STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355087	A. BUILDING _____ B. WING _____	C 04/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEDGEWOOD MANOR	**804 MAIN ST W CAVALIER, ND 58220**

(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 unannounced complaint survey conducted April 18-19, 2016, the sample included four residents for review. The complaint concern regarding injuries of unknown origin was substantiated.	F 000		
F 157 SS=E	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's	F 157		5/24/16

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

Electronically Signed | 05/10/2016

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F 157	Continued From page 1 legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy and procedure, and staff interview, the facility failed to notify the designated family members for 4 of 4 sampled residents (Resident #1, #2, #3, #4) who sustained bruises of unknown origin. Failure to notify a family member limited the family member's ability to make informed decisions regarding medical care. Findings include: Review of the facility policy and procedure, "Informed Family and legal representative," occurred on 04/19/16. This document, dated July 1997, stated, ". . . According to the Resident Bill of Rights and if the resident request, family will also be notified within 24 hours of any accident/occurrence, significant change in resident physical, mental, or psychosocial status, or change in your treatment and/or medication which has been significant. . . ." - Review of Resident #1's medical record occurred on April 18-19, 2016. Diagnoses included history of pressure and/or venous ulcers. The quarterly Minimum Data Set (MDS), dated 03/27/16, identified moderately impaired cognition and extensive assist of one or more persons required for bed mobility and transfers. The progress notes identified the following: * 04/13/16, ". . . New area noted to posterior heel 2 cm [centimeters] x [times] 1 cm . . . drainage	F 157	It is the practice of Wedgewood Manor to notify resident, family and physician of changes (injury, decline, room, ETC). A. i. For resident #1, family and physician have been notified of new area noted to the posterior heel 2cm x 1cm and also venous ulcer noted to the top of the left foot. Documentations were updated to reflect notification. ii. For resident #2, family and physician was notified of the 8cm x 3cm bruise to the left upper arm. Documentations were updated to reflect notification iii. For resident #3, family and physician was notified of all skin changes documented on 11/3/15, 02/02/15, 03/01/16 and 4/5/16. Documentations were updated to reflect notification. iv. For resident #4, family and physician was notified of bruises noted on 04/06/16. Documentations were updated to reflect notification B. A 100% audit of all residents chart with skin condition will be done to ensure that the responsible family and physician have been notified. C. On April 25,2016, an in-service and one on one education was conducted with licensed staff on the importance of notifying family members/responsible party and physician on any change in condition, injury, treatment change, or	

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F 157	Continued From page 2 noted. Area cleaned and dressing applied." * 04/14/16, "New ? [questionable] venous ulcer noted to the top of the left foot - area is scabbed/circular/dark red and slightly moist. Area cleansed with NS [Normal Saline] applied a foam drsg [dressing] for protection. . . . Monitor until resolved. To see wound clinic MD [physician]. Area to the right heel is yellowish/black in color. . . ." The medical record lacked evidence facility staff notified family of the new ulcers that developed on Resident #1's left foot and right heel and required medical treatment. - Review of Resident #2's medical record occurred on April 18-19, 2016. Diagnoses included Alzheimer's disease and vascular dementia with behavioral disturbance. The quarterly MDS, dated 03/27/16, identified severely impaired cognition and extensive assist of one or more persons required for bed mobility and transfers. The progress note, dated 12/03/15, identified, ". . . SKIN: Resident has a 8 x 3 cm bruise to left upper arm, the edges are yellow the center is fading purple. No pain with palpation at site. . . ." The medical record lacked evidence facility staff notified family of the significant bruise identified on Resident #2 left upper arm. - Review of Resident #3's medical record occurred on April 18-19, 2016. Diagnoses included falls, osteoporosis, abnormal gait, and abnormal mobility. The significant change MDS,	F 157	room change. Licensed Staff was also educated on accurate charting and documentation regarding skin assessments, skin breakdown, falls and proper incident report documentation. In addition, licensed staff was educated on proper documentation procedures and steps to follow when bruises of unknown origin are noted. D. DON\Designee will monitor daily 24hr reports and treatment records to ensure that appropriate assessment and notification has been accomplished – daily x 4 week, weekly x 3 months and quarterly x 1 year. Individual re-education will occur if there are concerns. QA monitoring started 4/25/16; outcomes/summary of findings shall be discussed by DON/Designee during monthly QA.	

