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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355080	A. BUILDING _____ B. WING _____	C 11/17/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNSEITH COM NURSING HOME	15 1ST ST NE DUNSEITH, ND 58329

(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 and complaint survey started on 11/15/10 and completed on 11/17/10, the sample included 2 residents for complete review, 7 residents for focused review, and 1 closed record review. The sample included 3 additional residents to verify specific concerns during the survey.	F 000		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: 1. Based on review of facility policy, review of professional reference, and staff interview the facility failed to develop and implement policies and procedures requiring immediate reporting, followed by a written report of the investigation with in five days of an incident involving alleged abuse to the State agency for 1 of 1 facility investigations reviewed during the survey. Failure to develop and implement a facility abuse policy, which reflects the regulations governing Long-Term Care, has the potential to delay investigations when allegations of abuse and/or neglect are reported to facility staff. Findings include: The Centers for Medicare and Medicaid Services (CMS) has outlined the standards of practice	F 226	F-226 1) (A) The Abuse, Neglect and Misappropriation of Resident Property Policy has been revised to address immediate reporting and timely notification (not to exceed 24 hours) to the State Health Department of Allegations of Abuse, Neglect and Misappropriation of Resident Property Policy (attached). This corrective action will affect Resident #1 and all residents. (B) The DON has checked the CNA abuse registry on staff members #6 and #7 and they are cleared to work. 2. (A) and (B) All residents have the potential to be affected these same deficient practices.	

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

Jerrill Brenno | Nursing Home Administrator | 12/10/10

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 226	Continued From page 1 regarding the reporting of abuse and neglect to the State agency which states, "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). "Immediately" means as soon as possible, but ought not exceed 24 hours after discovery of the incident, in the absence of a shorter State time frame requirements." - Review of the facility policy titled, "Administrative Policy Subject: Abuse, Neglect and Misappropriation of Resident Property - Investigation and Reporting" occurred on 11/16/10. This policy, dated 06/23/08, stated, "Reporting . . . 2. The Administrator, Director of Nursing, or Director of Social Services will make a telephone report to the State health Department within the first working day an allegation is received. This report can be submitted in writing via fax. . . ." The policy fails to identify facility staff will contact the State immediately. The policy identified facility staff will contact the State on the first working day after an allegation. As worded in the policy, allegations reported to staff between Friday evening and Sunday morning may not be reported to the State within 24 hours. - Review of alleged allegations of abuse occurred on 11/15/10, at 3:40 p.m., with an administrative staff member (#2). Review of an investigation, involving alleged physical abuse, identified Resident #1 alleged a staff member slapped	F 226	3. (A) Staff will be inserviced by the DON/Designee on the revised Abuse, Neglect and Misappropriation of Resident Property Policy. (B) The DON has developed A new check list for new CNA applicant (attached) that includes checking the CNA abuse registry before they are hired, including nurses that have been a CNA in the past. This checklist will be given to the Office Manager/ Assistant at time of signing employment papers who will check and initial that all registries have been checked. This will then be returned to the DON to continue new hire checklist.	

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F 226	Continued From page 2 him/her across the face, on 07/24/10, a Sunday. The date on the "Resident Grievance / Abuse Concern Form" date of referral is identified was 07/25/10, the following Monday. The description of the incident stated, "Res [resident] was getting washed up during AM [morning] cares on 07/25/10 [and] told CNA [staff name] that he wanted to get up earlier [at] 5 AM [and] put his light on. He then said the CNA, . . . slap [sic] across the face [and] turned his light off." The form identified no observed injury. The "Resident Grievance / Abuse Concern Form" includes a section stating "This section is completed by Social Services: Mark or document the officials that needed to be contacted for this referral or incident. ND State Abuse Department [blank]." The form showed facility staff investigated the allegation on 07/26/10 and 07/27/10. No documentation identified the facility contacted the State within 24 hours of the allegation and at the conclusion of the investigation. During an interview, on 11/17/10 at 11:30 a.m., an administrative staff member (#1) stated staff placed the report under the door of an administrative staff member's office and the report was first seen by administrative staff on Monday. The administrative staff felt Resident #1 was not a creditable witness, and chose not to contact the State regarding this allegation. This staff member stated the report of the investigation showed Resident #1 changed his/her story during the investigation. The regulation from CMS identified facilities are to contact the administrator and State agency immediately when informed of an allegation of	F 226	4. (A) DON/Designee will check 1 time each week for 4 weeks and then 1 time each week until 100% compliance for 2 consecutive weeks and again in 6 months that all incident reports of Abuse, Neglect and Misappropriation Of Resident Property have been reported immediately and the State Health Department was notified within 24 hours of alleged incident. This will be reviewed at the regularly scheduled QA meeting. (B) DON/Designee will check 1 time each week for 4 weeks and then 1 time each week until 100% compliance for 2 consecutive weeks and again in 6 months checking that all nursing department new hires have had the CNA abuse registry check before hire. This will be reviewed at the regularly scheduled QA meeting. 5. The corrective action will be completed by 12-20-10.	

