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
	355024	A. BUILDING _____ B. WING _____	05/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES	1315 S UNIVERSITY DR FARGO, ND 58103

(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 05/06/13 and completed on 05/08/13, the sample included 5 residents for complete review, 12 residents for focused review, and 3 closed records for review. The sample included 5 additional residents to verify specific concerns during the survey.	F 000		
F 164 SS=D	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 contract; or the resident.	F 164	F164 It is the facilities intent to 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 part payment contract; or the resident. Resident #4 is provided privacy during wound care. Resident #4 had no negative outcome. Like residents have the potential to be affected by this practice. Residents who require wound care will be provided dignity with shades drawn. Licensed Nursing staff was re-educated regarding providing resident privacy during treatments. The ADNS or designee will conduct three random audits every week for four weeks.	6/12/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Patricia Deirk | TITLE: Administrator | (X6) DATE: 5-30-13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 164	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, and staff interview, the facility failed to provide privacy for 1 of 1 sampled resident (Resident #4) observed receiving pressure ulcer treatment. Failure to provide care in a manner that promotes privacy is an infringement on the resident's rights and may lead to a loss of dignity. Findings include: Observation on 05/07/13 at 9:20 a.m. showed a nurse (#16) transported Resident #4 to his room to provide pressure ulcer treatment to his buttocks. The resident stood at the side of his bed with his back towards the window and his buttocks exposed. The nurse completed the treatment with the window shade half open. This ground floor window faced the parking lot. During an interview on 05/08/13 at 4:00 p.m., an administrative nurse (#1) and an administrative staff member (#8) had no comment when informed of the pressure ulcer treatment completed while the window shade remained half open with the parking lot and street traffic in view.	F 164	F164 The ADNS or designee will conduct three random audits every week for four weeks and then monthly for 6 months. Information gathered from audits will be forwarded to the QA&A committee for further review and recommendations. The corrective action will be completed by June 12, 2013.	
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe.	F 176	F176 The facility strives to provide care and services that support the residents to safely provide self-medications. Resident #10 was assessed and it was determined that resident was appropriate for medication administration. Care plan was updated to reflect this change.	6/12/13

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F 176	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy and procedure, resident interview, and staff interview, the facility failed to determine the ability to safely self-administer medications (SAM) for 2 of 2 sampled residents (Resident #10 and #12) who self-administered medications. Failure to determine if SAM is a safe practice placed the residents at risk for improper spacing and/or missed doses of medication. Findings include: Review of the facility policy titled "Self Administration of Medication Approval" occurred on 05/08/13. The policy, dated 2006, stated: ". . . To evaluate the patient's ability to consistently take their medication at the appropriate time, a nurse will observe the patient taking their medication for a seven day period. . . . If the patient is unable to demonstrate knowledge to assure safe self-administration of medications, self-administration of medication will not be allowed. . . ." - During the initial tour of the facility on 05/06/13 at 8:05 a.m., observation showed the following medications: Lumigan, Combigan (eye drops), and Maxitrol (eye ointment) stored on a chair in Resident #10's room. Review of Resident #10's medical record occurred on all days of survey. The record lacked an assessment for self administration of any medications. During an interview on 05/08/13 at 4:00 p.m., an	F 176	F176 Resident #12 does not have her medications left at bedside. These two residents had no negative outcome. Like residents have the potential to be affected by this practice. After review of Residents only resident #10 qualified for self- administration of medications. Licensed staff was re-educated regarding the process for determining a resident able to self – administer their own medications. ADNS or designee will conduct three random weekly audits for four weeks and then monthly for 6 months to ensure only residents with self-administration assessments will have medications at bedside. Information gathered from audits will be forwarded to the QA&A committee for further review and recommendations. The corrective action will be completed by June 12, 2013.	6/12/13 5/28&5/

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F 176	Continued From page 3	F 176		

administrative nurse (#1) and an administrative staff member (#8) stated the self-administration of medication assessment should have been completed for the three eye drops Resident #10 had at bedside.

- During the initial tour of the facility on 05/06/13 at 9:00 a.m., observation showed Resident #12 with two medication cups on her bedside table. One cup contained three pills and the other cup contained one pill. When questioned regarding these medications the resident stated, "Those are my pills. They leave them at my bedside, so I can take them when I eat."

Review of Resident #12's medical record occurred on all days of survey. Her physician orders identified the following 8:00 a.m. medications:
* Celexa 10 milligrams (mg) (for depression)
* Centrum Multivitamin
* Lisinopril 5 mg (for blood pressure)
* Magnesium Oxide 400 mg
* Metoprolol Tartrate 25 mg (for blood pressure)
* Mucinex 600 mg (for nasal congestion)
* Oyster Shell Calcium 500 mg
* Potassium Chloride 20 milliequivalents
* Vitamin B12 500 micrograms
* Vitamin D 1000 units
* Voltaren 100 mg (for pain)

The resident's current care plan failed to address the resident's ability to self administer medications.

During interviews on 05/07/13 at 3:55 p.m., a managerial nursing staff member (#3) confirmed the facility failed to assess/continuously monitor

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F 176	Continued From page 4 Resident #12's ability to safely self-administer medications, and failed to obtain a physician order to self-administer the above named medications.	F 176		
F 203 SS=E	483.12(a)(4)-(6) NOTICE REQUIREMENTS BEFORE TRANSFER/DISCHARGE Before a facility transfers or discharges a resident, the facility must notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand; record the reasons in the resident's clinical record; and include in the notice the items described in paragraph (a)(6) of this section. Except when specified in paragraph (a)(5)(ii) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged. Notice may be made as soon as practicable before transfer or discharge when the health of individuals in the facility would be endangered under (a)(2)(iv) of this section; the resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(i) of this section; an immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(ii) of this section; or a resident has not resided in the facility for 30 days. The written notice specified in paragraph (a)(4) of this section must include the reason for transfer or discharge; the effective date of transfer or	F 203	F203 The facility will notify the resident/family/legal representative of the transfer or discharge and in a language manner they understand. Resident #3,7,9,12,15 had no negative outcome from transferring and all have returned to facility and continue to reside in facility. Resident discharge to an acute care setting will have appropriate State form completed. Licensed staff was re-educated regarding completing the transfer form when a resident transfers to an outside facility. ADNS or designee will conduct random audits 3 times a week for 4 weeks and then monthly for 6 months to ensure completion of transfer form on discharge from facility. Information gathered from audits will be forwarded to the QA&A committee for further review and recommendations. The corrective action will be completed by June 12, 2013.	6/12/13

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F 203	Continued From page 5	F 203		

discharge; the location to which the resident is transferred or discharged; a statement that the resident has the right to appeal the action to the State; the name, address and telephone number of the State long term care ombudsman; for nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and for nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act.

