DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 _____	07/28/2011

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 25, 2011 and completed on July 28, 2011, the sample included two (2) residents for complete review, seven (7) residents for focused review, and one (1) closed record for review. The sample included three (3) additional residents to verify specific concerns during the survey.	F 000		
F 278 SS=B	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a	F 278	To ensure the MDS 3.0 assessment accurately reflects resident #__7's_ status and any other residents that may be affected by this practice: The MDS team member in charge of coding section H will be using a quarterly assessment form to correlate with the quarterly MDS 3.0 to reduce the chance of a coding error from the hard(paper) copy to the electronic copy of the MDS 3.0 (see Att. A). The changes were reviewed with the MDS nursing staff that complete sect. H. during a Nurse Manager Meeting. Section H of the Long Term Care Facility Resident Assessment Instrument MDS 3.0 Users Manual was also reviewed with the MDS nurses to ensure that assessments are accurately captured on the MDS. A correction to Section H-question H0200C to Resident #_7's_quarterly MDS with an ARD of 07/05/11 was	08/22/11 08/31/11

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

Patti Johnson | Administrator | 090111

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.

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 _____	07/28/2011

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 278	Continued From page 1 material and false statement. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON JULY 14, 2010. Based on observation, record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual (Version 3.0), review of facility policies/procedures, review of professional reference, and staff interview, the facility failed to complete Minimum Data Set (MDS) assessments which accurately reflected the resident's status for 1 of 9 sampled residents (Resident #7) identified with a toileting plan. Failure to accurately assess residents and complete portions of the MDS to reflect the care provided may affect the level of care. Findings include: The Long-Term Care Facility Resident Assessment Instrument User's Manual (Version 3.0), page 2-1 states, ". . . The RAI process is the basis for the accurate assessment of each nursing home resident . . .", and page Z-6 states, ". . . The importance of accurately completing and submitting the MDS cannot be overemphasized. The MDS is the basis for the development of: * an individualized care plan * the Medicare Prospective Payment System * Medicaid reimbursement programs * quality monitoring activities, such as the quality indicator/quality measure reports * the data-driven survey and certification	F 278	made to ensure the assessment accurately reflects the current status and was submitted to the Centers for Medicare and Medicaid Services (CMS) and the North Dakota Department of Human Services. The MDS Coordinator or appropriate designee will monitor that assessments accurately reflect the current status of resident #__7__ and a sample of other residents. QA to ensure the assessment accurately reflects the resident status will be completed weekly x 1 month, monthly x 3 months, and quarterly thereafter x 1 year. The MDS Coordinator or appropriate designee will report any concerns identified to the Administrator. If issues are identified, immediate corrective action will occur. The MDS Coordinator will submit a report of the monitoring results to the QA Committee during the scheduled monthly meetings.	09/01/11 09/01/11

PRINTED: 08/15/2011
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 _____	07/28/2011

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 278	Continued From page 2	F 278		

process
* the quality measures used for public reporting
* research and policy development . . ."
Each person completing a section of the MDS is required to sign the Attestation Statement (Z0400) on page Z-6 that reads, "I certify that the accompanying information accurately reflects resident assessment information for this resident . . . I understand that this information is used as a basis for ensuring that residents receive appropriate and quality care . . ."

The Centers for Medicare and Medicaid Services (CMS) has outlined the standards of practice regarding toileting programs in the Long-Term Care Facility Resident Assessment Instrument User's Manual, Version 3.0, dated 07/10, page H-6, which states "Toileting (or trial toileting) programs refer to a specific approach that is organized, planned, documented, monitored, and evaluated, and is consistent with the nursing home's policies and procedures and current standards of practice. . . ."

Review of the facility policy and procedure titled "Bladder and Bowel Management" occurred on 07/28/11. This undated policy stated,
"Policy: Each resident must be assessed for bladder and bowel functioning . . . quarterly and any change in condition that affects continence.
Purpose: The purpose of the bladder and bowel management program is to :
1. Address resident's individual needs with respect to continence of the bladder and bowel. . . ."