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dated 04/14/16 , identified long and short term memory impairment, extensive assist of two or more people required for bed mobility, and extensive assist of one person for transfers. The current care plan stated, ". . . Problem onset: SKIN . . . bruises easily due to aspirin use . . . Approaches . . . Monitor skin conditions with cares, report any redness or other problems to nurse for further evaluation. . . ."

Review of the progress note stated the following:
* 11/03/15 at 12:04 p.m.: ". . . BRUISE TO TOP OF RIGHT HAND NEAR THUMB WHICH IS FADING IN COLOR. . . ."
* 02/02/2016 at 6:26 p.m.: ". . . FADING BRUISE TO RIGHT HIP AND RIGHT BUTTOCK. . . ."
* 03/01/16 at 4:37 p.m.: ". . . Resident has a approx [approximately] 11cm [centimeter] x 4cm bruise to left hip - old - from previous fall. [The last documented fall was on 02/05/16 - approximately one month prior.] Noted 2 1 cm diam [diameter] bruised on left leg [and] another one on right leg, . . ." * 04/05/2016 at 5:13 p.m.: ". . . Noted a bruise on right arm 1 x 1.2cm . . . Bruise on right shin 1.2 x 2cm . . . Left lateral keg [sic] - bruise 2 x 2cm [and] 1.5 x 1cm scabbed area. Bruise on left hand, near thumb - 2.5cm x 3cm, this old , yellowish brown. Cluster of 3 small bruises on left arm near the elbow inside a 2 x 2.5cm area. . . ."

During an interview on 04/19/16 at 1:13 p.m., an administrative staff (#2) stated there was no documentation showing family and physician notification for the bruises documented on 11/03/15, 02/02/16, 03/01/16, and 04/05/16.

- Review of Resident #4's medical record

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F 157	Continued From page 4 occurred on April 18-19, 2016. Diagnoses included falls, hemiplegia (paralysis of one side), dementia, and Parkinson's disease. The significant change MDS, dated 03/22/16, identified moderately impaired cognition and limited assistance of one or more persons required for bed mobility and extensive assistance of one or more persons required for transfers. Review of the progress note, dated 04/19/16 at 8:47 a.m., stated, ". . . 4/6/2016 12:25 PM . . . Has 3 bruises on left forearm [and] hand. Rightshin [sic] 0.5 x 0.3cm bruise. 4 x5 cm bruise to right hand near thumb. . ." The medical record lacked evidence facility staff informed family or the physician of bruises documented on this date. The facility failed to provide any documentation, upon request by this surveyor, showing Resident #4's family or physician were notified of the bruises documented on 04/06/16. The facility presented documentation on 04/19/16 at 10:50 a.m. with an addendum of the progress note, dated 04/19/16 at 10:43 a.m., identifying "Fasmily [sic] & doctor notifyed [sic].", after documentation of the progress note showed no notification was made. During an interview on 04/19/16 at 12:23 p.m., two administrative staff (#1 and #2) stated no notification of the physician or family of bruises observed on 04/06/16 was documented before they added the addendum on 04/19/16 during the survey.	F 157		
F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT	F 225		5/24/16

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F 225	Continued From page 5 ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 225		

