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 _____	07/09/2015

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 standard Medicare/Medicaid recertification survey started on 07/06/15 and completed on 07/09/15, the sample included 4 residents for complete review, 12 residents for focused review, and 3 closed records for review. The sample included 6 additional residents to verify specific concerns during the survey.	F 000	Manor Care of Fargo plan of correction for annual survey dated July 07, 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 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.	F 164	F 164 SS=D 483.10 PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS: Staff nurse caring for residents #24 was educated on closing the MAR to protect patient privacy.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 8-5-15

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355024	A. BUILDING _____ B. WING _____	07/09/2015

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 164	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to maintain the privacy and confidentiality of the residents' medical and personal information on 2 of 4 days of survey (July 7-8, 2015). Failure to maintain confidentiality of residents' medical and personal information could allow unauthorized individuals to view residents' information. Findings include: Review of the facility policy titled "OWNERSHIP AND PROTECTION OF CLINICAL RECORDS" occurred on 07/09/15. This policy, dated 2015, stated, "GENERAL GUIDELINES: . . . The center maintains information contained in the clinical record as confidential, regardless of the form or storage method of the records. . . ." - Observation on 07/06/15 at 12:00 p.m. showed the Medication Adminstration Record (MAR) on top of the medication cart open to Resident #24's name and medications and no nursing staff present. - Observation on 07/07/15 at 3:33 p.m. showed the MAR on top of the medication cart open to Resident #1's name and medications and no nursing staff present. At 3:40 p.m. an administrative nurse (#7) passed by the medication cart and closed the MAR. - Observation on 07/08/15 at 12:57 p.m. showed the MAR on top of the medication cart open to Resident #24's name and medications and no	F 164	Residents residing at the facility have the potential to be affected by this practice. Education will be provided by the ADNS or designee regarding the patient's right to privacy and safeguarding medical information. ADNS or designee - TC ε Adm 8/11/15 dl. Audits will be completed three times weekly for four weeks then weekly for three months. Results of audits will be forwarded to QAA committee for review and recommendations. Date of compliance is August 13, 2015	

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 _____	07/09/2015

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 164	Continued From page 2 nursing staff present. During an interview on 07/09/15 at 11:43 a.m., an administrative nurse (#1) confirmed staff should close the MAR or cover any resident information.	F 164		
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide housekeeping services to maintain a sanitary and comfortable environment on 1 of 3 units (North East hallway). Findings include: - During the initial tour of the facility on 07/06/15 at 12:30 p.m., observation showed debris on the bathroom vents in rooms 80, 84, and 86. - Observation on 07/07/15 at 8:13 a.m. showed dust/debris hanging from the ceiling in room 86. During the tour of the environment on 07/09/15 at 2:00 p.m., an environmental services director (#18) agreed the bathroom vents in rooms 80, 84, and 86 were visibly dirty with debris.	F 253	F 253 Resident rooms 80, 84, 86 had bathroom vents cleaned and all ceiling corners dusted. All resident rooms were inspected any vents or ceiling corners identified were cleaned. Environmental Supervisor / Designee provided training to the housekeeping staff on cleaning process/ equipment and expectation. Environmental Supervisor / Designee will Audit all rooms weekly x 4 weeks, Monthly x 3 months any deficiencies will be remedied immediately. Findings will be forwarded to the facility QAPI committee for review and recommendations. Facility will be in compliance August 13, 2015	
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be	F 280		

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 _____	07/09/2015

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 280	Continued From page 3 incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy review, and staff interview, the facility failed to review and revise 5 of 16 sampled residents' care plans regarding transfers (Resident #5, #9, #11, and #16), toileting and repositioning (Resident #5), oxygen use (Resident #6 and #11), and use of glasses (Resident #6). Failure to update the care plan as the residents' status changes does not ensure the residents receive required cares and may result in lack of continuity of care. Based on review of the North Dakota Department of Health, Division of Health Facilities provider files, this facility has not sustained correction of this issue. This requirement was found to be out of compliance in 2013.	F 280	F 280 SS=E 483.20(d (3) 483.10(k)(2) PARTICIPATE IN PLANNING CARE=REVISE CP Care plan and task list were updated for Resident #5 to reflect total mechanical lift transfer, incontinence assessment was completed for this resident and care and comfort toileting implemented. Repositioning needs were clarified on task list and care plan to reflect current needs. Orders were clarified for Resident #6 and care plan updated to reflect current needs related to oxygen use and her use of eyeglasses were added to the care plan and task list. Care plan and task list were updated for Resident #9 to reflect mechanical lift transfer and to alert staff to the need to offer the urinal with cares and on a prn basis. Resident #11's care plan and task list were updated and now identify the use of a sit to stand lift for transfers and oxygen orders were reviewed and revisions were made to care plan and task list. Resident #16's transfer status was updated on the care plan and task list to reflect the need for a mechanical lift with two staff members.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355024	A. BUILDING _____ B. WING _____	07/09/2015