- Review of Resident #7's medical record

PRINTED: 08/15/2011
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 _____	07/28/2011

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 278	Continued From page 3 occurred July 27-28, 2011. Diagnoses included Alzheimer's, osteoporosis, renal disease, and diabetes. Resident #7's annual MDS, dated 10/05/10, identified always incontinent of urine and not on a toileting plan. Resident #7's Care Area Assessment (CAA) for urinary incontinence, dated 10/12/10, stated, "Bowel and Bladder assessment was completed and . . . placed on a check and change program, as has had no voiding episodes." Resident #7's care plan, dated 07/12/11, identified a problem of alteration in elimination and "check/change." On 07/27/11 at 4:15 p.m. observation showed two certified nursing assistants (CNAs #19 and #20) check and change Resident #7's incontinent brief. During an interview on 07/27/11 at 5:00 p.m., the two CNAs (#19 and #20) stated Resident #7 is not toileted and is a "check and change." Resident #7's quarterly MDSs, dated 01/04/11, 04/01/11 and 07/05/11 identified the resident as always incontinent of urine and on a scheduled toileting program. During an interview on 07/28/11 at 9:30 a.m., a nursing staff member (#21) agreed the resident is not on a toileting program and the coding was incorrect according to the RAI manual and the facility would need to submit a correction.	F 278		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309	To ensure adequate consistency of liquids and supervision for Resident	

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 _____	07/28/2011

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 309	Continued From page 4 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, policy and procedure review, family interview, and staff interview, the facility failed to ensure the care and services necessary to avoid choking, coughing, and/or injury for 1 of 1 sampled resident (Resident #3) receiving pureed foods and pudding thick liquids. Failure to provide the necessary care and services for a resident with swallowing problems places him/her at risk for choking and possible aspiration/injury. Findings include: Review of the facility policy "Thickened Liquids" occurred on July 28, 2011. This policy, dated 2002, stated, "Policy: All individuals requiring thickened liquids as recommended by the speech and language pathologist (SLP) and ordered by the physician will be serviced liquids in a form to minimize the risk of choking and aspiration. Procedure: 1. The food service department will receive a written order for individuals requiring liquids. . . . 3. The following consistencies may be ordered based on individual needs: *Thin - water, coffee, tea, . . . anything that will liquify in the mouth within a few seconds (1-50 cp [centipoise]) *Nectar-like - Fruit nectars such as apricot, . . .	F 309	#_3___, an in-service was held for the Nursing, Activity, and Dietary staff to review the Policy/Procedure on Thickened Liquids (See Att. B) and the Mealtime Policy (See Att. C). Our Consultant OT (trained in dysphagia therapy) completed and demonstrated the appropriate consistencies for thin, nectar-like, honey-like, and spoon thick/pudding consistencies during the scheduled mandatory meetings. The Dietary Manager or appropriate designee will monitor residents that use thickened liquids to ensure the ordered liquid consistency of the individual is delivered appropriately and that appropriate supervision and/or assistance is delivered to #_3___and a sample of other residents 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 Dietary Manager or appropriate designee in her absence will submit a report of the monitoring results to the QA Committee during the scheduled monthly meetings.	08/11/11 and 08/31/11 09/01/11

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 _____	07/28/2011

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 309	Continued From page 5	F 309		

maple syrup, eggnog. . . or beverages thickened to nectar consistency (51-350 cp) *Honey-like - thickened to honey consistency (351-1750 cp) *Spoon Thick - thickened to a pudding consistency (>1750 cp). Note: cp = centipoise, a measurement of the thickness of a liquid. 4. The SLP may request other consistencies based on the individual's condition and/or need. . . . 5. The facility will determine whether nursing or food service will thicken the liquids or if already thickened products will be used. Manufacturer's instructions will be followed when using thickening agents to provide the ordered consistency of liquids. 6. The registered dietitian/dietetic technician (RD/DTR) and/or nursing supervisor will monitor staff competency for compliance as part of quality assurance."

- Review of Resident #3's medical record occurred on July 25-28, 2011. Medical diagnoses for Resident #3 included dementia. Resident #3's current quarterly Minimum Data Set (MDS), dated 07/16/11, identified problems with long and short term memory, severe cognitive impairment, required supervision with eating, had no swallowing problems, and received a mechanical soft diet.

