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 _____	06/07/2012

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 standard Medicare/Medicaid recertification survey started on June 04, 2012 and completed on June 07, 2012 the sample included 5 residents for complete review, 11 residents for focused review, 3 closed records for review. The sample included 11 additional residents to verify specific concerns during the survey.	F 000		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, and review of a booklet identifying the facility's expectations for staff, the facility failed to provide care in a manner that maintained or enhanced the dignity for 4 of 19 sampled residents and 5 supplemental residents. Failure to knock on residents' doors prior to entering the room (Resident F, G, #7, #23, #24, #26, and #27), removing a resident from his/her room in order for staff to assist the roommate with personal cares (Resident #12), and failure to change a resident's soiled clothing (Resident #25) may negatively impact a resident's self-esteem, dignity and sense of self-worth. Findings include: An administrative nurse (#1) provided a booklet	F 241	Manor Care Health Services will promote care for residents in a manner that maintains or enhances each resident's dignity and respect. Resident #25 is assisted with changing soiled clothing as needed. The roommate for Resident #12 has been relocated to a different room to eliminate the need for one resident to leave the room while the other is cared for. Residents residing within the facility have the potential to be affected by this practice. Re-education on dignity and respect was provided during department meetings. Audits for the areas of concern will be completed three times weekly for four weeks by department managers. Additional audits will be completed as per QAPI Committee recommendations.	07/24/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Patricia Dunk	Administrator	7/12/12

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 241	Continued From page 1 for review on the morning of 06/07/12. Review of this booklet titled, "Survey Training Handbook for CNAs [certified nursing assistants]," identified a statement of "Always knock and identify yourself before entering a resident's room and then wait for a response." - Observations during the initial tour, on 06/04/12 of the "South Unit" and "Central Hall" showed: *12:55 p.m., an unidentified staff member entered Resident #26's closed door room without knocking or announcing her presence. *1:15 p.m., an unidentified activities staff member entered occupied resident rooms without knocking or requesting permission to enter the rooms. *1:30 p.m., an unidentified staff member entered Resident #27's closed door room without knocking or announcing her presence. - On 06/04/12 at 5:10 p.m., while a surveyor interviewed Resident G in her room, a CNA (#2) opened the door without knocking or announcing herself. Resident G stated staff do not knock on the door all the time. - Observation on 06/04/12 at 5:30 p.m., showed Resident #24 seated in a wheelchair in his room. A CNA (#2) entered the resident's room through the open door. The CNA failed to knock or announce herself prior to entering the room. - During interview on 06/05/12 at 11:30 a.m., Resident F stated "only some of the staff members" knock on her room door before entering. - Observation on 06/05/12 at 5:05 p.m., showed	F 241		

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F 241	Continued From page 2 Resident #23 seated in a wheelchair in his room. An unidentified staff member entered the resident's room through the opened door. The staff member failed to knock or announce himself prior to entering the room. - Observation on 06/05/12 between 8:00 p.m. to 8:32 p.m., showed Resident #25 sat in the hallway by a nurses station with pureed food on the resident's shirt and chin. Observation of the noon meal on 06/05/12 identified Resident #25 as dependent on staff for eating. - Observation on 06/05/12 at 8:15 p.m., showed Resident #12 propelled his wheelchair out of his room into the hallway after two CNAs (#3 and #4) asked the resident to leave his room while they cared for his roommate. The CNA (#3) placed the roommate's bedside table on Resident #12's side of the room, where Resident #12 previously sat. The CNAs then transferred the resident's roommate to bed. During an interview on 06/04/12 at 5:00 p.m., Resident #12 identified his room as being too small, and stated facility staff place his roommate's bedside table on his side of the room and sometimes forget to move it back. - Observation during a dressing change to Resident #7's coccyx by a supervisory nursing staff member (#9) and a health care provider (#10), on 06/06/12 at 9:25 a.m., showed a staff member opened the door to the resident's room and entered without knocking or requesting permission to enter the room. During interview, on 06/07/12 at 10:30 a.m., the supervisory nursing staff member (#9) identified the individual as a CNA (#11).	F 241		

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F 241	Continued From page 3 During an interview on 06/07/12 at 9:15 a.m., an administrative nursing staff member (#1) stated she expected "staff to knock and say who they are" before entering a resident's room.	F 241		
F 246 SS=E	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident, group, and staff interview, the facility failed to provide reasonable accommodations of individual needs for 7 of 19 sampled residents (Resident C, F, G, J, K, I, and #16) and 5 of 11 supplemental residents (Resident A, D, E, H, and L). The facility failed to answer call lights in a timely manner (Resident E, F, K, G, J, and A), address the needs of residents in a timely manner (Resident #16, B, D, C, and H); and place the call light within reach for a resident (Resident #8). These occurrences have the potential affect the quality of life and quality of ca provided to all residents who reside in the fa..ity. Findings include: The residents with the letter identifiers have indicated they would like to remain anonymous to	F 246	Manor Care Health Services will provide care and services that accommodate the individual needs of each patient. Resident #8 continues to use a trapeze and requests call light be kept on the trapeze. The resident is able to demonstrate that he can access and use call light when observed. Resident #16's care plan was modified to include toileting at routine times and upon request. Residents residing in the facility have the potential to be affected by delays in answering call lights. Re-education was provided to staff during department meetings on answering call lights promptly, keeping the call light on until the resident's needs are addressed, and ensuring the call light is within reach. Audits of call light response times, resident interviews, and observations will be completed three times weekly for four weeks by department managers or designee Results of audits will be reviewed by QAPI committee and additional audits will be completed as directed by the QAPI committee.	07/24/12

