| 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 _____ | 02/27/2019 |

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

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| F 000 | INITIAL COMMENTS<br><br>The standard Medicare/Medicaid recertification started on 02/25/19 and concluded on 02/27/19. | F 000 | | |
| F 657 SS=D | Care Plan Timing and Revision<br>CFR(s): 483.21(b)(2)(i)-(iii)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(2) A comprehensive care plan must be-<br>(i) Developed within 7 days after completion of the comprehensive assessment.<br>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--<br>(A) The attending physician.<br>(B) A registered nurse with responsibility for the resident.<br>(C) A nurse aide with responsibility for the resident.<br>(D) A member of food and nutrition services staff.<br>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.<br>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.<br>(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, review of facility policy, and staff interview, the facility failed to ensure staff reviewed and revised the comprehensive | F 657 | 1. On 2/27/2019 the care plan for resident #42 was updated to include removal of no tub baths, surgical site | 3/26/19 |

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

Electronically Signed | 03/20/2019

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 657 | Continued From page 1<br>care plan to reflect the resident's current condition for 1 of 15 sampled residents (Resident #42). Failure to revise the care plan to reflect the residents' current condition limited the staff's ability to communicate needs and ensure continuity of care for residents.<br><br>Findings include:<br><br>Review of the facility's policy titled "Careplan Policy and Procedures" occurred on 02/27/19. This undated policy stated, "To develop a comprehensive careplan . . . to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. . . . The careplan will be periodically reviewed and revised by a team of qualified persons after each assessment and also as the resident's condition changes. . . ."<br><br>Review of Resident #42's medical record occurred on all days of survey. The current care plan stated, "No tub bath 12/24/18 . . . May shower, keep incision covered 12/24/18 . . . 12/24/18 PT [physical therapy] as outlined . . . 12/24/18 Surgical Site (R) [right] hip . . . 12/24/18 treatment as outlined (see ETAR) [electronic treatment administration record] . . ." Physician's orders stated, "Change occlusive dressing to right hip incision . . . Discontinue Date: 1/07/19 . . . Monitor right hip incision twice daily until healed. Discontinue Date: 1/22/19 . . . Physical Therapy to see 5 days week x 12 weeks for therapeutic exercise, therapeutic activities, gait/transfer/balance training. Stop Date: 2/14/19 . . . May shower, cover incision with water proof dressing. No tub bath until directed. Discontinue Date: 2/14/19 . . ." | F 657 | monitoring, and Physical Therapy.<br><br>2. All residents having a change in condition have the potential to be affected by this practice.<br><br>3. The policy Reviewing and Revising the Care Plan has been reviewed. The interdisciplinary team and Nurses attended as in-service training to include a review of this policy presented by the MDS Coordinator on March 26,2019.<br><br>4. Resident Care Coordinator or designee will review Care Plans two times per week for two weeks for residents experiencing a change of status (nurse notified, physicians orders, and QA changes) to assure changes have been made to the care plan. Then DON or designee will review CP weekly times one month to assure review and revisions of care plans. Results will be reviewed by the Risk Management/Quality Assurance Committee until such time substantial compliance has been achieved as determined by the committee. | |

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| F 657 | Continued From page 2<br><br>Resident 42's care plan failed to reflect her current condition.<br><br>During an interview on the morning of 02/27/19, an administrative nurse (#2) confirmed staff failed to update Resident #42 care plan. | F 657 | | |
| F 689 SS=D | Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, professional reference review and staff interview, the facility failed to ensure staff were educated on and utilized adequate securement devices to prevent accidents during transportation in the facility van for 1 of 1 sampled resident (Resident #47). Failure to properly secure Resident #47's electric mobility scooter in the facility's van resulted in an accident with the potential for serious resident injury.<br><br>Findings include:<br><br>Resident #47's current care plan identified, ". . . Impaired mobility with potential for falls . . . Contracture's to bilateral hands, bilateral ankles and left foot. Non-ambulatory. . . . " A Quarterly Minimum Data Set (MDS) dated 01/26/19 | F 689 | 1. Resident #47 will not be transported via facility van until employees/departments approved to transfer residents in the facility vehicles have been educated and trained in the correct procedures to secure a resident for transport.<br><br>2. All residents being transported via facility vehicle have the potential of being affected by this practice.<br><br>3. A new Resident Safe Transport Policy has been implemented. The following employees/departments who are designated and approved to transfer residents in the facility vehicles and will be educated and trained by the | 3/26/19 |