This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview, the facility failed to notify the resident and/or the resident's family/legal representative, in writing, of a transfer, including the destination and the reason for the transfer, and the resident's right to appeal the action, for 5 of 5 sampled residents (Resident #3, #7, #9, #12, and #15) transferred to the hospital.

Findings include:

Review of Resident #3, #7, #9, #12, and #15's medical records occurred on all days of survey and identified the residents transferred to the hospital on the following dates:
* Resident #3: 03/02/13
* Resident #7: 07/26/12, 11/14/12, 08/10/12, and

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F 203	Continued From page 6 01/08/13 * Resident #9: 04/07/13 * Resident #12: 11/30/12 and 01/31/13 * Resident #15: 04/20/13 The records for the above residents lacked evidence the facility provided the residents and/or their family/legal representative written notice of the transfers, including the reason for the transfers, the effective date of the transfers, the location to which they transferred the residents, and the right to appeal the actions. An interview with administrative staff (#1 and #8) occurred on 05/08/13 at 4:00 p.m. Both confirmed the facility had not provided notices of transfer to the residents and/or family members when the residents were hospitalized. These staff provided no policy/procedure regarding this process.	F 203		
F 278 SS=D	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	F 278	F278 The facility strives to ensure that the Minimum Data Set is accurate and reflects the resident's current status. Resident #2's MDS was corrected to reflect an accurate assessment. Like residents have the potential to be affected. Residents with pressure ulcers had their MDS's reviewed and modified as needed. MDS persons were re-educated regarding gathering the appropriate information for the MDS.	6/12/13

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F 278	Continued From page 7 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 material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review, review of professional reference, and staff interview, the facility failed to ensure the Minimum Data Set (MDS) accurately reflected the resident's status for 1 of 5 sampled residents (Resident #2) with a current pressure ulcer. Failure to accurately assess and code the MDS may affect the level of care provided to residents. Findings include: The Centers for Medicare and Medicaid Services Long-Term Care Facility Resident Assessment Instrument User's Manual, Version 3.0, revised October 2012, page 3-4 stated, "A dash [-] value indicates that an item was not assessed. This most often occurs when a resident is discharged before the item could be assessed." Page M-2 stated, "Pressure Ulcer Risk Factor: Examples of risk factors include immobility and decreased functional ability; co-morbid conditions . . . impaired diffuse or localized blood flow; resident refusal of care and treatment; . . . exposure of	F 278	F278 MDS persons were re-educated regarding gathering the appropriate information for the MDS. ADNS or designee will conduct audits on all new pressures ulcers for 6 months to ensure that the MDS regarding pressure ulcer is accurate. Information gathered from audits will be forwarded to the QA&A committee for further review and recommendations. The corrective action will be completed by June 12, 2013.	6/12/13

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skin to urinary and fecal incontinence . . ." Page M-4 stated, "Steps to Assessment 1. Review the medical record . . . 2. Speak with direct care staff and the treatment nurse . . . 3. Examine the resident and determine whether any ulcers are present . . ."

Resident #2's medical record, reviewed on all days of survey, identified the resident had Influenza A and pneumonia in early January 2013. Nurse Practitioner (NP) progress notes identified the following:
* 01/08/13: ". . . recently was very ill et [and] frail . . . He has been bedridden. He had developed an area of excoration [sic] on his R [right] buttock which as [sic] worsened to a lg [large] portion of his sacrum & [and] buttock . . . 7.4 x [by] 7.7 [centimeters] area of pressure ulcers . . . Problem New to Examiner: Stage 2 Pressure Ulcer to sacrum/buttocks . . . worsening . . ."
* 01/10/13: ". . . recent illness. He has been on his back and developed 2 pressure ulcers to his buttocks/sacrum. He c/o [complained of] pain @ [at] the site. . . . 7.5 x 7 cm [centimeters] . . . Stage 2 PU [pressure ulcer] to sacrum/buttocks unstable worsening . . ."

An annual MDS, dated 01/14/13, identified Resident #2 required extensive assistance with bed mobility, was frequently incontinent of urine and always incontinent of stool. Under Section M Skin Conditions, Item M0210 showed a "-" indicating staff did not assess that item, even though NP Progress Notes identified Stage 2 pressure ulcers on 01/08/13.

During an interview, on 05/07/13 at 2:15 p.m., an MDS nurse (#4) stated she only documents a

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F 278	Continued From page 9 pressure ulcer on the MDS if the facility's wound team has recorded an assessment of the ulcer. Record review identified the wound team failed to assess Resident #2 during the 01/14/13 MDS assessment period.	F 278		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policies, and resident and staff interview, the facility failed to review and revise the comprehensive care plan to reflect the residents' current status for 2 of 17 sampled residents (Resident #13, and #15). Failure to revise the	F 280	F280 The facility strives to provide a comprehensive care plan must be developed with 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibilities to the resident, and other appropriate staff in disciplines as determined by the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. Resident #15 had her care plan updated to reflect the current adaptive equipment being used for her. Resident #13 had her care plan and nursing assistant worksheet updated to reflect that she is to have no straws-liquids per cup. Resident's that require adaptive equipment have the potential to be affected by this practice.	6/12/13

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F 280	Continued From page 10 care plans limited staff's ability to communicate care needs and ensure continuity of care for each resident. Findings include: Review of the facility policy titled "Adaptive Eating Devices" occurred on 05/08/13. The policy, dated 04/07/06, stated: ". . . 2. Physician's orders are not required for adaptive eating devices. . . . 4. . . . Adaptive eating devices are included on the care plan . . . " - Resident #15's medical record, reviewed on all days of survey, identified she had been admitted/readmitted to the facility on three occasions. Her diagnoses included cellulitis of the hands, venous/arterial insufficiency, skin disorder/picking at skin/hands resulting in amputation of multiple fingers. The resident's admission Minimum Data Set (MDS), dated 04/18/13, identified intact cognition, set-up assistance for eating, and therapeutic diet. Meal observations showed the following: * 05/07/13 at 8:17 a.m., the resident stated, "It's hard for me to use a knife and fork to cut." She also requested a mug (versus a glass) for each liquid on her tray. * 05/07/13 at 12:17 p.m., the resident held a knife as if stabbing something, and dropped the knife twice while cutting her chicken breast into 1 1/2 inch squares. She stated, "I prefer to do it myself, but the knife slides through." * 05/08/13 at 9:00 a.m., the resident stated, "I have difficulty with slippery foods, like noodles and peaches," and reported using built-up silverware on previous admissions as per	F 280	F280 Resident's that require adaptive equipment for eating had their Care Plans, Tray Tracker and CNA worksheet updated to reflect current status. Licensed staff was re-educated regarding revising care plans to ensure residents needs are met. ADNS or designee will conduct three weekly random audits for four weeks, then monthly for 6 months to ensure the use of adaptive equipment, is including the resident's care plan. Information gathered from audits will be forwarded to the QA&A committee for further review and recommendations. The corrective action will be completed by June 12, 2013.	6/12/13

