STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355046	A. BUILDING _____ B. WING _____	C 02/04/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN ACRES MANOR	1 E MAIN ST CARRINGTON, ND 58421

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification and complaint survey, started on 02/02/10 and completed on 02/04/10, the sample included 4 residents for complete review, 9 residents for focused review, and 2 closed records for review.	F 000	1. Resident #1 will have splint applied as ordered. Left hand splint off at HS, left hand splint on am then on 2 hrs, off 2 hrs while awake until HS. With a visual reminder and schedule placed in resident room. *See attachment C.	
F 318 SS=D	483.25(e)(2) RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview, and family interview, the facility failed to ensure that residents with limited range of motion received appropriate treatment and services to prevent further decline for 1 of 1 sampled resident (Resident #1) who required a positioning device to prevent further decline of affected extremities. Findings include: - Review of Resident #1's medical record occurred all days of survey. Diagnoses included, cerebral vascular accident-middle cerebral accident with left hemiparalysis (CVA-MCA), depression, dysphagia, and history (hx) of trans-ischemic accidents (TIA's). A transfer form dated, 11/24/09, identifies use of a left hand splint with instructions which stated; ". . . L. [left] hand splint off @ [at] hs [hour of sleep], L hand splint	F 318	2. Any resident with specific orders regarding splint application have the potential to be affected by this practice. 3. Nursing staff will be in serviced 2/24/10. To prevent the possibility of decline in ROM a schedule will be posted in resident room with specific instructions as to when it is to be applied. Any resident who has an order for splint placement that is to be removed at different times other thank, on am, off pm will have individualized schedules posted in their rooms as a visual reminder to nursing staff of splint usage. If schedule needs to be altered for any reason nurse must be notified and documentation completed. 4. Restorative aide will monitor placement of splints that are to be removed at different times. This practice will be monitored two times a day per week for four weeks, two	

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

Administrator 2-24-10

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 318	Continued From page 1 on in a.m. then on 2 hrs [hours], off 2 hrs. w/a [while awake] until hs." Review of Resident #1's care plan identified the problem of "Decreased mobility, potential for falls related to recent CVA with left hemiparesis, original date of 12/01/09. Goals: . . . She will not develop contractures . . ., Approaches included: Dependent for transfers via a Hoyer lift and two person assist. . . . (L) [left] hand splint - refer to family's request for schedule to wear." - Observations on 02/02/10 through out the morning, showed Resident #1 either in bed, up in her wheelchair, or at the dining room table and not wearing her left arm splint. During an interview on 02/02/10 at 6:30 p.m., a family member (#1) stated staff were not applying Resident #1's arm splint routinely and she was concerned that it would affect Resident #1's arm in a negative way. - Observation on 02/03/10 at 8:00 a.m. and 8:50 a.m., showed Resident #1 lying in bed without her left arm splint in place; her arm resting on her abdomen. At 11:00 a.m., certified nursing assistant (CNA #6) applied Resident #1's left arm splint while she sat in her wheelchair. CNA (#6) stated; "She only has it on when she's up." Observation at 2:00 p.m. showed Resident #1 sitting in her chair with the splint off and arm supported with a pillow. During an interview on 02/03/10 at 2:00 p.m., two therapy staff members (#8 & #7) stated nurse aides are responsible for the application of Resident #1's splint.	F 318	times a day per month per one quarter, and two times a day per quarter for one year. Results will be reported to QA Committee. 5. ~~3/3/10~~ 3/1/10 per T.C. & DON JJ	

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F 318	Continued From page 2 - Observation on 02/04/10 at 10:10 a.m., showed Resident #1 sitting in her wheelchair with the arm splint resting in her lap, padded side down, and her arm rested on the splint, with no straps applied. Review of physician's orders identified the following: * 11/09/09, "L. hand splint on q [every] am, 2 hrs. on 2 hrs. off, w/a. L. hand splint off @ hs per family request." * 12/07/09, "Please refer to families request for splint schedule. . . ." Signage posted in Resident #1's room stated: * "Please do not put splint on at all during night. * Please do not put it on too tight. It makes her hand swell & [and] hurt. * Please put splint on only during daytime hours. 2 hours on-no longer than 2 hours on, otherwise her arm turns blue & swells & hurts, if left on longer than 2 hours. * Also remember to put brace on loose." Interviews, on 02/03/10, with nursing staff members (#3 & #4) verified Resident #1 was not on a schedule for splint placement and removal and the CNAs did not document when the splint was on and off. The facility failed to follow physician orders for Resident #1 in regards to applying her arm splint, which increases the possibility of further decline occurring to the affected extremity.	F 318		
F 356 SS=C	483.30(e) NURSE STAFFING The facility must post the following information on a daily basis: o Facility name.	F 356		