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| F 689 | Continued From page 3<br>identified uses manual or electric wheelchair for mobility, transferred with supervision, locomotion on and off the unit with supervision, and range of motion impairment on both sides upper and lower.<br><br>A nurse's note, dated 02/11/19, stated, ". . . [Resident #47] was found on the floor of the facility van when she arrived from her dental appointment. Her scooter tipped over and the [Resident #47] is lying on her back without hitting her head and it was towards the van door. The scooter tipped over her side [sic]. . . ."<br><br>Review of the facility's incident report, dated 02/11/19, stated , ". . . a maintenance staff member reports . . . he made no attempts to use the ratchet secures or seatbelt to secure the [Resident #47] for transport . . . turning a corner returning to the facility, the electric scooter tipped toward the front of the vehicle and the resident slid off the scooter landing on the van floor. . ." Resident #47 did not sustain injuries related to the fall.<br><br>During an interview on 02/27/19 at 9:14 a.m., a maintenance staff member (#6) stated, "Yes I did transport Resident #47 in the facility van on 02/11/19 while she was seated on her scooter." "No I did not strap in her or the scooter." The staff member (#6) indicated he had not received education regarding securing Resident #47 on her scooter in the van for transport. Staff member (#6) stated, "We are no longer transporting Resident #47 in the van on her scooter, she must be in a wheelchair." | F 689 | Compliance Coordinator and the Restorative Nurse or designee on March 26, 2019 in the correct procedures to secure a resident for transport:<br>a. Nurses<br>b. Certified Nursing Assistants<br>c. Maintenance<br>d. Activities (except Clergy)<br>e. Restorative<br>f. Administrator<br>g. Ward Clerk<br><br>4. Restorative Nurse will Monitor the safety of transfers by the facility vehicle weekly times four-week, monthly times one quarter, and quarterly times three. Results will be reviewed by the Risk Management/Quality Assurance Committee until such time substantial compliance has been achieved as determined by the committee. | |
| F 697 SS=D | Pain Management<br>CFR(s): 483.25(k) | F 697 | | 3/26/19 |

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| F 697 | Continued From page 4<br><br>§483.25(k) Pain Management.<br>The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, review of facility policy, and staff interview, the facility failed to provide treatment and services in a manner to maintain the highest practicable physical well-being for 2 of 5 sampled residents (Resident #47 and #55) verbalizing pain. Failure of staff to report, document, and act on the resident's pain placed the residents at risk for continued pain and worsening health conditions.<br><br>Findings include:<br><br>Review of the facility policy, titled "Standing Orders" occurred on 02/26/19. This policy, dated 02/18/19, stated. ". . . Moist heat or K-pad applied up to three times per day as needed 15-20 minutes for muscle discomfort up to 5 days, then notify MD [medical doctor] if needed longer. . . ."<br><br>- Review of Resident #47's medical record occurred on all days of survey. Diagnoses included, polyneuropathy (damage to peripheral nerves), chronic pain, osteoarthritis, osteoporosis, poliomyelitis (a disease that affects the central nervous system), and low back pain. The Quarterly Minimum Data Set (MDS), dated 01/26/19, identified frequent, moderate pain | F 697 | 1. Resident #47 pain management has been reviewed by Resident Care Coordinator and with resident Consultation, the physician was informed of resident wishes. Non-pharmacological interventions will also be offered prior to use of pharmaceutical interventions.<br><br>Resident #55 Non-pharmacological interventions will be offered prior to administration of pharmacological interventions.<br><br>2. All residents identified as being at risk for pain have the potential to be affected by this practice.<br><br>3. A new Pain Management Policy has been implemented.<br>A special requirement will be added to all PRN pain medication orders to require the documentation of all non-pharmacological interventions offered prior to administrating a pain medication.<br><br>All licensed nurses will be in serviced on this policy and the special requirement added to the PRN pain medication | |