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F 226	Continued From page 3 abuse. When a resident alleged a CNA slapped his/her face, the facility failed to contact the State immediately, and report the facility's findings of their investigation to the State. 2. Based on record review, review of facility policy and staff interview, the facility failed to implement their policy regarding checking the Certified Nurse Aide (CNA) abuse registry for 2 of 3 newly hired staff members (#6 and #7) who currently are, or have been, CNAs. Failure to check the appropriate certification board has the potential for the facility to offer employment to a person with a work history of abuse and/or neglect, placing residents at risk. Findings include: - Review of the facility policy titled, "Administrative Policy Subject: Abuse, Neglect and Misappropriation of Resident Property - Investigation and Reporting" occurred on 11/16/10. This policy, dated 06/23/08, stated, "Protective Procedures: Screening: In an effort to assure protection of our vulnerable resident population, all potential employees are screened. Screening consists of: . . . d. Contacting appropriate certification or licensing Board to assure the applicant has accurate credentials, that their licenses are unencumbered, or to determine what capacity, if any, the licensing/certifying board will permit the individual to work." On 11/15/10, the facility provided a list of staff hired in the last four months. Review of the staff files for two of the three staff members (#6 and #7), showed the facility failed to check the certified nurse aide abuse registry, for staff who	F 226		

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F 226	Continued From page 4 are/were CNAs, during the hiring process. The facility hired the staff members (#6 and #7) on 09/03/10 and 10/14/10. Review of the employee file showed one staff member (#7) currently working as a CNA and the other staff member (#6) had previously worked as a CNA, prior to becoming a licensed nurse. During an interview on, 11/17/10 at 4:20 p.m., an administrative staff member (#2) identified the facility should have checked the CNA abuse registry for the two staff members (#6 and #7) at the time they were hired.	F 226		
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, record review, resident interview, and staff interview, the facility failed to provide care in a manner and environment that maintained or enhanced each resident's dignity and in full recognition of their individuality, for 3 of 9 sampled residents (Resident #2, #6, and #8) and 1 of 4 supplemental residents (Resident #11) regarding assistance during meals (Resident #2, #6, and #11) and visibility of a bedside commode (Resident #8). Failure to provide assistance during meals, failure to feed a resident in a dignified manner, and failure to store the commode away from the bedside when not in use did not maintain or enhance the residents' dignity,	F.241	F-Tag 241 (A) Resident #2 will have assistance and encouragement provided to him during mealtime. a)assist to cut up his food b)observe when he needs assist to scoop his food up from his plate. c)observe and assist when resident needs assist to be fed. d)ensure resident # 2 has the proper utensils/dishes to feed self. (B) Resident # 11 will have assistance or cueing with feeding. (C) Resident # 6 will not have his food scraped off his mouth or his clothing protector and fed back to him thus providing dignity with feeding. (D) Resident # 8 will have her commode removed from her room each morning and returned each night for her to use during the night (only time she uses it).	

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F 241	Continued From page 5 self worth, or esteem. Findings include: - Review of Resident #2's medical record occurred on November 15-17, 2010. The facility admitted the resident in 05/89. Current diagnoses included quadriplegia and aphasia. The resident's current quarterly Minimum Data Set (MDS) identified the resident required supervision and set-up help for eating and a plate guard for meals. Resident #2's current care plan, dated 09/23/10, stated "Problem . . . Self care deficit with eating. Uses lip plate . . . Problem . . . Potential risk for choking episodes . . . Encourage him to take smaller bites. Encourage him to chew foods thoroughly and to eat slowly. . . ." Observation at meal times identified Resident #2 seated in his wheelchair at a dining room table, eating independently from a lipped plate or bowl after meal set-up by facility staff and the following: *11/16/10, 8:05 a.m. - The resident dropped pieces of fried egg on his clothing protector, scraped the pieces off with his spoon, and ate them throughout the meal. Facility staff members walked by him without providing assistance or encouragement. *11/16/10, 11:45 a.m. - The resident dropped pieces of his taco on his clothing protector, scraped the pieces off with his spoon, and ate them throughout the meal. The resident received a small shallow bowl, without a lipped edge, with peaches. The resident attempted to use his spoon to eat the peaches but was unable to do so because of the shallow bowl. Resident #2 then picked up the bowl and ate the peaches from the	F 241	2. All residents who are fed by staff, have difficulty feeding themselves, and who use a commode at bedside have the potential to be affected by these deficient practices. 3. The DON/Designee will inservice the nursing staff on the importance of providing assistance to all residents during mealtime and feeding residents in a dignified manner. The nursing staff will also be inserviced on storing and covering commodes when not in use.	