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F 246	Continued From page 4 facility staff and therefore are not included on the resident roster. - Review of Resident #8's medical record occurred on June 04-07, 2012. Current diagnoses included left extremities weakness due to a previous stroke. The quarterly Minimum Data Set (MDS), dated 03/27/12, identified a Brief Interview for Mental Status (BIMS) score of "12" or moderately cognitively impaired, no acute changes in mental status, and extensive assistance of one or two persons required for bed mobility and transfers. Resident #8's Activities of Daily Living (ADL) Care Area Assessment (CAA), dated 07/08/11, stated ". . . He is able to voice need to use bathroom. He is able to move self some in bed with use of trapeze . . ." Resident #8's current care plan, dated 03/28/12, stated "Focus, ADL Self care deficit . . . He is able to participate with cares. . . . Interventions . . . Encourage to participate in self care. . . .;" and, dated 07/08/11, stated "Focus, At risk for falls . . . Interventions, Have commonly used articles within easy reach including the TV. Reinforce need to call for assistance. . . ." Resident #8's Interdisciplinary Progress Notes stated the following: *10/15/11 at 6:15 a.m., "Pt. [Patient] found on the floor by CNA [certified nursing assistant]. Pt. fell out of bed, pt. was trying to reach for his trapiz [sic] and missed, hit left eye on draw [sic], pt. was evaluated and taken up from the floor by Hoyer lift [full body mechanical lift]. Steri strip was applied to left eye."	F 246		

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F 246	Continued From page 5 *10/15/11 at 9:30 a.m., "Pt. seem [sic] disorientated, called on call doctor [physician's name], ordering to send pt. to ER [emergency room]." *10/15/11 at 12:30 p.m., "Pt. back from ER orders to resume all previous nursing home orders. Return pt. to care of primary care doctor. Remove steri strip in 6 days." *04/08/12 at 1:23 p.m., "Pt. was reaching for TV and put his legs to the side of bed to sit up and slid down to side of bed onto floor mat. Call light is now in reach. . . . No injuries noted. . . . Neuro's [Neurological checks] implemented." During interview with a supervisory nurse (#9), on 06/06/12 at 9:50 a.m., additional information regarding these falls was requested. The facility staff provided a "Fall Report" for each incident. The report for the fall on 10/15/11 failed to identify the location of the call light and the trapeze at the time of the fall. The report for the fall on 04/08/12, stated ". . . G. Documentation . . . Call light was connected to TV and pt was trying to reach this. Education was done to CNA's [certified nursing assistants] to make sure call light is always in reach." During interview with a supervisory nurse (#9) and an administrative nurse (#1), on 06/07/12 at 10:30 a.m., additional information regarding the location of the call lights and trapeze for these falls was requested. The facility staff provided a single page "Incident Report" for each fall. The Incident Reports failed to provide additional information. Observation throughout the survey, on June 04-07, 2012, showed Resident #8 lying in bed	F 246		

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F 246	Continued From page 6 with an overhead frame and a trapeze bar attached to the frame. Resident #8 reached up, grasped the trapeze bar with his right hand, and independently repositioned himself in bed. The Interdisciplinary Progress Notes, Fall Reports, and Incident Reports identified Resident #8 fell or slid from his bed while reaching for his trapeze bar or call light. The fall on 10/15/11 resulted in a cut over his eye, possible disorientation, and required a visit to the emergency room. Failure of facility staff to accommodate Resident #8's needs for independent bed mobility with the trapeze bar and to request assistance with his call light resulted in falls and injury. - Review of Resident #16's medical record occurred on June 06-07, 2012. identified the resident as moderately cognitively impaired, and required extensive assistance of two persons for transfers. A random observation of Resident #16 on 06/05/12 at 10:25 a.m. showed him seated in a wheelchair in the doorway of his room. Resident #16 communicated to an administrative nurse (#5) his need to use the bathroom. This administrative nurse (#5) instructed a CNA (#23) to help Resident #16. While the CNA (#23) went to find another CNA (as Resident #16 required the assistance of two staff persons for transfers) and obtain a change of clothes for the resident, a CNA (#24) obtained Resident #16's blood pressure. An unidentified activity staff member stopped to complete a one-to-one visit with Resident #16 and the resident once again	F 246		

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F 246	Continued From page 7	F 246		

expressed his need for assistance to use the toilet. The activity staff member stated to the resident, "I will get someone." During this time period, a licensed practical nurse (#25) worked on a computer in the vicinity. At 10:47 a.m. (22 minutes later) staff members (#25 and #26) provided toileting assistance to Resident #16.

- During the initial tour of the facility on 06/04/12 at 1:45 p.m., Resident F expressed concerns with staff responding to/answering her call light. Resident F stated in January 2012 she had an episode of difficulty with her breathing. Resident F stated she activated her call light and it took staff "25 minutes" to respond to her need for assistance.

- Review of Resident J's MDS identified the resident as cognitively intact and the facility identified the resident as interviewable. During an interview on 06/04/12 at 5:00 p.m., Resident J reported he pushed his call light at the beginning of a television show and after the 30 minute show ended, his call light still remained unanswered. The resident stated this occurred in May 2012.

- During an interview on 06/04/12 at 5:05 p.m., Resident G stated she waited "45 minutes for staff to answer a call light" last Friday between 6:00 p.m. to 7:15 p.m. Resident G stated she wanted to take a shower.

- On 06/05/12 at 10:00 a.m., facility staff assisted interviewable Resident A, B, C, D, E, and I to participate/attend the resident group interview. The group provided the following information:
* Resident A stated residents can wait 40-45 minutes for staff assistance, and stated staff will

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F 246	Continued From page 8 stop doing cares with a resident if someone else needs help. Resident A stated she went to an activity and when she left her room, the roommates call light was on and when she returned 45 minutes later the call light was still on. * Resident A, C, D and H stated residents wait longer at night (evening or night) for assistance. Each resident stated they can wait up to two hours to get a pain pill from the nurse. Resident H stated she gets a lot of medications at bedtime and often has to wait. * Resident E identified sitting on the toilet for 45 minutes while nursing staff provided assistance to another resident. Resident E identified another resident in one of the hallways who takes an excessive amount of staff time, so the staff do not have time to assist other residents. Resident E stated either the facility is short of staff or they need a special team for this other resident. - During an interview on 06/05/12 at 4:00 p.m., Resident K, who is identified as cognitively intact, reported waiting 30 minutes for her call light to be answered when wanting to lie down after a meal. - During interview, on 06/05/12 at 4:40 p.m., Resident I reported he used his call light to alert staff of his need for toileting, waited approximately 45 minutes for assistance, and was incontinent because of the delayed response time. He reported this incident occurred approximately one week ago. - Observation on 06/05/12 at 8:15 p.m. showed Resident B sat in her wheelchair in her room crying with her call light on. When asked,	F 246		