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 280	Continued From page 4 Findings include: Review of the facility policy titled "Documentation" occurred on 07/09/15. This policy, dated June 2012, stated, ". . . Care Plan Documentation: An interdisciplinary team, including the patient and family, develops an individualized care plan . . . The care plan includes measurable goals . . . as well as staff interventions to assist the patient with goal attainment. . . ." - Review of Resident #16's medical record occurred on 07/09/15. Diagnoses included muscle weakness, gait abnormality, and spinal stenosis with neurogenic claudication (pain or weakness in the buttocks or legs). The annual Minimum Data Set (MDS), dated 06/23/15, and the quarterly MDS, dated 03/23/15, indicated extensive assistance of two or more staff for transfers and walking in the room or corridor did not occur. Resident #16's current care plan stated, "Focus: ADL [Activity of Daily Living] Self care deficit related to generalized weakness secondary to s/p [status post] lumbar decompressive laminectomy [spinal surgery] for stenosis, left knee arthritis . . . Interventions: . . . Transfer independently in room and hallway with WC [wheelchair], Assist PRN [as needed] for transfers. . . . Focus: Resistive/noncompliant with repositioning . . . Interventions: . . . Transfers with a standing lift . . . Focus: At risk for falls due to impaired balance/poor coordination . . . Interventions: . . . Provide assist to transfer and ambulate as needed . . ." The current certified nurse aide (CNA) Kardex stated, "ADLs/Restorative Care: *ADL Assist - May ambulate independently in halls with FWW [front wheeled walker], assist	F 280	Residents who have ambiguous information on care plan and task list have the potential to be affected by this practice. Task list reports were audited and care plans and task lists updated based on audit findings. ADNS or designee provided education to licensed nurses, nurse managers, and CNAs on ensuring accuracy of care plans and task lists. Education included information on updating care plans and task lists as well as notifying the nurse or nurse manager of any concerns noted when CNAs review task lists prior to providing care and services. ADNS or designee - per TC c Adm - 8/11/15 - dl. 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 recommendations. Date of compliance is August 13, 2015.	

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 _____	07/09/2015

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 280	Continued From page 5 PRN for transfers. . . . * Transfers with a standing lift . . ." On 07/09/15 at 1:15 p.m., , observation showed Resident #16 in his wheelchair in his room. The CNA (#10) stated the resident transfers with a stand lift and two staff assist. During an interview on 07/09/15 at 1:45 p.m., an administrative nurse (#1) stated the physical therapist said Resident #16 should only use a lift due to weakness, and he has transferred with the stand lift for three months or more. The facility failed to review and revise Resident #16's care plan and CNA kardex to accurately reflect his ambulation and transfer status. During an interview on the afternoon of 07/09/15, an administrative nurse (#7) stated staff also update care plans if physician orders change or a significant change occurs. - Review of Resident #5's medical occurred on July 7-9, 2015. Diagnoses included dementia, paralysis agitans (Parkinsons), muscle weakness, history of falls and walking difficulty. A quarterly MDS, dated 04/11/15, indicated extensive assistance of two or more staff for transfers and toileting, and walking in the room or corridor did not occur. Resident #5's current care plan stated, "Focus: At risk for alteration in skin integrity related to: incontinence, nutritional deficit, and impaired mobility . . . Interventions . . . Encourage to reposition as needed . . . Focus: Urinary incontinence . . . Interventions . . . At established toileting times, ask if toileting is needed and	F 280		

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 _____	07/09/2015

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 280	Continued From page 6	F 280		

remind patient that it is time to use toilet . . . Identify voiding pattern and establish toileting program . . . Focus: ADL Self Care deficit as evidenced by deconditioned state, weakness . . . Interventions . . . Transfer with standing lift with assist of 2 . . . Focus: At risk for falls due to impaired balance/poor coordination, unsteady gait, involuntary movements . . . Interventions . . . Encourage to transfer and change positions slowly . . . Provide assist to transfer and ambulate as needed . . . " The CNA kardex stated, "ADL Assist- 2 person assist. [stand lift] for transfers . . . Toilet in bathroom PRN for BM [bowel movement] with standing lift . . . Transfer with standing lift with assist of 2 . . ."

On 07/07/15 at 11:46 a.m., observation showed Resident #5 in his wheelchair in his room. The CNAs (#19 and #20) transferred the resident with a Hoyer [mechanical lift] lift from the wheelchair to his bed. The CNAs changed the resident's soiled brief and positioned him on his back.

On 07/07/15 at 12:30 p.m., 1:48 p.m., 3:17 p.m., and 4:26 p.m., observation showed Resident #5 lying on his back in bed. The resident was lying on his back in bed. No toileting cares were observed for over four hours.

On 07/07/15 at 1:48 p.m.,

On 07/07/15 at 5:00 p.m., observation showed Resident #5 lying on his back in bed. Two CNAs (#21 and #22) changed the resident's soiled brief with BM (bowel movement) and urine.