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F 225	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on information provided by the complainant, record review, and staff interview, the facility failed to immediately report and/or investigate injuries of unknown origin for 4 of 4 residents (Resident #1, #2, #3, and #4) identified as having bruises. Failure to immediately report and/or investigate injuries of unknown origin placed Resident #1, #2, #3, and #4, as well as other residents in the facility, at risk for further injuries and/or potential abuse, and did not enable the facility to determine the causative factors for the injuries and/or implement corrective actions. Findings include: Information provided by the complainant indicated the facility failed to investigate an injury of unknown origin. - Review of Resident #1's medical record occurred on April 18-19, 2016. Diagnoses included muscle weakness and abnormalities of gait and mobility. The quarterly Minimum Data Set (MDS), dated 03/27/16, identified moderately impaired cognition and extensive assist of one or more persons required for bed mobility, transfers, and locomotion on the unit. The care plan, dated 03/11/16, identified, ". . . SKIN . . . Monitor skin conditions with cares, report any redness or other problems to nurse for further evaluation . . ."	F 225	It has always been the policy and practice of Wedgewood Manor to investigate/report allegations/individuals. A. i. For resident #1 bruise of 11cm x 6cm has been resolved. Don/Designee will ensure resident□s care plan of monitoring skin condition with cares is followed. Discrepancies will be thoroughly investigated and addressed accordingly. ii. For resident #2 bruise of 8cm x 3cm has been resolved. There will be thorough review of incident report, physician orders, nurses□ notes and weekly skin charts. Proper investigation will be conducted to determine causative factors if there are any discrepancies found. Interventions will be put in place. iii. For resident #3, bruises noted have resolved. Resident□s skin condition will be monitored daily with cares since resident bruises easily. Incidence of bruises to the (L) upper inner thigh area measuring 2.7 x 3cm and 2 x 1cm will be reported to State health Department. Discrepancies will be investigated to determine causative factors and interventions will be put in place. Findings of investigation will be forwarded to State accordingly. iv. For resident #4, bruises have been resolved. Resident was moved closer to the nurses□ station for better monitoring. All documentations including skin	

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F 225	Continued From page 7 The current phyician's orders identified Resident #1 received Aspirin daily. The progress note, dated 03/09/16, identified, ". . . SKIN: Has an 11 x [times] 6 cm [centimeter] bruise to top of left foot, appears to be some waht [sic] faded already. . . ." The medical record lacked evidence of a skin assessment (prior to the bruise fading), an investigation including the exact circumstances of the incident/possible causative factors for the bruise to the top of Resident #1's left foot, any corrective actions the facility implemented, and any documentation of when the bruise resolved. Failure to conduct an investigation to determine the causative factors for the significant bruise to Resident #1 may result in additional bruising or injury. - Review of Resident #2's medical record occurred on April 18-19, 2016. Diagnoses included Alzheimer's disease and vascular dementia with behavioral disturbance. The quarterly MDS, dated 03/27/16, identified severely impaired cognition, extensive assist of one or more persons required for bed mobility and transfers, and limited assist of one person for locomotion on the unit. The care plan, dated 03/16/16, identified, ". . . SKIN h/o [history of] bruising . . . Bruising to hands and arms from running into walls adn [sic] hitting hallway side rails . . . Monitor skin conditions with cares, report any redness or other problems to nurse for further evaluation . . . Applied arm protectors due to bruising on arms . .	F 225	assessment charts will be reviewed for any discrepancies. There will be thorough investigation to determine causative factors and interventions will be put in place if there are discrepancies found. B. The facility recognizes the potential of other residents being at risk due to failure of properly investigating causative factors concerning bruises of unknown origin. Expectations regarding process and procedure of skin assessment, injuries of unknown origin, un-witnessed falls and falls with major injuries have been reviewed with all staff. Documentations have been revised and updated to help staff identify, document, report and investigate bruises of unknown origin. C. On 4/25/2016, an in-service on skin assessment, charting guidelines, fall charting, incident report documentation and resident abuse and neglect was conducted with all staff. Facility also implemented the STOP and WATCH program all staff was educated to look for various changes in resident condition including unusual change in skin condition. All departments have STOP and WATCH forms available to their staff. Administrator/DON or designee will also ensure detailed investigation is carried out to determine factors concerning bruises of unknown origin. D. DON/Designee shall monitor daily reports and treatment records daily x 4 weeks, weekly x 3 months and quarterly x 1 year to ensure that skin assessments	

