toilet her often . . ."<br><br>Observation on 10/25/11 at 2:30 showed Resident #4 laying on her bed. Two CNAs (#6 and #11) rolled the resident from side to side, without regard to her fractured hip, to check the resident's brief (dry). Resident #4 grimaced and began to cry. The two CNAs utilized the full body mechanical lift and transferred the resident to her wheelchair. Observation showed the resident's hair on the outside of the lift sling during the transfer and, as the sling slid upward, it pulled the resident's hair and she continued to cry.<br><br>Observation on 10/25/11 at 4:30 p.m. showed two CNAs (#6 and #11) utilized a mechanical lift and transferred Resident #4 from her wheelchair to her bed. The CNAs again rolled the resident from side to side several times, without regard to her fractured hip, as they removed her wet brief, provided perineal cares, applied a clean brief, and adjusted her clothing. Resident #4 grimaced and cried during this observation and continued | F 309 | | |

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| F 309 | Continued From page 14<br>to cry as the CNAs transferred her back into her wheelchair.<br><br>An observation on 10/24/11 at 5:50 p.m. showed two CNAs, other than CNAs (#6 and #11), provided incontinence cares for Resident #4 while she layed on her bed. Two CNAs (#9 and #10) placed a rolled blanket between the resident's legs before they slowly rolled her from side to side. Resident #4 did not show any outward signs of pain such as facial grimacing or crying.<br><br>Review of Resident #4's October 2011 medication administration record (MAR) identified facility staff administered the resident's scheduled Tylenol at 12:00 p.m. and 6:00 p.m. and two Vicodin tablets on 10/25/11 at 9:00 p.m. for "pain [with] cares." The medical record failed to show the CNAs (#6 and #11) reported Resident #4's episodes of facial grimacing and crying during cares on 10/25/11 at 2:30 p.m. and 4:30 p.m.<br><br>During an interview on 10/27/11 at 11:05 a.m., a nurse manager (#4) stated she expected the CNAs to be careful while providing cares for Resident #4 and they should have reported the resident's pain. | F 309 | | |
| F 315 SS=D | 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER<br><br>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an 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 | F 315 | The CNA's will mark a Bladder & Bowel Flow Sheet for Resident #4 that has hourly increments on it. This evaluation will be done for 72 hours. The Bladder & Bowel team, who is comprised of the DON and Restorative Nurse, will review the evaluation. From this evaluation, it will be determined if Resident #4 is a candidate for a bladder program. After this review, the care plan will be | 12/1/11 |

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| F 315 | Continued From page 15<br>infections and to restore as much normal bladder function as possible.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, and staff interview, the facility failed to assist 1 of 7 sampled residents (Resident #4) dependent on staff for toileting needs. Failure to toilet Resident #4 as care planned may have resulted in the resident's incontinence episode and subsequent fall.<br><br>Findings include:<br><br>Review of Resident #4's medical record occurred on all days of survey. Medical diagnoses included Alzheimer's disease, dementia, a fall on 09/24/11, and a hip fracture identified on 09/27/11. The resident's current Minimum Data Set (MDS), dated 09/18/11, identified short and long term memory difficulties, frequently incontinent of bladder, and required extensive assistance for toilet use and personal hygiene.<br><br>Resident #4's current care plan stated, "Problem: . . . Altered bladder elimination . . . Approaches: Toilets with assist of 2 upon rising, mid [middle] AM, after dinner, before supper, HS [bedtime], 12 MN [midnight], when awake @ night & upon request . . ." Another problem stated, "09/29/11 Rt [right] hip fx [fracture], forgets not to bear wt [weight] on RLE [right lower extremity] NWB [non-weight bearing] to RLE. Approaches: Transfer [with] total mechanical lift assist of 2."<br><br>Observation on 10/24/11 at 5:50 p.m. showed | F 315 | updated according to Resident #4 toileting needs.<br><br>A list of residents who are incontinent of urine was made. From this list of incontinent residents, the Bladder & Bowel team will decide if any of these residents would be a candidate for a Bladder program.<br><br>If they are a candidate, an evaluation will be done and times of toileting will be marked down so CNA's will know when to take the residents to the toilet. The Restorative Aides will also be notified of the times so they can remind the CNA's to take the resident to the toilet. This way, the CNA's will get into the habit of taking the residents at a time that works for the resident.<br><br>The CNA's will have a meeting on 11/25/11 to be educated on the importance of toileting residents and following the care plan.<br><br>The Restorative Nurse and DON will do a QA. This QA will be filled out weekly for 1 month and monthly for 5 months. The form will list the name of the incontinent resident and what their care plan says. From this information, they will monitor to see if CNA's are taking residents to the bathroom according to what the care plan says. From this, an action will be determined and the care plan will be updated if needed. | 12/01/11 |