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F 241	Continued From page 6 bowl. Facility staff members walked by him without providing assistance or encouragement. *11/16/10, 4:40 p.m. - The resident received a bowl of soup and a small disposable plastic cup of chicken salad. He attempted to use his spoon to eat the chicken salad but the small size of the cup did not allow him to get a spoonful. Resident #2 then picked up the plastic cup and ate the chicken salad from the cup. After consuming the chicken salad Resident #2 had an episode of coughing. At this time, facility staff questioned "Are you O. K.?" to which he responded "Yes." After the resident consumed the soup, he picked up the bowl and licked the inside. Facility staff members walked by him without providing assistance or encouragement and failed to determine the nature or cause of his coughing. - Observation in the facility dining room during the noon meal on 11/16/10 at 11:55 a.m. identified a licensed nurse staff member (#5) feeding Resident #6 a pureed diet. The staff member stood at his side and over him, bending forward to spoon the meal items and then to feed the resident. The staff member dropped food items on the resident's clothing protector, scraped it off, placed it on the dish, and fed it back to the resident. The resident had food material at the edge of his mouth which the staff member (#5) scraped off, placed it on the dish, and fed it back to the resident. During interview, on 11/17/10 at 11:45 a.m., an administrative nursing staff member (#2) reported Resident #2 resists assistance in the dining room, but she expected staff would place his chicken salad on his plate. This staff member (#2) agreed scraping and feeding the scraped food material to Resident #6 was not appropriate.	F 241	4. DON/designee will monitor in the Dining Room 4 times/week for 2 weeks and weekly until compliant for 2 consecutive weeks and again in 6 months to ensure all residents are getting the help they need and that they are fed with dignity. The DON/Designee will monitor 4 times/week those rooms who have residents using a bedside commode to ensure that the commodes are either stored in another room if not being used during the day, or are covered when not in use. The monitoring will continue weekly until 100% compliance is observed for 2 consecutive weeks, and again in 6 months. This will be reviewed at the regularly scheduled QA meeting. 5. The corrective action will be completed by 12/20/2010.	

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F 241	Continued From page 7 The facility identified Resident #2 is at risk for choking, needs encouragement for smaller bites, requires an adaptive plate, and resists assistance during meals. The facility staff provided a disposable plastic cup for his chicken salad and failed to assist him to access this meal item. The facility staff acknowledged his coughing episode but failed to recognize consuming the chicken salad from the plastic cup may have been a potential cause. Failure to provide assistance and encouragement for Resident #2 resulted in consuming his meal in an undignified manner, potential reduced self esteem, and placed him at risk of choking. Scraping food material and feeding the scrapings to Resident #6 did not provide a dignified dining experience for the resident. -Observation on 11/15/10 at 4:50 p.m. and 11/17/10 at 8:00 a.m. showed Resident #11 sitting at an assisted feeding table drinking milk from a nosey cup (a drinking aide that allows drinking without lifting the head, one side is cut lower than the other to prevent interference with the nose or eyeglasses). The resident held the nosey cup in a manner that allowed the milk to run down the sides of her mouth. Resident #11 dropped food onto her clothing protector while attempting to eat. Facility staff walked by and a CNA (unidentified) sitting next to the resident feeding another resident did not assist or cue Resident #11 while she ate. Failure to provide assistance or cueing for Resident #11 while she ate resulted in consuming her meal in an undignified manner and potential for reduced self esteem.	F 241		

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F 241	Continued From page 8 - Observation during the initial tour, on 11/15/10 at 11:15 a.m., identified a commode at Resident #8's bedside. Random observation on all days of survey showed the commode in the resident's room at the bedside or at the foot of the bed, uncovered, and clearly visible from the hallway. During interview, on 11/16/10 at 5:10 p.m., Resident #8 reported she uses the commode for toileting only at night. The resident reported the facility staff keep the commode in her room and "it could go someplace else." During interview, on 11/17/10 at 11:45 a.m., an administrative nursing staff member (#2) reported Resident #8's bedside commode could be stored in the bathroom when not in use during the day. Failure to remove Resident #8's commode from the room, when not in use, did not provide the resident a dignified room environment.	F 241	F-Tag 246 1. Resident #6 has been assessed on Dec. 3rd by our occupational therapist who has ordered a new wrist/hand splint to keep this residents hand open and dry. The care plan will be updated when the new splint arrives. The new splint will be kept in his room where it will be readily accessible for staff to apply. Resident #12 will be repositioned to the proper feeding position by the CNA before feeding him. 2. All residents who need adaptive equipment to prevent pressure sores, and all residents requiring assistance to be fed have the potential to be affected by these deficient practices.	
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview the facility failed to accommodate the needs for 1 of 2 sampled residents (Resident #6)	F 246		

