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 02/09/2012

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 completed February 8-9, 2012, the sample included 2 sampled residents and 3 closed records.	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.	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to develop review, and/or revise the residents' comprehensive plan of care to address specific problems identified for 1 of 1 sampled resident (Resident #5) at risk for dehydration and constipation. Failure to develop, review and revise the resident's care plan limits the staff's	F 279	To remain in compliance with all federal and state regulations, the Center has taken or will take actions set forth in the following plan of correction. The following plan of correction constitutes the Center's allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated. It is the practice of this facility to utilize the results of assessments completed to develop, review and revise a resident's comprehensive plan of care. F279 1. Resident #5 is no longer a resident in this facility. 2. Residents most recent Care Area Assessment (CAA) for nutrition and hydration will be reviewed with current care plans to identify any residents lacking a nutrition and/or hydration care plan when the CAA stated we would proceed to care plan. Resident's charts and bowel records will be reviewed for	3/19/2012

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 3/9/2012

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 279	Continued From page 1 ability to communicate changes in the resident's status and care, and to ensure continuity of resident care. Findings include: - Review of Resident #5's medical record occurred on all days of survey. Diagnoses included cerebrovascular accident (CVA), dysphagia, end stage renal disease, small bowel obstruction (associated with a recurrent ventral hernia) and chronic constipation. The admission Minimum Data Set (MDS), dated 01/19/12, identified moderately impaired cognition, extensive assistance required with eating and toileting, frequent bowel incontinence, mechanically altered diet, and special treatments including dialysis. Areas triggered on the Care Area Assessment (CAA) included: Activities of Daily Living (ADL) Function, Nutritional Status, and Dehydration. The ADL Function CAA stated, ". . . frequently incontinent of bowel. . . ." The Nutritional Status CAA stated, ". . . The CVA has resulted in her having dysphagia and she is receiving mechanical soft textures . . . she doesn't like the altered textures or thickened liquids . . . She doesn't follow the swallowing strategies very well and can be impulsive. . . . Her intakes are < [less than] 50% [percent] on average at meals and she does have multiple refusals of meals . . . She is not receiving a therapeutic diet at this time, to try to increase her intakes, especially with the altered textures and thickened liquids . . ." The Dehydration CAA stated, ". . . dx [diagnosis] of ESRD [end stage renal disease] with HD [hemodialysis] 3 times/week. . . . She also does have a h/o [history	F 279	residents needing a constipation care plan. 3. Nutrition, hydration and constipation care plans will be added to existing care plans as needed. Licensed nurses will be re-educated on the need to care plan constipation for new and existing patients by Administrative Director of Nursing Services or designee by 3/19/2012. Resident Assessment Coordinator or designee will check CAAs and care plans prior to sign off of completion date to ensure all CAAs proceeding to care plans have corresponding care plan problems. 4. Six resident care plans will be audited weekly for four weeks for inclusion of nutrition, hydration and/or constipation care plans if applicable. monthly for 6 months after first audit by DON 03/21/12 Results of the audits will be reviewed by the Quality Assurance Performance Improvement (QAPI) Committee 2:30 pm administration	

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F 279	Continued From page 2 of] chronic constipation. . . ." The Physician Orders stated the following: * On 01/26/12: oral cares daily for dry mouth, Aquaphor [cream] applied before bed for dryness, and Lactulose every day * On 01/27/12: mechanical soft diet with nectar-like thick liquids * On 01/29/12: Fleets enema every day as needed for constipation * On 01/29/12: flat plate xray of the abdomen for constipation The Interdisciplinary Progress Notes stated the following: * 01/29/12 at 11:00 p.m., "Pt [patient] c/o [complains of] abd [abdominal] cramping and constipation. . . . lactulose adminster [sic]. Pt continue [sic] to c/o discomfort, fleet enema administered, pt. continue [sic] to have abd cramp. [cramping] . . . NP [nurse practioner] update [sic] and T.O. [telephone order] for flat plate of the abd. daughter here [and] aware of order. abd. xray done tonight. . . ." The Xray report, dated 01/29/12, stated, ". . . Indication: HX [history] Of constipation . . . IMPRESSION: There is moderate colonic constipation." The Interdisciplinary Progress Notes revealed the following: * 01/30/12 at 12:00 noon, ". . . Pt sent to . . . [Name of Hospital]. . . ." * At 9:00 p.m., "Pt returned from Hospital . . . Dx [diagnosis] of constipation [and] abdominal [sic]. New orders for Miralax 17 g [gram] po [by mouth] BID [and] Senna [1] tab BID. . . ."	F 279	for continued compliance by the ADNS or designee. Additional audits will be completed as directed by the QAPI Committee. 5. Completion date is 3/19/2012.	

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F 279	Continued From page 3 * 01/31/12 at 2:01 p.m., ". . . Pt/daughter will want to sign a release to use the Miralax even if it is not thickened and understand the risk . . . " * 02/05/12 at 10:01 p.m., ". . . When pt returned, the daughter insisted that she receive a bisacodyl suppository. He [sic] abdomen felt distended. Gave pt suppository at 7:00 p.m. No results yet. . . . Resting now." * 02/06/12 at 3:48 a.m., ". . . Pt is distended and bowel sounds are present in all four quadrants. . . ." * At 10:50 a.m., "Patient daughter very upset and wanted her mother sent to the ER [emergency room] bc [because] she appears to be more lethargic. Daughter also believes that her mother is having more difficulty breathing r/t increased constipation. . . ." * At 1:16 p.m., "Spoke with ER nurse . . . patient is being admitted for pneumonia and possible UTI." The Nurse Practioner's Exam Details reports stated the following: * 01/17/12. ". . . constipation persistent . . . DC [discontinue] Miralax Lactulose 30 ml . . ." * 01/30/12, ". . . constipation persistent . . . daughter insisted she be sent in vs [versus] facility do interventions to remove stool . . . send to ED [emergency department] per insistence of daugh [daughter]. . . ." * 02/01/12, ". . . constipation persistent . . . continue [with] scheduled laxatives. . . ." * 02/06/12, ". . . breaths through her mouth dry from dialysis thickened liquids . . . fluid volume deficit persistent on dialysis thickened liquids - Pt refuses to eat, drink, take meds [medication] . . ." During interview in the morning of 02/08/12, an	F 279		

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F 279	Continued From page 4 administrative nursing staff member (#1) stated the resident was admitted to the hospital "with pneumonia and fluid volume deficit." During interview on 02/09/12 at 12:20 p.m., an nursing staff member (#1) confirmed the dehydration care plan from her previous admit was "cancelled" and facility staff had started a new one, "but didn't finish it." She also confirmed the current care plan failed to address both dehydration and constipation. The care plan lacked any evidence the resident was at risk for dehydration and/or constipation. The care plan failed to identify the interventions the facility had attempted and/or had in place to address the symptoms of dysphagia, poor intake, and chronic constipation.	F 279		