6/10/13 1:55 pm. per te & DNS Melissa Crockett

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355024	A. BUILDING _____ B. WING _____	05/08/2013

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MANOR CARE HEALTH SERVICES	1315 S UNIVERSITY DR FARGO, ND 58103

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F 280	Continued From page 11 occupational therapy's recommendation. An occupational therapy evaluation, dated 01/19/13, identified, ". . . Pt's [patient's] fine motor abilities significantly impaired [secondary to] multiple finger amputations. . . ." The occupational therapy (discharge) summary, dated 02/01/13, identified, ". . . Issued pt red foam tubing for toothbrush and eating utensils. . . ." During an interview the morning of 05/08/13, a therapy staff member (#19) stated, "She's [Resident #15] very familiar to us. She shouldn't have to eat like that. She had red tubing over her utensils, like her toothbrush, pencil, silverware." The resident's care plan failed to reflect adaptive utensils as recommended by her occupational therapist and/or mug use as requested by the resident. - Review of Resident #13's medical record occurred on 05/08/13. Diagnoses included dysphagia, muscle weakness, and difficulty with walking. The current MDS, dated 04/12/13, identified the resident with long and short term memory problems, severely impaired with daily decision making, and required extensive assistance with bed mobility, transfers, and locomotion. The current care plan stated, " . . . Focus: . . . Self care deficit as evidenced by weakness/reconditioning related to physical limitations . . . Interventions: May amb [ambulate] to bathroom with FWW [front wheeled walker] per self . . . "	F 280		

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F 280	Continued From page 12 Resident #13's CNA worksheet identified the resident as able to ambulate to the bathroom per self with FWW. During an interview on the afternoon of 05/08/13, an administrative nurse (#3) reported Resident #13 requires extensive assistance of one to ambulate. Resident #13's current care plan and CNA worksheet failed to identify the resident required extensive assistance with ambulation. Resident #13's current physician's orders, dated 04/30/13, stated," . . . 3. no straws-liquids per cup . . ." Resident #13's current care plan and CNA worksheet failed to identify no straws for Resident #13.	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of professional reference, and staff interview, the facility failed to ensure staff provided care in accordance with current physician's orders for 1 of 1 sampled resident (Resident #2) with discontinued physician's orders on the treatment record. Failure to update the computerized physician's orders and treatment record resulted in the resident receiving a discontinued treatment to his coccyx ulcer.	F 281	F281 The facility strives to provide or arrange services to meet professional standards of quality. Resident #2 had their treatment order updated to reflect current order. Resident #2 had no negative outcome. Like residents had the potential to be affected. Residents with treatment orders had them checked and validated for accuracy. Licensed staff was re-educated regarding performing the month end order process.	6/12/13

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

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F 281	Continued From page 13 Findings include: Taylor, Lillis, and LeMone, Fundamentals of Nursing, Fourth Edition, 2001, Lippincott, page 578 stated, "Checking the Medication Order . . . Increasingly numbers of healthcare facilities are computerizing patient records, including medication records. The nurse is responsible for checking that the transcription of the medication order is correct by comparing it with the original order. . . ." Observation of a dressing change for Resident #2 occurred on 05/07/13 at 9:25 a.m. Observation showed the nurse (#7) removed a Mepilex Border (a self adherent bordered foam dressing) and packing from Resident #2's coccyx ulcer. After cleansing the wound, the nurse (#7) placed a Mesalt dressing, cut to fit the wound, then covered it with a 4 x 4 gauze, ABD [a type of dressing], and tape. The nurse did not pack the wound. Resident #2's medical record, reviewed on all days of survey, identified a wound team progress note, dated 05/01/13, which showed the wound to be 1 centimeter (cm) deep with 1.8 cm tunneling. Review of Resident #2's handwritten practitioner's orders identified the following: * 02/06/13: "Mesalt [a dressing used for deep wounds] to wd [wound] on coccyx qd [daily], [change] outside dsg [dressing] of 4 x 4s [gauze] et [and] ABD prn [as needed] . . ." * 03/08/13: "Cont [continue] same cares [with] Mesalt Packing" * 03/28/13: "Cover pressure ulcer [with] Mepilex [with] Border, dc [discontinue] 4 x 4 [and] tape."	F 281	F281 ADNS or designee will perform monthly audits for 6 months on the MARS/TARS to validate accuracy of orders. Information gathered from audits will be forwarded to the QA&A committee for further review and recommendations. The corrective action will be completed by June 12, 2013.	6/12/13

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F 281	Continued From page 14 Staff failed to update the computerized physician's order sheet which identified the 02/06/13 order as the current pressure ulcer treatment. Review of Resident #2's 2013 treatment records showed staff failed to update the computerized sheets with the current treatment orders: March: the 02/06/13 order discontinued on 03/28/13 and the 03/28/13 order handwritten on the sheet. April: the 02/06/13 order printed on the sheet, discontinued on 04/02/13 and the 03/28/13 order handwritten on the sheet. May: the 02/06/13 order printed on the sheet and signed off as completed by nursing May 1-7, 2013 The above treatment sheets (March - May 2013) failed to identify staff should pack the wound. During an interview, on 05/07/13 at 12:30 p.m., two administrative nurses (#2 and #5) confirmed the practitioner wrote new dressing orders for Resident #2 on 03/28/13, but the 02/06/13 order remained on Resident #2's current computerized physician's orders and treatment records. Failure to ensure staff updated the computerized record resulted in Resident #2's receiving a discontinued treatment for his pressure ulcer and may have delayed healing.	F 281		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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	F 309	F309 The facility strives to ensure that each resident receives the 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.	6/12/13