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| F 315 | Continued From page 16<br>Resident #4 laying on her bed. Two certified nursing assistants (CNAs) (#9 and #10) removed the resident's wet brief and placed her on a bed pan but the resident failed to void. After pericares, the two CNAs utilized a full body mechanical lift and transferred Resident #4 from the bed to her wheelchair. Observation showed the sling had a large open area designed to fit a resident's buttocks which would allow a resident to be placed on the toilet.<br><br>Observation on 10/25/11 from 7:40 a.m. to 11:55 a.m. showed Resident #4 seated in her wheelchair. Resident #4's "Incident Details" report, dated 10/25/11 at 1:20 p.m., stated, ". . . nurse tryed to reach her before she fell . . . Immediate interventions . . . Remind CNA to toilet her often . . ." During an interview on 10/25/11 at 1:30 p.m., a CNA (#11) stated Resident #4 fell from her wheelchair at 1:20 p.m. At that time, two CNAs (#6 and #11) utilized a mechanical lift, transferred her to bed, and changed her wet brief.<br><br>Observation on 10/25/11 at 2:30 p.m. showed two CNAs (#6 and #11) checked Resident #4's brief (dry), utilized the mechanical lift, and transferred her from the bed to a wheelchair. At 4:30 p.m., the two CNAs transferred her back to bed and changed her wet brief. A CNA (#6) stated staff check and change Resident #4's brief rather that utilize the toilet since her fracture.<br><br>Facility staff failed to assist Resident #4 with her toileting needs mid-morning and after dinner as care planned, and chose to check and change the resident's brief rather than offer use of the toilet. | F 315 | | |
| F 323 | 483.25(h) FREE OF ACCIDENT | F 323 | | 12/1/11 |

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| F 323 SS=D | Continued From page 17<br>HAZARDS/SUPERVISION/DEVICES<br><br>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>This REQUIREMENT is not met as evidenced by:<br>1. Based on observation, record review, staff interview, and facility procedure review, facility staff failed to ensure the safety needs for 1 of 1 sampled resident (Resident #2) who exhibited wandering behaviors and eloped from the facility, on two occasions without staff realizing the resident had exited the building. Failure to identify the exit point used by the resident allowed the resident to exit the facility a second time without staff knowledge. Failure to implement specific safety measures while investigating the malfunction of the security door placed Resident #2 and other wandering residents at greater risk for elopement episodes.<br><br>Findings include:<br><br>Review of the facility procedure titled "Elopement" occurred on 10/27/11. This policy, last revised July 2008, stated, "Purpose . . . To clearly define mechanisms and procedures for monitoring and managing residents at risk for elopement. These include identifying environmental hazards and individual resident risk, including the need for supervision; evaluating/analyzing hazards and | F 323 | REsident #2 wanderguard bracelet was changed during the survey and it worked on the west door. It is tested daily and it shows it is working. Resident #2 condition has deteriorated and he doesn't wander anymore. He is sleeping better at night and is not wandering at night either. The care plan for Resident #2 was updated to include elopements from the facility.<br><br>Every resident that wears a wanderguard bracelet was taken to the west door during the survey. This door locked immediately when they got close to it. These bracelets are cehcked daily by nursing staff and documented on the treatment administration record. Maintenance personnel also check each door weekly and document this.<br><br>The door alarm company has been notified and will be here 11/29/11 to check all of the doors and the magnetic strips and boxes.<br><br>The elopement policy was reviewed. The part of the policy which gives direction to the nurse and start out 10. In the event of a resident elopement: Was added to the elopement checklist worksheet. It will be all on one page for easy access for thenurses. This will be placed with the packets regarding disasters and hung on the bulletin boards at each nurses station.<br><br>The nurses will be instructed on this worksheet and what needs to be included on the GSS#401-Incident Report, including outdoor environmental conditions. They will also be told of the importance to notify family and the physician. A sample care plan will also be discussed with them. This was put on the back of a form entitled, "Account- | |