On 07/08/15 at 9:30 a.m., observation showed two CNAs (#23 and #24) transferred the resident from the wheelchair to his bed using a Hoyer lift.

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 _____	07/09/2015

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 280	Continued From page 7 The CNAs changed the resident's soiled brief with BM and urine, and positioned him on his back. During observations on July 7-8, 2015, staff failed to reposition Resident #5 off his back as lie in bed. Staff transferred Resident #5 with a hoyer lift and failed to offer toileting. During an interview on 07/09/15 at 11:43 a.m., an administrative nurse (#1) stated she expected staff to toilet Resident #5 before and after meals, and staff should reposition the resident every two hours and as needed. During an interview on 07/09/15 at 1:00 p.m., a physical therapy director (#26) stated Resident #5 stopped therapy 3 months ago. The physical therapy director stated due to the resident's weakness, staff should use the Hoyer lift, not a stand lift. The care plan states to use a stand lift during transfers. The facility failed to review and revise Resident #5's care plan and CNA kardex to accurately reflect his ambulation, toileting, and transfer status. - Review of Resident #9's medical record occurred on July 7-9, 2015. Diagnoses included difficulty in walking, dementia, muscle weakness, and below knee amputation. An admitting MDS, dated 12/22/14, and a significant change MDS, dated 06/15/15, indicated extensive assistance of two or more staff for transfers and toileting. Resident #9's current care plan stated, "Focus: . . . ADL Self care deficit related to physical limitations and weakness . . . Interventions . . .	F 280		

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

ATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355024	A. BUILDING _____ B. WING _____	07/09/2015

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 280	Continued From page 8	F 280		

toilet resident before and after meals and prior to PT/OT [physical therapy/occupational therapy] sessions . . . transfer with mechanical lift . . ." The CNA kardex stated, "ADLs/Restorative Care: ADL assist - Usually a 2 person with mod [moderate] level of assist with the Hoyer lift . . . Gait belt for transfer/ambulation . . ."

On 07/07/15 at 7:59 a.m., observations showed two CNAs (#10 and #19) transferred the resident from the bed to his wheelchair with a Hoyer lift.

On 07/08/15 at 2:00 p.m., observation showed two CNAs (#19 and #23) transfer Resident #9 from the wheelchair to his bed with a Hoyer lift. The CNA (#23) stated the resident used the urinal already. The CNAs asked the resident if they should check his brief. The CNAs checked the resident's dry brief and reapplied the same brief on the resident. The CNAs transferred the resident from the bed to his wheelchair with the Hoyer lift.

During an interview on 07/09/15 at 11:43 a.m., an administrative nurse (#1) stated Resident #9 is able to tell the staff when he needs to use the urinal. The administrative nurse confirmed Resident #9 does not need a toileting program.

The facility failed to review and revise Resident #9's care plan to accurately reflect his toileting needs and use of urinal and revise the CNA kardex to accurately reflect his transfer status.

- Review of Resident #11's medical record occured on all days of the survey. The resident's comprehensive care plan showed, ". . .ADL Self care deficit as evidenced by weakness/dehydration related to physical

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 _____	07/09/2015

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 280	Continued From page 9	F 280		

limitations . . .Transfer with min [minimal] assist with gait belt, patient uses walker and staff assist with 1-2 people. . . ." Review of Resident #11's CNA Kardex showed, ". . .OXYGEN cont. [continuously]"

Review of Resident #11's physician's orders for July 2015 identified, ". . . O2 (oxygen) AT 2L [liters] PER NASAL CANNULA AS NEEDED . . . KEEP O2 SATS [saturation] > [greater than] 92% . . ."

Observations on 07/06/15 at 5:27 p.m. in the hallway and on 07/07/15 at 7:46 a.m. in the Dakota dining room showed the resident without any oxygen applied.

Observations on 07/07/15 at 8:55 a.m., 11:08 a.m., and 4:47 p.m., showed staff members used a sit-to-stand mechanical lift to transfer the resident to and from the bed and bathroom.

During an interview at 11:25 a.m. on 07/09/15, an administrative nurse (#11) stated staff neede to update the care plan as the residents' needs change.

- Review of Resident #6's medical record occured on all days of the survey. The resident's comprehensive care plan and CNA Kardex failed to include the resident's use of oxygen. The CNA Kardex identified, ". . . Glasses (doesn't have with her) . . ."

Review of Resident #6's physician's orders for July 2015, identified, ". . .OXYGEN 2L NC [nasal cannula] AS NEEDED. KEEP SATURATION > 90% . . ."

TEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355024	A. BUILDING _____ B. WING _____	07/09/2015

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 280	Continued From page 10 Observation on 07/06/15 at 5:24 p.m. and 07/07/15 at 7:57 a.m. in the Dakota dining room showed the resident wore eye glasses and oxygen as she sat at the table.	F 280		
F 281 SS=E	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 record review, policy review, and staff interview, the facility failed to provide services to meet professional standards of practice for 4 of 16 sampled residents (Resident #1, #8, #10, and #15). Failure to transcribe orders accurately resulted in a medication error for Resident #8 and incorrect intake of feeding tube formula for Resident #1. Failure to verify completion or lack of ability to complete medication and treatment administration (Resident #8, #10, and #15) does not assure the resident is receiving care as ordered, or allow for an accurate evaluation of the resident's plan of care. Finding include: Review of the facility policy titled "Medication and Treatment Administration Guidelines" occurred on 07/09/15. This policy, dated December 2014, stated, ". . . Medication and Treatment Orders: . . . * Orders are transcribed and noted by the licensed nurse. The licensed nurse noting an order is responsible for accurate transcription and initiation of orders . . . Medication Administration: * Medications are administered in accordance	F 281	F 281 SS=E 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS Orders for resident #8 were clarified and corrected on June 27th, prior to survey and resident #8 is receiving the correct medication. Resident #8's MAR and TAR were reviewed and comprehensive review of labs, weights, and vital signs completed with no negative outcomes noted related to missed signatures on MAR and TAR. Resident # 10's MAR and TAR were reviewed, a new pain assessment completed, labs reviewed, nurses notes reviewed for any reports of shortness of breath, and BM records reviewed with no negative findings related to missed signatures on MARs and TARs. Resident #15 is no longer residing at the facility. Resident #1's order was updated prior to survey and resident #1 continues to receive the correct tube feeding formula at this time. Review of dietary notes and weights indicate there were no negative outcomes related to the transcription order.	

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

TEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355024	A. BUILDING _____ B. WING _____	07/09/2015

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 281	Continued From page 11 with the following "rights" of medication administration . . . right medication, right dose, . . . right documentation . . . Documentation: * Medications and treatments administered are documented immediately following administration or per state specific standards * Medications not administered according to physician orders are reported to the attending physician and documented in the clinical record including the name and dose of the medication and reason . . . * The licensed nurse is responsible for validating documentation is completed for any medication administered during the shift . . ." - Review of Resident #8's medical record occurred on all days of survey. The resident was admitted on 06/18/15. Resident #8's physician orders showed the following: * 06/18/15 - Albuterol nebulizer every 4 hours as needed (PRN) * 06/18/15 - Atrovent nebulizer every 4 hours PRN * 06/23/15 - "Change Atrovent to give every 4 hours while awake and every 6 hours PRN Resident #8's June 2015 Medication Administration Record (MAR) showed the following: * 06/23/15 - Staff discontinued the PRN Albuterol and Atrovent nebulizers * 06/23/15 - DuoNeb (Albuterol and Atrovent combination) every 4 hours while awake. On 06/27/15, staff wrote "Wrong Med D/C [discontinued]" in the column dated 06/28/15. * 06/23/15 - DuoNeb every 6 hours PRN. Staff wrote "Wrong Med D/C" by this entry, but did not date the entry.	F 281	Residents who have new orders have the potential to be affected by this practice. Monthly physician order sheets were audited prior to August 1st and updated when indicated to reflect current orders. Transcription of orders to MAR and TAR were validated during this process. ADNS or designee will provide education to licensed nurses on transcription and validation of orders. Licensed nurses will be educated on signing off medication at the time of administration and reviewing MAR and TAR entries at the end of their shift to validate sign off is completed. Education will also be provided on completing validation of physician order sheets. ADNS or designee per TC c ADM - 8/11/15 - dl. Audits will be completed five times weekly for four weeks then three times weekly for three months. Results of audits will be submitted to the QAPI committee for review and recommendation. Date of compliance is August 13, 2015.	

*TEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355024	A. BUILDING _____ B. WING _____	07/09/2015

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 281	Continued From page 12 * 06/27/15 - Atrovent every 4 hours while awake and every 6 hours PRN The transcription error by the facility resulted in Resident #8 receiving the wrong nebulizer (DuoNeb) for four days. See F333. Resident #8's MARs, dated 06/18/15 to 07/08/15, lacked evidence staff administered Resident #8's medications and completed treatments and assessments as ordered. The following lists the number of times in 21 days staff failed to document completion of the order: * DuoNeb nebulizer six times daily - 9 * Osmolite (tube feeding) infusing at ordered rate - 6 * Carvedilol twice daily (bid) (antihypertensive) - 4 * Glycopyrrolate four times daily (qid) (secretions) - 3 * NovoLog short-acting insulin qid - 3 * Ipratropium nebulizer six times daily - 3 * Lantus long-acting insulin daily - 2 * Vitamin D3 daily - 2 * Glipizide bid (diabetes) - 1 * Famotidine bid (ulcer) - 1 * Phos-NaK bid (potassium and sodium phosphates) - 1 * Atorvastatin daily (cholesterol) - 1 * Aspirin daily - 1 * Nystatin liquid three times daily (tid) (antifungal) - 1 * Tamsulosin daily (enlarged prostate) - 1 * Coumadin daily (blood thinner) - 1 * Clotrimazole qid x 2 weeks (antifungal) - 1 * Tube feeding volume at end of shift - 35 * oxygen at 2 liters/minute every shift - 23 * flush feeding tube with water qid - 13 * pain assessment every 8 hour shift x 7 days, then daily - 12	F 281		

