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JUN 29 2015
Division of Health Facilities

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 05/14/2015

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 started on 05/13/15 and completed on 05/14/15, the sample included 4 current residents for complete review and 1 closed record. The sample included the observation of 3 additional residents to verify specific concerns during the survey.	F 000	Manor Care of Fargo plan of correction for complaint survey dated May 14, 2015. The statements on this plan of correction are not admittances to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the center has taken or will take action as set forth in the following plan of correction. The plan of correction constitutes the center's assertion of compliance. All alleged deficiencies cited have been or will be corrected by dates indicated.	
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 facility policy and procedures, and staff interview, the facility failed to ensure staff followed professional standards of practice regarding performing skin assessments for 1 of 1 sampled resident (Resident #3) observed with multiple bruises. Failure to ensure staff completed a thorough assessment of all skin alterations may result new bruises/injuries not being identified, causative factors not being determined and the progress or lack of healing progress not being monitored. Findings include: Review of the facility policy for abuse prohibition "PHASE 3: IMPLEMENT" occurred on 05/14/15. The policy, dated 2011, stated, "ONGOING MANAGEMENT STRATEGIES: On the basis of information obtained and analysis performed in the assessment and planning phases, the next step is to implement an organized approach for	F 281	F 281 Resident #3 has received care and services as he allows for monitoring of bruises. Monitoring of bruises to chest wall is impacted by his personal preference that staff not view the front of his unclothed body. Staff request permission and complete visualization of bruises when agreed upon by resident. Residents with skin alterations have the potential to be affected by this practice.	6/20/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 06/11/2015

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 281	Continued From page 1 the management of actual and potential skin alterations. SKIN OBSERVATIONS: Nursing assistants perform daily skin observations with routine care. The Skin Worksheet is completed by the nursing assistant at least two times per week with the patient's bath (shower, tub, bed). Results are submitted to the licensed nurse for review and follow-up as needed. Nursing assistants can initiate a 'New Alert' in PCC [point click care - used for nursing assistant electronic charting] to communicate changes in skin condition to the licensed nurse. Note: The Skin Worksheet is a communication tool and is not maintained as part of the clinical record. SKIN EVALUATIONS: . . . Documentation of the evaluation is located in the Treatment Administration Record or progress note. Weekly skin alteration evaluations are completed by the licensed nurse for those wounds not being evaluated by the wound team (e.g., skin tears, surgical incisions, rashes, etc.) The findings are documented on the Skin Alteration Record." Review of Resident #3's medical record occurred on May 13-14, 2015. Diagnoses included depressive disorder and dementia with behavioral disturbance (Alzheimer's type). On the afternoon of 05/13/15, observation of Resident #3 included evidence of an injury to the right forearm and multiple bruises on the resident's body, including bruising to the chest	F 281	The ADNS or designee will provide education to licensed nurses regarding the need to complete weekly review of skin alterations when residents are agreeable to a visual examination. Education will be conducted June 11, 12, 15 2015. ADNS or designee will conduct Audits of skin sheets, Audits will be completed three times weekly for four weeks and then weekly for three months. Results of audits will be forwarded to the QAPI committee for review and recommendation. Date of compliance is June 20, 2015.	

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F 281	Continued From page 2 which had not previously been identified by facility staff. A "SKIN ALTERATION RECORD" stated "Directions: Identify location of skin alteration and mark it on the body graphic below. Use one form for each site. Complete report weekly and as needed. The metric system is used to measure skin alterations." Resident #3's skin alteration record, initiated on 05/05/15, identified the "Type of Alteration" as "Burn," "Bruising/Scrape." The record included a diagram of a human body to show the "skin alteration site." The diagram showed areas by marks or slashes to indicate the burn/bruising/scrape present. The marks or slashes included: * Two marks on right forearm and two on the right upper arm * Two marks on the left upper forearm, one at the elbow and one on the wrist above the thumb * A slash mark on the anterior thigh of both legs just above the knees * Two marks on the posterior right and left forearm The record lacked any of the required/additional information of "Measurements . . . Description of Alteration . . . " The record identified the "Skin Surrounding Alteration" as "Discoloration - blue, purple, yellow" (specific color not specified) and no pain at the site(s). The next entry, dated 05/13/15, lacked measurements, and description of alteration. The record identified the "Skin Surrounding Alteration" as "Discoloration - blue, purple, yellow" (specific color not identified) and no pain at the site(s). Review of Resident #3's progress notes identified the following:	F 281		

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F 281	Continued From page 3 * 05/03/15 at 8:44 p.m., ". . . went to have a shower and no problem. . . ." * 05/04/15 at 11 a.m., written by provider as a late entry, ". . . There is a large bruise on posterior FA [forearm] that is painful to touch. Pt [patient] rates pain as 8/10 when touched and rotated." * 05/04/15 at 2:40 p.m., written by social services staff member, ". . . His wife thought he may have fallen d/t [due to] bruise on right arm. . . . Also said he has a bruise on his left top of his foot. Nursing aware. . . ." * 05/04/15 at 11:24 p.m., "Received x-ray results at [8 p.m.], with impression as mildly displaced oblique distal ulnar metadiaphyseal fracture . . . client sent to ER [emergency room] by ambulance." * 05/04/15 at 11:40 p.m., "Pt returned from emergency room at 11:30 p.m. New orders for sling and splint to be left in place on right forearm at all times." The discharge instructions identified the resident with right arm pain, and ecchymosis (bruising). * 05/07/15 at 3:47 p.m., written by provider, ". . . multiple bruises from hitting walls and people. . . ." * 05/09/15 at 9:46 p.m., "weekly skin check done nio [sic] new skin changes noted, right arm in sling, continuously, will continue to monitor." * 05/09/15 at 10:56 p.m., ". . . had his shower, . . ." * 05/13/15 at 11:09 p.m., "patient had shower at [9 p.m.] . . . weekly skin assessment completed and no new skin abnormality noted. skin dry/intact. will continue to monitor." During interview on the morning of 05/14/15, an administrative staff member (#1) stated if the nurse is unavailable/busy during a resident's bath to assess the resident's skin, the certified nursing	F 281		

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F 281	Continued From page 4 assistant (CNA) will complete a form to notify the nurse of their observations of any bruising/skin issues. During interview on the afternoon of 05/14/15, an administrative staff member (#1) agreed Resident #3's record lacked complete assessments and thorough documentation of all the injuries/bruises on the skin alteration record including specific information of size and description.	F 281		