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| F 323 | Continued From page 18<br>risks; needs, goals, plan of care and current standards of practice; and monitor/modifying interventions as needed. . . . 10. In the event of a resident elopement: . . . d. Notify the administrator, charge nurse or their designees immediately. . . . d. In all cases, family will be notified of the incident. e. Notify the physician. f. The Resident / Visitor Incident Report (GSS #401) will be completed. When completing the [form], be sure to include the following information: 1) Weather conditions at the time of elopement: raining, snowing, evening, daylight, temperature, etc. . . . 12. After an elopement has occurred, use the Elopement Checklist Worksheet that follows as a reference to ensure all required steps were followed. This is a worksheet and therefore not part of the Medical Record. . . . Elopement Checklist Worksheet, Environmental Hazards 8. Is an individual resident safety alarm, i.e. wander alert bracelet, used? 9. If resident has an individual safety alarm, was it in working order? 10. Was the exit door alarm activated when the resident eloped? 11. If the exit door did not have an alarm, is the door within the sight of a staff member at all times? 12. Is the exit door alarm in working order?"<br><br>- During initial tour of the facility on 10/24/11 at 12:12 p.m., an administrative nursing staff member (#5) identified Resident #2 wanders. This staff person explained Resident #2 ambulates independently, wanders up/down the halls, into the dining room, he tries to exit the building, is confused, and wears a wander guard.<br><br>Random observations made throughout the days of October 24-27, 2011, showed Resident #2 | F 323 | ing for REsidents at Risk for Elopement". The QA coordinator will be notified of any elopements. She will fill out a form called "Elopement QA". She will fill this out every time there is an elopement for 6 months and the findings will be reported to QA committee monthly.<br><br>Accidents & Supervision<br><br>The CNA's will mark a Bladder & Bowel Flow Sheet for Resident #4 that has hourly increments on it. This evaluation will be done for 72 hours. The Bladder & Bowel team, who is comprised of the DON and REstorative Nurse, will review the evaluation. From this evaluation, it will be determined if Resident #4 is a candidate for a bladder and bowel prgram. After this review, the care plan will be updated according to REsdient #4 toileting needs to help prevent Resident #4 from falling.<br><br>A list of residents, at a high risk of falls, will be made. These residents care plans will be reviewed and any needed updates will be made. This form is entitled, "High Risk for Falls". It will also include a history of falls during the past 6 months. From this list, the Bladder & bowel team will review this list to see if residents could be candidates for a Bladder & Bowel program.<br><br>A resident fall log has also been atarted. It asks about time of day, contributing factors, what the resident was doing before the fall and what the intervention will be. This form will be taken to the Falls & Safety Committee meeting each month. This committee is comprised of the Administrator, QA coordinator, DON, Unit managers, PT, Risk Management, Social | 12/01/11 |

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| F 323 | Continued From page 19<br>wore a wanderguard bracelet, ambulated freely around the nurses' station, in the halls, through the south solarium, and dosed/napped in recliners by the bird aviary.<br><br>Review of the medical record for Resident #2 occurred October 24-27, 2011. The facility admitted Resident #2 in 11/2010 with diagnoses including generalized anxiety disorder, altered mental status, and senile dementia with depressive features. A quarterly Minimum Data Set, dated 08/15/11, identified Resident #2 wanders daily, is independent walking in the room and the corridor, and with locomotion on/off the unit. A physician order, dated 11/17/11 stated, "Wanderguard bracelet. Check function daily."<br><br>Interdisciplinary Progress Notes for Resident #2 identified the following:<br>* 03/02/11 at 5:00 p.m. "A staff member exited the front door - Res [resident] was close by [and] just followed him out the door - The door alarm sounded. Res walked so fast he was almost to the street. Nurse was calling him back - The staff member who just left turned around [and] helped bring res back."<br>* 03/14/11 at 9:00 a.m. "door alarm sounding [at] the front - upon [check]ing it out noticed 2 staff members bringing res back into facility."<br>* 04/07/11 at 2:45 p.m. "found to have cut off wanderguard and while nurse was getting replacement band resident went out the door and followed side walk in front of building around the drive way circled back to front door returning with staff. Did not leave property and was not outside for very long. Wanderguard replaced and resident accepted it."<br>* 06/12/11 at 8:30 p.m. "Out South door [times] 2 | F 323 | Worker and Staff Development. At this meeting, we will decide if a resident or residents need something extra like activities or toileting to prevent a fall from occurring.<br><br>There will be a nurses meeting on 11/23 and a CNA meeting on 11/25/11 to educate them on toileting needs and preventing falls.<br><br>A QA will be done by the QA coordinator. She will do this 2 times for 1 month and then monthly for 5 months. She will fill out the form entitled "Summary of High Risk for Falls". Any unusual findings will be reported to the Unit managers and DON. A solution will be discussed and the care plan will be updated accordingly. | 12/01/11 |

