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 _____	07/18/2013

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 standard Medicare/Medicaid recertification survey started on July 15, 2013 and completed on July 18, 2013 the sample included two (2) residents for complete review, eight (8) residents for focused review, and one (1) closed record for review. The sample included one (1) additional resident to verify specific concerns during the survey.	F 000		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to assess the safety of self-administration of medications (SAM) for 1 of 2 sampled residents (Resident #6) observed with medications left in her room. Failure to determine if SAM is a safe practice has the potential to result in a medication error. Findings include: Review of the facility policy titled "Self Administration of Medications-Residents" occurred on 07/18/2013. This policy, dated December 1998, stated, ". . . 1. Residents will not be permitted to administer or retain medications in their room unless so ordered by the attending physician . . . and approved by the care planning	F 176	To ensure Resident #6 and any other resident that desires to self administer their own medications is safe: The facility revised their Policy on Self Administration of Medications (see Att. A). The facility will inform licensed nursing staff and the Interdisciplinary Team of the new policy at their monthly meeting. Resident #6 had an assessment completed, the Interdisciplinary Team and her PCP approved Resident # 6's ability to complete self administration of medications. Resident # 6's care plan and medication administration (MAR) was updated to reflect her ability to safely self administer her own medications. Any resident that desires to self administer their medications will have an assessment completed as per facility policy. The assessment will be reviewed by the Interdisciplinary Team and if that resident is approved to self administer their own medications, nursing will obtain an order from their PCP. Once approved the order	08/09/13 08/13/13 07/19/13 08/22/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Patti Johnson | TITLE: Administrator | (X6) DATE: 08/09/13

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 176	Continued From page 1 team. 7. The self-administration of medications for the residents will be periodically re-evaluated based on change in residents [sic] status/condition . . ." During observation of medication administration on 07/16/13 at 7:55 a.m., a nursing staff member (#4) prepared 11 oral medications for Resident #6 and left them in a cup on her bedside stand. The nursing staff member (#4) stated Resident #6 self-administers her medications after the nurse prepares them. An observation on 07/16/13 at 8:30 a.m., showed Resident #6 eating breakfast in her room. Observation showed a medication cup containing pills next to her plate and no staff present. Resident #6 stated, "I take my pills as I eat my breakfast." Review of Resident #6's medical record occurred on all days of survey. Resident #6's 8:00 a.m. medications include: * Diovan (for hypertension) * Imdur (a cardiac medication) * Digoxin (a cardiac medication) and * Celexa (an antidepressant) * Bumex (a diuretic) * and some over-the-counter medications The record failed to identify a doctor's order or an assessment for SAM. During an interview on 07/17/13 at 10:55 a.m., an administrative nurse (#1) stated they do not have an order for Resident #6 to self-administer her medication, and they did not complete the SAM process for Resident #6.	F 176	will be added to their MAR and their individualized plan of care. The DON or designee will monitor that the policy on "Self Administration of Medications" is followed by nursing staff and the interdisciplinary team weekly x 1 month, monthly x 3 months, and quarterly thereafter x 1 year. The Administrator will be notified of any issues. If issues are identified, immediate corrective action will occur. The DON or designee will submit a report of the monitoring to the QA committee during the scheduled monthly QA meetings.	08/22/13

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F 371	Continued From page 2	F 371		
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, review of the facility's kitchen cleaning schedule, review of facility policy and procedure, and staff interview, the facility failed to ensure food available for residents is stored, prepared, and served under sanitary conditions during 2 of 3 days (July 15 and 17, 2013) of kitchen observations. Failure to discard a partially consumed chicken roll after the labeled "use by" date, failure to label a package of ham slices with a "use by" date, and failure to clean the exhaust vent hood over the stove and ovens placed residents, staff, and visitors who consumed food items prepared at the facility at risk of food borne illness. Findings include: Review of the facility policy and procedure, "Food Storage," occurred on 07/18/13. This undated document stated ". . . Procedure: All food items will be stored in original packaging or in covered and sealed containers or bags, and will be labeled as follows: . . .	F 371	To ensure the facility is storing, preparing, distributing, and serving food under sanitary conditions: The Dietary Department revised their policies on "Food Storage" (See Att. B) and "Cleaning Hoods and Filters." (See Att. C). The policy revisions will be reviewed with the Dietary Department at their next monthly meeting. The Dietary Manager or Assistant Dietary Manager will monitor to ensure food is stored, prepared, distributed, and served under sanitary conditions, and the exhaust vent hood is cleaned as per facility policy weekly x 1 month, monthly x 3 months, and quarterly thereafter x 1 year. The LRD or Administrator will be notified of any issues. If issues are identified, immediate corrective action will occur. The Dietary Manager or Assistant Dietary Manager will submit a report of the monitoring to the QA Committee during the scheduled monthly QA Meetings.	08/09/13 08/16/13 08/22/13