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F 225	Continued From page 8 ." The current phyician's orders identified Resident #2 received Aspirin daily. The progress note, dated 12/03/15, identified, ". . . SKIN: Resident has a 8 x 3 cm bruise to left upper arm, the edges are yellow the center is fading purple. No pain with palpation at site. . . ." Failure to conduct an investigation to determine the causative factors for the significant bruise to Resident #2 may result in additional bruising or injury. - Review of Resident #3's medical record occurred on April 18-19, 2016. Diagnoses included falls, osteoporosis, abnormal gait, and abnormal mobility. The significant change MDS, dated 04/14/16, identified long and short term memory impairment, extensive assist of two or more people for bed mobility, and extensive assist of one person for transfers. The current care plan stated, ". . . Problem onset: SKIN . . . bruises easily due to aspirin use . . . Approaches . . . Monitor skin conditions with cares, report any redness or other problems to nurse for further evaluation. . . ." Review of the progress note stated, ". . . 10/13/2015 10:31 AM . . . BRUISES TIMES 2 [two] TO THE INNER LEFT THIGH NEAT [sic] BUTTOCKS. MEASUREMENTS TAKEN AND REPORT FILLED OUT. . . ." The incident report, dated 10/13/15 at 7:00 a.m., stated, ". . . Brief Explanation . . . Upon skin [check] in bed prior to shower - 2 bruises noted to L [left] upper inner thigh area - 2.7 x 3 cm [;] 2 x1 cm. Purple in color	F 225	and treatment records are completed as scheduled and appropriate incidences are reported and investigated accordingly. QA monitoring started on 4/25/16; outcomes and summary of findings shall be discussed by the DON/designee during monthly QA.	

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non-raised non tender. 2 in between these are fading yellow. (May have pinched on toilet seat in b/room [bathroom]. . . . Manager's and/or Interdisciplinary team's . . . POTENTIAL CONTRIBUTING FACTORS . . . Unknown . . . FINDINGS/FOLLOW UP MEASURES Spoke [with] staff and staff feel that the bruises could be from the toilet seat in BR [bathroom]. Resident is a poor historian and unable to remember. . . ."

During an interview on 04/19/16 at 1:13 p.m., an administrative nurse (#2) stated no investigation occurred for the new and old bruises found on Resident #3's left inner thigh. Failure to conduct an investigation to determine the causative factors for the suspicious bruises may result in additional bruises or injury.

Review of the progress note stated, ". . . 11/03/15 12:04 PM . . . BRUISE TO TOP OF RIGHT HAND NEAR THUMB WHICH IS FADING IN COLOR. . . ."

Review of the progress note stated, ". . . 2/2/2016 6:26 PM . . . FADING BRUISE TO RIGHT HIP AND RIGHT BUTTOCK. . . ."

Review of the progress note stated, ". . . 3/1/16 4:37 PM . . . Resident has a [sic] approx [approximately] 11cm x 4cm bruise to left hip - old - from previous fall. Noted 2 1 cm diam [diameter] bruises on left leg [and] another one on right leg, . . ."

Review of the progress note stated, ". . . 4/5/2016 5:13 PM . . . Noted a bruise on right arm 1 x 1.2cm . . . Bruise on right shin 1.2 x 2cm . . . Left lateral keg [sic] - bruise 2 x 2cm [and] 1.5 x 1cm

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F 225	Continued From page 10	F 225		

scabbed area. Bruise on left hand, near thumb - 2.5cm x 3cm, this old, yellowish brown. Cluster of 3 small bruises on left arm near the elbow inside a 2 x 2.5cm area. . . ."

Failure to conduct an investigation to determine the causative factors for the multiple bruises to Resident #3 may result in additional bruises or injury.

- Review of Resident #4's medical record occurred on April 18-19, 2016. Diagnoses included falls, hemiplegia (paralysis of one side), dementia, and Parkinson's disease. The significant change MDS, dated 03/22/16, identified moderately impaired cognition and limited assistance of one or more persons for bed mobility, and extensive assistance of one or more persons for transfers.

Review of the progress note stated, ". . . 4/6/2016 12:25 PM . . . Has 3 bruises on left forearm [and] hand. Rightshin [sic] 0.5 x 0.3 cm bruise. 4 x 5cm bruise to right hand near thumb. . ."

During an interview on 04/19/16 at 12:23 p.m., an administrative staff member (#2) stated no investigation occurred to determine the cause of the bruises documented on 04/06/16.

During an interview on 04/19/16 at 9:20 a.m., an administrative staff member (#1) stated an incident report should be completed for bruises and/or skin tears with an unknown origin.

Failure to conduct an investigation to determine the causative factors for the significant bruise to Resident #4 may result in additional bruising or

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F 225	Continued From page 11 injury.	F 225		