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| F 323 | Continued From page 20<br>past 15 min. [minutes] (Door Alarmed) Ret'd [returned] by staff ReDirrection [sic]."<br>* 07/11/11 at 8:00 a.m. "found walking down road around NF [nursing facility]. [Resident #2's name] was compliant when walked into building after short stroll to other side of building. Alarm for wanderguard sounded when entering building. Unaware of which door exited. F/U [follow up] with nurse [and] unit supervisor to inform."<br>* 10/20/11 at 2:00 a.m. "Res. had been walking in hallways tonight. At 1:30/AM Res. was noted by CNA [certified nurse aide] walking down sidewalk in front of facility. Res wears a wanderguard bracelet. Alarm had worked on East Wing door earlier, but did not alarm on West Solarium door. When door checked opened but after code punched reset and locked. Res. redirected into facility without any problem GSS 401 completed."<br><br>The care plan failed to address Resident #2 actually exited, eloped, from the building.<br><br>During an interview, on 10/25/11 at 11:30 a.m., an administrative nursing staff member (#8) provided the Resident/Visitor Incident Report completed for the elopement of 10/20/11 and stated she would need to look into the elopement episode on 07/11/11. On 10/26/11 at 4:25 p.m. this same staff member (#8) stated the information for the elopement of 07/11/11 is written in the medical record, however, facility staff failed to complete a Resident/Visitor Incident Report.<br><br>The Resident/Visitor Incident Report, dated 10/20/11, identified the following investigation: "10/20/11 He [Resident #2] went out the West door. Staff brought him back in. Maintenance is checking out the door [and] calling the company. | F 323 | | |

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| F 323 | Continued From page 21<br>We will have night nurse check all the doors [with] a bracelet tonight. 10/21/11 Night nurse found all doors alarmed quickly. Maintenance is checking magnetic strips and boxes. [Resident #2's name] isn't sleeping at night much and sleeping more during the day. [psychiatrist's name] visited him today [and] added a med [medication]." This report failed to identify the facility notified the family, Resident #2's attending physician, and failed to address the environmental conditions at the time of elopement as per facility policy.<br><br>During an interview, on 10/26/11 at 1:20 p.m., a maintenance management staff member (#14) stated the temperature on 10/20/11 was below freezing, he did not know the exact temperature, but clearly remembers the temperature fell below freezing that night. When asked about the elopement of 07/11/11, this staff member (#14) stated staff informed him of the elopement when he arrived at work that morning, he checked all the doors and all worked normally. Review of weather information obtained on "wonderground.com" for Bottineau, N.D. for 10/20/11 showed a chart of the days temperatures. This chart identified a temperature of 25.7 degrees Fahrenheit at 1:32 a.m.<br><br>During an interview on 10/26/11 at 3:45 p.m., a maintenance management staff member (#14) identified the facility had changed Resident #2's wanderguard earlier today. This same staff member (#14) identified he completed the environmental tour with Resident #2's old wanderguard in his pocket, and stated he triggered the alarms at every secured door in the facility except the West solarium door. The maintenance staff member (#14) identified the | F 323 | | |

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| F 323 | Continued From page 22<br>doors are checked using a random wanderguard bracelet and a hand held testing device by both maintenance staff and nursing staff. This staff member (#14) reported he has never run into a situation where one bracelet does not alarm at a specific door and he had a call into the manufacturer.<br><br>Failure of facility staff to investigate Resident #2's elopement of 07/11/11 when staff found the resident walking on the road, may have contributed to the resident eloping from the facility again at 1:30 a.m. on 10/20/11. Failing to investigate Resident #2's specific wanderguard after a another elopement in which an alarm did not sound placed the resident at continued risk of elopement. Failure to implement specific safety measures while investigating the door malfunction also placed Resident #2 at greater risk of another elopement episode.<br><br>2. Based on observation, record review, and staff interview, the facility failed to provide the necessary care and services for 1 of 4 sampled residents (Resident #4) who experienced a fall in the facility. Failure to assist Resident #4 with her toileting needs mid-morning and after dinner as care planned may have resulted in her fall.<br><br>Findings include:<br><br>Review of Resident #4's medical record occurred on all days of survey. Medical diagnoses included Alzheimer's disease, dementia, a fall on 09/24/11, and a hip fracture identified on 09/27/11.<br><br>Resident #4's current Minimum Data Set (MDS), dated 09/18/11 (prior to the fracture), identified a | F 323 | | |