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F 246	Continued From page 9 Resident B stated she had been waiting for 30 minutes to go to bed. Resident B stated a nurse's aide said she would assist her in five minute, but "she never came back." A nursing staff member (#8) entered Resident B's room and stated to her the CNA went to help someone else "so it will be longer." Within five minutes of observing Resident B crying, a random CNA walked by the room, turned off the resident's call light, and failed to assist this resident. At 8:35 p.m., observation showed a CNA in Resident B's room assisting her. During an interview on 06/05/12 at 8:30 p.m., Resident L stated she has rang her call light up to an hour before getting staff assistance at bedtime. During an interview on 06/07/12 at 9:15 a.m., an administrative nurse (#1) stated the maximum time a resident should wait for a call light to be answered is 15-20 minutes.	F 246		
F 309 SS=E	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 and plan of care. This REQUIREMENT is not met as evidenced by: 1. Based on observation, record review, policy and procedure review, and staff interview, the	F 309	Manor Care Health Services will provide care and services to attain or maintain the highest practicable physical, mental, and psychosocial wellbeing for each resident based on individual assessment. Orders ~~were~~ (= 14) obtained for residents #1,4,15, and 18 for AV fistula monitoring. Care plans were updated to include correct arm for blood pressure ~~and lab~~ & ~~draws~~. Resident #9 had his port successfully flushed and maintenance	

Will include provision to notify lab other than vice care plans.
per T. C. with Patty Dirk, cadm. 7/17/12 at 11:05 am.

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F 309	Continued From page 10 facility failed to provide the necessary care and services for 4 of 4 sampled residents (Resident #1, 14, #15, and #18) who currently receive hemodialysis utilizing a dialysis fistula (a connection between a vein and artery allowing access to the vascular system for hemodialysis). Failure to assess and monitor residents' fistulas on a routine basis does not ensure facility staff will detect potential complications associated with these devices such as infections, leakage, and thrombosis and promptly notify/report these complications to a health care provider. Findings include: Review of the facility's policy titled, "Assessment of Arterio Venous Shunts, Fistulas, and Grafts," occurred on the morning of 06/07/12. The policy dated 12/2009, stated, "PURPOSE: The evaluation of arterio venous shunts, fistulas, and grafts by a licensed nurse is intended to facilitate early detection of potential complications which includes signs and symptoms of infection, leakage, and thrombosis [blood clot]. Any abnormal signs and symptoms should be reported to the physician immediately. . . . Procedure . . . 7. Observe for signs and symptoms of infection including: pain, tenderness, swelling or redness around the patient's access area. 8. Palpate- place a hand over the site for the presence of thrill. 9. Auscultate- using the stethoscope, listen for the presence of bruit over the site (swooshing sound) 10. The frequency is determined by the patient's condition and physician ordered- a minimum frequency every 24 hours . . . Document completion of assessment on the TAR [Treatment Administration Record] . . . ."	F 309	flushes were ordered to be completed monthly. Covered mugs were ordered and placed for Resident #6 and #9 to eliminate use of straws at bedside. Resident #12 received Jobst stockings on 06-05-12. Residents who require monitoring of implanted devices, AV fistulas, and those who require thickened liquids or receive new orders have the potential to be affected. Nursing staff were re-educated on areas of concern during department meetings. Audits will be completed three times weekly by nurse managers or designee. Additional observations will be conducted as per QAPI Committee recommendations.	07/24/12

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F 309	Continued From page 11 - Review of Resident #1's medical record occurred on June 04-07, 2012. The facility admitted Resident #1 in March 2012. The resident's diagnoses include Type II diabetes mellitus, end stage renal disease (receives hemodialysis on Tuesday, Thursday, and Saturday), osteomyelitis, and right below the knee amputation. Resident #1's care plan, identified a focus problem of "Renal insufficiencies related to chronic renal failure on hemodialysis," dated 04/02/12. Resident #1's care plan failed to identify the presence and location of his fistula utilized during hemodialysis and failed to specify the need that blood pressure reading and any venepuncture be obtained only on the fistula free right arm. Review of Resident #1's "Tasks Kardex" (used by CNAs) failed to identified the need to refrain from obtaining blood pressure readings from the resident's left arm related to the presence of a fistula used during his hemodialysis. - Review of nursing progress notes, dated 06/03/12 stated: *4:00 a.m.- "Pt [patient] had call light on wanting nurse . . . Pt dialysisn [sic] site was bleeding . . . Pt left upper arm dylasis [sic] site was bleeding. Area was clean [sic] cover with 2 - 4 x 4 gauze and covered with Kerlix. Will monitor. Pt had no c/o [complaints of] pain." *3:10 p.m. - "Resident fistula still bleeding this morning after dialysis run yesterday. Wrapped with Coban, not helpful. Also noted some 2+	F 309		

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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 309	Continued From page 12 pitting edema to [left] arm and hand. VSS [vital signs stable], expect slightly bradycardic at 59 bpm [beats per minute], WNL [within normal limits] for resident. [name of nurse practitioner] notified and ordered to send pt into ER for further eval [evaluation] and tx [treatment] . . . ." *9:30 p.m.- "Pt returned from ER [emergency room] orders to leave new fistula wrap on until taken off on Tuesday 06/05/12 at dialysis. New dressing is dry and intact. Pt has 0 [zero] c/o pain [at] the site, VS [vital signs] WNL. Will continue to monitor." Resident #1's record lacked evidence facility staff re-assessed his bleeding fistula site prior to 3:10 p.m. (a time span of greater than 11 hours). Upon return from the ER on 06/03/12, facility staff assessed the fistula site at 9:30 p.m. and at 3:27 a.m. on 06/04/12. Resident #1's record lacked evidence of any further assessment of the fistula on June 5. During interview on 06/06/12 at 11:10 a.m., a staff nurse (#29) stated it is the practice of the facility to identify a resident's fistula site on the TAR to ensure daily monitor/assessment of the site by nursing staff. Review of Resident #1's March-June 2012 TARs lacked an entry prompting/reminding staff to assess the fistula site on his left arm. - Review of Resident #15's medical record occurred on June 06-07, 2012. The facility admitted Resident #15 in April 2012. The resident's diagnoses include Type II diabetes mellitus, and end stage renal disease (receives hemodialysis on Monday, Wednesday, Friday,	F 309		