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F 246	Continued From page 9 who required the use of a hand splint and 1 of 1 supplemental resident (Resident #12) observed being fed by staff using improper positioning. The facility failed to provide reasonable accommodations of individual resident needs. Findings include: - Review of Resident #6's medical record occurred on November 15-17, 2010. Diagnoses included: closed skull fracture with intracranial injury, spastic hemiplegia and hemiparesis. The Annual Minimum Data Set (MDS), dated 08/08/10, identified Resident #6 with a short and long term memory problem and moderate impairment with daily decision making. Functional limits identified partial loss of one side of his body and required total assist of 1 to 2 persons for all Activities of Daily Living (ADL's). Resident #6's current comprehensive care plan, dated 11/11/10, stated "Problem: Resident is at risk for pressure ulcer . . . Goal: Resident will have no new pressure ulcers develop. . . Approaches: . . . 7.) Palm-guard to left hand to keep fist open and prevent pressure sore areas. . . . " An annual physical therapy evaluation, dated 07/24/10, identified Resident #6 with limited function for range of motion and partial loss of voluntary movement to his hand including wrist or fingers. Observation on all days of survey showed the facility staff used a rolled wash cloth to keep Resident #6's hand open and dry. The facility staff failed provide a proper palm-guard as care planned. During interviews with certified nurse assistants	F 246	3. The DON/Designee will inservice the nursing staff on the importance of following the care plan/care card individualized to each resident. The DON/ Designee will also inservice on the importance of feeding in proper position. 4. The DON/Designee will monitor 5 residents/week until all residents have been monitored ensuring that all adaptive equipment on the residents care plan/care card are in place and that residents who need assistance in chairs are in proper position to be fed. Monitoring would continue until 100% compliancy is reached for 2 consecutive weeks and again in 6 months. This will be reviewed at the regularly scheduled QA meetings. 5. The corrective action will be completed 12-2-10.	

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F 246	Continued From page 10 (CNA's) (#12, and #13), on 11/16/10 and 11/17/10, stated they did not know where Resident #6's palm-guard was. "It might be in the laundry. Laundry usually comes back on the same day." During an interview on 11/17/10 at 10:45 a.m., an administrative nursing staff member (#2) stated she would expect staff to follow the care plan. An administrative staff member (#2) stated Resident #6's palm guard was found in the laundry closet and had not been returned to the resident because it was not marked as belonging to him. The facility staff failed to follow up in a timely manner the return of Resident #6's palm-guard to properly keep his hand open and reduce the change of developing pressure sores. - Review of Resident #12's medical record occurred on 11/17/10 at 9:00 a.m. Diagnoses included: seizure disorder, closed head injury, hemiparesis, and organic mood disorder. The resident's care plan reviewed on 10/21/10, stated "Problem: Left sided paralysis. . . assistance required with transfers, poor sitting balance, . . . Goal: Resident to demonstrate maintained ROM in all extremities . . . Approaches: . . . Staff to have protective padding [pillow on left side of w/c [wheelchair] for positioning as he allows] . . . Staff to be sure he is positioned well when in Geri chair. . . ." Observation on 11/16/10 at 11:45 a.m. identified Resident #12 in the dining room being fed by a CNA (#11). Resident #12 sat in his Geri-chair, leaning to his left, with his head hanging to the left and no support noted in the wheelchair to aid in positioning. The CNA continued to feed the	F 246		

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F 246	Continued From page 11 resident without repositioning him. Resident #12 coughed several times during the meal, and the CNA (#11) continued to feed him. At 12:04 p.m. a staff nurse (#10) entered the dining room, left, returned with a bath blanket and repositioned Resident #12 to a sitting position, supporting his left side. The CNA (#11) then continued to feed the resident. Further observation did not identify any further coughing from the resident during the meal. During an interview on 11/17/10 at 10:00 a.m., an administrative staff member (#2) stated she would expect staff to properly position Resident #12 in his chair at all times.	F 246		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview the facility failed to provide appropriate pressure relief for 1 of 3 sampled residents (Resident #6) with a history of pressure sores. Failure to provide pressure ulcer preventive measures for Resident #6 placed him at risk of developing pressure ulcers.	F 314	F-Tag 314 The Dunseith Community Nursing Home does have a Skin Care Policy/Program for preventing and healing pressure sores. See Attached. Resident #6 has been assessed by our Physical Therapist on Dec. 9, 2010. Resident #6 now has new heel-lifts on both heels. His care plan has been changed to remove the entry that heels must be floated on pillows as the resident now has heel lifts on which are adequate and more effective pressure relief than floating heels on pillows. Restorative Nursing orders have been changed to reflect the same. 2. All residents have the potential to be affected by this deficient practice.	