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F 309	Continued From page 15 and plan of care. This REQUIREMENT is not met as evidenced by: 1. Based on observation, record review, review of facility policy and procedure, review of professional literature, and staff interview, the facility failed to ensure 2 of 2 sampled residents (Resident #3 and #12) observed in a reclined position and 1 of 1 sampled resident (Resident #15) observed without required adaptive equipment received the care and services necessary to attain the highest degree of safety possible while eating in their room and/or in the dining room. Failure to provide proper positioning and/or adaptive equipment has the potential to affect the residents' overall swallow safety, putting them at greater risk of aspiration and limiting their nutritional intake. Findings include: Review of the facility policy titled "Meal Service: In Patient Room" occurred on 05/08/13. The policy, dated March 2010, stated: ". . . 4. Assist into an upright sitting position. . . ." - Resident #12's medical record, reviewed on all days of survey, identified diagnoses including dehydration and reflux. The current plan of care stated, ". . . Focus: ADL [Activities of Daily Living] Self care deficit . . . Interventions: . . . Set up with . . . eating. . . . Focus: Altered nutrition and possible weight changes . . . Interventions: . . . Encourage and	F 309	F309 Resident #12 was repositioned at an upright, comfortable position to assist with eating/medication. Resident #3 was repositioned at an upright, comfortable seated position to assist with eating/drinking. Resident was reassessed by PT on 6/6/12. Resident #11 had barrier cream applied to her peri-area. All three residents had no negative outcomes. Like residents have the potential to be affected by this practice. Residents will be repositioned at an upright, comfortable position to receive food/fluids/medication. Incontinent resident who receive peri-care, will have barrier cream applied as needed. Licensed staff, CNAs & dining room monitors were re-educated regarding positioning of residents during meals/fluids and providing barrier cream after peri-care as needed. ADNS or designee will conduct random audits 3 times a week times 4 weeks, then monthly for 6 months to ensure residents are in correct position and that barrier cream is applied after peri-care as needed.	6/12/13 5/28,30 & 6/6

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F 309	Continued From page 16 assist as needed to consume foods and fluids offered. . . ." Observations revealed the following: * On 05/07/13 at 8:00 a.m., a nursing staff member (#18) administered medications to Resident #12, as she laid in a reclined position (25 degree angle) in bed. * On 05/07/13 at 8:25 a.m., the resident fed herself breakfast following tray set-up. Her bed had been raised slightly (45 degree angle). The resident coughed twice during her meal. * On 05/07/13 at 12:20 p.m., the resident fed herself dinner following tray set-up. Her bed remained in a reclined (45 degree angle) position. During an interview the morning of 05/08/13, an administrative nurse (#1) agreed Resident (#12) should be placed in an upright position during meals. During an interview on 05/08/13 at 2:05 p.m., a therapy staff member (#20) stated, "Our expectation would be that they would sit her [Resident #12] at 90 degrees." Failure to 1) raise the head of Resident #12's bed as close to 90 degrees as possible during meals and/or medication pass and 2) identify Resident #12's signs/symptoms of aspiration (coughing during meals), may lead to decreased intake, reflux, and aspiration. - Review of Resident #3's medical record occurred on May 6-8, 2013. Diagnoses included dysphagia and muscle weakness. The residents quarterly Minimum Data Set (MDS), dated 04/14/13, identified she received a mechanically	F 309	F309 Information gathered from audits will be forwarded to the QA&A committee for further review and recommendations. The corrective action will be completed by June 12, 2013.	6/12/13

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F 309	Continued From page 17 altered diet and required extensive assistance with eating. Observation during the noon meal on 05/06/13 at 12:55 p.m. showed Resident #3 seated in a reclining tilt wheelchair in a reclined position (30 degree angle) with her chin elevated. A CNA (certified nursing assistant) (#25) fed the resident a regular diet with ground meat. During the meal, the resident cleared her throat. Observation on 05/06/13 at 1:45 p.m. showed a CNA (#26) provided a drink of water to Resident #3, as she lay in a reclined position (10 degree angle) in bed. During an interview on 05/08/13 at 4:00 p.m., a speech therapy staff member (#27) confirmed residents should be positioned as upright as each resident tolerates and keep their chin down when offered food and fluids. The therapy staff member stated a clearing of the throat can be a "subtle sign of aspiration in lungs that can be delayed up to five minutes" after taking a bite of food. Failure to sit Resident #3 upright when offering food and fluids may lead to aspiration. 2. Based on observation, policy and procedure review, record review, and staff interview, the facility failed to apply barrier cream following incontinence for 1 of 7 sampled residents (Resident #11) requiring extensive assistance with personal hygiene. Failure to protect the resident's skin has the potential to affect the resident's overall comfort level and put him/her at risk of skin breakdown.	F 309		

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F 309	Continued From page 18 Findings include: Review of the facility policy titled "Incontinence Care" occurred on the afternoon of 05/08/13. The policy, dated December 2012, stated, "Purpose: To outline a procedure for cleansing the perineum and buttocks after an incontinence episode or with daily care. . . . Apply skin protectant products, if needed, and/or as tolerated, per manufacturer's instructions. . . ." Review of Resident #11's medical record occurred on May 6-8, 2013. The quarterly MDS, dated 03/26/13, identified the resident as frequently incontinent and requiring extensive assistance for toileting and personal hygiene. Resident #11's current care plan stated "Urinary incontinence related to cognitive deficits r/t [related to] dementia . . . Apply skin moisturizers/barrier creams as needed. . . ." Observation on 05/06/13 at 5:10 p.m. showed a CNA (#28) provided incontinence care for Resident #11 who had been incontinent of urine. The CNA removed the resident's brief in bed and completed perineal cares. Observation of Resident #11's buttocks and perineum showed the skin to be reddened. The CNA stated, "Yes, I know that hurts [when she touched the perineum]; not sure what that is from." The CNA then gently continued to cleanse the area; however, failed to apply protective skin cream. Observation on 05/07/13 at 1:30 p.m. showed a CNA (#25) provided incontinence care for Resident #11 who had been incontinent urine and bowel. The CNA removed the resident's brief and	F 309		

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F 309	Continued From page 19 completed perineal cares. Observation of Resident #11's buttocks and perineum showed the skin to be reddened. The CNA failed to apply protective skin cream. Observation on 05/08/13 at 9:30 a.m. showed a CNA (#22) provided incontinence care for Resident # 11 who had been incontinent of urine and bowel. The CNA removed the resident's brief and completed perineal cares. Observation of Resident #11's buttocks and perineum showed the skin to be reddened. The CNA failed to apply protective skin cream. During an interview on 05/18/13 at 4:15 p.m., an administrative nursing staff member (#1) confirmed facility staff should use protective skin cream if a resident has reddened skin after an episode of incontinence.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based record review and staff and family interview, the facility failed to ensure staff provided needed assistance with oral hygiene for 1 of 1 sampled resident (#16) requiring extensive dental work. Failure to provide oral care contributed to the resident requiring oral surgery for extensive tooth decay.	F 312	F312 The facility strives to ensure that a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Resident #16 is assisted with oral care twice daily. Resident #16 has had no complications from her oral surgery. Residents who require assistance with oral care were reviewed and Care Plans and CNA Task list updated as needed.	6/12/13