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F 309	Continued From page 13 and Saturday). Resident #15's care plan, identified a focus problem of "Renal insufficiencies related to chronic renal failure on hemodialysis," dated 04/18/12. Resident #15's care plan failed to identify the presence and location of his fistula utilized during hemodialysis and failed to specify the need that blood pressure reading and any venepuncture be obtained only on the fistula free right arm. Review of Resident #15's TAR identified an entry dated, 06/06/12, which stated, "Monitor bruit to [left] fistula." Resident #15's record lacked evidence facility nursing staff assessed/monitored the resident's left fistula the two months prior (April and May 2012). - Review of Resident #18's medical record occurred on 06/07/12. The resident's diagnoses included renal failure. Observation of cares on 06/07/12 at 9:45 a.m., showed a fistula in Resident #18's right arm. Review of Resident #18's care plan on the morning of 06/07/12 identified it lacked an approach for nursing staff to check/monitor the resident's fistula for a thrill/bruit. Review of Resident #18's TAR failed to show an entry to check the resident's fistula for a thrill/bruit. - Review of Resident #14's occurred on June 06-07, 2012. The facility admitted Resident #14 on 05/23/12, with diagnoses of end stage renal	F 309		

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F 309	Continued From page 14 disease, anemia, malnutrition, muscle weakness, atrial fibrillation, and recent hip fracture with surgery. The record identified he receives hemodialysis three times a week via a right arteriovenous fistula. Resident #14's medical record failed to identify the resident's hemodialysis assess site had been monitored per facility guidelines prior to 06/06/12. During an interview on 06/07/12 at 9:15 a.m., administrative nurse (#5) confirmed monitoring of thrill/bruits should be identified on the care plan, task kardex, and treatment sheet. On 06/07/12 at 10:00 a.m., an administrative nurse (#1) stated the facility missed obtaining orders and monitoring for dialysis fistula sites for Resident #1, #14, #15, and #18 until it was brought to their attention by the survey team. 2. Based on record review, review of facility policy and procedure, and staff interview, the facility failed to provide the necessary care and services regarding flushing an implanted Heparin lock port for 1 of 1 sampled resident (Resident #9) with a central venous line. Failure to ensure the central venous line was flushed for the period March 04-June 07, 2012 placed the resident at risk of infection, clot formation, and complications related to the heparin lock. Findings include: Review of the facility policy and procedure, "Accessing Implanted Ports," occurred on 06/07/12. This document, dated January 2009, stated "PURPOSE: To safely access an	F 309		

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F 309	Continued From page 15 implanted port . . . DOCUMENTATION: Document on Medication Administration Record [MAR]: including type, volume, and concentration of flushes administered. . . ." Review of Resident #9's medical record occurred on June 04-07, 2012. The facility admitted the resident in August 2010. Current diagnoses included history of oropharyngeal cancer. The quarterly Minimum Data Set (MDS), dated 05/12/12, did not identify the resident received an anticoagulant during the previous seven days. Resident #9's physician orders, initiated on 02/04/12 and renewed on 05/30/12, included "Heparin lock flush 100 unit for Hep [Heparin] -lock 100 units/ml [milliliter] V [volume]. Flush port-a-cath once a month with 5 ml (500 units) of Heparin (on the 4th). Flush port with 10 ml normal saline before Heparin monthly (on the 4th)." (Heparin is an anticoagulant used to keep blood from coagulating at the tip of the catheter.) Resident #9's current care plan lacked information regarding the Heparin lock, the flushes as ordered, monitoring or precautions for staff, or reasons for the Heparin lock. Review of Resident #9's Medication Administration Records (MARs) for the months of March through June 07, 2012 identified the monthly Heparin lock flushes on approximately the 4th day of each month but not initialed, indicating the flushes were not done. During interview, on 06/07/12 at 10:30 a.m., a supervisory nursing staff member (#9) and an administrative nursing staff member (#1) reported	F 309		

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F 309	Continued From page 16 they would investigate Resident #9's Heparin lock flushes. On 06/07/12 at 1:15 p.m., a staff member (#9) provided a copy of initialed, unsigned handwritten communication notes between the facility staff and the facility's health care provider (HCP) (#10) regarding Resident #9's Heparin lock flushes, as follows: *03/03/12 - "I tried to flush [Resident #9]'s port today & [and] had difficulty again (?) I will be back Wed. [Wednesday] if want to look @ [at] it then." *04/03/12 - "? [Resident #9] port - couldn't get to flush last month. Due again. What to do? Question if appropriate to discontinue flushes & have discussed - Can talk [with] me. Thanks." Written in the margin, "Monday [(HCP) (#10's) initials] to flush." *05/07/12 - "Did we ever decide what to do with his port? (Just throwing notes.)" Written response, no date - (From HCP (#10) "Nurse was to get supplies ready & call me - never did." *05/14/12 - "Did you want his port flushes d/c [discontinued]? . . ." Written response, no date - (From HCP (#10))"3 x's [times] someone was to get me the supplies et [and] call me et this hasn't happened." The facility staff failed to complete the monthly flushes as ordered. The facility staff failed to identify Resident #9's Heparin lock port, flushes, and precautions such as bleeding or redness on the resident's care plan. These failures placed Resident #9 at risk of potential infection at the port site, clot formation and complications related to these risks. 3. Based on observation, record review, review of professional reference, resident interview, and	F 309		

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F 309	Continued From page 17 staff interview, the facility failed to ensure residents received the necessary care and services for 2 of 2 sampled residents (Resident #6 and #9) with physician orders to not have straws for liquids, and for 1 of 1 sampled resident (Resident #12) with physician orders for compression stockings. Failure to provide care and services as ordered placed Resident #6 and #9 at risk of preventable aspiration, pneumonia, and side effects and placed Resident #12 at risk of lower leg swelling and skin breakdown. Findings include: Review of Resident #9's medical record occurred on June 05-07, 2012. The facility admitted the resident on 08/12/10. Current diagnoses included dementia, gastroesophageal reflux disease, and history of oropharyngeal cancer. The quarterly Minimum Data Set (MDS), dated 05/12/12, identified supervision and setup help with eating and no swallowing disorders. Resident #9's Activities of Daily Living (ADL) Care Area Assessment (CAA), dated 08/18/11, stated ". . . He continues to be followed for glottic lesion which is felt to be granulation tissue from prolonged intubation . . . He does have history of throat cancer. . . ." The resident's Nutrition Quarterly Assessment, dated 05/25/12, stated ". . . He continues to receive a Regular diet and is no [sic] to use straws and has no s/s [signs/symptoms] or c/o [complaints of] chewing or swallowing difficulties. . . ." Resident #9's current care plan, revised 05/25/12, stated "Focus, impaired nutrition & [and] possible weight changes r/t [related to] . . . h/o [history of]	F 309		