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 _____	07/09/2015

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 281	Continued From page 13 * flush G (gastric) tube with 30 milliliters water after medications - 10 * assess for nausea, vomiting, diarrhea every shift - 10 * temperature while on antibiotics every shift- 8 * assess bowel sounds every shift - 8 * head of bed up 30 degrees with feeding every shift - 8 * change dressing to G-tube site daily - 6 * change G-tube syringe every night - 5 * accu-checks qid (blood sugar) - 3 * weekly skin checks - 3 * Braden scale (assessment for risk of skin breakdown) every week - 2 On several occasions, the licensed nurse initialed and circled the time a medication (Carvedilol, Atrovent nebulizer, Digoxin) was due (indication the medication was not given), but failed to document why the medication was not administered. - Review of Resident #10's medical record occurred on all days of survey. Resident #10's MAR, dated June 2015, lacked evidence staff administered Resident #10's medications and completed treatments and assessments as ordered. The following lists the number of times in 30 days staff failed to document completion of the order: * Perform Pain Relieving Gel to knees bid - 7 * Combivent inhaler qid (wheezing) - 6 * Calcium/Vitamin D tid - 3 * Coumadin daily - 2 * Lactulose bid (laxative) - 2 * Gabapentin tid (pain) - 1 * Acetaminophen tid (pain) - 1 * Senna bid (laxative) - 1	F 281		

TEMENT OF DEFICIENCIES / PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355024	A. BUILDING _____ B. WING _____	07/09/2015

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 281	Continued From page 14 * check placement of left leg tubigrip every shift - 19 * use lamb's wool between toes daily - 9 * remove left leg tubigrip daily to check skin - 7 * assess pain daily - 4 * weekly skin checks - 1 On several occasions, the licensed nurse initialed and circled the time a medication (Lactulose, erythromycin eye ointment, and oxygen) was due, but failed to document why the medication was not administered. - Review of Resident #15's medical record occurred on 07/09/15. Resident #15's MAR, dated June 2015, lacked evidence staff administered Resident #15's medications and completed assessments as ordered. The following lists the number of times in 30 days staff failed to document completion of the order: * Ferrex daily (iron supplement) - 8 * Levoxyl daily (thyroid hormone replacement) - 2 * B-complex daily (vitamin) - 2 * I-Vite daily (multivitamin/mineral) - 2 * MiraLax powder daily (laxative) - 1 * assess pain daily - 2 During an interview on 07/09/15 at 10:29 a.m., a licensed nurse (#9) stated the nurse should circle her initials in the time slot when a medication is due if the resident refused or is not in the facility to take the medication. During an interview on 07/09/15 at 11:15 a.m., an administrative nurse (#1) stated nurses are expected to sign the MAR as proof the medication was given or treatment carried out, or	F 281		

STATEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355024	A. BUILDING _____ B. WING _____	07/09/2015

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 281	Continued From page 15 explain why the medication/treatment was not done. Failure to properly document Resident #8, #10, and #15's MARs by either initialing medication/treatments/assessments as administered/completed, or initialing and circling the initials, and explaining in the Nurse's Medication Notes on the back of the MAR why the medication/treatment/assessment was not administered/completed does not ensure the residents received medications or cares as ordered, or allow the health care team to properly assess the effectiveness of the medication/treatment. - Review of Resident #1's medical record occurred on all days of survey. Diagnoses included dysphagia. The record identified a gastrostomy tube (G-tube) for feeding. A dietary note, dated 04/06/15, stated, ". . . Patient [Resident #1] has been receiving his nutrition & [and] hydration through his feeding tube with the orders being for 2Cal HN [TwoCal HN - a brand name of formula] 250 mL [milliliters] bolus BID [twice a day] & 2 Cal HN at 65 mL/hr [hour] and start at [7:00 p.m.] & run till [sic] 845 mL has infused with a 15 mL water flush every hr. This writer has recalculated his est [estimated] caloric needs at 1939 and will recommended [sic] decreasing his tube feedings 2 Cal to 2 Cal 300 mL [milliliters] bolus at [3:00 p.m.] . . . which will provide him with 2290 calories, 95.6 g [grams] of protein and 996 mL in fluids. . . ." A dietary note, dated 06/12/15, stated, "Patient [Resident #1] had order changes for his tube feeding on 4/6/15 however he has been receiving the prior orders . . . bolus of 2 cal HN 250 mL BID . . . The change on 4/6/15 was . . . 300 mL bolus	F 281		