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F 312	Continued From page 20 Findings include: During an interview on 05/08/13 at 10:25 a.m., a family member (#1) expressed concerns that Resident #16 "doesn't get her teeth brushed." The family member (#1) stated facility staff let the resident perform her own oral hygiene without assistance. The family member (#1) stated Resident #16 has dementia, does not properly clean her teeth, and recently required extensive dental work. Review of Resident #16's medical record occurred on May 07-08, 2013 and identified the facility admitted the resident in October 2011. A quarterly Minimum Data Set (MDS), dated 04/06/13, identified Resident #16 had severe cognitive impairment, did not resist cares, and required supervision and set up with personal hygiene. Resident #16's current care plan, revised 07/09/12, stated, ". . . Set up assist for grooming, oral cares, personal hygiene. . . ." The Certified Nursing Assistant (CNA) task card, undated, also identified set up assistance with oral hygiene. The record showed, on 04/30/13, the resident had oral surgery at a local hospital for extraction of four teeth. A dental progress note, dated 04/04/13, stated, ". . . Very heavy generalized plaque, Moderate scattered calculus build-up throughout, heavy generalized bleeding. Tissues are generalized red and inflammed [sic]. . . . Due to extensive decay and mobility as well as risk of asperation [sic] of crowns, [physician's name] recommends referral to oral surgeon for extractions of #15, 18, 28, and 19. Explained to patient the lower partial will likely	F 312	F312 Licensed staff & CNAs were re-educated regarding providing adequate oral hygiene to residents. ADNS or designee will conduct random audits 3 times a week for 4 weeks, then monthly for 6 months to ensure compliance. Information gathered from audits will be forwarded to the QA&A committee for further review and recommendations. The corrective action will be completed by June 12, 2013.	5/28 & 30

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F 312	Continued From page 21 not fit well after the extractions. . . . Home care appears to be poor at this time. It looks as if the lower partial had not been removed in some time, as there was a very heavy amount of plaque on it today. . . . Please help [Resident #16] with brushing directly every morning and every night well along the gumlines. Please also be sure to remove her lower partial and brush it at night. She should leave the partial out at bed time to allow tissues to breathe. . . ." The dental record indicated Resident #16 would require six fillings in addition to the extractions. Failure to ensure staff provided necessary assistance with oral hygiene contributed to the extensive plaque build-up, multiple fillings, and tooth extractions.	F 312		
F 364 SS=D	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation, policy and procedure review, record review, and staff interview, the facility failed to prepare pureed food using methods to ensure a smooth texture and enhance flavor for 1 of 1 sampled resident (Resident #11) receiving a pureed diet who experienced weight loss. Failure to ensure foods served to residents are prepared to promote palatability, and serve foods residents deem	F 364	F 364 It is the practice of this facility to provide each resident food that is palatable, attractive and at the proper temperature Resident #11 has shown no significant weight loss. Residents who require pureed diet have the potential to be affected by this practice. RD or Designee has provided education to the Dietary Staff regarding preparation of Pureed Diets. RD or Designee will conduct audit on residents with pureed diets weekly for 4 weeks, then monthly for 6 months to monitor preparation of pureed foods, palatable, and texture.	6/12/13 5/23/13

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F 364	Continued From page 22 palatable may impact food intake of residents. Findings include: Review of the facility policy titled "Consistency Modified Foods" occurred on the afternoon of 05/08/13. The policy, dated 04/07/06, stated, ". . . When pureed foods are required, either shaped pureed products are used or the regular item is pureed. . . . Pureed foods are pudding-like or have a consistency similar to mashed potatoes with a homogenous consistency, without coarse textures. . . . If meats must be pureed, regular recipes having instructions similar to the following: For pureed meat, use shaped pureed product. Prepare according to package directions. If pureed product is not available, place desired number of portions in food processor and process. Add 1 T [tablespoon] of liquid and 1 T thickener per serving and process smooth. Adjust liquid and thickener to give mashed potato consistency. Serve using # [number per recipe] scoop. Serve with sauce or gravy. . . . Instructions similar to the following for other types of pureed foods appear on the respective regular recipes: Fruits and Vegetables . . . Bread . . . Rice and Pasta . . . Preparing and Serving Pureed Foods . . . Thickener and liquids are added as needed to achieve the appropriate consistency, which is similar to mashed potatoes for drier foods, or pudding for foods with higher moisture content. . . ." - During the group interview on 05/06/13 at 3:20 p.m., the residents (identified by the facility as being interviewable) described the food as "bland."	F 364	F364 Information gathered from audits will be forwarded to the QA&A committee for further review and recommendations The corrective action will be completed by June 12, 2013.	6/12/13

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Review of the recipes and "pureed instructions" for the meats and vegetables observed prepared the week of May 6-8, 2013, identified to ". . . Add 1-2 T [tablespoon] liquid per serving. Process until smooth. Adjust liquid and add thickener, as needed to obtain appropriate consistency. . . ." None of the recipes specified the type of liquid to add.

During an interview on 05/07/13 at 9:00 a.m. regarding the ingredients of the pureed biscuit served Resident #11, a dietary staff member (#10) stated, "Some cooks add water and some add milk."

Observation on 05/07/13 at 3:00 p.m. showed a dietary staff member (#21) preparing the pureed meat for the evening meal. The staff member blended cooked cubed beef for pureed beef stroganoff. When interviewed regarding the ingredients in the pureed beef, the staff member confirmed the mixture contained five servings of beef and one half cup water. Facility staff adding water during the preparation of a food item dilutes the flavor.

During an interview on the morning of 05/08/13, a dietary staff member (#10) confirmed she used only water to prepare the pureed baked fish. After requesting a pureed test tray from trayline, the staff member (#10) stated she does not usually puree unbreaded fish and the result was "like marshmallow." Another dietary staff member (#9) stated the dietitian said to use mayonnaise and lemon pepper in the pureed fish.

A test tray for the noon meal on 05/08/13 consisted of the following pureed foods: baked

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fish, pineapple salsa, mashed potatoes, gravy, carrots, and pears. Four surveyors agreed the fish tasted flavorless or "fishy" with a dry, shredded texture. Four surveyors agreed the pureed bread tasted bland and inedible.

- Review of Resident #11's medical record occurred on May 6-8, 2013. Diagnoses included dysphagia and dementia. The resident's most recent annual Care Area Assessment (CAA) for nutrition stated, ". . . BMI [body mass index] 16.6 [underweight < 18.5]. . . too low underweight . . . enhanced food and supplement 6x/day. . . ice cream on tray lunch/supper . . . feeding assistant cue encourage to eat . . . let know done not open mouth or wave hands . . . mechanically altered diet not like textures if food not smooth will spit out . . . diagnosis dementia contributes only liking smooth foods. . . expected FTT [Failure To Thrive] Dx [diagnosis] . . . Albumin 3.0 [abnormal < 3.5] . . ."

