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 _____	03/05/2014

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 03/03/14 and completed on 03/05/14, the sample included 4 residents for complete review, 9 residents for focused review, and 2 closed records for review. The sample included 2 additional residents to verify specific concerns during the survey.	F 000		
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, review of facility policy, and staff interview, the facility failed to ensure 1 of 1 supplemental resident (Resident #16) observed with side rails in the middle of the bed remained free from physical restraints. Failure to ensure side rails are medically necessary and do not obstruct Resident #16's freedom of movement placed the resident at risk for loss of independence and injuries related to bedrail use. Findings include: Review of the facility policy titled "Restraints" occurred on 03/05/14. This undated policy stated, ". . . Definitions . . . Physical restraint - Any manual method or physical or mechanical device, material, or equipment attached or adjacent to the residents body that the individual cannot	F 221	F 221 1. Resident #16 will have the side rails in the upright position (assist rail) at all times when staff is not in attendance. 2. Any resident who has a bed with the assist rail style of side rail has the potential to be evaluated as the rail being used as a restraint. 3. Side rail policy has been updated. Side rails if on the bed, will be in an upright position when resident is in the bed and staff are not in attendance. If a side rails is utilized in the down position, cognitively impaired residents will have a restraint assessment completed with a reduction plan in place. Cognitively intact residents will be educated and provide consent for the use of side rails. Care plan will refer to the side rail in upright position as assist rails and he down position as side rails. Staff will be educated on this process.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature] Admin	Adm.	3-31-14

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 221	Continued From page 1 remove easily which restricts freedom of movement or normal access to one's body. . . ." Observation on 03/04/14 at 7:57 a.m. showed Resident #16 in bed with side rails that obstructed the middle of the bed on both sides. Observation showed the bed positioned away from the wall approximately three feet (enabling the resident to exit on both sides of the bed). Resident #16 repeatedly yelled, "Help me." The nurse (#10) then entered the room, and the resident stated, "Get me up so I can have breakfast." Observations at 8:54 a.m. and approximately 9:30 a.m. showed Resident #16 in bed with both side rails obstructing the middle of the bed. Observation on 03/04/14 at 1:29 p.m. showed Resident #16 asleep on her bed with one side rail positioned in the "up" position (i.e. a quarter rail) and the other side rail in the "down" position (obstructing the middle of the bed). Observation on 03/05/14 at 7:40 a.m. and 8:42 a.m. showed Resident #16 in bed with side rails on both sides of the bed in the "down" position (obstructing the middle of the bed). Review of Resident #16's medical record occurred on March 4-5, 2014. Diagnoses included dementia. The current Minimum Data Set (MDS), dated 02/19/14, identified severely impaired cognition and extensive assistance from two or more people for bed mobility and transfers. The MDS did not identify the use of a restraint. Resident #16's current care plan stated, ". . . Impaired mobility with potential for falls related to confusion and pain. Wheelchair dependent. . . . Side rails x 2 . . ."	F 221	4. QA coordinator and committee will monitor side rail positioning on beds 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. April 5, 2014	

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F 221	Continued From page 2 Nurses' notes stated the following: *02/22/14 at 1:46 a.m.: ". . . at 2300 [11:00 p.m.], staff heard res [resident] talking loudly. . . . When staff entered room, found res with feet on floor, buttocks barely on bed, and husband trying to hold res on bed. Res stated she wanted to get up. . . ." *11/10/13 at 2:26 a.m.: ". . . calling out loudly 'get me up' . . . found sitting at edge of bed times one. . . ." An "Evaluation for Use of Side Rails" assessment, dated 02/22/13, stated, ". . . Why is the use of side rail(s) being considered . . . Request by resident to assist [with] positioning in bed . . . Recommendations . . . Side rail(s) is/are recommended at this time due to: Resident request . . . Recommended type . . . 1/4 rail left upper . . . right upper . . . Comments . . . 1-6-14 Cont. [continue] use per resident request stating 'I need that.' Family et [and] resident aware of risk of entrapment. . . ." Record review identified an evaluation for quarter side rails; however, observation showed the quarter side rails in the "down" position, which obstructed the middle of the bed and restricted Resident #16's movement. During an interview on the morning of 03/05/14, a supervisory nurse (#4) stated some staff members put the side rails down, and others leave them in up position. The nurse stated the facility refers to the side rails as "quarter rails" whether they are in the "up" position or the "down" position.	F 221		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY	F 241		