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 _____	07/09/2015

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 281	Continued From page 16 of 2 cal HN at [3:00 p.m.] & to run for an hr. This writer has informed nursing . . ." Nursing staff failed to transcribe Resident #1's dietary order onto the Medication Administration Record (MAR) correctly and Resident #1 received the wrong amount of TwoCal HN from 04/06/15 to 06/12/15.	F 281		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE COMPLAINT SURVEY COMPLETED ON 02/26/15. Based on record review, professional reference, "Care Path" form, and staff interview, the facility failed to provide interventions to promote regular bowel elimination for 1 of 9 sampled residents (Resident #9) with a diagnosis of constipation. Failure to monitor the resident's bowel status and provide as needed (PRN) laxatives to relieve constipation has the potential to cause discomfort due to lack of regular bowel elimination. Findings include:	F 309	F 309 SS=D 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Resident #9's medical record was reviewed and a bowel assessment completed. Orders were reviewed and bowel care medications validated for this resident. Residents who have episodes of constipation have the potential to be affected by this practice. Review of bowel records was completed upon survey exit and interventions provided when indicated. The ADNS or designee will provide education to licensed nurses on bowel management including bowel assessment and use of routine or PRN medications to manage constipation.	

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 _____	07/09/2015

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 309	Continued From page 17 Review of the information titled "Care Path: Gastrointestinal (GI) Symptoms" (provided by the facility when a bowel protocol/policy was requested) occurred on 07/09/15. This "Care Path", dated 2011, stated, "New or Worsening GI Symptoms or Signs: . . . *Constipation . . . Evaluate Symptoms and Signs for Immediate Notification *Abdominal tenderness or distention *Absent or hyperactive bowel sounds . . . Manage in Facility . . . *Initiate medications for . . . constipation as appropriate . . . Monitor Response . . ." "Nursing 2014 Drug Handbook," 33rd ed, Wolters Kluwer, Pennsylvania, page 193, identified, Benztropine (antiparkison), Atorvastatin (antilipemic), and Mirtazapine (antidepressant) as medications that have adverse side effects such as constipation. Review of Resident #9's medical record occurred on all days of the survey. Diagnoses included constipation. The current care plan stated, "Focus . . . Bowel Elimination Alteration; Constipation related to: Medications . . . Goal . . . Will have bowel movement at least q [every] 3 days . . . Interventions . . . Administer medications per physician order & observe effectiveness . . . Report S&S [signs and symptoms] constipation . . . no BM [bowel movement] for 3 days . . ." Medications included Benztropine twice a day, Atorvastatin every night at bedtime, Mirtazapine at bedtime, Docusate/Senna (stool softener) every day, Miralax powder (laxative) twice a day, Lactulose (laxative) once daily, Bisacodyl (laxative) 10 mg rectal suppository insert 1 suppository rectally every day as needed. Review of Resident #9's bowel report identified	F 309	ADNS or designee - per TLC Adm - 8/11/15 -dl. Audits will be completed five times weekly for four weeks then three times weekly for three months. Results of audits will be submitted to the QAPI committee for review and recommendation. Date of compliance is August 13, 2015.	

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 _____	07/09/2015

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 309	Continued From page 18 the following related to BM: - March 2015 * 03/05/15: Large * 03/05/15 to 03/09/15: no BM for three days (no Bisacodyl suppository offered as per orders, care plan, or gastrointestinal care path) * 03/09/15: Large - June 2015 * 06/19/15: Medium * 06/20/15 to 6/23/15: no BM for three days (no Bisacodyl suppository offered as per orders, care plan, or gastrointestinal care path) * 06/23/15: small The facility failed to administer as needed medication for constipation and report no bowel movement for 3 days. During an interview on 07/09/15 at 1:40 p.m., an administrative nurse (#7) stated the facility has no bowel protocol and the expectation is for staff to use PRN bowel medications as ordered for the resident and/or call the physician.	F 309		
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, record review, review of facility policy, resident interview, and staff interview, the facility failed to provide the necessary assistance for 5 of 16 sampled	F 312		