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| F 323 | Continued From page 23<br>problem with short and long term memory, required extensive assistance for transfers, toilet use, and personal hygiene, and a history of a fall without injury. A fall risk assessment, dated 09/24/11, identified a score of "22," which indicated Resident #4 at high risk for falls.<br><br>Resident #4's current care plan stated, "Problem: . . . Altered bladder elimination . . . Approaches: Toilets with assist of 2 upon rising, mid [middle] AM, after dinner, before supper, HS [bedtime], 12 MN [midnight], when awake @ night & upon request . . ." Another problem stated, "09/29/11 Rt [right] hip fx [fracture], forgets not to bear wt [weight] on RLE [right lower extremity] NWB [non-weight bearing] to RLE. Approaches: Transfer [with] total mechanical lift assist of 2."<br><br>Observation on 10/25/11 from 7:40 a.m. to 11:55 a.m. showed Resident #4 seated in her wheelchair and staff did not assist the resident to the toilet as care planned. Resident #4's "Incident Details" report, dated 10/25/11 at 1:20 p.m., stated, "Resident was trying to transfer self from wheelchair to davenport. Sensor mat went off and nurse tried to reach her before she fell. She missed sitting on davenport and sat on the floor . . . Immediate Interventions: . . . Keep reminding resident not to stand per self. Remind CNA [certified nursing assistant] to toilet her often . . . Comment: Resident has dementia of Alzheimer's type. Forgets she can't stand or walk per self. Need reminder often."<br><br>During an interview on 10/25/11 at 1:30 p.m., the nurse (#7) stated Resident #4 probably needed to use the toilet. The CNA (#6) stated after Resident #4 fell, she and a CNA (#11) assisted the resident | F 323 | | |

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| F 323 | Continued From page 24<br>to her bed and changed her wet brief. | F 323 | | |
| F 371 SS=E | 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY<br><br>The facility must -<br>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and<br>(2) Store, prepare, distribute and serve food under sanitary conditions<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, policy and procedure review, manufacturer's recommendations, and staff interview, the facility failed to store, prepare, and serve foods in a safe and sanitary manner for 2 of 2 days (10/24/11 and 10/26/11) of dietary observations. Areas observed included the kitchen, nursing nutrition centers, and activity program food storage area. These practices increase the residents' potential risk of foodborne illness.<br><br>Findings include:<br><br>Review of the facility policy and procedure titled "Food Storage" occurred on 10/27/11. This policy, last revised November 2010, stated, "Purpose: To ensure that food is stored properly. Policy: Food will be stored under sanitary conditions. . . . 4. Foods which have been opened or prepared will be placed in an enclosed container, dated and labeled. . . . Cover, date and label trays of | F 371 | During survey, all items found were disposed of prior to survey team leaving the facility.<br><br>Dietary staff is to check:<br>1) All opened bottles of thickened liquids for opened dates to ensure they are used within 10 days of opening.<br>2) That all protein based drinks (kemps and milkshakes) are labeled with a thawed date and used within 14 days of thaw date.<br>3) All other opened products for opened dates and dispose of properly.<br>4) All puddings and Jell-O cups are going to be purchased pre-packaged in single serving sizes with dates monitored.<br><br>A Dietary Plan of Correction inservice will be held on 11/29/11 for updates and education on policy and procedures of food storage.<br><br>Refrigerators will be monitored in activities, north nutrition, south nutrition, and within the kitchen and recorded daily by night cook. Dietary manager will monitor weekly with a QA report monthly for 3 months and then quarterly x2 and report to QA committee. | 12/1/11<br><br>12/01/11 |