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F 371	Continued From page 3 Opened packages: Contents of food products that have been opened and/or partially used are to be placed in sealed containers or bags. . . . Packages that are opened will also be dated with the opened date and a use-by date. . . . The use-by date will be determined as follows: . . . Processed fresh meats, 3 days or less . . . Any food that is . . . undated, or past the use-by or expiration date will not be used. . . ." Review of the facility policy and procedure, "General Sanitation of Kitchen," occurred on 07/18/13. This undated document stated "Policy, The staff shall maintain the sanitation of the kitchen through compliance with a written, comprehensive cleaning schedule. Procedure: 1. Cleaning and sanitation task for the kitchen will be recorded. . . . 5. A cleaning schedule will be posted and employees will initial and date tasks when completed. . . ." - Observation in the walk-in cooler during the initial kitchen tour, on 07/15/13 at 2:10 p.m., identified a partially consumed two pound processed chicken "roll" in a sealed plastic bag, dated "07/10" and "07/13" and a partially consumed package of ham slices in a sealed bag with an illegible black mark. A supervisory dietary staff member (#3) present during the tour reported staff use the meats for sandwiches for residents. This staff member also reported the dates on the chicken roll identified the staff opened the package on "07/10/13" and "07/13/13" was the use-by date. This staff	F 371		

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F 371	Continued From page 4 member (#3) also reported the smudge on the package of ham slices may have been the date opened and use-by date; however, the date was not legible. The staff member (#3) removed and discarded the chicken roll and ham slices at the time of observation. - Observation during the kitchen tour, on 07/17/13 at 10:00 a.m., showed the exhaust hood over the stove and ovens soiled with heavy palpable grease and debris. A supervisory dietary staff member (#3) present during the tour reported facility staff clean the exhaust hood on a regular basis. Review of the July 2013 cleaning schedule "Weekly Duties . . . Tues. [Tuesday]; Clean oven hood & [and] vents. . . ." showed initials for cleaning of the exhaust hood on 07/03/13 and 07/09/13. The staff member (#3) confirmed the initials were those of a staff member and reported she (staff member #3) was not aware of any monitoring of the exhaust hood cleaning by supervisory or management staff. Failure to ensure facility staff date food products with the opened date and use-by date and failure to ensure facility staff cleaned the exhaust hood placed residents, staff, and visitors at risk of food borne illness.	F 371		
F 431 SS=D	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 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	F 431	To ensure drugs and biologicals used in the facility are labeled and stored in accordance with Federal and State laws: The policy on "Medication Labels/Reorders" (See Att.D) and the "Medication Storage Policy" (See Att E) will be reviewed with Licensed Nursing	08/13/13

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F 431	Continued From page 5 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, record review, review of facility policy and procedure, and staff interview, the facility failed to ensure medications were labeled in accordance with currently accepted professional principles for 1 of 5 residents (Resident #12) observed during medication pass and failed to store drugs and biologicals in locked compartments for 1 of 2 medication carts observed during review of the medication room/carts. Failure to identify discrepancies	F 431	Staff and Med Techs at their monthly meeting. These policies will also be reviewed by Contract Agency Staff that are assigned to our facility on an ongoing basis and to new contract staff during their initial orientation to our facility. A new prescription was obtained for Resident # 12's Metolozone to reflect the correct order. The medication with the incorrect label was removed. The DON/ designee or consulting pharmacist will monitor that these policies on storing drugs and biologicals are followed and monitor that labels are correct on Resident # 12 and a sample of residents weekly x 1 month, monthly x 3 months, and quarterly thereafter x 1 year. The Administrator will be notified of any issues and immediate corrective action will occur. The DON or designee will submit a report of the monitoring to the QA Committee during the scheduled monthly meetings.	08/22/13 08/09/13 08/22/13

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F 431	Continued From page 6 between medication labels and Medication Administration Records (MARs) placed the resident at risk for adverse health effects and has the potential to result in medication errors. Failure to store all medication securely could result in unauthorized access to medications. Findings include: Review of the policy titled "Medication Labels/Reorders" occurred on 07/18/13. This policy, dated June 2001, stated, "Purpose: Medications are labeled in accordance with facility requirements and state and federal laws. Only the provider pharmacy modifies or changes prescription labels. . . . 5. Medications labels . . . If the physician's directions for use change . . . the nurse places a signal label on the container indicating there is a change in the direction use. When such a label appears on the container, the medication nurse checks the residents [sic] current MAR or the physician's order for up-to-date information. . . . 6. If directions for use change, the provider pharmacy is informed so that a new label can be ordered and applied. . . ." Review of the policy titled "Medication Administration guidelines" occurred on 07/18/13. This policy, dated March 2002, stated, "Procedure: . . . 7. . . . Always keep medication cart in clear view or lock before you leave it unattended. . . ." - During observation of medication pass on 07/16/13 at 8:20 a.m., a nursing staff member (#6) administered Resident #12's metolazone (a diuretic) 2.5 milligrams (mg). The Electronic MAR identified the medication metolazone 2.5 mg is to	F 431		

