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	355046	A. BUILDING _____ B. WING _____	02/19/2015

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 survey started on February 17, 2015 and completed on February 19, 2015, the sample included four (4) residents for complete review, nine (9) residents for focused review, and two (2) closed records for review.	F 000	F 314 Pressure Ulcer Care Plan 1. Resident #1 will have two cushions and care plan followed by placing cushion under her at all times when up in chair. 2. Any resident that is care planned for a cushion in their chair has the potential to be affected by this practice. 3. Nurses and CNA's will be reeducated on cushion placement and the importance of following the plan of care for cushion placement. 4. QA coordinator and committee will monitor cushion placement and following care plan weekly times one month, monthly times one quarter, and quarterly times one year. Results will be reported to QA committee at weekly QA meetings. 5. March 20, 2015	
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 03/05/14. Based on observation, record review, professional reference, and staff interview, the facility failed to provide the necessary care and services to promote healing of pressure ulcers for 1 of 2 sampled residents (Resident #1) with a current pressure ulcer. Failure to provide a pressure relieving device for Resident #1's wheelchair and recliner may have contributed to a delay in the healing of Resident #1's pressure ulcer. Findings include:	F 314		

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

Administrator 3-6-15

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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Review of "Prevention of Pressure Ulcers: Quick Reference Guide," National Pressure Ulcer Advisory Panel, Washington, D.C., 2009, stated on page 18, ". . . 4.3 Limit the time an individual spends seated in a chair without pressure relief. . . ."

Review of Resident #1's medical record occurred on February 17-19, 2015. The resident's diagnoses included fracture of pubis closed, fracture of sacrum/coccyx closed, and rheumatoid arthritis. The facility admitted Resident #1 on 01/22/15. The admission Minimum Data Set (MDS), dated 01/29/15, identified Resident #1 as cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15. This MDS identified Resident #1 required extensive assistance of two persons for bed mobility/transfers, occasionally incontinent, and having one unhealed Stage 3 pressure ulcer.

The facility's "Wound Assessment Reports" identified a pressure ulcer on Resident #1's sacrum/inner coccyx. These reports showed the following:
*01/22/15 - 3 cm [centimeters] x 2 cm x 0.10 cm - small serous drainage, epithelial tissue 10%, granulation tissue 15%, slough tissue 75% (wound bed).
*01/28/15 - 3 cm x 2 cm x 0.10 cm - no change in wound bed.
*02/04/15 - 2.5 cm x 1.4 cm x 0.10 cm - epithelial tissue 25%, granulation tissue 25%, slough 50% wound bed.
*02/10/15 - 2.5 cm x 1.5 cm x 0.10 cm - no change in wound bed.
*02/17/15 - 2.6 cm x 1.4 cm x 0.10 cm - no change wound bed; however, the assessment

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stated, ". . . noted to have improved wound bed with increased granulation tissue present. Continues to have yellow wound bed [slough] to center."

These assessment reports identified the treatments for Resident #1's pressure ulcer as follows:
*01/24/15 - "TBC [generic for Granulex a blood flow stimulating spray] two times a day to coccyx until healed.
*02/10/15 - "Calmoseptine [barrier cream] two times a day to coccyx until healed."
*02/16/15 - "Ostomy [moisture absorbing] powder and calmoseptine two times a day to coccyx until healed."

A resident interview occurred on 02/17/15 from 4:40 p.m. to 5:10 p.m. in Resident #1's room with her seated in a recliner. Observation showed no pressure relieving cushion in the recliner. Resident #1 stated having no cushion is uncomfortable at times and she asked facility staff why they could not provide two cushions [one for her wheelchair and one for her recliner].

Resident #1's care plan identified ". . . Potential for impaired skin integrity related to 2 current pressure ulcers, decreased mobility, and incontinence. One unstageable ulcer to bottom of left heel and one stage 3 pressure ulcer to sacrum . . . skin care cushion to wheelchair . . ."