Nurses notes identified the following:
*07/20/11 at 6:10 p.m. - "CNA [certified nursing assistant] reported resident coughing/unable to clear throat. . . . Temp 101.5. Suctioned and removed light yellow to white phlegm each time she was able to cough. Gradually sounded better . . . Oxygen started at 5 L [liters] NC [nasal cannula] . . . Tylenol given . . . HOB [head of bed] elevated and resident assisted to sit straight up. MD [medical doctor] notified of status - orders to

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 _____	07/28/2011

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 309	Continued From page 6 give Z-Pac (an antibiotic) as directed either pill form or liquid. Informed at that time that resident was not a good pill taker at time but said to go with the order provided. Left message for rehab coordinator for ? [question] eval [evaluation] needed as resident had been eating in the dining room [with] the correct meal/consistency per self. . . . " *07/21/11 at 12:55 p.m. - "Resident did not take her noon oral medication due to coughing spell." *07/21/11 at 1:15 p.m. - "Resident coughed on fluids at breakfast this am. Will do a trial of nectar consistency. All departments notified. . . ." *07/21/11 at 1:48 p.m. - "Resident was coughing on thickened milk at dinner time. She could not swallow it down or cough it out. Resident was suctioned. O2 [oxygen] after suctioning was 69% on RA [room air], non-rebreather mask was applied at 15 liters . . . MD updated on change of status and notified that resident was being sent to the ER [emergency room]. ER nurses were updated as well as family. . . " Resident #3 returned from the hospital on 07/23/11 with a diagnosis of aspiration pneumonia and an order for Rocephin [an antibiotic] and a pureed diet with pudding thick liquids. Resident #3's current care plan identified the following: Problem: *H/O [history of] aspiration pneumonia. . . Approach: . . . Set up and cue. Prefers to feed self. Slow eater. . . . Sits @ [at] supervised table. Resident likes to be (I) [independent]. Monitor during meal time. Assist as needed. . . . Nursing to monitor closely for s/sx [signs and symptoms] of pain, aspiration, coughs, throat clears, water eyes, wet gurgly voice. . . . Problem: Potential for infection. . . *H/O pneumonia - aspiration. *Dysphagia. Approach:	F 309		

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 _____	07/28/2011

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 309	Continued From page 7 Follow dysphagia guidelines. . . . Suction PRN . . . 7/23/11 Sitting on C-wing meals until further notice. Sit up . . . for 1/2 hr [hour] [after] meals. . . ." Observation of the evening meal occurred at 4:45 p.m. on 07/25/11. Resident #3's family member sat with the resident during the meal. The family member stated her mother needs to be watched closely while she eats because of a choking episode she recently experienced. Resident #3 received pureed food and three glasses of thickened liquids. The consistency of the liquid in two of the glasses was pudding thick, but the consistency of the liquid in the third glass was nectar thick. Resident #3's family member set this glass aside and stated that sometimes the thickened liquids from the dietary department are not thickened to pudding thick, which she stated was "not safe." Observation at 12:30 p.m. on 07/26/11 showed an occupational therapy staff member sitting with Resident #3 during the meal. A "Dysphagia Communication Note" written by the therapist after the evaluation on 07/26/11 stated, "Dining Supervision: Close. . . Liquid: Spoon thick. . . Techniques: Slow Rate. Oral intake: when alert and attentive only. Keep upright for 30 minutes after meal. Alternate solids/liquids. Special Notes: Nursing to monitor closely for signs/symptoms of aspiration - coughs, throat clears, watery eyes, wet gurgly voice. Therapist to follow for treatment. . . ." Observation at 9:50 a.m. on 07/26/11 showed a full glass of thickened water on Resident #3's night-stand. The consistency of the water was between nectar or honey thick, not pudding thick.	F 309		

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 _____	07/28/2011

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 309	Continued From page 8 Staff did not offer Resident #3 this water during the observation. Observation at 3:25 p.m. on 07/26/11 showed a CNA (#6) reached for a full glass of thickened water on Resident #3's night-stand. The consistency of the water was nectar or honey thick, not pudding thick. The CNA stated, "We need to get her a fresh glass." Another unidentified staff member (#13) took the glass out of the room and prepared a new glass of thickened water in the kitchenette at the nurse's station. The staff member added three and a half partially filled scoops of the thickening powder to the glass of water. The staff member stated she does not measure the powder and that she "does better mixing it by eye, instead of measuring as I can tell by the consistency." Observation at 9:45 a.m. on 07/27/11 showed the CNA (#3) brought Resident #3's breakfast tray into the room and set it in front of her. The meal consisted of pureed eggs, pureed cereal and pureed bread; pudding thick water, juice and milk; and a half of a banana, which was not pureed. The CNA left the room and occasionally checked in on the resident, but did not closely monitor her during the meal. Observation showed Resident #3 picked up the banana and attempted to peel it. The surveyor asked the CNA if the resident should have the banana and the CNA stated, "I was wondering about that" and she went and asked the nurse. The CNA came back to the room and stated staff are supposed to smash the banana so that it is pureed. The CNA smashed the banana to a pureed consistency for the resident and again left the room. Resident ate some of the pureed food and the pudding thick liquids in her room without supervision from staff.	F 309		