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 _____	07/09/2015

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 312	Continued From page 19 residents (Resident #2, #6, #13, #14, and #16) and 4 supplemental residents (Resident #20, 21, 22, and 23) to maintain oral hygiene, grooming, and/or nutrition. Failure to provide assistance as needed resulted in poor oral hygiene, personal hygiene, and grooming, and may result in skin breakdown and poor nutritional status. Based on review of the North Dakota Department of Health, Division of Health Facilities provider files, this facility has not sustained correction of this issue. This requirement was found to be out of compliance in 2013. Findings include: Review of the facility policy titled "Oral Hygiene and Denture Care" occurred on 07/09/15. This policy, dated January 2011, stated, "PURPOSE: To remove plaque and food debris from teeth and mouth, decrease mouth odor, massage gums and clean tongue and to promote moist lips and mouth . . ." Review of the facility policy titled "AM [morning] care" occurred on 07/09/15. This policy, dated December 2009, stated, "PURPOSE: To provide AM care in preparation for daily activities. . . . PROCEDURE: . . . 14. . . . shave as needed. . . ." - Review of Resident #6's medical record occurred on all days of the survey. The resident's quarterly Minimum Data Set (MDS), dated 06/16/15, identified severely impaired cognition and limited assistance of one person for personal hygiene. Observation during initial tour on 07/06/15 at 1:30 p.m. showed Resident #6 sat in a wheelchair in	F 312	F 312 SS=E 483.25 (a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS Resident #6 was offered a dental referral to address build up on teeth. Care plan and task list were revised to reflect the need for oral care after meals. Resident #14's care plan and task list were updated to address assistance with meals. Resident #2 was referred to therapy, a hand splint has been implemented, and care plan and task list updated. Resident #16, #13,#20, #21,#22 and #23's care plans and task lists were updated, to offer shaving care daily and as needed. T.C. c adm 8/11/15 -dl. Residents who are dependent on staff to complete oral care, meal intake, and care of facial hair have the potential to be impacted by this practice. Review of dependent residents was completed and care plans updated when indicated. ADNS or designee will provide education to licensed nurses on providing supervision and oversight for compliance with daily hygiene tasks through observation of residents and redirection of certified nursing assistants as needed. Certified nursing assistants will be provided education on providing oral	

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 _____	07/09/2015

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 312	Continued From page 20 her room. Resident #6 smiled, revealing a large amount of off-white build up along the resident's gum line of her upper teeth. At 5:24 p.m., Resident #6 sat in the dining room before the supper meal. Observation showed the off-white build up remained on the resident's teeth. Observation on 07/07/15 at 8:31 a.m. showed Resident #6 sat in her room after the morning meal. As the resident opened her mouth and spoke, observation showed a large amount of food caked on the resident's teeth, and pieces of food fell from her mouth into her lap. The Certified Nurse Assistant (CNAs) (#3 and #4) entered the room at 8:34 a.m. and transferred Resident #6 into bed. Staff failed to provide any oral care for the resident. During an interview at 12:00 p.m. on 07/09/15, an administrative nurse (#1) stated she expected staff to provide oral cares at planned times and in between as the resident needed. - Review of Resident #14's record occurred on 07/09/15. The resident's annual MDS, dated 06/14/15, identified with severely impaired cognition and extensive assistance of one person for eating. Observation in the Dakota dining room on 07/07/15 at 11:55 a.m. showed Resident #14 seated across the table from a CNA (#4) who was feeding another resident. Resident #14 chewed and sucked on a cloth napkin, stuck his fingers in a cup of pears, put his fingers in his mouth, and then grabbed a fork and speared a pear after multiple attempts. Resident #14 dangled his cloth napkin in the air, wiped the pear on the napkin, and then ate the pear. Resident #14 then chewed	F 312	care, meal assistance, and assistance with care of facial hair. ADNS or designee - per TC c adm 8/11/15-dl. ADL audits will be completed three times weekly for four weeks then weekly for three months. Results of audits will be submitted to the QAPI committee for review and recommendations. Date of compliance is August 13, 2015.	

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 _____	07/09/2015

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 312	Continued From page 21 on his napkin again and put it on the table. The CNA (#4) asked if the resident was done or needed help. The resident responded, "Huh?" and staff continued to assist the other resident. Resident #14 felt around on the table and spilled a mug of milk. The CNA (#4) again asked if the resident was done, but Resident #14 only mumbled. The resident poked the tips of his fingers with a fork, and brushed the fork along his shorts. Another CNA (#8) walked by the table and provided the CNA (#4) a clean spoon but did not assist Resident #14. Resident #14 picked up the empty mug and attempted to drink from it. The CNA (#4) refilled the mug with more milk at 12:06 p.m. and returned to her chair across the table. At 12:08 p.m., the resident dropped a fork on the floor, and the CNA (#4) handed him one from across the table. The resident took a heaping bite of food and then attempted to cut the tablecloth with the fork, pushing down and sawing back and forth. He wedged the fork between his plate and plate warmer, lifting the plate in the air. The CNA (#4) laughed and asked what the resident was doing but provided no physical assistance with eating. The resident rocked back and forth, moving farther away from the table for the rest of the noon meal. No other physical assistance was provided to the resident until 12:30 p.m. when the CNA (#4) assisted the resident out of the dining room. During an interview on 07/09/15 at 12:25 p.m., an administrative nurse (#1) stated Resident #14's function had improved, but she expected staff to provide cueing and increased assistance with eating as the resident needed. - Resident #2's quarterly MDS, dated 04/20/15 identified moderate cognitive impairment, range	F 312		