Observation showed and interviews with a physical therapist (#4) on 02/18/15 at 10:55 a.m., a certified nursing assistant (#5) on 02/19/15 at 6:55 p.m., and a restorative therapy assistant (#6) on 02/19/15 at 8:45 a.m. confirmed Resident #1 was without a pressure-relieving cushion on:

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F 314	Continued From page 3 *02/17/15, 4:40 p.m. - 5:55 p.m. - recliner *02/18/15, 10:15 a.m. - 10:55 a.m. - recliner *02/18/15, 4:45 p.m. - 6:55 p.m. - wheelchair *02/19/15, 8:00 a.m. - 8:45 a.m. - wheelchair During an interview on 02/19/15 at 11:15 a.m., a restorative nurse (#8) stated Resident #1 goes from wheelchair to recliner and staff are supposed to switch the cushion back and forth because the cushion is comfortable and the resident liked it. Failure to ensure a pressure relieving device is utilized in Resident #1's wheelchair and recliner may have resulted in delayed healing of her pressure ulcer and placed her at risk for the development of additional pressure ulcers.	F 314	F 327 Hydration 1. Resident # 2 will be offered water after cares or during any nursing and CNA interaction. 2. All residents who have the potential for dehydration and are unable to drink themselves have the potential to be affected by this practice. 3. Nurses and CNA's will be reeducated on the updated hydration policy of offering fluids after interacting with resident or any resident cares. (Policy Offering Drinking Water (Hydration) attached) 4. QA coordinator and committee will monitor water being offered after cares or during interactions weekly times one month, monthly times one quarter, and quarterly times one year. Results will be reported to QA committee at weekly QA meetings. 5. March 20, 2015	
F 327 SS=D	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to provide fluids during cares and observation of meals for 1 of 5 sampled residents (Resident #2) who required supervision with eating and hydration. Failure to offer fluids placed Resident #2 at risk for dehydration, urinary tract infections, and constipation. Findings include:	F 327		

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Review of Resident #2's medical record occurred on February 17-19, 2015. The resident's diagnoses included Alzheimer's dementia and hypopotassemia. The current quarterly Minimum Data Set (MDS), dated 01/18/15, identified Resident #2 with severely impaired cognition, and requiring supervision of one person with eating.

A dietary note, dated 01/16/15, stated, ". . . Meal intake varies inconsistently . . . needing assistance and supervision for dining . . ."

Resident #2's current comprehensive nutrition assessment, dated 01/16/15, lacked an assessment of the resident's estimated fluid needs.

Resident #2's care plan, dated 01/22/15, stated, ". . . Potential for impaired nutritional [status] related to confusional state . . . Setup and supervision to limited assist with dining . . . Potential for dehydration related to confusional state . . . Encourage, provide, and assist to consume adequate fluids . . . "

During the breakfast meal on 02/17/15, a certified nursing assistant (CNA) (#3) seated at the table with Resident #2 confirmed the resident required supervision with meals.

Observation of meal intake and interview of a dietary staff member (#10) on 02/19/15 at 9:15 a.m. identified fluid intake with meals in cubic centimeters (cc):
*02/18/15 - Breakfast Meal - 90 cc of 420 cc offered.
*02/18/15 - Noon Meal - 300 cc of 420 offered.
*02/19/15 - Breakfast Meal - 300 cc of 420 cc offered.

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F 327	Continued From page 5 This revealed a meal intake of fluids that equaled 690 cc of 1260 cc offered. Observation of Resident #2's personal cares showed: *02/17/15 at 4:40 p.m., 02/18/15 at 9:30 a.m., and 02/18/15 at 1:35 p.m. - no water offered. *02/18/15 at 2:30 - 3:15 p.m. - Resident #2 seated in the front lobby - no water offered. (The facility provides a coffee break daily at 3:00 p.m. Resident #2 did not attend the coffee break.) *02/18/15, 3:15 p.m. and 3:50 p.m. - Resident #2 remained in the front lobby and refused personal cares - no water offered. During an interview on 02/19/15 at 10:55 a.m., an administrative nursing staff member (#1) confirmed CNAs should offer residents fluids during personal cares if they are not able to obtain fluids themselves. Failure to offer fluids at all opportunities placed Resident #2 at risk for dehydration and does not allow her to achieve her highest practicable well-being.	F 327		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections	F 441	F 441 Infection Control 1. Hand Washing will be done using soap and water after contact with resident's mucous membranes and body fluids or excretions at all times after glove removal. 2. All residents who are assisted by staff have the potential to be affected by this practice. 3. Nurses and CNA's will be reeducated on the hand washing procedure with emphasis on washing hands after glove removal as well as when to use soap and water or alcohol rubs. 4. QA coordinator and committee will monitor hand washing procedure focusing on glove removal and placement weekly times one month, monthly times one quarter, and quarterly times one year. Results will be reported to QA committee at weekly QA meetings. 5. March 20, 2015	