Observation of facility staff feeding Resident #11 pureed meals revealed the following:
*05/07/13, breakfast meal - Observation showed CNA (#23) spooning lumps from resident's hot cereal. A CNA (#23) stated to dietary staff member (#10) "Resident did not touch pureed food because eats smooth foods only."
*05/07/13, noon meal - Observation showed the resident's spinach had visible texture. A CNA (#23) stated, "Any texture and will not eat food she spits it out."

During an interview on the afternoon of 05/08/13, an administrative dietary staff member (#11) identified the facility had not utilized pre-packaged pureed foods for months. The staff member

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F 364	Continued From page 25 agreed pre-packaged pureed food has better texture and agreed increased blending of pureed food may improve texture. The staff member confirmed facility staff used water to prepare pureed meat, vegetables, i.e. zucchini, and bread. This staff member agreed dietary staff should use ingredients other than water to prepare pureed foods to enhance palatability and intake. Failure to prepare pureed food using methods to ensure a smooth texture and enhanced flavor may have contributed to Resident #11's decreased food intake.	F 364		
F 369 SS=D	483.35(g) ASSISTIVE DEVICES - EATING EQUIPMENT/UTENSILS The facility must provide special eating equipment and utensils for residents who need them. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to ensure the appropriate use of assistive devices during meals for 1 of 1 sampled residents (Resident #15) with multiple amputated fingers. Failure to ensure built up utensils and mugs were available placed Resident #15 at risk for decreased meal intakes and a loss of dignity related to food spillage. Findings include: Review of the facility policy titled "Adaptive Eating Devices" occurred on 05/08/13. The policy, dated 04/07/06, stated: ". . . 1. Adaptive equipment is given following evaluation and recommendations	F 369	F 369 Manor Care Health Services will identify and provide special eating equipment and utensils for residents who need them. Resident #15 has been provided a mug for her liquids and provided built up utensils. Residents who require assistive devices for eating have the potential to be affected by this practice. Residents tray tracker and care plans were updated to reflect current status. Education was provided to Nursing Staff, Room Monitors and Dietary Staff regarding on Assistive Devices Eating Equipment/Utensils.	6/12/13

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F 369	Continued From page 26 by the rehabilitation professional. . . . 4. . . . Adaptive eating devices are included on the care plan . . . 6. . . . It is suggested that . . . commonly used items such as . . . adaptive utensils . . . cups be maintained in dietary. . . ." Resident #15's medical record, reviewed on all days of survey, identified diagnoses including amputation of multiple fingers. The current plan of care stated, ". . . Focus: ADL Self care deficit . . . Interventions: . . . May be IND [independent], assist as needed . . . ." The care plan failed to address the resident's need for adaptive equipment including built-up silverware and mugs. Observations revealed the following: * On 05/07/13 at 8:17 a.m., the resident sat at bedside eating cereal with a spoon. She stated, "It's hard for me to use a knife and fork to cut." She also requested a mug versus a glass for her liquids. * On 05/07/13 at 12:17 p.m., the resident fed herself dinner. (She held the knife as if stabbing something.) She dropped the knife twice while cutting her chicken breast into 1 1/2 inch squares. She stated, "I prefer to do it myself, but the knife slides through." * On 05/08/13 at 9:00 a.m., the resident sat at bedside eating breakfast. She stated, "I have difficulty with slippery foods, like noodles and peaches." She reported having built-up silverware on previous admissions as per occupational therapy's recommendation. The occupational therapy evaluation, dated 01/19/13, identified, ". . . Pt's [patient's] fine motor	F 369	F369 RD or Designee will complete audit 3 times a week for 4 weeks, then monthly for 6 months on Residents to ensure that Eating Assistive Devices are used per recommendation. Information gathered from audits will be forwarded to the QA&A committee for further review and recommendations The corrective action will be completed by June 12, 2013.	6/12/13

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F 369	Continued From page 27 abilities significantly impaired [secondary to] multiple finger amputations. . . ." The occupational therapy summary, dated 02/01/13, identified, ". . . Issued pt red foam tubing for toothbrush and eating utensils. . . ." During an interview the morning of 05/08/13, a therapy staff member (#19) stated, "She's [Resident #15] very familiar to us. She shouldn't have to eat like that. She had red tubing over her utensils, like her toothbrush, pencil, silverware." During an interview the morning of 05/08/13, an administrative nurse (#1) agreed Resident (#15) should have built-up silverware and mugs on her meal trays. The facility failed to ensure Resident #15 had the adaptive equipment needed to eat independently, without difficulty.	F 369		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, policy and procedure review, and staff interview, the facility failed to	F 371	F 371 It is the practice of this facility to store food and clean equipment in a safe and sanitary manner. No residents were identified as consuming outdated food items. Residents are at potential risk if food is not stored, distributed and served under sanitary conditions. The 3 pounds of diced ham and 4 pounds of salami were discarded. The hand washing sink was repaired on May 7th, 2013.	6/12/13 5/7/13

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F 371	Continued From page 28 store and prepare food in a safe and sanitary manner for 1 of 1 kitchen. These practices placed residents at risk for contamination of food during storage and preparation which can lead to food borne illness. Findings include: Review of a facility policy titled "Handwashing" occurred on 05/07/13. The policy, dated 04/07/06, stated, "Hands are washed in a designated handwashing sink in the kitchen. . . . Hands are washed using the following steps: . . . Apply soap and lather using a rotating motion and vigorous friction for at least twenty seconds. . . ." Review of a facility policy titled "Storage of Food" occurred on 05/07/13. The policy, dated 04/07/06, stated, ". . . Store potentially hazardous foods under refrigeration at or below 41 [degrees] for a maximum of 7 days, unless there is a different manufacturer's 'use by' date specified. . . ." - The initial dietary tour of the kitchen occurred on 05/06/13 at 7:45 a.m. Observation of the sink used to wash hands showed the sink failed to drain. Water filled the sink's basin when this surveyor attempted to wash her hands and nearly overflowed from the sink. Observation of the walk-in cooler showed a metal pan labeled, "04/25/13 (10 days prior) for chef salad," contained a sealable, plastic bag of approximately 3 pounds, diced, cooked ham. Observation of the reach-in cooler showed a sealable, plastic bag of approximately 4 pounds, sliced salami, labeled 04/27/13 (9 days prior).	F 371	F371 RD or Designee provided education to dietary staff that included the proper storage, preparation, distribution and service of food under sanitary condition. Education was provided to all staff regarding the system to report non-functioning equipment. Random audits completed 3 times a week for 4 weeks, then monthly for 6 months by the RD and/or Dietary Manager to confirm that food items in the refrigerator(s) are labeled, dated and within the acceptable date range and that sinks are draining properly. Information gathered from audits will be forwarded to the QA&A committee for further review and recommendations. The corrective action will be completed by June 12, 2013.	5/23/13 5/21 & 6/6 6/12/13