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F 241	Continued From page 3 The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility staff failed to provide care in a manner to enhance the dignity of 2 of 13 sampled residents (Resident #3 and #13) dependent on staff for assistance with Activities of Daily Living (ADLs). Failure to ensure dignity during meals and to ensure residents are dressed appropriately does not recognize the individuality of each resident or enhance their quality of life. Findings include: Review of the facility policy titled "Quality of Life - Dignity" occurred on 03/05/14. This policy, revised October 2009, stated, ". . . Residents shall be treated with dignity and respect at all times. . . . Residents' private space and property shall be respected at all times . . . Staff will knock and request permission before entering residents' rooms . . . Staff shall speak respectfully to residents at all times . . ." - Resident #13's medical record, reviewed on March 4-5, 2013, identified diagnoses of cerebral artery occlusion with infarct (stroke), and hemiplegia. A significant change Minimum Data Set (MDS), dated 01/27/14, identified the resident had moderately impaired cognition and required extensive to total assistance for all ADLs.	F 241	F241 1. Resident #13 will be covered fully upon transport to and from tub room. Staff will leave the incontinent product in storage until the resident is ready to have it applied. Staff will wait for a response when knocking on the door to resident room before entering the room. Resident #3 will be spoken to like an adult at all times. 2. All residents have the potential to be affected by this practice. 3. Policy Quality of Life- Dignity has been reviewed. A bathing cape will be made to apply to residents during transport to and from the bathing suite. Staff will be reeducated on privacy and dignity with a video, "Sensitizing our Desensitized, Sensitive Staff", by Cat Selman. An in service will be provided to Nurses on 3/25/2014 and the CNA's on 4/2/2014.	

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F 241	Continued From page 4 The current care plan stated, ". . . Problem: Requires assistance with bathing, dressing . . . related to cerebral artery infarcti [sic], left sided hemiplegia . . . Approaches: . . . Extensive assist for dressing . . . Extensive to dependent assist for whirlpools . . ." During the initial tour on the morning of 03/03/14, observation from the doorway of Resident #13's room showed an incontinent product lying open on his bed. Approximately ten minutes later an unidentified Certified Nursing Assistant (CNA) transported Resident #13 from the whirlpool room to his room, wearing a shirt and a towel wrapped around his lap. The CNA failed to completely cover the resident prior to transporting him down the hallway. Observation on 03/05/14 at 8:40 a.m., showed an unidentified CNA knocked and entered the room as two other CNAs (#1 and #2) provided Resident #13's incontinence cares as he laid in bed. The unidentified CNA failed to wait for a response prior to entering the room. - Resident #3's medical record, reviewed on all days of survey, identified diagnoses of Alzheimer's dementia and Parkinson's disorder. An annual MDS, dated 02/01/14, identified the resident had severely impaired cognition and required extensive assistance for eating. The current care plan stated, ". . . Problem: Impaired chewing and swallowing with potential for choking and aspiration. Pockets food. Frequent poor meal intake, weight decline. . . . Approaches: . . . Dependent with dining. . . ." Observation on 03/04/14 at 12:08 p.m., showed	F 241	4. QA coordinator and committee will monitor Dignity and Privacy issues 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. April 5, 2014.	

