STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355069	A. BUILDING _____ B. WING _____	05/26/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND CARE CENTER	620 14TH AVE NE DEVILS LAKE, ND 58301

(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 05/23/11 and completed on 05/26/11 the sample included four residents for complete review, nine residents for focused review, and two closed records for review. The sample included two additional residents to verify specific concerns during the survey.	F 000		
F 164 SS=B	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment	F 164	1. Resident #9 will be re-direct- & ed to the public phone locat- 2. ed in A-Solarium or hallway phone. Facility will also speak to residents family again regarding getting him a personal phone/line. Charting room phone will no longer be in use after re-location of charting area. on June 29, 2011 Education will be given at mandatory nursing meeting scheduled for July 13, 2011. per phone ℄ DON, Tammie Roed 7-13-11 @ 1436 AB 3. New Wing Charting Room will be relocated and medical records will be stored in closed cabinets when not in use. Front records will also be stored in closed cabinets to ensure confidentiality of residents records.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Marinda Olson
TITLE: Administrator
(X6) DATE: 7/1/11

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 164	Continued From page 1 contract; or the resident. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 05/13/10. Based on observation and staff interview, the facility failed to maintain the privacy and confidentiality of the residents' personal and clinical records during random observations on 2 of 4 days, May 25-26, 2011, of survey. Failure to maintain confidentiality of residents' clinical records could allow residents' medical information to be viewed by an unauthorized individual(s). Findings include: Observation on the morning of 05/25/11, showed Resident #9 exiting the front charting room where portions of the residents' medical record (intake/output records, bowel/bladder records) are stored and not locked. Resident #9 was unattended by staff. Observation on the afternoon of 05/25/11, showed Resident #9 unattended in the new charting room. The charting room contained confidential medical records including Minimum Data Sets, intake and output records, and bowel anf bladder records. The resident used the telephone at the desk and called two different family members. Observation on 05/26/11 at 8:57 a.m., showed Resident #9 attempting to make a phone call in the new charting room. No staff members were	F 164	4. Continual monitoring of residents records per administrative staff or other assigned person to ensure confidentiality of records. This will include daily audits of MAR's and TAR's x 1 month, then weekly x 1 month, then monthly thereafter.for 1 year. Chart location will be moved on June 29, 2011 and mandatory education will be held on July 13, 2011. 5. Monitoring will occur beginning July 14, 2011. QA's will be reviewed quarterly at scheduled QA meetings. If any issue is identified during an audit, correction will done, including staff education immediately. See exhibit A for audit sample. Compliance date: July 14, 2011 per phone call w Tammie, DON 7-13-2011 @ 1436 AS	

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F 164	Continued From page 2 present. Observation on 05/26/11 at 9:00 a.m., showed a medication cart with a medication administration record, (MAR), opened, and unattended by staff. The confidential resident information identified on the medication record included, in part, name, room number, prescribed medications, allergies, and name of physician. The nursing staff member (#2) administering medications was observed at the opposite end of the hall and a resident was observed walking by the medication cart. An interview with an administrative nursing staff member (#3) occurred on 05/26/11 at 10:15 a.m. The staff member stated she was aware of Resident #9 going into the new charting room to use the telephone and she also stated the residents' MARs should never be open and unattended.	F 164		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide care in a manner that enhanced the dignity and respect for 2 of 2 sampled residents (Resident #10 and #13) and 1 of 2 supplemental residents (Resident #17) receiving total assistance with eating in the dining room during 2 of 3 meals observed and 1 of 6	F 241	1. Nursing meeting held June 6, 2011, discussed current deficiencies. Staff #1 present at meeting. Education given in regards to treating residents with dignity. Staff educated on using napkins (cloth or paper) to clean residents face. Educated all on proper feeding. Staff educated on privacy and dignity regarding exposed body parts and keep residents covered and to provide privacy for all residents.	

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F 241	Continued From page 3 sampled residents (Resident #6) requiring mechanical lift assistance with transfers. Findings include: - Observation on 05/25/11 from 8:15 a.m. to 8:45 a.m., showed a certified nursing assistant (CNA) (#1) feeding Resident #13 spoonfuls of pureed cooked cereal and eggs. The CNA scraped excess eggs and cereal from the resident's face and mouth, refilled the spoon, and re-fed the food to the resident throughout the meal. - Observation on 05/25/11 at 8:10 a.m., showed a CNA (#1) feeding Resident #10 her breakfast meal. The CNA scraped the excess food from the resident's mouth and chin and re-fed it to her. The CNA (#1) failed to use the napkin available to wipe Resident #10's face. - Observation on 05/25/11 at 12:30 p.m., showed a CNA (#1) feeding Resident #17 in the dining room. The CNA scraped excess yogurt from the resident's mouth with a spoon. Observation further showed the CNA wiped Resident #17's face with her clothing protector several times during the meal. - Observation on 05/24/11 at 3:50 p.m., showed a CNA (#4) transferred Resident #6 from a wheelchair into her bathroom using a mechanical lift. The CNA placed the harness around the resident's chest, but failed to tighten the safety strap. The harness slid upwards during the lift, exposing the resident's left breast. The CNA failed to pull the resident's shirt down or cover the resident's breast until after she transferred Resident #6 back into her wheelchair following	F 241	2. Residents who require assistance with feeding are identified in plan of care and are assigned seating in dining room and diner. Will monitor compliance with QA's. New staff will also be educated at orientation upon hire. 3. Mandatory nursing staff meeting is scheduled for July 13, 2011. Mandatory dietary staff meeting is scheduled for July 12, 2011. 4. Continual monitoring by doing meal audits will begin on July 14, 2011. Audits will be conducted daily x 1 month, then weekly x 1 month, then monthly thereafter for 1 year. Mandatory education will be completed on July 12 and 13, 2011. 5. Monitoring will occur beginning on July 14, 2011. QA's will be reviewed quarterly at scheduled QA meetings. If any issue is identified during an audit, correction will be done, including education (staff) immediately. See exhibit B for audit example. Compliance date: July 14, 2011	