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F 314	Continued From page 12 Findings include: - Review of Resident #6's medical record occurred on November 15-17, 2010. Diagnoses included: closed skull fracture with intracranial injury, spastic hemiplegia, hemiparesis, and history of pressure sore to right heel. The Annual Minimum Data Set (MDS), dated 08/08/10, identified Resident #6 with a short and long term memory problem and moderate impairment with daily decision making. Functional limits identified partial loss of one side of his body, total assistance of 1 to 2 persons for all Activities of Daily Living (ADL's), and a history of resolved ulcers. Resident #6's current care plan dated, 11/11/10, stated "Problem, Resident is at risk for pressure ulcers . . . Resident has history of pressure sore., Goals, resident will have no new pressure ulcers develop. . . Approaches, . . . Staff to assist him with turning/repositioning at least every 2 hours. . . . Heels elevated off bed using pillows or other device (pillow should be placed under calves so that heels "float". . . ." Review of Resident #6's restorative nursing program, not dated, stated under skin care; ". . . Elevate heels off bed on pillow left heel. . . . Other: At risk for pressure sores . . . Heel-lift continuously to Rt. [right] foot and no shoe on left foot or right foot." Observations all days of the survey identified Resident #6 lying in a supine position in bed with both heels resting directly on the bed with no support to have his heels off the bed. *11/15/10 at 2:45 p.m. Resident #6 was lying in bed with both heels resting on the bed until 4:00	F 314	3. DON/Designee will inservice the nursing staff on the importance of following the care plan/care card for preventing pressure ulcers and ensuring that all preventative measures are in place. 4. DON/Designee will monitor 10 residents per week until all residents are monitored ensuring that all preventative measures on the their care plan/ care card are in place for preventing pressure sores. Monitoring will continue at 4 residents/week until 100% compliancy is reached for 2 consecutive weeks and again in 6 months. This will be reviewed at the regularly scheduled QA meeting. 5. The corrective practice will be completed by 12-20-2010.	

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F 314	Continued From page 13 p.m. *11/16/10 at 9:40 a.m. Resident #6 was laid down in supine position with heels on the bed until 11:15 a.m. *11/16/10 at 1:00 p.m. Resident #6 was laid down for a nap in the supine position with both heels resting on the bed until 4:00 p.m. *11/17/10 at 9:45 a.m. Resident #6 was transferred from his wheelchair to the bed, placed in a supine position with both heels resting on the bed. During an interview, on 11/17/10 at 10:00 a.m., an administrative staff nurse (#2) stated she would expect staff to follow the care plan when positioning Resident #6's legs. The facility was asked to provide a policy and procedure regarding pressure sore prevention. No policy was provided. The lack of facility staff providing appropriate/adequate measure relief to Resident #6's feet placed the resident at risk for developing avoidable skin breakdown.	F 314		
F 366 SS=D	483.35(d)(4) SUBSTITUTES OF SIMILAR NUTRITIVE VALUE Each resident receives and the facility provides substitutes offered of similar nutritive value to residents who refuse food served. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident and staff interview, the facility failed to ensure each resident received substitutes when they refused food served or meals which honored individual food preferences for 2 of 2 sampled	F 366	F-Tag 366 1. Residents #1, 13, and 5 will be provided with a substitute meal of similar nutritive value, if they do not want to eat the scheduled meal. Resident #5 will have desired condiment available to use with his meals. He will not be served potatoes.	

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F 366	Continued From page 14 residents and one supplemental resident who requested substitutes (Resident #1 and #13) or identified food preferences (Resident #5). Failure to provide residents with their desired food preferences or substitute food items when they refuse foods served places residents at risk of weight loss. Findings include: Food Preferences: - On 11/16/10 at 11:00 a.m., interview occurred with Resident #5 and the Dietitian (Staff #4). In discussing the upcoming meal, the dietitian indicated the facility would serve Indian tacos. The dietitian told Resident #5 since he couldn't have Indian tacos, the dietary staff made him a chef salad. Resident #5 indicated he didn't want a chef salad because he doesn't have teeth and could not chew the lettuce. The dietitian talked about chopping the lettuce, and the resident still indicated a desire not to have a chef salad. When a staff member delivered the meal, Resident #5 received a chef salad and hard boiled eggs. Condiments/seasonings were also discussed during the above interview. The resident indicated an awareness that he cannot have salt in his diet but did express a desire for more pepper and/or Tabasco sauce with his meals. He indicated staff bring him one "pepper packet" (a single serving packet) and he would like more. The dietitian indicated he could have more pepper with his meals and she said she would add it to his card. When a staff member delivered the meal, Resident #5 received one pepper packet with his meal.	F 366	2. All residents who do not want to eat the scheduled meal or desire condiments have the potential to be affected by this deficient practice. 3. The Dietician will make a list of substitute meal choices to offer residents that do not want to eat the scheduled meal. The Dietician will inservice Dietary Staff on preparing substitute meals, having supplies on hand to prepare substitute meals, and giving residents desired condiments. The DON will inservice CNA staff on offering residents that do not want to eat the scheduled meal a choice of substitute meals. 4. Dietary Manager/Designee will monitor 5 different residents at 2 meals a week for 4 weeks and then 1 meal a week until compliance is met at 100% for 2 consecutive weeks, and again in 6 months to assure that (A) residents who do not want to eat the scheduled meal are offered a substitute meal of similar nutritive value and (B) Desired condiments are given to residents who want them. Results of monitoring will be reviewed at the regularly scheduled QA meeting. 5. The corrective action will be completed by 12-21-10.	