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F 241	Continued From page 5 Resident #3 sitting at an assisted table in the dining room. Each time the CNA (#3) attempted to feed Resident #3 pureed consistency foods, he refused to open his mouth and pursed his lips. The CNA (#3) made comments throughout the meal, including "are you being stubborn," and "you're a little stinker." During an interview on 03/05/14 at 10:50 a.m., an administrative staff member (#4) stated staff are expected to "completely cover" residents prior to transport from the whirlpool room, and agreed residents should be addressed in an age appropriate manner.	F 241	F309 1. Resident #2. 3, & 17 will be will be in an upright position as close to 90 degrees as possible when eating or drinking. 2. Any resident has the potential to be affected by this practice. 3. Policies Preparing the Resident for a Meal, Assisting the Resident with In-Room Meals, and Assisting the Impaired Resident with In-Room Meals have been updated. CNA's and Nurses will be reeducated on positioning of residents when eating or drinking with a training module: <u>The Dining Experience</u> it is designed for all employees to help them create a pleasant dining environment for clients and identify what makes meals appealing. It also helps them properly prepare, assist and position a client while eating or drinking. They will also be reeducated on the signs and symptoms of aspiration. An in service will be provided to Nurses on 3/26/2014 and CNA's on 4/2/2014.	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of the facility's policy and procedure, review of professional literature, and staff interview, the facility failed to provide the care and services necessary to attain the highest degree of safety possible for 2 of 2 sampled residents (Resident #2 and #3) and 1 supplemental resident (Resident #17) observed receiving liquids while in a reclined position. Failure to ensure residents were positioned properly resulted in Resident #3	F 309		

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F 309	Continued From page 6 showing signs/symptoms of aspiration and placed Resident #2 and #17 at risk of aspirating. Findings include: Review of the facility policy titled "Dining Guidelines" occurred on 03/05/14. This undated policy stated, ". . . Make sure resident is in an upright position, with head not tilted backwards . . ." Nancy B. Swigert, "The Source for Dysphagia: Third Edition", LinguiSystems, Inc, 2007, pages 15, 47, 125, 128, 137 and the educational handouts identified, ". . . Any patient who . . . has been diagnosed with a neurological disorder may be at risk for aspiration. . . . Signs of pharyngeal dysphagia are coughing or choking during a meal [Observed with Resident #3 on March 3-4, 2014] . . . During the oral intake of . . . foods and/or liquids, it is optimal for a patient to be seated at a 90 degree angle . . . in a chair. . . . Even a slightly reclined position while eating greatly increases the risk of premature loss of food over the back of the tongue [Observed Resident #2, #3, and #17 in a reclined position on March 3-4, 2014] . . ." - Resident #3's medical record, reviewed on all days of survey, identified diagnoses of Alzheimer's dementia and Parkinson's disorder. An annual MDS, dated 02/01/14, identified the resident had severely impaired cognition and required extensive assistance for eating. The current care plan stated, ". . . Problem: Impaired chewing and swallowing with potential for choking and aspiration. . . . Frequent poor meal intake, weight decline. . . . Approaches: . . . Dependent with dining . . . Monitor for . . .	F 309	4. QA coordinator and committee will monitor positioning while eating or drinking weekly times one month, monthly times one quarter, and quarterly times one year. Results will be reported to QA coordinator or DON at weekly QA meetings. 5. April 5, 2014.	

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F 309	Continued From page 7 increased difficulty when dining with . . . swallowing, choking, and aspiration. . . ." Observations showed the following: * On 03/03/14 at 3:00 p.m., after assisting Resident #3 into bed, two Certified Nursing Assistants (CNAs) (#13 and #14) raised the head of his bed to an approximate 50 degree angle and assisted him with a glass of water. Resident #3 cleared his throat and coughed (an indication Resident #3 had poor vocal fold closure and secretions had entered his airway). * On 03/04/14 at 8:40 a.m., a CNA (#1) raised the head of Resident #3's bed to an approximate 60 degree angle and fed him breakfast. Resident #3 coughed immediately after the second or third sip of thin liquids from a cup on three separate occasions, and demonstrated a delayed cough between attempted teaspoons of pureed foods. - Resident #17's medical record, reviewed on all days of survey, identified a diagnosis of esophageal reflux. The quarterly MDS, dated 01/04/14, identified the resident had severely impaired cognition, required supervision and one person assistance for eating. The current care plan stated, ". . . Problem: Alteration in health maintenance related to . . . gastroesophageal reflux disease . . . Approaches: . . . Encourage resident to remain upright for at least 30 minutes following meals . . . Head of bed elevated as needed . . ." During the initial tour on the morning of 03/03/14, observation showed an unidentified nurse administering Resident #17's medications as he laid in bed. The head of Resident #17's bed remained at a 25 degree angle as he swallowed	F 309		