per phone
call c Tammie, DON
on 7-13-11 @ 1436 AS

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F 241	Continued From page 4 toileting. An interview with an administrative nursing staff member (#3) occurred on 05/26/11 at 8:15 a.m. The staff member stated CNAs are trained to not scrape food from a resident's face with their eating utensils. She agreed the CNA transferring Resident #6 should have tightened the lift's safety strap and should have pulled the resident's shirt down to cover her exposed breast.	F 241		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy and procedure, and staff interview, the facility failed to ensure the safety of 1 of 6 sampled residents (Resident #6) requiring the use of a mechanical stand-up lift device. Failure to properly apply and use assistive devices has the potential to cause injury and pain. Findings include: Review of the facility policy and procedure titled, "Using mechanical lifts for the safe transfer of our residents" occurred on 05/26/11. This policy, undated, included the "EZ Stand Operating	F 323	1. Resident #6 reassessed. She would not allow staff to tighten belt to keep sling in place. Resident #6 changed to a hoyer lift transfer. 2. All residents currently requiring the use of a PAL lift will be re-evaluated by July 8, 2011. 3. Mandatory staff education will be held July 13, 2011. Education will include Lift policy and procedure review, PAL lift video review. PAL lift competency evaluation of staff along with resident assessment will be completed monthly on residents requiring the use of a PAL lift. (See exhibit C, D, E)	

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F 323	Continued From page 5 Instructions", and stated, ". . . Apply Harness: 1) Position the top of the harness . . . around the upper body of the patient (approximately 4-5 inches below the underarm). 2) For the safety of the patient, securely fasten the safety strap around the patient's chest." Review of Resident #6's medical record occurred on all days of survey. Resident #6's diagnoses included general pain, weakness, anxiety, and dementia. The resident's most recent Minimum Data Set (MDS), dated 04/20/11, identified a Brief Interview for Mental Status score of 05, indicating severe cognitive impairment. The MDS also showed the resident required extensive to total assistance with all activities of daily living. The resident's careplan, dated 04/29/11, showed use of a PAL (mechanical assistive stand up device) every two hours for toileting. Observation on 05/24/11 at 11:15 a.m., showed a certified nursing assistant (CNA) (#5) assisted Resident #6 with toileting using a PAL lift. The CNA applied the harness, but failed to tighten the safety strap. The harness slid up into the resident's underarm area during the lift. Resident #6 stated, "Ow, ow, this hurts my arms." Following toileting, the resident was again assisted to a stand up position. Resident #6 stated, "This is the hard part" (referring to the lifting process). The CNA lowered the resident into her wheelchair and removed the harness. This surveyor asked Resident #6 if the harness caused her pain during transfers. The resident stated, "Yes, it hurts my shoulders. I have arthritis." Observation on 05/24/11 at 1:40 p.m., showed a	F 323	4. Continual monitoring by doing PAL Lift audits will be completed weekly x 3 months, then monthly indefinately. Audits will be discussed at quarterly QA meetings. Mandatory education will be completed July 13, 2011. 5. Monitoring will occur beginning on July 14, 2011. QA's will be reviewed quarterly at scheduled QA meetings. If any issue is identified during an audit, correction will be done, including staff education immediately. See exhibit F for PAL Lift Audit) Compliance date: 7-14-11 -per phone call w Tammie, DON 7-13-11 @ 1436 AS	

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F 323	Continued From page 6 CNA (#5) toileted Resident #6 using a PAL lift. The CNA failed to tighten and secure the harness strap and it slid upwards. The resident stated, "That hurts my arms just terrible. Oh no, no." Observation on 05/24/11 at 3:50 p.m., showed a CNA (#4) assisted Resident #6 with toileting using a PAL lift. The CNA failed to tighten the harness safety strap and it slid upwards into the resident's underarm areas. Resident #6 stated, "Ow, ow. Not too high." An interview with an administrative nurse (#3) occurred on 05/26/11 at 10:15 a.m. The nurse stated facility staff train the CNAs to tighten and secure the PAL lift harness to prevent it from sliding up under the residents' arms.	F 323		