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F 366	Continued From page 15 Another interview occurred later that same day with the dietitian (Staff #4). This staff member said she purchased Tabasco sauce for Resident #5. She also indicated she put information on his card that he can have more than one pepper packet with meals. Observation during the supper meal on 11/16/10 revealed Resident #5 received one packet of pepper and did not receive Tabasco sauce. Observation during the noon meal on 11/17/10 revealed a staff member brought Resident #5's tray containing one packet of pepper and no Tabasco sauce. The staff member did not ask if Resident #5 if he would like more pepper. When asked by the surveyor about the pepper, the resident indicated they "brought me one [packet], they always bring one." When asked if he would like more pepper, he said, "Ya, that would be nice." Resident #5 also received potatoes as part of his meal. When asked, the resident indicated he did not like these potatoes and would not be eating them. Observation during the meal found resident #5 ate other foods on his plate, but did not eat the potatoes. Review of Resident #5's tray card occurred at 8:00 a.m. on 11/17/10. The tray card contained no information to indicate Resident #5's preference for pepper. However, the card did identify "no potatoes." During interview at 8:00 a.m. on 11/17/10, a dietary staff member (#3) stated staff refer to these tray cards for information on what to serve each resident. Requested Substitutes: During a confidential interview held on 11/15/10 at 2:45 p.m., Resident A indicated the facility doesn't	F 366		

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F 366	Continued From page 16 offer food substitutes. When asked if the resident could have something more or different (regarding food) he/she said, "No." - During observation of the noon meal on 11/16/10, a staff member gave Resident #1 his food, which included an Indian taco and tomato soup. The resident did not want the Indian taco, gave the plate to the dietitian (#4) and asked for mashed potatoes. After some discussion between staff members, the dietitian indicated to the surveyor that the facility makes homemade mashed potatoes and they did not have any made. Although kitchen staff indicated the substitute for the Indian taco as soup and a sandwich, they did not offer Resident #1 a sandwich or any other substitute. The staff member (#4) told Resident #1 to eat his soup. -Observation on 11/17/10 at 12:00 p.m. identified Resident #13 asked a dietary aide (unidentified) for something different to eat for her meal. Resident #13 stated: "I don't like sauerkraut and polish sausage." Staff offered Resident #13 a chicken patty which she refused. Resident # 13 stated, "I had a chicken patty yesterday and it was so hard I couldn't eat it." The dietary aide did not offer Resident #13 any other choices. Resident #13 settled for a polish sausage and boiled potato. Resident #13 took one bite of the sausage then got up and left the table. During an interview on 11/17/10 at 12:40 p.m. Resident #13 stated, "They don't have many choices to pick from if you don't like something. They did not offer me anything but a boiled potato and polish sausage, not even a vegetable to replace the sauerkraut. I guess I'll be hungry when supper comes around. I sometimes fix	F 366		

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F 366	Continued From page 17 myself macaroni and cheese in my room if they don't serve foods I like."	F 366		
F 441 SS=E	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 (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.	F 441	F-441 Resident #3 has contact precautions in place.She has had one negative urine culture (11-23-10). We are in the process of obtaining 2 more cultures. Resident #7-lab work since admission confirms VRE in the urine. Contact precautions and appropriate signage is in place. The cna instruction card is Taped on top of the nightstand, where it is clearly visible. Appropriate PPE is readily available for use. Housekeeper #9 has been inserviced in the correct procedure for cleaning isolation rooms. 2.) All residents have the potential to be affected by this deficiency	

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F 441	Continued From page 18 This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview, and review of facility policy and procedure the facility failed to provide a safe and sanitary environment to help prevent the development and transmission of disease and infection for 2 of 2 sampled residents with a history of Methicillin Resistant Staphylococcus Aureus (MRSA) or Vancomycin Resistant Enterococcus (VRE) (Resident #3 and #7) and 1 of 4 supplemental residents (Resident #14); failed to ensure staff training and education in the facility's Infection Control Program; and failed to develop policies and procedures regarding dressing changes. These failures may have delayed treatment of infectious diseases for residents and placed all residents, visitors, staff, and the public at risk of developing disease and infections. Findings include: Review of the facility's Infection Control Policy and Procedure, Drug Resistant Organisms (DRO's), occurred on November 16-17, 2010. This document, revised 11/09, stated "POLICY: All residents infected or colonized with DRO's will be assessed for possible placement in Contact Precautions in order to minimize the risk of transmission to others. . . . PURPOSE: To aid in the prevention and control of DRO's within the facility while maintaining quality care for those residents who are colonized or infected with DRO's. PROCEDURE: . . . 2.) Identification of residents	F 441	3.) The infection control officer will have the admissions coordinator request that any labwork that was done in the hospital, be forwarded to this facility prior to admission or hospital return so that informed decisions can be made and appropriate isolation/precautions can be implemented and staff education be provided. The Housekeeping orientation checklist has been updated to include training and education on the proper procedure for the cleaning of isolation rooms. The Infection Control Officer will Inservice staff regarding the DRO policy, signage and cleaning. 4.) The Infection control officer will conduct Quality Assurance monitoring to be sure that correct isolation / precaution interventions are in place for the residents who are currently identified with a DRO and all new admissions and hospital returns. 12-14-10. Telephone call to DON at 11:10 AM. Add to POC: "DON will provide developed policies and procedures regarding dressing changes." DSM	