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 _____	07/28/2011

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 309	Continued From page 9 During interview the morning of 07/28/11, an administrative dietary staff member (#12) confirmed consistencies of pudding thick liquids have been a problem. During interview at 9:30 a.m. on 07/28/11, an administrative nursing staff member confirmed staff should monitor Resident #3 while eating and provide the correct consistency of food and fluids. Failure of staff to provide Resident #3 with food and fluids in the correct consistency and failure to provide close monitoring as ordered placed the resident at risk for another choking/aspiration episode.	F 309		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON JULY 14, 2010. Based on observation, record review, policy/procedure review, and staff interview, the facility failed to ensure residents receive	F 315	To ensure an appropriate individualized toileting plan and provision of appropriate assistance with incontinence cares for resident #_3__and resident #__4__ and any other resident that may be affected by this practice; mandatory meetings were held for the licensed nurses and Certified Resident Assistants (CRA's) to review the revisions made to the strategies/approaches on the Prompted Voiding and Toileting Routines section of the Bladder and Bowel Management Policy and Procedure (see Att. D). QA monitoring will be completed by the DON or appropriate designee to ensure that the toileting policy and appropriate assistance with	08/11/11 and 08/31/11 08/10/11 09/01/11

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 _____	07/28/2011

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 315	Continued From page 10 appropriate services to prevent urinary tract infections and to restore as much normal bladder function as possible for 2 of 6 sampled residents (Resident #3 and #4) on a toileting program. Failure to implement an individualized toileting plan and provide assistance with incontinence cares does not allow residents to achieve the highest level of continence possible, and places them at risk for impaired skin integrity, urinary tract infections, and a loss of dignity and comfort. Findings include: Review of the facility policy titled "Bladder and Bowel Management," occurred on 07/28/11. This undated policy stated, "POLICY: Each resident must be assessed for bladder and bowel functioning . . . quarterly and any change in condition that affects continence. PURPOSE: The purpose of the bladder and bowel management program is to: 1. Address resident's individual needs with respect to continence of the bladder and bowel. 2. Initiate appropriate strategies and interventions. 3. Provide learning opportunities. 4. Monitor and evaluate resident outcome. PROCEDURE: . . . B. Care Planning 1. The interdisciplinary team will initiate a written plan of care upon completion of the bladder and bowel continence assessment and update as necessary. 2. Promote the independence and dignity of continent residents by: . . . Assisting as required. 3. Develop an individualized toileting routine for each individual resident. 4. Ensure that all residents, where possible, are toileted e.g., toilet incontinent residents. . . . 6. Reassess and evaluate the effectiveness of the resident's continence care plan on a quarterly basis. 7. Educate staff, resident and families on	F 315	incontinence care is provided to resident #_3_ and _#_4_ and a sample of other residents weekly x 1 month, monthly x 3 months, and quarterly thereafter. The Administrator will be notified of any issues. If issues are identified immediate corrective action will occur. The DON will submit a report of the monitoring results to the QA Committee during the scheduled monthly meetings.	

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 _____	07/28/2011

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 315	Continued From page 11 continence/incontinence care. . . " Review of the policy titled "Interventions to Promote Urinary Continence" occurred on 07/28/11. This undated policy stated, "Strategies/Approaches - Bladder Routines. Description. . . . Purpose of a toileting routine: Restore a normal pattern of voiding. Reduce incontinent episodes. Provide for resident comfort. Hygiene. Safety. Increased self-esteem. Prevent skin breakdown. Interventions: 1. Assist resident to transfer to toilet or commode. . . 5. Allow resident 5 minutes to void. 6. Provide peri-care as required. . . .12. Toilet the resident at the following times based on the individual resident's pattern - Upon awakening in the morning; After breakfast; Before or after lunch; Before or after supper; At bedtime; During the night if resident is awake. . . ." - Record review for Resident #4 occurred on July 26-28, 2011. Medical diagnoses included Alzheimer's disease, urinary retention, benign prostatic hyperplasia, constipation, and history of urinary tract infections (UTIs). The most recent quarterly Minimum Data Set (MDS), dated 07/15/11, identified Resident #4 with short and long term memory problems, severe impairment with daily decision making, extensive assistance with toileting and transfers, frequent bowel and bladder incontinence, and a toileting program. The medical record identified an order dated 07/25/11 for Cipro 500 mg twice a day for treatment of a urinary tract infection. The current comprehensive care plan stated, "PROBLEM: Self Care Deficit. BHP/Retention . . . Incontinent B/B [bowel and bladder] . . .	F 315		

