North Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	8009	A. BUILDING: _____ B. WING _____	08/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR ST JOSEPH	404 4TH AVE W EDGELEY, ND 58433

(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) COMPLETE DATE
B 000	INITIAL COMMENTS The announced licensure survey, conducted August 09-10, 2016, included a complete review of 5 current residents, and focused review of 2 closed records. The survey identified no Tier I findings and three Tier II deficiencies.	B 000		
B 921	33-03-24.1-09,1,a GOVERNING BODY a. All services provided by the facility to meet the needs of the residents, including admission, transfer, discharge, discharge planning, and referral services. This state licensing rule is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to ensure self-preservation capability, and enforce the facility's " Admission Criteria and Continued Stay Criteria" for 1 of 1 resident (Resident #2) who required extensive assistance of two staff, and the use of a mechanical lift and wheelchair for transfer, ambulation, and locomotion. Failure to follow established facility criteria for admission and continued stay placed Resident #2 at risk, as well as other residents and staff at potential risk for harm and injury. Findings include: Review of the facility admission and discharge criteria occurred on 08/09/16, and included the following: "Admission Criteria - Manor St Joseph requires that all applicants for admission be capable of self-preservation (the ability to evacuate the facility independently or with	B 921	(1) Resident #2 is on a waiting list for a skilled Nursing Facility and will be transferred as soon as an opening is available. Meanwhile we will use the Sunporch exit to evacuate (if necessary) which has no stairs. Care plan has been revised to address this. E-Score with-in time allowance. (2) All Residents in the facility have the potential to be affected as they age + their conditions deteriorate. (3) Staff have been informed to notify Administrator +/or DON of any changes in Resident's Status.	

Health Resources Section

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Tammy A Jarqula — TITLE: Administrator — (X6) DATE: 8-25-16

D.H.

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B 921	Continued From page 1	B 921	(4) 9-24-16; or sooner if bed becomes available. (5) Administrator & DON	

minimal assistance). Applicants must be able to perform ADLs [activities of daily living] independently or with minimal assistance. . . . Continued Stay Criteria - A transfer will be necessary under the following conditions: a) we are not able to give adequate care to meet his/her needs physically or mentally b) Resident is no longer capable of self-preservation c) Resident puts them self, or other residents, employees, or visitors at risk for injury or harm. . . ."

Review of Resident #2's record occurred on 08/09/16, and included a signed copy of the above referenced admission/continued stay criteria. The criteria had been signed by Resident #2's power of attorney on 05/20/13, the day of Resident #2's admission to the facility.

Review of Resident #2's Nurses' Progress notes, dated 02/17/16 and 05/24/16, identified Resident #2 as dependent on staff for dressing, toileting, hygiene, and bathing; and requiring extensive assistance of two staff for bed mobility, transfer utilizing a mechanical lift, and locomotion via wheelchair.

Resident #2's plan of care regarding the resident's self-preservation ability indicated the following: "Resident is capable of self-preservation with assist. Goal - To be able to exit the building in the event of emergency. Approach/Plan - Resident's room is right next to emergency exit. Keep WC [wheelchair in room at all times in order to do rapid transfer and go. . . ."

Observation showed the "emergency exit" next to Resident #2's room consisted of an exit door leading out onto a small concrete platform with five steps to ground level. Evacuating Resident #2 in the manner addressed in the plan of care

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B 921	Continued From page 2 would result in taking her per the wheelchair onto the small platform. Evacuation of Resident #2 would result in an inability to close the exit door due to the size of the platform, and no plan/means for movement of the resident to a place of safety. Observation at 11 a.m. on 08/09/16, showed two staff members (#3 and #4) assist Resident #2 to the bathroom. Once in the bathroom, both staff members assisted Resident #2 from the wheelchair to a standing position. Once standing Resident #2 required repetitive cueing to turn/pivot and sit on the toilet. Staff member (#3 and #4) indicated Resident #2 needed two staff to manage most of the resident's care related needs. During an interview with an administrative staff member (#1) on the afternoon of 08/09/16, the staff member concurred Resident #2 required more than Basic Care, and did not meet the facility's admission and continued stay criteria.	B 921		
B 928	33-03-24.1-09,2,h GOVERNING BODY h. Personnel policies to include checking state registries and licensure boards prior to employment for findings of inappropriate conduct, employment, disciplinary actions, and termination. This state licensing rule is not met as evidenced by: Based on review of personnel files, and staff interview, the facility failed to check the registry prior to employment for allegations of abuse for 2 of 5 individuals (#2, and #4) hired by the facility. Failure to check appropriate state registries and	B 928		

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B 928	Continued From page 3 licensure boards prior to employment for history of inappropriate conduct, abuse, and actions taken placed all residents at risk for avoidable harm, neglect, misappropriation of personnel property, or mentally/emotional distress. Findings include: On the afternoon of 08/10/16, review of the personnel files showed the following: -The facility hired and staff person #2 began employment as a nurse aide and in housekeeping/laundry on 12/01/14. The facility did not check the state nurse aide abuse registry for a history of prior allegations of abuse. -The facility hired and staff person #4 began employment on 01/26/15 as the facility activity director. The facility did not check the state nurse aide registry prior to, or since employment. Following a request for additional information regarding the registry check for the above referenced staff, two administrative staff members (#1 and #2) provided no additional information and concurred the registry had not been checked prior to employment for employees' #2 and #4.	B 928	(1) For Staff #2 & #4 State Registries have been checked and no allegations of abuse found. (2) All Residents have the potential to be affected. (3) Will ensure that the State registries and licensure boards are checked on all staff (not just nursing staff) prior to employment. (4) 8-10-16 (5) Administrator & DON	
B1110	33-03-24.1-11,1 EDUCATION PROGRAMS 1. The facility shall design, implement, and document educational programs to orient new employees and develop and improve employees' skills to carry out their job responsibilities. This state licensing rule is not met as evidenced by: Based on review of personnel files, and staff interview, the facility failed to provide 5 of 5	B1110		

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B1110	Continued From page 4 employees with orientation to their job and job related duties. Failure to provide new employees with orientation to the facility and their specific job responsibilities, including competency evaluation of the tasks assigned them, placed all residents at risk for avoidable harm and/or injury. Findings include: On the afternoon of 08/10/2016, review of five personnel files showed on the day of employment each employee and an administrative staff member signed a form showing the employee received general orientation to the facility, and would receive, "two days of side by side on the job instruction and observation of the routine, and on the third day performs assigned work under supervision of an assigned worker." Personnel files showed no evidence of the employees receiving the referenced orientation to their specific job responsibilities, and an appropriate supervisory staff person determined competency prior to the employee working independently. During an interview on the afternoon of 08/10/16 with two administrative staff persons (#1 and #2), the staff persons concurred the employees and staff person #1 had signed the above referenced orientation form on each employee's day of hire. The staff persons (#1 and #2) did not provide additional information showing the above referenced orientation to each individual's job responsibilities had occurred; and did not provide additional information identifying the specific position tasks/responsibilities the employee would receive orientation and competency determination for.	B1110	(1) All new employee orientation records will include specific job responsibilities and competency evaluations. (2) All residents have the potential to be affected if staff aren't properly trained. (3) A specific "New Employee Training Checklist" form has been developed. (4) 8-25-16 (5) Administrator + DON	