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F 309	Continued From page 18 dysphagia . . . goltic [sic] lesions . . . no straws . . ." Resident #9's recurring physician orders, renewed on 05/30/12, included "No Straws." Observation on June 04-06, 2012, identified a disposable cup with water and a straw at Resident #9's bedside and Resident #9 consumed water from these cups. During interview, on 06/05/12 at 2:30 p.m., a certified nursing assistant (CNA) (#7) reported she provided the resident with water from a cup with a straw. During interview, on 06/06/12 at 9:50 a.m., a supervisory nursing staff member (#9) confirmed Resident #9 should not receive fluids with a straw. - Review of Resident #6's medical record occurred on all days of survey. Diagnoses included dysphagia, macular degeneration and legally blind. Review of the resident's physician orders showed a diet order, dated 05/29/12, stating ". . . regular/thins - no mixed consistency - no straws . . . " Resident #6's current care plan identified, " . . . Focus: Risk for alteration in hydration related to times of times [sic] of forgetfulness, blindness due to macular degeneration & needing tray set-up, . . . dsyphaiga [sic] . . . Interventions . . . no straws . . . " Observation on 06/05/12 at 3:50 p.m., showed Resident #6 assisted by a CNA (#7) to lay down in bed. This CNA obtained a glass with a straw and offered a drink of water to the resident who declined the drink and stated she was not	F 309		

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F 309	Continued From page 19 suppose to have straws. - Review of Resident #12's medical record occurred on all days of survey. Medical diagnoses included diabetes, cerebral vascular accident (CVA), left hemiparesis, left side sensory loss, and hypertension. Review of an annual Minimum Data Set, dated 02/22/12, identified Resident #12 as cognitively intact and required extensive assistance of two or more staff members for dressing. On 06/01/12, the resident's physician ordered Jobst compression stockings (long, tight fitting stockings that keep mild pressure on the legs) to both legs up to the knees for treatment of edema. The resident's current care plan failed to address the use of compression stockings. During an interview on 06/04/12 at 5:00 p.m., Resident #12 (identified by the facility as interviewable) stated the resident and resident's family brought up the use of compression stockings to his physician related to the resident's leg pain. The resident reported his physician recently visited and ordered compression stockings. Resident #12 stated he had not seen or worn the stockings the physician ordered on 06/01/12. Observation showed the resident did not have compression stockings on. Review of Resident #12's treatment record showed a line drawn through 06/01/12 to 06/05/12 related to the use of Jobst compression stockings. Observation on 06/05/12 at 11:40 a.m., showed a CNA (#12) assisted Resident #12 to dress and	F 309		

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F 309	Continued From page 20 transfer out of the bed. The CNA failed to place compression stockings to legs. At 3:45 p.m. and 9:10 p.m. on 06/05/12, observation showed no compression stockings worn by the resident while in his wheelchair. During an interview on 06/05/12 at 5:45 p.m., a nurse (#13) identified there were no compression stockings in Resident #12's room and a staff member was sent to obtain a pair. During an interview on 06/06/12 at 2:00 p.m., a supervisory nurse (#9) reported facility had failed to obtain a pair of stockings for Resident #12.	F 309		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident interview, family interview, staff interview, and policy review, the facility failed to provide the appropriate treatment and services to maintain or improve ambulation abilities for 2 of 2 sampled ambulatory residents (Resident #9 and #12) who were not offered ambulation. Failure to provide these residents with the opportunity to ambulate limited their ability to reach their highest practicable physical, mental, and psychosocial well-being possible. Findings include:	F 311	Manor Care Health Services will provide appropriate treatment and services to maintain or improve their ADL functional status. Resident #9 and #12 were referred to physical therapy for assessment, treatment, and modification of restorative ambulation programs. Patient #12 agreed to wear AFO as tolerated. Residents who require assistance with ambulation and use of AFO/splints have the potential to be affected. Like residents were reviewed and treatment plans/care plans were modified when indicated.	

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F 311	Continued From page 21 - Review of the policy and procedure titled "Ambulation" occurred on 06/07/12. This policy, dated 12/2009, stated, ". . . PURPOSE: To provide physical support and appropriate safety precautions while walking . . . EQUIPMENT: assistive device (as indicated) . . . PROCEDURE: 1. Verify nursing/therapy or physician orders for ambulation as well as instructions for specific techniques . . . SUGGESTED DOCUMENTATIONS: ADL WORKSHEET or PCC [point click care] . . . Time(s) of day ambulation occurred, distance ambulated including type of assistive device used . . . Unusual observation and/or complaints and subsequent interventions including communications with physician . . ." - Review of Resident #9's medical record occurred on June 04-07, 2012. The facility admitted the resident on 08/12/10. Current diagnoses included constipation, dementia, congestive heart failure, and recent suicidal ideations (05/12). The quarterly Minimum Data Set (MDS), dated 05/12/12, identified moderate cognitive impairment, required extensive assistance of one person for transfers, walking did not occur, independent locomotion on the resident care unit, and no limitation in range of motion. Resident #9's Activities of Daily Living (ADL) Care Area Assessment (CAA), dated 08/18/11, stated ". . . He does transfer self at times. . . . He has not ambulated in past week, but has in past month. . . . Plan to continue to maintain current level of functioning. . . .". Resident #9's current care plan, revised 02/21/12,	F 311	Nursing staff were re-educated on the use of AFOs/braces and on the restorative ambulation program by the Administrative Director of Nursing Services. Audits of documentation in POC and PCC will be completed three times weekly for four weeks. Additional audits will be completed as per QAPI recommendations.	07/24/12