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| F 697 | Continued From page 5<br>present that limited daily activities and made it hard to sleep. Pain medications included Fentanyl 100 mcg (microgram)/hr (hour) patch, 1 patch transdermally every three days, Oxycodone HCL 5 mg (milligrams) 1 tablet every 4 hours as needed (PRN) pain, Aleve 220 mg 1 tablet every 12 hr, Gabapentin 100 mg 1 tablet three times every day and Cymbalta 60 mg 1 capsule every day.<br><br>Review of Resident #47's medication administration record (MAR), showed the nursing staff administered 91 doses of PRN Oxycodone January 1-31, 2019 and 75 doses February 1-26, 2019. Review of the nurses' documentation regarding the reason for PRN Oxycodone administration showed, ". . . rated pain 10/10 . . . still the dull pain on my back that goes for ever . . 10/10 achy pain in lower back . . . back pain . . . 10/10 low back pain, sharp in nature . . . back and left hand . . . pain is sharp . . . 10/10 . . . Resident asked for a pain pill for her back, dull pain, 10/10 It is always the same, 5:00 AM I woke up in pain. Resident moaning and facial grimacing . . . complains of left leg pain teary eyed. This leg never hurts me. . . ."<br><br>The current care plan stated, ". . . Alteration in comfort, chronic pain related to past history of polio with degenerative arthritis and osteoporosis, plantar fascitits, upper/lower back pain. Polyneuropathy . . . K-pad (hot water pad) as needed in bed-chart if used during your shift . . . report increased pain trend to physician, Attempt non-pharmacological pain relief measures such as repositioning, back rubs. Document effectiveness. . . ." | F 697 | administration on March 26, 2019.<br>4. The Director of Nursing or designee will audit PRN pain administration and use of non-pharmacological intervention to ensure interventions are being implemented.<br>Director of Nursing or designee will monitor physician notification of increased use of pain medication.<br><br>This monitoring will be completed weekly times one-month, monthly times one quarter and quarterly until substantial compliance has been achieved. Results will be reviewed by the Risk Management/Quality Assurance Committee until such time substantial compliance has been achieved as determined by the committee. | |

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| F 697 | Continued From page 6<br>Review of the CNA (certified nurse assistant) completed care task charting showed Resident #47 used her K-pad daily from 10/26/18 to 11/26/18 and again from 02/04/19 to 02/26/19. An administrative staff nurse (#5) stated the gap in charting reflected the time the K-pad was not functioning. She was not aware of alternative heating options offered to Resident #47 for pain during this period of time.<br><br>Review of Resident #47's treatment administration (TAR) record for January and February, 2019 failed to identify non-pharmacological interventions for pain.<br><br>During an interview on 02/27/19 at 1:30 p.m., an administrative staff nurse (#1) indicated staff failed to notify Resident#47's physician of increased pain and increased use of PRN Oxycodone.<br><br>The facility failed to report the increased pain trend to the physician and attempt non-pharmacological pain relief measures prior to administering PRN pain medications.<br><br>- Review of Resident #55's medical record occurred on all days of survey. Diagnoses included dorsalgia and osteoarthritis. Pain medications included Hydrocodone/Acetaminophen 5/325 mg 1 tablet every 4 hours as needed (PRN) pain, Ibuprofen 200 mg 2 capsules every 6 hours PRN pain, and Tylenol 325 mg 2 tablets three times a day (TID) for pain. The current care plan stated, ". . . Alteration in comfort, pain related to osteoarthritis, chronic low back pain, history of compression fx [fracture]. . . . Attempt | F 697 | | |