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F 441	Continued From page 6 in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to follow standard infection control practices for 5 of 11 sampled residents (Resident #2, #6, #7, #9, and #11) observed during toileting cares. Failure to follow infection control practices related to hand hygiene has the potential to cause or spread infection within the facility. Findings include:	F 441		

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Review of the facility policy titled "Handwashing/Hand Hygiene" occurred on 02/19/15. This policy, dated 09/30/11, stated, ". . . All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors . . . Employees must wash their hands . . . using antimicrobial or non-antimicrobial soap and water under the following conditions . . . after contact with a resident's mucous membranes and body fluids or excretions . . . the use of gloves does not replace handwashing/hand hygiene . . ."

Review of the facility policy titled "Perineal Care" occurred on 02/19/15. This policy, dated 07/25/11, stated, " . . . Remove gloves and discard into designated container. Wash and dry your hands thoroughly . . ."

- Observation of care for Resident #7 occurred on 02/17/15 at 3:58 p.m. A CNA (#2) assisted the resident onto a bedpan. The resident voided and had a bowel movement. The CNA (#2), wearing gloves, removed the bedpan to the bathroom, returned to the resident and provided perineal care, and then removed her gloves. The CNA (#2) failed to complete hand hygiene after removing the gloves. The CNA (#2) then dressed the resident, manipulated two wigs and the head form they were stored on, placed the resident's hearing aid, used a walkie talkie to call another CNA (#3), brought the resident's mirror to her, applied a gait belt, and with assistance from the other CNA (#3) transferred the resident to her wheelchair. After transferring Resident #7 to her wheelchair, the CNA (#7) entered the bathroom donned gloves and rinsed out the bedpan. After wiping the water from the bedpan, the CNA (#2)

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stored the bedpan, removed her gloves, and washed her hands.

- Observation of care for Resident #6 occurred on 02/17/15 at 4:27 p.m. A CNA (#2) wore gloves to assist the resident with toileting, perineal care after voiding, and transferred her to an electric wheelchair. The CNA (#2) then removed the gloves. Without performing hand hygiene, the CNA (#2) assisted the resident to transfer to her recliner with the aid of a gait belt, manipulated the controls of the electric wheelchair, gave the resident her mirror and hair brush, and moved the resident's over bed table. The CNA (#2) then washed her hands.

The CNA (#2) failed to perform hand hygiene after completing perineal care prior to performing other tasks for Resident #6 and #7.

- Observation on 02/18/15 at 10:20 a.m. showed two CNAs (#14 and #15) provided toileting cares to Resident #9. The CNA (#14) donned gloves and cleansed the rectal area of a small, soft bowel movement. The CNAs (#14 and #15) then assisted Resident #9 to stand and pivot transfer to the wheelchair. Both CNAs removed their gloves after Resident #9 was seated in the wheelchair. One CNA (#14) adjusted the resident's clothing, wheeled her to the bedside, and assisted the other CNA (#15) to stand and pivot transfer Resident #9 to her bed. The CNA (#14) then performed hand hygiene with an alcohol-based hand rub. This CNA (#14) failed to perform hand hygiene after completing perineal care, prior to performing other tasks.

- Observation on 02/18/15 at 9:30 a.m. showed a CNA (#14) provided perineal care for Resident #2

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F 441	Continued From page 9 after the resident voided. After completing perineal care for Resident #2, the CNA (#14) removed her gloves, applied a tab alarm, removed a gait belt, applied foot pedals, then performed hand hygiene. The CNA (#14) failed to perform hand hygiene after completing perineal care, prior to performing other tasks. - Observation on 02/19/15 at 09:15 a.m. showed a CNA (#9) provided perineal care to Resident #11 after an incontinent bowel movement (BM). The CNA donned gloves and cleansed the rectal area with visible BM on the wipe. After completing perineal care, the CNA (#9) removed her gloves and used the EZ stand lift, to assist Resident #11 into the wheelchair. The CNA (#9) removed the sling from behind the resident's back, applied the leg rests to the wheelchair, adjusted Resident #11's clothing, and then performed hand hygiene. The CNA (#9) failed to perform hand hygiene after completing perineal care, prior to performing other tasks. During an interview on 02/19/15 at 11:55 a.m., an administrative nurse (#1) confirmed staff are expected to perform hand hygiene after removing gloves before doing other tasks.	F 441		