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F 371	Continued From page 29 Interview of a dietary staff member (#9) identified dietary staff use the salami to prepare cold, snack sandwiches. Interview of an administrative dietary staff member (#10) identified the deli meats should be stored no more than "7 days." The main dietary tour of the kitchen occurred on 05/07/13 at 3:00 p.m. with an administrative dietary staff member (#11). When this surveyor attempted to wash her hands, the handwashing sink failed to drain. Water filled the sink's basin and nearly overflowed. The hand sink filled before the twenty seconds required for proper handwashing. The administrative dietary staff member (#11) identified this hand sink as the only available hand sink in the kitchen. During interviews on the afternoon of 05/07/13 and 05/08/13, an administrative dietary staff member (#11) stated reduced amounts of deli meats should be thawed and stored to ensure use within 7 days. The staff member further identified the hand sink had not been reported to maintenance staff until 05/08/13 and agreed it should be maintained in a condition that allows adequate handwashing.	F 371		
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	F 441	F441 Manor Care Health Services will follow the established Infection Control Program designed to provide safe, sanitary conditions and to prevent the development or transmission of disease and infection.	6/12/13

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F 441	Continued From page 30 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. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEYS COMPLETED ON 06/17/10, 07/21/11, AND 06/07/12. 1. Based on observation, record review, review of facility policy and procedure, and staff interview,	F 441	F441 Resident #1, #2, #3, #4, and #6 wounds were assessed for signs and symptoms of infection with none noted. Residents #12, #17, #23, #24, and #25 cracked and/or torn arms, back, and/or leg rests of their wheelchairs were replaced. Residents were assessed and remain free of signs and symptoms of infection. Resident #23 wheelchair seat pad has been replaced. Resident has shown no sign or symptoms of infection. Resident #22 urine container was replaced and new urine container is placed in a hanging bag when not in use. The open bag containing incontinence products that was found on floor was discarded. Resident was assessed without any signs or symptoms of urinary infection. Residents who receive wound care were assessed with no signs or symptoms of wound infection. Wheelchairs and seat pads reviewed and any cracked/torn parts replaced and pads with approved protective cover in place. Urine containers and incontinence pads stored are appropriately. License Nurses were educated on Dressing Changes. License Nurses and CNA's also educated on Bed Pan/Urinal policy. All staff was educated on Infection Control.	6/12/13 5/28&30/13

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F 441	Continued From page 31 the facility failed to follow infection control practices for 5 of 6 sampled residents (Resident #1, #2, #3, #4, and #6) who received dressing changes. Failure to follow infection control practices for these residents placed facility staff, residents, and visitors at risk for potential infection. Findings include: Review of a facility policy titled "Dressing Change: Nonsterile (Clean) and Sterile (Aseptic)" occurred on 05/08/13. The policy, dated December 2009, stated: ". . . 8. Apply latex free non-sterile gloves, 9. Remove soiled dressing and discard in trash bag . . . 11. Remove latex free non-sterile gloves and discard in trash bag, 12. Perform hand hygiene, 13. Establish clean field . . . 14. Apply latex free sterile gloves for sterile dressing change or clean pair of latex free non-sterile gloves for non-sterile dressing change, 15. Cleanse wound per physician's orders, 16. Remove gloves and perform hand hygiene, 17. Apply latex free sterile gloves for sterile dressing or latex free non-sterile gloves for non-sterile dressing, 18. Apply dressing and secure per physician's orders, 19. Remove gloves and discard, 20. Perform hand hygiene . . . 22. Return equipment to designated area and clean/dispose as indicated. . . ." - Resident #6's medical record, reviewed on all days of survey, identified diagnoses including prostate and bone cancer, renal failure, and infection of the urinary tract/nephrostomy tubes. The treatment record identified the following: * "Peroustay dressing to b/l [bilateral]	F 441	F441 ADNS or designee will conduct random audits on 5 residents 3 times weekly for 4 weeks, then monthly for 6 months to ensure that dressing changes are completed per policy, wheelchairs are without cracks and/or tears, wheelchair pads are with covers, and urine containers and incontinent products are stored properly. Information gathered from audits will be forwarded to the QA&A committee for further review and recommendations The corrective action will be completed by June 12, 2013.	6/12/13

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F 441	Continued From page 32 nephrostomy tubes every 7 days." * "Cleanse [with] Betadine around each nephr. [nephrostomy] tube." Observation on 05/07/13 at 12:40 p.m. showed the following: * Dressing change of the left nephrostomy site: The nurse (#18) gowned and gloved and attempted to remove the soiled dressing from the resident's back. The dressing was partially removed, exposing a portion of the wound area. When he realized the dressing/tape was sticking to the resident's back, he reached under his gown and retrieved a pair of scissors from his pants pocket. The nurse failed to remove his soiled gloves prior to reaching under his gown and into his pants pocket. * Dressing change of the right nephrostomy site: Minutes later, the nurse (#18) regloved and used the scissors [which he had previously sanitized with a sani-wipe] to remove the dressing/tape. The nurse (#18) laid the soiled scissors on the bedside table [with only a third lying on the towel]. After cleansing the site with Betadine, the nurse (#18) placed the new dressing and secured it in place with tape. The nurse (#18) reached under his gown, retrieved a pen from his shirt pocket, and wrote the date/his initials on the dressing. The nurse (#18) removed his gloves and the disposable items on the towel/bedside table. He then sanitized the scissors with an alcohol wipe and placed them on top of the dresser. The nurse failed to place soiled items on the towel, failed to remove the soiled gloves prior to reaching under his gown and into his shirt pocket, failed to sanitize the soiled scissors and the bedside table with a sani-wipe.	F 441		

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During an interview the morning of 05/08/13, an administrative nurse (#1) agreed staff should remove soiled gloves prior to retrieving items, place soiled items on a towel, and properly sanitize soiled equipment.

- Review of Resident #3's medical record occurred on May 6-8, 2013. Diagnoses included debility, muscle weakness, diabetes mellitus with neuropathy, and chronic pressure ulcer. The resident's quarterly Minimum Data Set (MDS) identified an unstageable deep tissue ulcer and ulcer care.

The current physician's order stated "MeSalt [absorbent wound dressing] to (R) [right] heel ulcer after cleansing, apply 4X4 [four inch by four inch gauze], and wrap with Kerlix [gauze roll].