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F 311	Continued From page 22 stated "Focus, ADL Self care deficit related to . . . generalized weakness . . . Interventions . . . Few steps only with transfers. Does not ambulate for a distance. . . ." Resident #9's Physical Therapy Weekly Status Note, dated 11/18/10, stated ". . . Pt. [Patient] amb. [ambulated] 300' [feet], 100' [with] FWW [front wheeled walker], mod [moderate] (I) [independence] [with] wc [wheelchair] follow. Pt. tol. [tolerated] well. . . ." Resident #9's Assessment and Discontinue note, dated 11/20/10, stated "Pt. has reached max. [maximum] functional potential @ [at] this time . . . Therapy follow-up program initiated to enable pt. to maintain strength et [and] endurance gained . . . Pt. verbalized understanding of follow-up program et agreed to participate. . . . D/C [Discharge] Recommendations: . . . Amb. daily [with] staff. . . ." Observation on June 05-07, 2012 identified Resident #9 transferred himself to and from his bed and wheelchair, and toilet and wheelchair independently with standby assistance of a facility staff member. On 05/05/12 at 3:10 p.m., a certified nursing assistant (CNA) (#3) reported Resident #9 ambulated independently in his room to the bathroom without an assistive device while the CNA summoned the surveyor for the observation. During interview, on 06/05/12 at 7:30 p.m., Resident #9's responsible party reported he had questioned the facility staff why the staff did not assist the resident to ambulate. He reported he did not receive an answer.	F 311		

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F 311	Continued From page 23 During interview, on 06/06/12 at 9:50 a.m., a supervisory nursing staff member (#9) reported she did not know why Resident #9 was not assisted to ambulate. During interview, on 06/07/12 at 10:30 a.m., with a staff member (#9) and an administrative nursing staff member (#1) additional information was requested regarding Resident #9's ambulation. Facility staff provided no additional information. - Review of Resident #12's medical record occurred on all days of survey. Medical diagnoses include cerebrovascular accident (CVA) with left sided hemiparesis, left side sensory loss, dysarthria, type 2 diabetes, and difficulty walking. The resident's annual MDS, dated 02/22/12, identified the resident as cognitively intact, required extensive assistance of 1 person for transfers, bed mobility, locomotion off unit, and dressing; walking in corridor required limited assistance of 1 person; and walking in room did not occur. The facility identified Resident #12 as interviewable. Resident #12's current care plan stated, " . . . Focus: ADL [Activity of Daily Living] self care deficit as evidenced by L. [left] sided weakness related to physical limitations - CVA with L hemiplegia . . . Date initiated 2/22/2011 . . . Interventions . . . Ambulation: CNA 1 assist to ambulate with hemiwalker - AFO [ankle-foot orthotic] on L foot BID [twice a day]. Refuses at times. . . . Ambulate to and from bathroom with Hemiwalker and AFO on L. Foot . . . date initiated: 11/16/2011 . . ." Resident #12's "Therapy Follow Up	F 311		

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F 311	Continued From page 24	F 311		

Communication," dated 11/10/11, describes the resident's needs to use a hemiwalker and AFO for walking, ambulation, and transfers.

Resident #12's physician order, dated 03/30/12, stated for physical therapy to check brace fit related to a scab on the left great toe and send for a fitting if a new brace needed.
Resident #12's physicians orders signed 06/01/12, included, ". . . UP WITH ASSIST 1 PIVOT WBAT [weight bear as tolerated] LT [left] AFO WHEN UP. . . . LAP TRAY FOR WHEELCHAIR. KEEP ON AT ALL TIMES IN CHAIR. USE SLING TO LEFT ARM WHEN TRANSFERRING. . . ."

Observation on 06/05/12 at 11:40 a.m., showed a CNA (#12) transferred Resident #12 from bed to wheelchair without the foot brace or sling in place and without using the hemiwalker. The AFO brace was observed in the resident's room on a chair.

Review of documentation regarding Resident #12's ambulating twice a day with a hemiwalker and AFO showed Resident #12 had not ambulated since 04/09/12. The documentation further showed the resident either refused, had been documented as not applicable, or had nothing documented from 04/10/12 through 06/05/12 (57 days).

During an interview on 06/05/12 at 4:50 p.m., a supervisory nurse (#17) reported that Resident #12 had a developed a sore on his foot on 03/30/12, and the resident had not worn the brace or walked due to the sore which the record identified as healed on 05/22/12.

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F 311	Continued From page 25 During an interview 06/05/12 at 5:45 p.m. with a physical therapist (#16), he reported after receiving an order, on 03/30/12, he reviewed the brace for fit, no changes were made to the brace, and the brace had not been discontinued. During an interview on 06/06/12 at 3:15, the physical therapist (#16) reported Resident #12 should wear the brace for functional tasks including ambulating, transferring, and weight bearing tasks as the brace supports the left leg and helps with foot drop. During an interview on 06/06/12 at 1:55 p.m., Resident #12 identified walking for the first time today in months and wearing his brace for the first time since developing a foot sore at the end of March. Facility staff failed to inform the resident's physician or physical therapist that the resident had not been ambulated for the past 57 days. Even though the physical therapist reviewed the brace and no changes were ordered and the sore healed, the facility failed to ambulate Resident #12 or utilize the brace for transfers.	F 311		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and	F 314	Manor Care Health will provide care and services that promote healing of pressure ulcers. Resident #6 is offered repositioning with cares and is repositioned as she allows. Resident #4 continues to be up for meals and is assisted up just before the meal starts and returned to bed when she finishes her meal. Care plans	

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F 314	Continued From page 26 services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, professional reference review and staff interview, the facility failed to ensure that 2 of 6 sampled residents with pressure sores (Resident #4 and #6) received the necessary treatment and services to promote healing of the pressure ulcers. Failure to ensure residents are repositioned may result in delayed healing. Findings include: Review of the facility policy on Pressure Ulcers occurred on the afternoon of 06/06/12. The facility policy consisted of a "SKIN PROCESS FLOW." This policy, undated, identified assessing, planning, implementing and evaluation of skin issues. The policy lacked specific interventions including care planning measures for residents with pressure ulcers. The Centers for Medicare and Medicaid Services (CMS) has outlined the standards of practice regarding pressure ulcers. The standards state,"The care plan for a resident who is reclining and is dependent on staff for repositioning should address position changes to maintain the resident's skin integrity. This may include repositioning at least every 2 hours or more frequently depending upon the resident's condition and tolerance of the tissue load (pressure). Depending on the individualized assessment, more frequent repositioning may be	F 314	were updated as indicated and orders reviewed and clarified for the identified patients. Residents at risk for or who have pressure related skin breakdown have the potential to be affected. Treatment plans and care plans were updated for like patients when indicated. Nursing staff was re-educated on the provision of and documentation of repositioning by the Administrative Director of Nursing Services. Audits will be completed by nurse managers or designee three times weekly for four weeks. Additional observations will be completed as per the QAPI Committee's recommendations.	07/24/12