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| F 371 | Continued From page 25<br>individually poured items such as glasses of juice, milk, supplements. 5. Expiration dates will be checked on a regular basis and foods/fluids which have expired will be discarded. Potentially hazardous foods will be discarded after three (3) days in refrigerator. . . ."<br><br>"Mighty Shakes" and "Kemps Plus 2" are milk-based supplements. Manufacturer guidance for both products identified a thawed shelf life of "Up to 14 days." As a milk-based food product, these are potentially hazardous foods. The manufacturer's guidance for Thick and Easy juices and waters identified an opened shelf life of "Up to 10 days."<br><br>- The initial dietary tour, on 10/24/11 at 11:55 a.m., with a dietary staff member (#3) showed the following in the walk-in cooler:<br>* One opened chocolate Mighty Shake, on a tray with other snacks, with an opened date of 09/23 (31 days prior).<br>* 15 thawed chocolate Mighty Shakes in a case and five on the tray with the opened shake above, all 21 lacked a thaw date.<br>* 11 thawed maple nut Kemps Plus 2, with a thaw date of 09/19 (35 days prior).<br>* 10 thawed root beer Kemps Plus 2, without a thaw date.<br>* Nine facility prepared containers of jello, dated 09/25 (29 days prior).<br>* A tray containing facility prepared containers of pudding, dated 10/07 (24 days prior).<br>* One opened Thick & Easy cranberry juice, without an opened date.<br><br>- The full dietary tour, on 10/26/11 at 10:35 a.m., with a dietary staff member (#3) showed the | F 371 | | |

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| F 371 | Continued From page 26<br>following in the walk in cooler:<br>* 10 thawed maple nut Kemps Plus 2, with a thaw date of 09/19 (37 days prior).<br>* 8 thawed root beer Kemps Plus 2, without a thaw date.<br>At the North Nurses Station:<br>* Thick & Easy lemon water, with an opened date of 08/19 (68 days prior).<br>In the Activity Room refrigerator:<br>* Commercially prepared frosting with an opened date of 08/18/11 (69 days prior). Manufactures guidance on the label stated dispose of unused portion within 30 days.<br><br>An interview, during the full kitchen tour, with the dietary staff member (#3) identified that after the initial kitchen tour, staff could not identify the day they removed the Mighty Shakes from the freezer, so the staff disposed of the product. This same staff member identified the Kemps Plus 2 as good for 14 days from the thaw date and that she was not aware of a shelf life for opened thickened water. During the full dietary tour, this staff member (#3) disposed of the outdated/undated Kemps Plus 2. | F 371 | | |
| F 431 SS=E | 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS<br><br>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.<br><br>Drugs and biologicals used in the facility must be | F 431 | Before the surveyors left, the nurses labeled count sheets for each controlled substance that was not being counted. Together, two of the nurses working, counted these medications and wrote the count on the labeled forms. These forms are in the Medication Administration Record book.<br><br>The nurses will have a meeting on 11/23 to discuss the policy on controlled substances which explains when to count these medications. | 12/1/11 |

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| F 431 | Continued From page 27<br>labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.<br><br>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.<br><br>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, review of facility procedure, and staff interview, the facility failed to maintain accurate reconciliation of controlled drugs dispensed from 1 of 2 nursing stations (East/West nurse's station). Failure to maintain an accurate count of controlled substances does not allow staff to identify missing doses.<br><br>Findings include:<br><br>Review of the facility procedure titled "Controlled | F 431 | The QA coordinator will check each MAR monthly for 6 months to see if these is a count sheet for controlled substances given on a routine basis and for PRN's (as needed basis). The DON will be notified if there are any missing and the findings will be reported to the QA committee monthly.<br><br>Addendum: The QA corrdinator will check each MAR on each end. | 12/01/11 |

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| F 431 | Continued From page 28<br>Substances" occurred on 10/27/11. This policy, last revised January 2009, stated, "Purpose To provide verification and correct count of controlled substances on hand To provide safe storage for controlled substances . . . Procedure 1. One nurse unlocks the controlled substances storage unit and counts controlled drugs, per state regulations, on hand for each resident. 2. The other nurse assists by watching and verifying the count in the individual resident's Medication Administration Record (MAR) . . . or alternate Controlled Substance Record (CSR). . . ."<br><br>On 10/27/11 at 9:10 a.m., review of the East/West medication room took place with a nursing staff member (#1). Observation showed the facility lacked count sheets, either on the MAR or the CSR, for controlled medications kept in the medication carts on the East/West nursing station for two residents receiving controlled medications three times a day.<br><br>A nursing staff member (#2) identified nursing staff do not keep counts of controlled substances administered on a routine basis, only those given on an as needed basis which conflicts with the facility's policy. | F 431 | | |
| F 441 SS=E | 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS<br><br>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.<br><br>(a) Infection Control Program<br>The facility must establish an Infection Control | F 441 | Resident #2, #3, and #12 live on the East/West wing. There are different CNA's that work each wing. So the nurses on the E/W wing will observe each CNA do peri-care on Residents #2, #3 and #12. The nurses have been assigned to observe certain CNA's and will follow the "Focus Audit" on peri-care. | 12/1/11 |