Observation on 05/06/13 at 3:25 p.m. showed a nursing staff member (#24) performed hand hygiene, pulled her hair back into barrette, then entered Resident #3's room to complete the resident's dressing change. The nurse donned gloves and placed her supplies, including scissors, onto the resident's bed without establishing a clean field. The nurse cut the Kerlix dressing and removed the 4X4 and MeSalt dressings from the resident's heel. The staff member confirmed the MeSalt dressing contained a yellow drainage from the open ulcer. The staff member cleansed the wound with normal saline spray and applied clean MeSalt, 4X4, and Kerlix dressings to the resident's heel ulcer. The nurse failed to remove her contaminated gloves, sanitize her hands, and apply clean gloves before she cleansed the wound and applied clean dressings to Resident

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F 441	Continued From page 34 #3's wounds. - Observation on 05/07/13 at 9:20 a.m. showed a nurse (#16) transported Resident #4 to his room to provide pressure ulcer treatment. The resident stood at the side of the bed, the nurse cleansed the buttocks fold area with normal saline and gauze, and applied triad ointment to the open areas. The nurse failed to change gloves and perform hand hygiene after cleansing the buttocks fold and before applying ointment. - Observation of a dressing change for Resident #2 occurred on 05/07/13 at 9:25 a.m. Observation showed a pressure ulcer to the resident's coccyx. A licensed nurse (#7) removed the soiled dressing, cleansed the wound, and changed her gloves. The nurse (#7) then opened a Mesalt dressing, removed a scissor from her pocket, cut the dressing to fit the wound, and completed the dressing change. The nurse failed to sanitize the scissor, which she removed from her pocket, prior to cutting the clean dressing. - Observation of a dressing change for Resident #1 occurred on 05/08/13 at 7:40 a.m. Observation showed a pressure ulcer to the resident's coccyx. Two licensed nurses (#3 and #5) washed their hands and donned gloves. One nurse (#3) removed the soiled dressing and packing, saturated with tan drainage. After cleansing the wound, the nurse (#3) prepared to insert new packing. The second nurse (#5) left the room and returned with an unpackaged scissor, which the other nurse (#3) used to cut the packing. She then inserted the packing into Resident #1's coccyx wound. The second nurse (#5) then cleaned the scissor using an alcohol wipe, not a	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355024	A. BUILDING _____ B. WING _____	05/08/2013

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F 441	Continued From page 35 sanitizing wipe. The nurses failed to sanitize the scissor before or after use during the dressing change. During an interview on 05/08/13 at 3:45 p.m. an administrative nurse (#1) stated the nurse would have obtained the scissor used for Resident #1's dressing change from the treatment cart. She stated staff should use Sani-wipes for sanitizing scissors before and after use when performing dressing changes. 2. Based on observation and staff interview, the facility failed to ensure resident care items were stored appropriately and resident equipment was maintained in a sanitary manner in 2 of 2 resident care units (North and South). Failure to store and maintain resident care items and equipment in a sanitary manner has the potential for the spread of infections. Findings include: Observation on all three days of survey revealed: *The arms, back, and/or leg rests of Resident #12, #17, #23, #24, and #25's wheelchairs were cracked and/or torn leaving an uncleanable surface. *The foam seat pad in Resident #23's wheelchair had no protective covering. A towel had been used to lay over the top of the foam but had slid to the back of the pad. There was a moderate amount of food-type particles on the pad and a few dark-colored stain areas. *An empty urine container was stored on the floor by the toilet in Resident #22's bathroom. An opened bag containing incontinence products was stored on the floor beside the container.	F 441		

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F 441	Continued From page 36 Interview with administrative staff (#3, #8, #14, and #15) occurred on 05/08/13 at 10:30 a.m. and 2:50 p.m. revealed: *Staff are to fill out a work order for any repairs needed on wheelchairs and turn it into the maintenance director. The maintenance director was not aware of the above resident wheelchairs needing repairs. *Protective coverings were available for all foam wheelchair pads and should have been used on Resident #23's foam pad. *Empty urine containers should be stored in plastic bags and hung from a bar in all residents' bathrooms. Resident care items should be stored on a shelf and not on the floor. *No policy/procedure was available for the above issues.	F 441		
F 456 SS=E	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure emergency equipment remained in safe operating condition in 2 of 2 resident care units (North and South Units). Failure to ensure the suction machines remained functional in case of an emergency situation placed residents at risk for choking and aspiration. Findings include:	F 456	F456 The facility strives to ensure that all essential mechanical, electrical, and patient care equipment is in safe operating condition. South Unit suction machine was replaced and new machine remains in working condition. North Unit suction machine cord was found and attached at the time of survey and remains in working condition. Suction machine will be tested weekly. Education was provided to Lic. Nurses regarding Emergency Management: Crash Cart Policy.	6/12/13 5/8/13 5/8/13 5/27&30/13

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F 456	Continued From page 37 Review of the facility policy titled "Emergency Management: Crash Cart" occurred on 05/08/13. This policy, dated 2006, stated, " Purpose: To provide easy access to and transport of emergency equipment necessary for immediate use in the event of a patient medical crisis. Guideline: . . . Stock each crash cart with the emergency equipment and care items identified. . . . suction machine set-up with suction cannulas attached, etc. . . ." - Observation of the South wing emergency suction machine, located on the crash cart, occurred on 05/08/13 at 1:45 p.m. with an administrative nurse (#3). The administrative nurse plugged the suction machine into the outlet, and the machine did not produce suction. The nurse tried a different electrical outlet and the machine again did not produce suction. It took approximately 10 minutes for a staff member (#17) to supply a working suction machine to the crash cart. During an interview on 05/08/13 at 2:10 p.m., an administrative nurse (#3) stated staff check to verify the suction machine is on the crash cart, and confirmed staff should check to make sure it is working. - Observation of the North wing emergency suction machine occurred on 05/08/13 at 2:05 p.m. with nursing staff (#5, #12, and #13). The suction machine was inoperable, because the cord to the suction machine was missing. Staff searched for approximately ten minutes and was unable to find the missing cord. Facility staff had to disconnect the facsimile machine and use that	F 456	F456 Education was provided to Licensed Staff regarding Emergency Management: Crash Cart Policy. ADNS or designee will conduct 3 weekly audits times 4 weeks, then monthly for 6 months to ensure Suction Machines remain functional. Information gathered from audits will be forwarded to the QA&A committee for further review and recommendations The corrective action will be completed by June 12, 2013.	6/12/13

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F 456	Continued From page 38 cord to operate the suction machine. Interview with an administrative nurse and administrative staff (#1 and #8) occurred on 05/08/13 at 4:00 p.m. These staff were unaware the cord to the suction machine was missing.	F 456		