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F 309	Continued From page 8 his medication and water from a glass. - Review of Resident #2's medical record occurred on March 3-5, 2014. Medical diagnoses included esophageal reflux, esophagitis, and mucositis. The admission MDS, dated 02/25/14, identified the resident required extensive assistance for eating. Resident #2's current care plan stated the approach "Encourage and provide assist for adequate fluid intake." Observation on 03/03/14 at 4:20 p.m., showed Resident #2 laying in bed with her neck brace on, with the head of the bed raised to an approximate 45 degree angle. A Licensed Practical Nurse (LPN) (#12) failed to raise the head of her bed prior to assisting her with a glass of water. During an interview on 03/05/14 at 10:50 a.m., an administrative staff member (#4) stated staff are expected to place residents "as upright as possible" prior to offering them food or water. The facility failed to position Resident #2, #3, and #17 as close to 90 degrees as possible prior to allowing them to eat/drink and failed to recognize Resident #3's signs/symptoms of dysphagia and/or aspiration (throat clearing and/or coughing/choking).	F 309		
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	F 314		

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F 314	Continued From page 9 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: Based on observation and medical record review, the facility failed to implement interventions to aid in the prevention of pressure ulcers for 1 of 7 sampled residents (Resident #5) at risk for pressure ulcer development. Failure to ensure the resident's heels remained free from pressure may result in the development of avoidable pressure ulcers. Findings include: - Review of Resident #5's medical record occurred on all days of survey. Diagnoses included dementia, peripheral vascular disease, and diabetes mellitus. The current Minimum Data Set (MDS), dated 02/07/14, identified short and long term memory problems, moderately impaired daily decision-making skills, extensive assistance from two or more people for bed mobility, at risk for pressure ulcers, and current skin tears and moisture-associated skin damage. A Braden Risk Assessment Report (a tool used to determine pressure ulcer risk) identified a score of 10, indicating high risk. Resident #5's care plan, dated 02/17/14, stated, ". . . Potential for skin breakdown related to incontinence, decreased mobility, diabetes mellitus, and peripheral vascular disease. Skin fragile, bruises and skin tears easily. Frequent	F 314	F314 1. Resident #5 will have their feet elevated and free of pressure when in bed. 2. Any resident who is at risk for pressure sores has the potential to be affected by this practice. 3. Nurses and CNA's will be reeducated on the policy Prevention of Pressure Ulcers. An in service will be provided by Roxanne Thomas, LPN Restorative Nurse on the proper use of pressure relieving devices. The Nurses will be in serviced 3/25/2014 and CNA's 4/2/2014. 4. QA coordinator and committee will monitor residents who are at risk for pressure ulcers weekly times one month and monthly times one quarter and quarterly times one year on the proper use of pressure relieving devices. Results will be reported to QA coordinator or DON at weekly QA meetings. 5. April 5, 2014.	