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F 356	Continued From page 3 o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to post the actual hours worked by licensed and unlicensed staff directly responsible for resident care during 3 of 3 days of survey; and failed to maintain the posted data for 2 of 2 months of staffing data requested for review. Findings include:	F 356	1. No resident was affected by this practice. 2. Residents do not have the potential to be affected by this. 3. Nursing staff will be in serviced 2/24/10. The facility will post nurse staffing data in a prominent place on a daily basis. This will include but is not limited to: Facility name, Resident census, Current date, total number and the actual hours worked by the following categories of licensed and non-licensed nursing staff directly responsible for resident care per shift: -Registered Nurses -Licensed Practical Nurses -Medication Aides -Certified nursing assistant This data will be maintained for a minimum of 18 months and will be available upon request. This will be accomplished by a form being completed by the night nurse on a daily basis and be updated every shift as needed.	

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F 356	Continued From page 4 Observations on all days of survey (February 02-04, 2010) identified staffing data posted near the Central Station failed to include the actual hours worked by licensed and unlicensed staff providing direct resident care. The posting included hours worked by registered nurses not directly responsible for resident care, such as the director of nursing, infection control nurse, and Minimum Data Set coordinator. On 02/03/10 at 2 p.m., when asked to provide the last two months of posted hours, an administrative nurse (#2) stated, "We don't keep those." The nurse further stated she would follow-up and determine if the facility had the data. When interviewed, on 02/03/04 at 3:30 p.m., three administrative staff members (#1, #2, and #11) verified they did not maintain the data as required.	F 356	The actual hours worked will be tabulated by the Director of Nurses or designees on the following day and be kept in a binder in the DON's office for at least 18 months. *See attachment D 4. QA will be monitored weekly for one monthy, monthly for one quarter, and quarterly for one year to ensure accuracy and timeliness of the form completion by the Quality Assurance Coordinator. Results will be reported to the Quality Assurance Committee. 5. 3/1/10	
F 371 SS=D	483.35(i) SANITARY CONDITIONS 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, professional literature review, and staff	F 371		

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F 371	Continued From page 5 interview, the facility failed to store, prepare, and serve food in a safe and sanitary manner in 1 of 1 kitchen and 1 of 1 nourishment center. Failure to follow safe food sanitation practices has the potential to result in food borne illness and can affect all residents who consume food stored in these areas. Findings included: The facility's policy titled, "Food Handling," stated, ". . . 2. Food is stored in a sanitary manner, protecting it form [sic] contamination. . . . 7. Food preparation equipment . . . surfaces are effectively sanitized to destroy potential disease carrying organisms. . . ." The facility's policy titled, "Food Storage," stated, ". . . Freezer . . . 3. All foods not stored in original packaging must be securely wrapped or in plastic container. . . . Refrigerator and walk-in cooler . . . 5. All foods should be covered and stored off the floor. . . . 6. . . . Foods stored in original containers must be dated upon opening. 7. Raw meats will be thawed on pans . . . to avoid contamination from dripping and spills. . . ." The facility's policy titled, "Food Preparation," stated, ". . . Cooking temperatures for specified foods: . . . 2. Meats 165 degrees or above. . . ." The 2005 Food Code, published by the Food and Drug Administration (FDA), page 62, stated, ". . . (1) Separating raw animal foods during storage . . . from . . . (b) Cooked ready-to-eat foods; . . ." - An initial tour of the facility's kitchen occurred on 02/02/10 at 5:43 a.m. Observation showed the following in the walk-in cooler:	F 371	1. Proper food storage and sanitary practices will be provided within food service operations to protect all residents from food borne illness. 2. All residents dining at this facility have the potential to be affected by improper food storage and sanitary practices. 3. The current policies relating to food service operations will be provided to and reviewed with all dietary staff at an in-service on March 3, 2010. Additionally, the nursing staff involved with use of ice packs used in treatments will be educated to proper storage of ice packs stored in nourishment center freezer at nurses meeting on 2/24/10. *See attachment A 4. All dietary staff will be responsible to monitor for unsanitary conditions, and verbally report any unsafe findings to the dietary manager for immediate corrective action. The dietary manager will do weekly inspections of identified	