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F 431	Continued From page 7 be administered daily. Observation of the label on Resident #12's bottle identified metolazone 2.5 mg alternate every other day with 1.25 mg. The nurse (#6) stated the physician's order changed on 04/11/13 (over three months ago) and the pharmacy had not sent the new label yet. The bottle of metolazone failed to show a signal label on the container indicating there was a change in the directions for use per facility policy. - During review of the medication room and carts on 07/18/13, observation showed the medication cart for wings A and B in the hallway without a nurse in attendance. Observation showed the cart was unlocked and the surveyor could open the medication cart. The cart remained unlocked and unattended by the medication nurse (#5) from 8:20 a.m. until 8:25 a.m. During interview on 07/17/13 at 4:15 p.m., an administrative nurse (#1)confirmed the label on Resident #12's metolazone was not updated.	F 431		
F 441 SS=D	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 in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and	F 441	To ensure the facility provides a safe, sanitary, and comfortable environment and to help prevent the development and transmission of infection to Resident # 2 , Resident #5 and any other residents in the facility: The facility will review it's "Hand Washing Hygiene Policy" (See Att.F) with all employees. This policy is also included in the orientation process of new employees and contract employees. Facility or contract employees will continue to	08/22/13

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F 441	Continued From page 8 (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 record review, observation, review of facility policy, and staff interview, the facility failed to follow standard infection control practices for 1 of 1 sampled resident (Resident #2) observed during urinary catheter cares and 1 of 5 sampled residents (Resident #5) observed during personal cares. Failure to provide catheter care according to acceptable standards of practice placed Resident #2 at risk for developing a urinary tract infection. Failure to use gloves and perform hand hygiene appropriately during personal cares has the potential to spread infection within the facility.	F 441	receive a review of hand washing with their annual in-service training and as needed throughout the year. The "Catheter Care Policy" (See Att. G) was revised to include the procedure on emptying an urinary drainage bag. The revised policy on catheter care will be reviewed with licensed nursing staff and CNA's. The facility Administrator and DON collaborated with Contract Nursing Management to ensure Contract Nursing Services employees follow the facility process; they will receive a copy of the facility policy. The policy will also be reviewed with employee nursing staff, CNA's, and contract staff during their initial orientation process, with their annual orientation, and as needed. Monitoring of these infection control practices will occur by the DON/Infection Control Coordinator or appointed designee weekly x 1 month, monthly x 3 months, and quarterly thereafter x 1 year. The Administrator will be notified of any issues that are identified and immediate corrective action will occur. The DON or designee will submit a report of the monitoring results on hand hygiene and catheter care to the QA Committee during the scheduled monthly QA meetings.	08/15/13 08/04/13 08/22/13

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F 441	Continued From page 9 Findings include: Review of facility policy titled "HAND HYGIENE" occurred on 07/18/13. This policy, dated 2009, stated, ". . . I. HANDWASHING . . . after going to the restroom, and before eating, perform hand hygiene with either a non-antimicrobial soap and water or an antimicrobial soap and water. . . ." - Review of Resident #2's medical record occurred July 15-18, 2013. Resident #2's current care plan identified the following: "Elimination . . . urinary retention and an indwelling foley catheter . . . Foley catheter cares, follow standard precautions with emptying foley bag/with cares . . ." On 07/16/13 at 1:25 p.m., observation showed a certified nursing assistant (CNA) (#2) prepared to empty Resident #2's urinary catheter leg drainage bag. Resident #2 sat in the recliner with his feet on the floor while the CNA removed the protective cap from the drainage bag tube and laid the cap on the floor. The CNA opened an alcohol swab and cleansed the end of the tubing and laid the remaining unopened packets of alcohol swabs on the floor. The CNA emptied the urine, picked up an alcohol swab from the floor, tore it open and cleansed the end of the tube. The CNA picked up the cap from the floor, did not cleanse the cap, and put it on the end of the catheter drainage tube. During an interview on the morning of 07/18/13, an administrative staff nurse (#1) stated the facility did not have a specific policy regarding emptying a resident's urinary catheter leg bag but expected standard infection control practices to be followed.	F 441		

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F 441	Continued From page 10 - On 07/16/13 at 11:30 am., observation showed a CNA (#2) assisted Resident #5 with dressing and preparing for the noon meal. While standing next to her bed, the CNA (#2) helped the resident remove her nightgown, changed the resident's incontinence product, and disposed of it in the garbage can by the bed. The resident adjusted her incontinence product and touched her perineal area before the CNA helped her finish dressing. After Resident #5 dressed, the CNA helped her walk to her wheelchair and transported the resident to the dining room for the noon meal. The CNA failed to perform hand hygiene and failed to assist the resident to wash her hands.	F 441		