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 _____	07/28/2011

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 315	Continued From page 12	F 315		

APPROACH: . . . Toileting: assist with perineal cares as allows/needed. . . . On timed toileting program. . . ." The care plan further identified staff could use the Hoyer lift for transfers if sleepy and unable to stand.

A "Bowel and Bladder Assessment", dated 06/24/11, identified Resident #4 on an every 2 hour toileting schedule. The "Bowel and Bladder Training Records" for June-July 2011 showed, during scheduled toileting times, staff consistently documented no toileting of Resident #4 when dry. During the next scheduled toileting episodes after being dry, the records consisently indicated incontinence with toileting.

Observations on 07/26/11 at 9:30 a.m. showed Resident #4 dozing off with his eyes closed. Two certified nursing assistants (CNAs) (#7 and #11) transferred Resident #4 into bed using the Hoyer lift. The CNAs did not provide toileting and did not check Resident #4's brief. During a follow up interview at 12:30 p.m., the CNA (#7) stated Resident #4 is "checked and changed." The CNA (#7) stated she did not check Resident #4 at 9:30 a.m. because she "forgot." She further stated she checked the resident at 11:00 a.m., and he was wet.

Observation on 07/27/11 identified the following:

* 9:35 a.m. Resident #4 awake and alert. Two CNAs (#7 and #8) toileted the resident using the stand lift. Observation showed Resident #4's brief wet with urine. The CNAs did not provide frontal pericare to Resident #4.

* 11:15 a.m. Two CNAs (#7 and #8) offered

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 _____	07/28/2011

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 315	Continued From page 13 Resident #4 toileting, which he refused. The CNAs did not toilet Resident #4 at that time and did not check his brief. * 2:55 p.m. Two CNAs (#9 and #10) transferred Resident #4 to the toilet using the stand lift. Observation showed the Resident's brief wet. The CNAs did not perform thorough frontal pericare prior to applying a dry brief. * 5:15 p.m. Two CNAs (#9 and #10) transferred Resident #4 to the toilet using a stand lift. Observation showed the Resident's brief dry. The resident did not void and sat on the toilet for less than a minute before the CNAs asked him if he was done. As the CNAs began to stand Resident #4 to a standing position, The resident he began to void into the toilet and into his dry brief. The CNAs lowered him to a sitting position, and he finished voiding in the toilet. The CNAs then changed the resident's wet brief and performed pericare. During an interview on the morning of July 28, 2011, an administrative staff member (#2) agreed staff should provide thorough perineal care for Resident #4 with his history of UTIs. She further agreed staff should follow the resident's toileting plan, initiate toileting when the resident is dry, and allow adequate time for toileting. - Review of Resident #3's medical record occurred on July 25-28, 2011. Medical diagnoses for Resident #3 included osteoarthritis and dementia. Resident #3's current quarterly MDS, dated 07/16/11, identified problems with long and short term memory, severe cognitive impairment, required extensive assistance with transfers, toilet	F 315		

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 _____	07/28/2011

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 315	Continued From page 14	F 315		

use and personal hygiene, frequently incontinent of bowel and bladder, and on a toileting program.

Resident #3's current care plan identified the following: "Problem: Alt [alteration] in elim [elimination] *occ [occasional] bladder incontinence *osteoarthritis . . .*chairbound *pain *hearing loss - deaf, difficulty communicating. . . *H/O [history of] UTI [urinary tract infections] . . . Goal: Resident will maintain current level of continence in 3 mos [months] Approach: Bowel and Bladder Assessment - timed toileting schedule. Wears briefs. Assist [with] toileting. Assist [with] hygiene . . ."