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F 314	Continued From page 27 warranted for individuals who are at higher risk for pressure ulcer development or who show evidence (e.g., Stage I pressure ulcers) that repositioning at 2-hour intervals is inadequate." - Review of Resident #4's medical record occurred on all days of survey. Resident #4's diagnoses included a Stage IV pressure ulcer on her coccyx, identified as a deep tissue injury five days after a hospital stay lasting five days. The resident's Minimum Data Set (MDS), dated 03/30/12, identified the resident as needing extensive assistance for bed mobility, transfers, dressing, toileting and as having a stage 4 pressure ulcer. Review of Resident #4's physician/provider orders, dated 05/30/12, included an order for "Up in chair for all meals in dining room not more than 30-45 minutes due to pressure ulcer." Resident #4's current care plan lacked the intervention to be up in a chair for a short period of time and/or designated period of time. On the evening of 06/05/12 at 8:05 p.m., observation showed Resident #4 sitting in her wheelchair in her room. An unidentified Certified Nursing Assistant (CNA) assisted another CNA to transfer the resident from her chair to her wheelchair. When asked, the CNA stated Resident #4 had been her wheelchair since 5:50 p.m., a total of 2 hours and 15 minutes. During interview on the afternoon of 06/07/12, two supervisory staff members (#1 and #14) stated the facility had no specific standard they follow for repositioning a resident with a pressure ulcer	F 314		

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F 314	Continued From page 28 other than what the resident can tolerate. - Review of Resident #6's medical record occurred on all days of survey. Medical diagnoses include pressure ulcer to the lower back (healing stage 4), legal blindness, anxiety, and history of colonized methicillin resistant staphylococcus aureus (MRSA) to the coccyx wound. The resident's MDS, dated 02/25/12, identified the resident as needing extensive assistance for bed mobility, transfers, and dressing, and as having a stage 4 pressure ulcer present upon admission. Resident #6's current care plan stated, ". . . Focus ADL [activity of daily living] self deficit related to chronic pressure ulcer to coccyx, blindness. . . . Interventions . . . Assist of 1 to turn and position in bed. . . . Focus Potential for pain secondary to pressure ulcer site, decreased mobility. . . . Interventions . . . Encourage/Assist to reposition frequently to position of comfort . . ." The care plan failed to identify the frequency of repositioning. Observation on 06/05/12 at 2:28 p.m. and again at 5:45 p.m., showed Resident #6 lying on her back in bed in the same position (over 3 hours). A CNA (#7) entered Resident #6's room at 3:50 p.m. to drain a urostomy bag, but failed to offer repositioning. During an interview on 06/06/12 at 2:45 p.m., a nurse practitioner (#14) stated the expectation is that Resident #6 should be repositioned every two hours to aide in healing her Stage 3 pressure ulcer.	F 314		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	F 431		

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F 431	Continued From page 29 The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy,	F 431	Manor Care Health Services will provide storage of medications and biologicals under proper temperature control. Upon notification that medications were being stored in the refrigerator where the temperature log indicated the medications were too cold the medications were removed and destroyed per company/pharmacy guidelines. The refrigerator was taken out of service and a replacement has been ordered, received and placed into service. An updated temperature log was placed at each medication refrigerator indicating the correct storage temperatures for medications and biologicals. Nurses were educated by the Administrative Director of Nursing Services on the correct temperature range for the medication refrigerator and on completing the temperature log daily. Review of termperature logs will be completed by nurse managers or designees three times weekly for four weeks and then as per QAPI Committee recommendations.	07/24/12

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F 431	Continued From page 30 staff interview, and review of professional literature, the facility failed to store medications at the proper temperature in 1 of 3 medication refrigerators (north medication refrigerator). Failure to maintain the temperature within an acceptable range has the potential to affect the potency and efficacy of the medication. Findings include: Review of the Nursing 2011 Drug Handbook occurred on 06/07/12. The Handbook identified insulin and tuberculin vials should be stored between 36 to 46 degrees Fahrenheit (F). Review of a facility log, titled "Refrigerator/Freezer Temperature Log," occurred on 06/07/12. The log included this statement: "NOTE: Refrigerator should be between 32 [freezing at 32 degrees] degrees and 40 degrees [F]. Notify supervisor when temperatures are not within these guidelines." A tour of the medication refrigerator on the north unit occurred on the morning of 06/07/12. The medication refrigerator thermometer read 30 degrees F. The refrigerator contained four unopened vials of insulin, a Tuberculin skin testing vial, as well as other medications. The Refrigerator/Freezer Temperature Log for June identified two additional readings at 32 degrees F (freezing); the May log identified 19 temperature readings between 30 - 32 degrees F; and the April log identified all readings recorded at 30-32 degrees F. On the morning of 06/07/12, an administrative staff member (#1) agreed the medication	F 431		

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F 431	Continued From page 31 refrigerator temperature of 32 degrees was too cold. On 06/07/12 at 12:30 p.m., an administrative staff member (#1) stated nursing staff disposed of the improperly stored medications within the refrigerator.	F 431		
F 441 SS=D	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 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	F 441	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. An order to discontinue the wound culture for resident #5 was obtained and universal precautions will continue for this patient. Resident #6 and #8 were monitored for signs of infection and none developed. Residents residing in the facility have the potential to be affected by this practice. Nursing staff were educated on infection control practices during department meetings. Audits will be completed by nurse managers or designee three times weekly for four weeks. Audits will be reviewed by the Administrative Director of Nursing or designee and forwarded to the QAPI Committee for further review. Additional audits will be completed as directed by the QAPI Committee.	07/24/12

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F 441	Continued From page 32 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 SURVEY COMPLETED ON 07/21/2011. Based on observation, review of facility policy and procedure, and staff interview, the facility failed to follow infection control practices for 1 of 4 sampled residents (Resident #5) who received dressing changes; 1 of 2 sampled residents (Resident #6) with a coccyx ulcer who received incontinence cares; and, 1 of 1 sampled resident (Resident #8) who performed partial perineal cares after toileting. 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 "BASIC CONCEPTS: HAND HYGIENE" occurred on 06/07/12. The policy, dated 06/02/06, stated: "Hand hygiene is the single most important measure for reducing the risk of the spread of infections. . . . Handwashing occurs after contact with . . . secretions, excretions and equipment or contaminated articles. Consistent practice of good hand hygiene procedures reduces	F 441		