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F 371	Continued From page 6 *Two and one half rolls of thawing raw ground beef stored on the same tray as one ham, labeled "fully cooked". *One approximate three gallon pot of uncooked, peeled, cut up potatoes stored on the floor. Interview with a dietary staff member (#10) occurred during the initial dietary tour. The staff member stated, "Probably not" when asked if the raw ground beef should be stored on a tray with a fully cooked ham. The dietary staff member placed the ham on another pan. Observation of a reach-in cooler during the initial dietary tour showed: *Two uncovered whole lemon meringue pies and one and one eighth, uncovered pumpkin pies stored on a shelf below other food/drink items. *Two opened undated 64 fluid ounce bottles of thickened apple juice. The manufacturer's label for the apple juice stated, "Refrigerate after opening. Discard if not used within 5 days." *One baked potato, uncovered, set directly on another container of leftover food. When interviewed on 02/03/10 at 2:30 p.m., an administrative dietary staff member (#9) stated, ". . . pies should be covered. . . and. . . potato should be in a container. . ." The main dietary tour occurred on 02/03/10 at 2:37 p.m. Observation showed the following: *A scoop stored inside a container of Benefiber [a powdered fiber enhancement]. An administrative dietary staff member (#9) agreed scoops should not be stored within the dry food product. Hand contact with the handle of the scoop may result in contamination of the food product. *A small mixer soiled with dried food debris beneath the head of the mixer, where dietary staff	F 371	deficient practices to assure that proper sanitary practices are followed for a one month time frame, monthly for three months, and quarterly thereafter for one year. If concerns are indentified, action will be implemented to correct deficient practices. The dietary manager will submit each report of the monitoring results to the QA Committee at scheduled meetings. *See attachment B 5. Date of correction 3/3/2010.	

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F 371	Continued From page 7 members connect mixing attachments. When interviewed during the main dietary tour, an administrative dietary staff member (#9) stated, "Mixer should be cleaned after each use." Observation of the nourishment center during the main dietary tour showed seven ice cream cups and one box of ice cream bars stored in a freezer with four ice packs used for resident treatments. During an interview on 02/03/10 at 2:30 p.m., an administrative dietary staff member (#9) stated, "We [dietary] don't store food in that freezer. The residents sometimes do."	F 371	1. The suction machine was fixed immediately upon notification of malfunction. 2. Any resident with swallowing difficulties has the potential to be affected by this. 3. Nursing staff will be in serviced on 2/24/10. The facility will maintain resident care equipment safe operating condition by implementation of a suction machine check list. The machine will be checked daily by nursing staff to ensure the equipment is in safe operating condition. *See attachment E 4. Director of Nursing will monitor suction machine checklist and suction machine safety weekly for one month, monthly for one quarter and quarterly for one year. Results will be reported to the quality assurance committee. 5. 3/1/10	
F 456 SS=D	483.70(c)(2) SPACE AND EQUIPMENT The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain resident care equipment in a safe, operating condition for 1 of 2 suction machines. Findings include: During review of the medication room on 02/03/10 at 2:25 p.m., a licensed nurse (#4) indicated staff store the suction machine at the nurses' station. Observation identified the suction machine on a stand in the corner of the nurses' station, covered with a cloth. When the nurse removed the covering and began assembling the equipment, she was unable to connect the filter to the machine. Observation showed a piece of plastic broken off in the outlet preventing connection of	F 456		

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F 456	Continued From page 8 the clean filter. When asked, the nurse stated whoever used it last did not report the non-functioning suction machine to maintenance for repair. The nurse immediately called maintenance and took the machine for repairs. The resident sample included residents with swallowing difficulties who have the potential to require emergency suctioning. The facility's failure to maintain resident care equipment in a safe, operating condition puts residents at risk for aspiration in an emergency situation.	F 456		
F9999	FINAL OBSERVATIONS Based on record review and staff interview, the complaint investigated in conjunction with the standard Medicare/Medicaid survey was not substantiated.	F9999		