Review of "Quarterly Continence Assessments," dated 01/31/11, 07/16/11, and 07/21/11, identified Resident #3 as "Incontinent - bladder incontinent on a daily basis. Bowel incontinent all or almost all of the time. . . . Bladder Control Pattern: Scheduled Toileting/Timed."

Observation at 9:50 a.m. on 07/26/11 showed two CNAs (#4 and #5) provided a bed bath and changed Resident #3's incontinent brief prior to getting the resident out of bed. The CNAs did not toilet Resident #3 after changing the incontinent brief.

Observation at 3:25 p.m. on 07/26/11 showed two CNAs (#5 and #6) assisted Resident #3 to transfer from her bed to the wheelchair. Resident #3 refused to have the CNAs bring her to the bathroom to void. The CNAs had not checked the resident's brief prior to getting her up to see whether it was wet or dry.

Review of Resident #3's "3-Day Voiding Trial"

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 _____	07/28/2011

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 315	Continued From page 15 dated July 26-28, 2011, showed an hourly schedule, however the documentation showed periods where staff only documented every two hours and for the morning of 07/26/11, staff failed to document anything. The "Bowel and Bladder Toileting Record for Timed Scheduled Toileting" from July 26-28, 2011 showed a schedule of toileting every 2 hours, but the documentation reveals discrepancies between the above two records and also with the observations made on July 26-27, 2011. It is unclear what Resident #3's specific "timed toileting schedule" actually is. During interview, the morning of 07/28/11, an administrative nursing staff member (#2) confirmed the specific toileting plan was not clearly defined, and staff were inconsistent with toileting Resident #3.	F 315		
F 323 SS=E	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: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 07/14/10. Based on observation, record review, review of policy and procedure, and staff interview, the facility failed to correctly utilize assistance devices	F 323	To ensure that each resident receives adequate supervision and assistance devices to prevent accidents the facility reviewed and revised it's policies and procedure on Safe Resident Lifting (See Att. E). An in-service was held for the Nursing Department. Our Consultant Occupational Therapist demonstrated appropriate transfer methods and a training video was reviewed by the licensed nurses and Certified Nursing Assistants demonstrating the proper use of the SARA 3000 (new stand lift). QA monitoring of resident	08/10/11 08/11/11 and 08/31/11 09/01/11

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 _____	07/28/2011

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 323	Continued From page 16 (stand lift and gait belt) during transfers for 3 of 6 sampled residents (Resident #2, #4 and #9) and 1 supplemental resident (Resident #13) requiring extensive to total assistance with transferring. Failure to utilize mechanical lifts and gait belts appropriately has the potential to cause injury or pain to residents who require a mechanical lift and/or gait belt for transfers. Findings include: Review of the facility policy titled "Policy and Safe Resident Lifting and Repositioning" occurred on July 28, 2011. This policy, undated, stated, ". . . All direct care staff members are encouraged to adhere to . . . safe lifting policies which are intended to eliminate unsafe lifting practices and reduce resident and caregiver injuries . . . 5. Manual lifting of residents is discouraged . . . Gait belts are to be utilized with transfers in and out of bed or the wc [wheelchair], recliners . . . to reduce chance of injuries . . ." - Record review for Resident #2 occurred on July 26-27, 2011. Medical diagnoses included peripheral vascular disease with venous stasis ulcer, congestive heart failure, diabetes and hypertension. The most recent quarterly MDS, dated 06/19/11, identified Resident #2 required extensive assist of one person for transfers. Observation of Resident #2 on 07/26/11 identified the following: * At 7:40 a.m., two certified nursing assistants (CNAs #17 and #18) utilized the facility's new stand lift to transfer Resident #2 from the bed to the toilet. Initially the CNAs applied the lift sling	F 323	# __2_, #_4__,_#9___, #__13___, and a sample of other residents that may be affected by this practice will be completed by the DON or appropriate designee 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 will submit a report of the monitoring results to the QA Committee during the scheduled monthly meetings.	

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 _____	07/28/2011

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 323	Continued From page 17	F 323		

upside down and began to stand the resident and then stated they realized "something is not right." Both CNAs stated the stand lift was new and neither of them had used it before. The two CNAs then turned the lift sling to the proper upright position and proceeded to transfer Resident #2.

* At 4:15 p.m., two CNAs (#15 and #16) utilized the facility's new stand lift to transfer Resident #2 from the wheelchair to the toilet. Both CNAs stated the stand lift was new and they had not used it before. Resident #2 expressed concern regarding getting to the toilet in time due to the CNAs taking longer than usual to complete the transfer.