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F 441	Continued From page 19 with resistant organisms. The resident's chart and the name plaque on their door will be labeled with a green dot sticker to identify the presence of a resistant organism. This will alert staff to review the care plan/care card for use of appropriate precautions. A stop sign will be placed on the door of the resident identified as having a DRO. The stop sign will instruct visitors to report to the nurses station prior to entering the resident's room. Nursing staff will educate them on appropriate hand washing and PPE precautions to be followed. . . . DEFINITIONS: . . . Colonized: The presence of microorganisms in or on a host with growth and multiplication but no tissue invasion, damage, or clinical symptoms present. MRSA colonization will persist for very long periods with no symptoms, especially in the chronically ill. . . . PROVIDING CARES . . . Documentation, education and follow-up: 1.) Note precautions on resident care plan and care card. Include specific instructions needing to be followed. Example-PPE to be used, specific restrictions if any. 2.) Document in chart that precautions were started, resident's reaction, education that was provided and any other pertinent information. Inform and educate the guardian and family members as well. 3.) Notify other staff and departments as indicated. Discontinuing Precautions: Precautions may be discontinued when three sets of cultures are completed and shown to be negative. . . . Family and Visitor Precautions: . . . Family education should be provided for caregivers prior to discharge home." - During the initial tour, on 11/15/10 at 11:15 a.m.,	F 441	QA monitoring will be completed 2 times per month until 100% compliance is met. Then 1 time per month until 100% compliance is met, and then 1 time every 3 months until 100 % is met. The infection control officer will also complete QA monitoring to be sure that new housekeeping staff have been inserviced and that all housekeeping employees are following the correct procedure for cleaning isolation rooms. This QA study will be done 1 time per week until 100% compliance is achieved, then 2 times per month until 100% compliant, then once per month until 100% compliance is met. An additional QA study will be completed in 6 months to ensure that once we achieve compliance, that compliance is sustained. These studies will be reviewed at the Quality Assurance Meetings. 5.) The corrective action will be implemented by 12-20-2010	

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F 441	Continued From page 20 observation identified signage on Resident #3's room door identifying "Contact Precautions" and "Visitors report to the Nurse's Station." Following the tour, when questioned regarding the nature of the resident's infection, a supervisory nursing staff member (#5) reported Resident #3 did not have an infection and the signage was in place to direct family members to the nurse's station as there was a concern regarding family conflicts. Review of Resident #3's medical record occurred on November 15-17, 2010. The facility admitted the resident from a tertiary care facility on 11/09/10. Resident #3's discharge orders from the tertiary care facility, dated 11/08/10 at 3:00 p.m., included diagnoses of "Hx MRSA & VRE." The resident's admission history and physical to the tertiary care facility, dated 09/28/10, and included in the resident's transfer records to the facility, stated ". . . Per infectious disease . . . grew Staph [staphylococcus] aureus, and started on vancomycin, but this grew out MSSA [Methicillin Sensitive Staphylococcus Aureus] . . ." Resident #3's admitting physician orders to the facility, dated 11/09/10, were to follow the discharge orders from the tertiary care facility. The facility anticipated the local physician to see the resident on regular rounds on 11/16/10. Resident #3's Nurse's Notes, dated 11/14/10 at 12:00 p.m., stated "Spoke to MD [physician] about Res. [resident] hx. [history] of MRSA & [and] VRE. Res. was treated but not tested thereafter. MD recommeded [sic] to have DON [Director of Nursing] follow DCNH [Dunseith Community Nursing Home] policy on Res. [with] possible VRE or MRSA." Resident #3's current care plan, undated,	F 441		