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F 441	Continued From page 33 nosocomial infections by preventing the spread of microorganisms. . . .STANDARD PRECAUTIONS . . . . Gloves . . . Remove gloves, after use in immediate work area, before touching noncontaminated items . . ." - On 06/05/12 at 8:25 p.m., during an observation of a dressing change of a pressure ulcer on Resident #5's right heel, the nurse (#8) removed the dressing from around the ankle with a scissors obtained from her right pocket. Observation showed two areas of drainage on the dressing. The nurse completed the dressing change, however failed to clean or sanitize the scissors, placed the scissors into her right pocket, left the room, pulled the scissors out of her pocket and placed them in a drawer in the medication/ treatment cart. Review of Resident #5's medical record identified an order for a culture and sensitivity (C & S) of a right heel wound on 04/25/12, and "if [no] MRSA, VRE [vancomycin-resistant enterococci], remove isolation cart." The record lacked a culture report. Upon interview on the afternoon of 06/07/12, a supervisory staff member (#9) stated nursing staff did not obtain a culture as no drainage occurred from the wound for the following week. During interview on the morning of 06/07/12, an administrative staff member (#1) stated the nurse should have cleaned the scissors after removing the dressings and prior to placing them in a pocket and/or the medication/treatment cart. Resident #5's history of having MRSA to this wound and observed drainage, has the potential to spread MRSA.	F 441		

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F 441	Continued From page 34 - Observation of Resident #8 receiving assistance for toileting occurred on 06/05/12 at 8:13 a.m. A supervisory nursing staff member (#9) and a certified nursing assistant (CNA) (#18) assisted the resident to stand and pivot transfer from a wheelchair to the toilet in his bathroom. At the completion of toileting, the staff members assisted Resident #8 to stand from the toilet, pivot transfer to the wheelchair, moved the wheelchair to the bedside, assisted the resident to stand, pivot transfer to the bed, and then lay down on the bed. During interview, at the completion of this episode of care, the CNA staff member (#18) reported Resident #8 was continent of bowel and bladder; he did void and had a bowel movement on the toilet; he did perform partial wiping of his rectal area; the staff member completed his perineal cares; and, the staff members did not change his brief which was not soiled. Observation showed the facility staff failed to offer or provide hand washing to Resident #8 after he performed partial rectal cares. - Review of Resident #6's medical record occurred on all days of survey. Medical diagnoses included history of a stage 3 pressure ulcer to lower back with history of colonized MRSA. Observation on 06/05/12 at 8:55 p.m. showed a nurse (#6) changed Resident #6's brief and provided perineal cares for an incontinent bowel movement. The nurse changed gloves and without performing hand hygiene, proceeded to remove an old dressing and gauze from inside a stage 3 pressure ulcer. The nurse should have	F 441		

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F 441	Continued From page 35 removed these gloves and applied new gloves before touching the clean dressing supplies. The nurse then applied new gauze inside the wound and placed a dressing over the wound. The nurse (#6) removed her gloves and without performing hand hygiene, placed blankets over the resident, adjusted the resident's call light, and left the resident's room. During an interview on 06/07/12 at 10:00 a.m., an administrative nurse (#1) stated facility staff are expected to perform hand hygiene after removing gloves and prior to doing other tasks.	F 441		
F 467 SS=C	483.70(h)(2) ADEQUATE OUTSIDE VENTILATION-WINDOW/MECHANIC The facility must have adequate outside ventilation by means of windows, or mechanical ventilation, or a combination of the two. This REQUIREMENT is not met as evidenced by: Based on observation, resident group interview, and staff interview, the facility failed to provide services to maintain a sanitary and comfortable interior regarding odors on 4 of 4 resident care units (North, Center, South, and New Hall) on 4 of 4 days of survey (June 04-07, 2012). Failure to provide effective housekeeping services and adequate ventilation to control odors in the facility did not provide a homelike atmosphere, limited the quality of life for all residents, and affected all staff and visitors. Findings include: During the initial facility tour, on 06/04/12 at 12:55	F 467	Manor Care Health Services will provide adequate outside ventilation. Maintenance services were provided and eliminated odors for identified residents. Residents residing in the facility have the potential to be affected by the presence of odors. Maintenance services of bathroom fans were completed and included the replacement of fan motors on two exhaust fans. Affected rooms were inspected and areas of concern addressed. Environmental observations/audits will be completed by the Environmental Services Manager or designee three times weekly for four weeks.	

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F 467	Continued From page 36 p.m., observation identified an odor of ammonia in the halls and resident rooms on all four resident care units. During the resident group interview, on 06/05/12 at 10:00 a.m., attended by 10 residents identified by the facility as interviewable, Resident A, B, and C reported odors and had requested deodorizers. Observation on June 04-07, 2012 identified the odor of ammonia in all four resident care areas. During the environmental tour, on 06/07/12 at 8:00 a.m., observation identified the odor of ammonia in all four resident care areas and in resident rooms as follows: North Hall - Room 99 Center Hall - Room 82, Room 70, Room 64 South Hall - Room 55, Room 53 New Hall - Room 23, Room 27, Room 26 During the tour the Center and New Hall bath room vents lacked air draw to pull a piece of tissue paper to the vents. Administrative staff members (#19), (#20) and (#21) present during the tour confirmed the odors. Following the tour, a maintenance management staff member (#22) provided maintenance schedules which identified the bathroom vents are on a monthly service schedule and were last serviced on 05/14/12. Observation identified the odor of ammonia in all resident care areas and hallways during the initial tour and each day of the survey. The malfunctioning exhaust system may have affected two of the four resident care areas since 05/16/12 (three weeks). Residents identified odors. The facility staff failed to identify odors and	F 467	Findings will be reviewed by the Administrator or designee and forwarded to the QAPI Committee for further review and follow up. Additional audits will be completed as directed by the QAPI Committee.	07/24/12

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F 467	Continued From page 37 provide effective housekeeping services and adequate ventilation on all four resident care units.	F 467		