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| F 441 | Continued From page 29<br>Program under which it -<br>(1) Investigates, controls, and prevents infections in the facility;<br>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and<br>(3) Maintains a record of incidents and corrective actions related to infections.<br><br>(b) Preventing Spread of Infection<br>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.<br>(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.<br>(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.<br><br>(c) Linens<br>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, review of facility policy, and staff interview, the facility failed to follow proper infection control procedures for 6 of 7 sampled residents (Resident #2, #3, #4, #10, #12, and #13) observed during peri-cares. Failure to follow infection control procedures related to hand hygiene and soiled washcloths has the | F 441 | REsidents #4, #10 and #13 live on the North Wing. So the nurses on the North Wing will observe each North CNA do pericare on REsidents #4, #10 and #13. These nurses have been assigned to observe certain CNA's and will follow the "Focus Audit" on pericare.<br><br>The CNA's were sent a memo on 10/30/11 on the steps of when to wash their hands when a new pair of gloves is needed and placing soiled clothing in a bag. They will also watch a required on-line inservice entitled, "Safe Food Handling Fundamentals" in the month of November. There is a portion of handwashing in this inservice.<br><br>The nurses will have a meeting on 11/23 to get instruction of the Focus Audit and what to watch for during their observations. The CNA's will have a meeting on 11/25 to get further instruction when to wash hands, when to remove gloves and to protect the environment from cross contamination.<br><br>A list of residents who receive peri-care from the CNA's was made. From this list of residents, the QA coordinator and infection control nurse will each watch 6 CNA's give pericare to 3 residents on this list. This monitoring will be done weekly for 1 month and then monthly for 3 months. | 12/01/11 |

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| | 355093 | A. BUILDING _____ B. WING _____ | 10/27/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| GOOD SAMARITAN SOCIETY - BOTTINEAU | 725 E 10TH ST BOTTINEAU, ND 58318 |

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| F 441 | Continued From page 30<br>potential for the spread of infection to other residents.<br><br>Findings include:<br><br>Review of the facility policy titled "Hand Hygiene and Handwashing" occurred on 10/27/11. This policy, dated 2009, stated, ". . . If hands are not visibly soiled or contaminated with blood or body fluids, use an alcohol-based hand rub for routinely cleaning your hands: . . . After having direct contact with a resident's skin. After having contact with body fluids . . . After touching equipment or furniture near the resident. After removing gloves . . ."<br><br>Review of the facility policy titled "Standard Precautions" occurred on 10/27/11. This policy, dated 2009, stated,<br>"PURPOSE: To prevent the risk of transmission of pathogens from both recognized and unrecognized sources of infection, by following procedures for standard precautions . . .<br>Hand Hygiene: Avoid unnecessary touching of surfaces in close proximity to the resident to prevent contamination of hands or surfaces . . .<br>Gloves: Gloves will be worn when contact with blood or other potentially infectious materials . . . (e.g., of a resident incontinent of stool or urine) could occur . . .<br>Care of the Environment: . . . Clean and disinfect surfaces that are likely to be contaminated with pathogens, including those that are in close proximity to the resident . . ."<br><br>- Observation on 10/24/11 at 5:50 p.m. showed Resident #4 laying on her bed. Two CNAs (#9 | F 441 | | |

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| F 441 | Continued From page 31<br>and #10) applied gloves, removed the resident's wet brief, provided perineal cares, and transferred the resident to a wheelchair. The CNAs removed their gloves and transported Resident #4 to the dining room. The CNAs failed to wash or sanitize their hands at all during this observation.<br><br>- Observation on 10/25/11 at 2:30 p.m. showed Resident #4 laying on her bed. Two CNAs (#6 and #11) applied gloves, checked the resident's brief, and found it dry. The CNAs removed their gloves and transferred the resident to a wheelchair and exited the room without washing or sanitizing their hands.<br><br>- Observation on 10/25/11 at 4:30 p.m. showed two CNAs (#6 and #11) transferred Resident #4 from her wheelchair to bed. The CNAs applied gloves and removed the resident's wet brief. The CNAs provided perineal cares, removed their gloves, and transferred Resident #4 back to her wheelchair. The CNA (#6) failed to wash or sanitize her hands before exiting the room.<br><br>- Observation on 10/26/11 at 11:30 a.m. showed Resident #13 on the toilet. The CNA (#12) applied gloves, removed the resident's soiled brief, and used two wet washcloths to cleanse the resident's perineal area. Observation showed feces on the washcloths. The CNA placed the soiled washcloths on the toilet tank behind the resident. She dried the resident's perineal area with a towel and placed the towel on top of the soiled washcloths. She then applied Resident's #2's clean brief, pulled up her pants, removed her gloves, and assisted the resident to her recliner. The CNA (#12) went back into the bathroom, picked up the bagged garbage and the soiled | F 441 | | |