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F 441	Continued From page 21 reviewed on 11/15/10 at approximately 3:00 p.m., stated "Problems . . . Admission papers indicate VRE . . . Approaches . . . Staff will use contact precautions when assisting res. [with] cares - use gloves." The care plan, when reviewed on 11/17/10, included the following undated entries which were not present on 11/15/10, "Problem . . . MRSA (+) [positive] @ [at] previous location. . . . Approaches . . . Contact Precautions, Put up appropriate labeling & identification, Obtain urine or lab draw to test for MRSA. . . ." Resident #3's physician orders included a telephone order, dated 11/16/10 at 1:25 p.m., stating "Routine UA [urinalysis]. Check for VRE." During interview, on 11/17/10 at 11:45 a.m., an administrative nursing staff member (#2) reported Resident #3 did not need monitoring or precautions for MSSA and did not have MRSA. Resident #3's medical record identified a history of MSSA, MRSA, and VRE. This staff member was uncertain why or when facility staff included the entries regarding MRSA on Resident #3's care plan. This staff member (#2) agreed the facility delayed beginning cultures to determine if VRE or MSSA remained present, to determine colonization of MRSA, and to determine if precautions remained necessary. This delay may have placed all facility staff, residents, and visitors at risk of exposure to these organisms. - Resident #7's medical record, reviewed on 11/16/10, identified the facility admitted the resident on 11/11/10 following a hospital stay. Current diagnoses included acute renal failure, diabetes, urinary tract infection (UTI), urine culture, VRE positive, and urine positive for Escherichia coli.	F 441		

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F 441	Continued From page 22 Resident #7's current care plan, dated 11/11/10, stated "Problem, Resident has a urinary tract infection. Possibly VRE from records. Goals, UTI will resolve within the next 14 days. Res. will test - [negative] for MRSA and VRE in next 90 days. Approaches, contact precautions used by staff. Label and put appropriate identification up. obtain urine or lab draw for testing. . . ." The resident's restorative nursing program, not dated, under special needs stated, ". . . contact precautions, good hand hygiene, gloves with direct cares, bathing and linen changes. gowns - wear if suspect that you will be coming in to contact with contaminated secretions." Resident #7's physician's orders dated 11/16/10 stated. ". . . UA [urinalysis] routine and check VRE." During initial tour, observation, on 11/15/10 at 11:30 a.m., identified Resident #7's door lacked any signage identifying contact isolation precautions. Observation on 11/17/10 at 8:20 a.m. identified the instruction card for isolation in Resident #7's night stand under her personal belongings, not readily available for staff to review. The room supplied only gloves in the bathroom. During interview, on 11/16/10 at 8:15 a.m., a CNA (#14) stated "staff are told at shift report if anyone is in isolation. There is a sign posted on the door and a green dot by their name. Gloves, mask, and gowns are kept inside the room in a stand by the door. There is a card on the stand with instructions."	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355080	A. BUILDING _____ B. WING _____	C 11/17/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 441	Continued From page 23 During an interview on 11/17/10 at 10:00 a.m., an administrative staff nurse (#2) stated "staff know where the gowns and masks are if they need them. We do not generally keep gowns and masks in resident rooms when in isolation." - Observation on 11/17/10 at 9:30 a.m., identified a housekeeper (#9) cleaning Resident #7's room. Resident #7's door had signage for contact isolation posted and a green dot by her name. The housekeeper positioned a utility cleaning cart half way into the resident's room. When finished cleaning the room, the housekeeper (#9) entered another room and continued her cleaning, without changing water or getting clean cleaning supplies. Failure to follow infection control guidelines for cleaning an isolation room has the potential for spreading infection to other resident rooms or other areas of the facility. During an interview, on 11/17/10 at 11:45 a.m., a housekeeper (#9) stated the facility hired her on November 1, 2010, and she had not gone through general orientation yet. The housekeeper (#9) stated she had one week of orientation shadowing another housekeeper and has been on her own for one week. She was not sure of the process for cleaning isolation rooms. During an interview, on 11/17/10 at 11:45 a.m., an administrative staff member (#1) stated the housekeeper had not gone through general orientation as it is scheduled for a later date. The maintenance supervisor (#16) is responsible for orientation of new employees to the housekeeping department. The maintenance supervisor (#16) reviews issues pertinent to housekeeping and infection control, there is no orientation check list used by the maintenance	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 441	Continued From page 24 supervisor. The facility was asked to provide educational documentation regarding housekeeping orientation, however, no information was provided. Failure to ensure staff training and education in the facility's Infection Control program places all residents, staff, and visitors at risk of exposure to organisms. During an interview, on the morning of 11/16/10, a housekeeping staff member (#8) stated postings on the resident's door will alert housekeeping staff to use precautions when cleaning the room of a resident in isolation. This staff member (#8) identified housekeeping staff should clean isolation rooms last, change the mop water before and after cleaning each room, and change the mop head. The director of housekeeping was not available during the survey and staff could not locate any pertinent policies.	F 441		
F9999	FINAL OBSERVATIONS Based on observation, record review, and staff interview, the complaint investigated in conjunction with the standard Medicare/Medicaid survey was not substantiated. However, a citation issued at F 366 is similar to the complainants concerns.	F9999		