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F 314	Continued From page 10 moisture related skin breakdown to abdominal folds, bilateral breasts and groin folds. . . . Approaches . . . Keep heels elevated off bed, free from pressure when in bed. . . ." Observations at the following times showed Resident #5 in bed, supine with her feet/heels resting directly on the mattress: *03/03/14 from 2:50 p.m. until 5:48 p.m. *03/04/14 from 8:22 a.m. until 10:41 a.m. *03/04/14 from 1:14 p.m. until 4:33 p.m. *03/05/14 from 7:50 a.m. until approximately 9:00 a.m.	F 314	F 323 1. Resident #3 will have his feet up on foot rests while being transported. 2. Any resident being transported has the potential of being affected by this practice.	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES 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. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to provide adequate supervision and assistance devices (foot pedals) for 1 of 1 sampled resident (Resident #3) observed transported in a wheeled (bathing) chair. Failure of the facility to ensure staff properly used assistance devices placed the resident at risk for possible accident and/or injury. Findings include:	F 323	3. An extension platform will be applied to all tub transport chairs that will support a larger base for feet to rest on during transport. Nurses and CNAs will be educated on the proper positioning of feet on the platform and reeducated on the use of foot pedals at all times when transporting a resident during an in service Nurses on 3/25/2014 and CNA's on 4/2/2014. 4. QA coordinator and committee will monitor the use of foot pedals during transport weekly times one	

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F 323	Continued From page 11 - Resident #3's medical record, reviewed on all days of survey, identified diagnoses of Alzheimer's dementia and Parkinson's disorder. An annual MDS, dated 02/01/14, identified the resident had severely impaired cognition and required total assistance for locomotion on the unit. The current care plan stated, ". . . Problem: Impaired mobility . . . Approaches: . . . Wheelchair dependent for locomotion. Dependent for staff to propel wheelchair. . . . Problem: Potential for impaired skin integrity related to . . . decreased mobility, edema, peripheral vascular disease . . . Approaches: . . . Keep heels free from pressure . . ." During the initial tour on the morning of 03/03/14, observation showed an unidentified Certified Nursing Assistant (CNA) transported Resident #3 to his room in a wheeled (bathing) chair without foot pedals. During the transport, Resident #3's right heel brushed along the carpet, making an audible noise. The unidentified CNA failed to ensure Resident #3's right heel cleared the floor during transport to avoid an accident or shearing and potentially causing pain and/or injury. During an interview on 03/05/14 at 10:50 a.m., an administrative staff member (#4) stated staff are to ensure residents feet are lifted and do not contact the flooring during transport.	F 323	month, monthly times one quarter and quarterly times one year and report to the QA coordinator or DON at weekly QA meetings. 5. April 5, 2014.	
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all	F 431		

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 _____	03/05/2014

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

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F 431	Continued From page 12 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. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. 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. 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. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to store all Schedule II (a drug with a high potential for abuse) medications in separately locked, permanently affixed compartments in 1 of 2 medication carts. Failure to implement a system to ensure secure	F 431	F431 1. All schedule II narcotics will be placed in a double locked drawer in the medication cart. 2. Any schedule II narcotic has the potential to be affected by this practice. 3. Policy Storage of Medications has been updated. Pharmacy will color code the packaging on all schedule II narcotics indicating the need to be placed in a double locked compartment on the medication cart. A list of schedule II narcotics will be placed in the narcotic count book for a reference. 4. QA coordinator or designee will monitor medication carts weekly times one month and monthly times one quarter and quarterly times one year and report to QA committee or DON at weekly QA meetings. 5. April 5, 2014.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 431	Continued From page 13 Schedule II medication storage may result in unauthorized access to these medications. Findings include: Observation of the medication cart on 03/05/14 at 10:30 a.m. showed a separate locked compartment located inside the locked medication cart. Observation showed several Schedule II medications inside this compartment. Observation also showed a multi-dose cartridge of oxycodone (a Schedule II medication) in a drawer above the separately locked compartment. A nurse (#10) stated they store as needed (prn) Schedule II medications and Fentanyl (a narcotic pain reliever) patches in the compartment, but do not store routinely ordered Schedule II medications in this compartment. During an interview on 03/05/14 at 11:00 a.m., a supervisory nurse (#11) confirmed the facility does not store regularly scheduled Schedule II medications in the separate locked compartment.	F 431		