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| F 441 | Continued From page 32<br>washcloths and towel with her ungloved hands, opened the resident's curtains and adjusted her call light, opened the door to the room, and exited. She entered the soiled utility room across the hall and disposed of the garbage and soiled cloths and stated, "I usually wash in here," and proceeded to wash her hands. The CNA (#12) failed to wash her hands when she removed her gloves and before touching items in the resident's room, and failed to cleanse the toilet tank when she removed the soiled cloths from the tank.<br><br>- Observation on 10/26/11 at 11:35 a.m. showed two CNAs (#12 and #13) assisted Resident #10 to the bathroom, pulled down her pants and wet brief, gave the resident the call light, and exited the room. Both CNAs failed to apply gloves before they assisted the resident and the CNA (#12) failed to wash or sanitized her hands before she exited the room.<br><br>During an interview on the morning of 10/27/11, an administrative nurse (#8) stated she expected facility staff to wash or sanitized their hands after assisting residents with cares.<br><br>- Observation of care for Resident #3 occurred on 10/25/11 at 9:11 a.m. Two CNAs (#12 and #16) transferred Resident #3 to bed for incontinence care. A CNA (#12) wearing gloves, provided pericare for Resident #3 using disposable wipes, cleansing with her right hand and holding Resident #3 on her side with her left. After cleansing the stool from Resident #3's buttocks, the CNA (#12) grasped the tube of cleanser with her right hand, squeezed a quantity of product onto a disposable wipe, and cleansed Resident #3 with this product. The CNA (#12) then | F 441 | | |

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| F 441 | Continued From page 33<br>cleansed Resident #3 again using a plain wipe. The CNA (#12) lowered the resident onto her back, wearing the same gloves, and cleansed Resident #3's frontal periarea. The CNA (#12) then dressed the resident. Still wearing the same gloves, the CNA (#12) opened the top drawer of the resident's bed side stand, placed the cleanser product in the drawer, closed the door, then removed her gloves.<br><br>- Observation of care for Resident #2 occurred on 10/25/11 at 3:20 p.m. A CNA (#15) assisted the resident with toileting. The CNA (#15) provided pericares for Resident #2 following an incident of bowel incontinence. The CNA (#15) first used disposable wipes, then cleansed Resident #2 with a soapy washcloth, followed by a wet washcloth, and dried with a towel. After using each, the CNA (#15) let them fall to the floor. The CNA (#15) gathered the wash clothes up with the towel and placed the bundle under her arm, holding the soiled linen to her clothing, keeping her hands free to tie the garbage bag. The CNA (#15) gathered the closed garbage bag and the soiled linen, and then carried both down and across the hall to the soiled utility room.<br><br>- Observation of care for Resident #12 occurred on 10/26/11 at 4:10 p.m. The CNA (#19), wearing gloves, placed a clean brief, and assisted the resident to dress. Without removing the gloves, the CNA (#19) assisted another CNA (#20) to transfer Resident #12 to his wheelchair using a full body mechanical lift. The CNA (#19) then went in the resident's dresser drawer for a new pair of socks, put on the resident's shoes, went into the bathroom and obtained a wash cloth from a cupboard, wet the cloth and washed the | F 441 | | |

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| F 441 | Continued From page 34<br>resident's face, placed the resident's nasal cannula, and positioned the resident's flaccid arm on a support. At this point, the CNA (#19) removed her gloves. The CNA (#19) removed the soiled linen and garbage to the soiled utility room where she washed her hands. During an interview at the end of the care observation, the CNA (#19) stated she wore the same gloves throughout the entire care provided.<br><br>During an interview, on 10/27/11 at 10:40 a.m., an administrative nursing staff member (#1) indicated staff are not to hold soiled linen next to their clothes and she would expect staff to remove gloves used for pericare prior to continuing other resident care. | F 441 | | |