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| F 697 | Continued From page 7<br>non-pharmacologic pain relief measures such as repositioning, back brace and warm packs as needed. . . ."<br><br>During an interview on 02/25/19 11:05 a.m., Resident #55 identified chronic back pain and had received Tylenol with some relief, but felt pain could be better controlled.<br><br>Resident #55's Pain Assessment, dated 02/01/19, stated, ". . . Location of pain: back. . . . What alleviates pain: positional changes, heat, topical analgesic . . . "<br><br>Review of Resident #55's MAR, for February 1-26, 2019 showed nursing staff administered 11 doses of PRN Hydrocodone /Acetaminophen and 10 doses of PRN Ibuprofen. The TAR identified the resident received no hot packs during this time period.<br><br>During an interview on 02/26/19 at 4:01 p.m., Resident #55 stated he would often use heat (electric heating pad) on his back at home for pain with some relief but has not been offered heat since admitted to the facility.<br><br>During an interview on 02/27/19 at 8:49 a.m., an administrative nurse (#1) confirmed staff should be using non-pharmacological interventions such as heat.<br><br>Facility staff failed to attempt non-pharmalogical pain interventions prior to administering PRN pain medications. | F 697 | | |
| F 880 SS=D | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f) | F 880 | | 3/26/19 |

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| F 880 | Continued From page 8<br>§483.80 Infection Control<br>The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a | F 880 | | |

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| F 880 | Continued From page 9<br>resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(v) The circumstances under which 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; and<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<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 infection control practices for 2 of 8 sampled residents (Resident #28 and #107) observed during personal cares. Failure to follow infection control practices related to proper use of personal protection equipment (PPE) (gloves) and hand hygiene has the potential to transmit infections to other residents, visitors, and staff. | F 880 | 1. The Certified Nursing Assistance were educated immediately on hand hygiene.<br><br>2. All residents have the potential to be affected.<br><br>3. All Certified Nursing Assistants will be in-serviced by the Compliance | |

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| F 880 | Continued From page 10<br><br>Findings include:<br><br>Review of the facility policy titled "Infection Prevention and Control Program" occurred on 02/27/19. This policy, dated 11/28/17, stated, ". . . 4. Hand Hygiene Protocol: a. All staff shall wash their hands when coming on duty, between resident contacts, after handling contaminated objects, after PPE removal, before/after eating, before/after toileting, and before going off duty. . . ."<br><br>- Observation on 02/25/19 at 4:56 p.m., showed two certified nurse aides (CNAs) (#8 and #9) performed perineal cares for Resident #28 in his room. After removing his/her gloves, the CNA (#9) failed to perform hand hygiene before leaving the room.<br><br>During an interview on 02/27/19 at 11:00 a.m., an administrative nurse (#7) reported staff should perform hand hygiene after removing gloves and after completing resident cares.<br><br>- Observation on 02/26/19 at 7:43 a.m., showed two CNAs (#3 and #4) assisted Resident #107 to finish dressing and to transfer from his bed to his wheelchair utilizing a stand lift. After removing her gloves and without performing hand hygiene, the CNA (#4) placed Resident #107's glasses, exited the resident's room, obtained the resident's hearing aid from a drawer at the nurse's station, placed the hearing aid in the resident's ear, combed his hair, and then washed her hands. The CNA failed to wash her hands before leaving the room and/or continuing cares. | F 880 | Coordinator on the facilities policy for hand hygiene. In-Service training will include policy review, video on hand hygiene with posttest.<br>4. Quality Assurance committee will conduct random CNA assessments during resident care time to ensure staff are adhering to facility protocols. These assessments will be conducted weekly times four. Monthly times one quarter and quarterly until substantial compliance has been achieved. Results will be reviewed by the Risk Management/Quality Assurance Committee until such time substantial compliance has been achieved as determined by the committee. | |

| 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 _____ | 02/27/2019 |

| 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 880 | Continued From page 11<br>During an interview on 02/27/19 at 11:28 a.m., three administrative nurses (#1, #2 and #5) all confirmed the CNA should have performed hand hygiene after removing gloves and prior to leaving the resident's room. | F 880 | | |