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 _____	C 01/25/2012

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 complaint survey beginning on January 24, 2012 and completed on January 25, 2012, the sample included thirteen (13) residents for focused review and two (2) closed record for review.	F 000	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the Facility has taken or will take actions set forth in the following Plan of Correction. The Plan of Correction constitutes the Facility's allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date indicated.	
F 312 SS=E	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 on observation, information from the complainant, family interview, facility policy review, resident interview, and staff interview, the facility failed to provide the necessary services to maintain adequate grooming for 6 of 13 sampled residents (Resident #7, #8, #9, #10, #11, #13) who require assistance with grooming. Failure to provide the grooming services necessary to maintain the residents' appearance does not respect the autonomy of each resident. Findings include: Review of facility policies occurred on January 25, 2012. A policy titled "AM CARE," dated January 2009, stated, "PURPOSE: To provide AM [morning] care in preparation for daily activities. . . . PROCEDURE: . . . 14. . . . comb hair and shave as needed. . . ."	F 312	It is the practice of this facility to provide the necessary services to maintain grooming for residents unable to carry out activities of daily living. 1. Resident #7, #9 and #13 are no longer in the facility. Residents #8, #10, and #11 are receiving assistance with hair care. These patients' task lists have been reviewed and updated as necessary to reflect assistance with hair care. 2. Residents requiring assistance with grooming will be identified by reviewing MDS coding for grooming and therapy evaluations of grooming ability.	2/27/2012

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

Administrator 2/16/12

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 312	Continued From page 1 Observations of residents with unkept hair and poor grooming included the following: * 01/24/12 at 12:15 p.m. in University dining room, two unidentified female residents ate lunch and their hair laid flattened down on the back and the sides of their heads. * 01/24/12 at 12:40 p.m. in Rehab dining room, Resident #10's hair stood up on top of his head, and one unidentified female resident's hair on the top and the sides of her head stood straight out and up while the hair on the top of her head lay flattened (matted) down. * 01/25/12 at 8:10 a.m. in Rehab dining room, a male Resident #9 sat with unshaved facial hair This resident stated in an interview that his wife or staff will obtain an electric razor for him to shave his facial hair. At 12:25 p.m., Resident #9 remained unshaven while eating lunch. * 01/25/12 at 8:15 a.m. in the University Dining Room, two resident's (Resident #13 and one unidentified resident) bangs stood straight up and the hair on the side and the back of their heads laid matted down. At 12:15 p.m., both residents' hair remained in the same state while they ate lunch. * 01/25/12 at 8:20 a.m. in Rehab dining room, Resident #11's hair on top of her head stood straight up and on the back of her head the hair laid flattened down. * 01/25/12 at 11:55 a.m., a CNA (#1) assisted Resident #8 out of bed for lunch. The resident's hair laid flat (matted) on the back and the left side of her head. The CNA assisted resident #8 to use the bathroom but failed to offer hair grooming. After the CNA left the resident's room, a physical therapy aide (#3) wheeled resident #8 down the hallway to the therapy room and assisted the resident to do exercises without fixing the	F 312	3. Task lists for residents requiring assistance with hair care or shaving will be updated as needed to reflect the level of assistance needed. Nursing staff will be re-educated on the provision of assistance for hair care and shaving by the Directors of Care Delivery or designee by 2/27/12. 4. Dining Room Monitors will complete observations of residents for shaving and combed hair three times a week for four weeks. Observation results will be brought to the QAPI meeting by the Administrative Director of Nursing Services or designee to monitor for compliance. Additional observations will be completed as directed by the QAPI Committee. 5. Completion date is 2/27/2012	

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F 312	Continued From page 2	F 312		

resident's hair. The resident worked with the physical therapy aide (#3) for 30 minutes prior to being brought to the Rehab dining room for lunch. At 12:25 p.m., Resident #8's hair remained flat on the back of her head and stood up on top while the resident ate lunch. Both staff members failed to assist the resident to comb her hair.

Review of Resident #8 and #9's activity of daily living (ADL) needs occurred on 01/25/12. Resident #8's ADLs identified her as needing hands on staff assistance with personal hygiene, and Resident #9's ADLs identified him as needing stand by assistance and supervision for cares.

During an interview on 01/25/12 at 1:20 p.m., a nurse manager (#3) identified Residents #8 and #9 as needing assistance with personal hygiene and her expectations would be for staff to offer and assist residents with grooming prior to leaving their rooms.

- Random observation of dining occurred on the afternoon of January 24, 2012. Observation identified the following:

* 11:55 p.m. Dakota Dining room. Three unidentified residents observed with unkept, uncombed hair.

* 12:05 p.m. Courtyard Dining room. One unidentified resident with unkept, uncombed hair.

Observaton on 01/24/12 at 5:15 p.m. identified a CNA (#4) transfered Resident #7 from his bed to his wheelchair. Observation showed Resident #7's hair sticking up towards the back of his head. The CNA did not encourage Resident #7 to comb

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his hair and did not assist with set up prior to bringing the resident to the dining room for supper.

- Record review for Resident #7 occurred on January 24-25, 2012. Resident #7's MDS, dated 01/02/12, identified set up assistance of one staff member for grooming.

Observation on 01/25/12 at 8:00 a.m. identified Resident #7 sitting in his wheelchair; hair sticking up in back.

- During an interview on 01/24/12 at 7:50 p.m., a family member A identified the following:
* concerns with grooming- haircombing and shaving
* has spoken to staff about concerns, and staff are aware
* staff do not initiate grooming for residents unless they are told to or reminded to complete it

- A random observation on 01/25/12 at 12:50 p.m. showed an unidentified male resident transported in a wheelchair by an unidentified staff member, the resident's hair uncombed and sticking up in the back.

During an interview on the afternoon of 01/25/12, two administrative staff members (#5 and #6) agreed staff need to ensure residents are assisted with grooming when needed and agreed this is a dignity/respect issue.