- A random observation on 07/26/11 at 10:55 a.m. showed two CNAs (#11 and #14) repositioned Resident #13 in her wheelchair. The CNAs applied a gait belt around Resident #13's waist, then grabbed her from underneath her arms (axilla) and lifted the resident up in her chair, without holding onto the gait belt.

- Record review for Resident #4 occurred on July 26-28, 2011. Medical diagnoses included Alzheimer's disease, anxiety, and a history of falls. The quarterly Minimum Data Set (MDS), dated 07/15/11, identified Resident #4 with short and long term memory problems, extensive assistance for transfers, and no recent falls.

The current comprehensive care plan stated, ". . . gait belt with transfers . . . Use Hoyer [lift] if sleepy . . . appropriate to use stand lift PRN [as needed] or assist of 2 for transfers. . . ."

Observation of Resident #4 on 07/27/11 identified

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 _____	07/28/2011

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 323	Continued From page 18 the following: * 9:35 a.m. Two CNAs (#7 and #8) transferred Resident #4 onto the toilet using the stand lift. Observation showed the sling and the safety belt from loose around the resident's waist. When the CNAs transferred Resident #4 to a standing position, the sling rode up underneath the resident's arms (axilla). Neither CNA adjusted the belt/sling to fit snuggly around the resident's waist during the transfer to or from the toilet. * 2:55 p.m. and 5:15 p.m. Two CNAs (#9 and #10) transferred Resident #4 from his bed into his wheelchair using a pivot transfer and a gait belt. The CNAs placed the gait belt loosely around the resident's waist. The CNAs grabbed Resident #4 from underneath his arms (axilla) with one hand and lifted upward while holding onto the loose gait belt with other hand. The CNAs brought the resident into the bathroom and transferred the resident from the wheelchair onto the toilet using a stand lift. Observation showed the sling and the safety belt loose around the resident's waist. When the CNAs transferred Resident #4 to a standing position, the sling rode up underneath the residents arms (axilla). Neither CNA adjusted the belt/sling to fit snuggly around the resident's waist during the transfer to or from the toilet. - Record review for Resident #9 occurred on July 27-28, 2011. Medical diagnoses included Rheumatoid arthritis, osteoporosis, Parkinson's disease, postural hypotension, and osteoarthritis. The most recent quarterly MDS, dated 06/26/11, identified Resident #9 with short and long term memory problems, severely impaired in daily decision making, and total assistance for	F 323		

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 _____	07/28/2011

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 323	Continued From page 19 transfers. The current comprehensive care plan stated, ". . . Transferring: . . . 1-2 [staff] or use stand aid, . . . Gait Belt with transfers - lift equipment as needed or 1-2 assist . . ." Observation of Resident #9 on 07/27/11 identified the following: * 3:25 p.m. Two CNAs (#9 and #10) transferred Resident #9 from a recliner to her wheelchair using a pivot transfer and a gait belt. The CNAs placed the gait belt loosely around the resident's waist. The CNAs grabbed Resident #9 from underneath her arms (axilla) with one hand and lifted upward while holding onto the loose gait belt with the other hand. The CNAs brought the resident into the bathroom and transferred the resident from her wheelchair to the toilet using a stand lift. Observation showed the sling and the belt loose around the resident's waist. When the CNAs transferred Resident #9 to a standing position, the sling rode up underneath the resident's arms (axilla). Neither CNA adjusted the belt/sling to fit snuggly around the resident's waist during the transfer to or from the toilet. * 5:25 p.m. Two CNAs (#9 and #10) transferred Resident #9 from her wheelchair to the toilet using a stand lift. Observation showed the sling and the belt from the stand lift loose around the resident's waist. When the CNAs transferred Resident #9 to a standing position, the sling rode up underneath the residents arms (axilla). Neither CNA adjusted the belt/sling to fit snuggly around the resident's waist during the transfer to or from the toilet.	F 323		

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 _____	07/28/2011

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 323	Continued From page 20 During an interview on the afternoon of 07/28/11, two administrative staff members (#1 and #2) stated staff are educated on the correct usage of mechanical lifts and gait belts on an ongoing basis and should be implementing the correct techniques. The staff members further stated the staff on the B wing were educated on the new mechanical lift.	F 323		