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 _____	07/09/2015

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 312	Continued From page 22 of motion impairment to both upper and lower extremities, extensive assistance for personal hygiene, and total assistance for bathing. The current care plan stated, "Focus: ADL [Activities of Daily Living] Self care deficit related to decreased mobility hx [history]: CVA left sided weakness, . . . Only has function of right arm . . . Interventions: . . . He requires extensive assistance with all ADLs, personal hygiene. He assists as able. . . ." Observation on 07/07/15 at 7:50 a.m. showed Resident #2 lying on his bed watching television with his left arm at his side and his hand contracted. The resident stated he had a stroke years ago which affected his left side. During an interview on 07/08/15 at 11:05 a.m., an administrative nurse (#1) stated the facility did not have a treatment plan in place to prevent contractures and skin breakdown to Resident #2's left hand. During an interview on 07/08/15 at 2:30 p.m., Resident #2 stated his left hand has been contractured for several years. When asked how his hand is cleaned, he stated he opens it himself on bath days, usually twice a week. Resident #2 demonstrated by prying his left hand/fingers open with his right hand. Observation revealed dirt under his untrimmed nails and an odor present. - Observation on 07/06/15 at approximately 1:15 p.m. showed Resident #16 in his wheelchair with his face unshaven and untrimmed ear hair, wearing a shirt with holes around the collar. Review of Resident #16's care plan on 07/09/15 identified an Activities of Daily Living (ADL) self care deficit with an intervention, dated 01/24/14,	F 312		

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 _____	07/09/2015

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 312	Continued From page 23 "Assist with daily hygiene, grooming, dressing, . . . as needed." - Review of Resident #13's medical record occurred on 07/09/15. Diagnoses included macular degeneration, glaucoma, and visual disturbance. A quarterly MDS, dated 04/16/15 identified extensive assist from 2 or more people for personal hygiene. Resident #13's care plan stated, "ADL self care deficit as evidenced by physical limitations related to weakness & pain & visual impairment . . . Interventions . . . Assist with daily hygiene, grooming . . ." Observations showed the following: - On 07/09/15 at 7:59 a.m., Resident #13 sat in her wheelchair at the dining room table with notable long facial hair on the resident's chin, neck, and upper lip. - On 07/09/15 at 11:10 a.m., Resident #13 sat in the beauty salon with unshaven facial hair. During an interview on 07/09/15 at 11:40 a.m., Resident #13 stated no staff member has offered to shave her facial hair and she would like to have them shaved. Random observations showed the following: - On 07/06/15 at approximately 1:30 p.m., Resident #20 sat in her room with unshaven chin hair. - On 07/06/15 at 5:24 p.m., Resident #21 asleep in his wheelchair by his room door and his face unshaven. - On 07/07/15 at 8:31 a.m., Resident #21 and #22 seated in the dining room. Both men were unshaven.	F 312		

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 _____	07/09/2015

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 312	Continued From page 24 - On 07/08/15 at 6:15 p.m., Resident #23, a female resident, with unshaven facial hair.	F 312		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and policy review, the facility failed to assess and consistently provide services to achieve or maintain as much normal bladder function as possible for 2 of 12 sampled residents (Residents #11 and #6) requiring assistance with toileting. Failure to assess and toilet Resident #11 and #6 may have resulted in avoidable incontinence and a loss of dignity. Findings include: Review of the facility's policy titled "Scheduled Toileting" occured on 07/09/15. This undated policy stated, ". . . Scheduled toileting or habit training is toileting at regular intervals, on a planned basis to coincide with the patient's voiding habits, such as every 2, 3, or 4 hours or before or after meals, upon rising and at bedtime.	F 315	F 315 SS=D 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER The Care plan and task list were revised for Residents #11 and 6 to reflect toileting routine, an incontinence assessment was completed and routine toileting implemented. Residents occasionally or frequently incontinent without a toileting plan have the potential to be affected by this practice. These residents were reviewed and assessments completed to determine toileting program. ADNS or designee provided education to licensed nurses, nurse managers, and CNA's on Incontinence Management Guidelines and facility toileting programs. ADNS or designee ed to TC & adm 8/11/15 -dl. 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 recommendations. Date of compliance is August 13, 2015.	

STATEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355024	A. BUILDING _____ B. WING _____	07/09/2015

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 315	Continued From page 25 . . .*Management Strategy - Prompted Voiding Scheduled Toileting *Suggested Criteria - May or may not have an identifiable pattern, May or may not have the sensation to void, Have trunk control and able to sit on commode or toilet without or only minimal assistance Cognitive impairment but able to recognize own name or common objects, Unable to learn new skill, delay voiding or resist urge to void . . ." - Review of Resident #11's medical record occurred on all days of survey. The annual Minimum Data Set (MDS), dated 03/30/15, identified moderately impaired cognition, extensive assistance of two people for toilet use, and frequent bowel and bladder incontinence. Review of Resident #11's Certified Nurse Assistant (CNA) Kardex identified, ". . . * Provide assistance with toileting * Provide incontinent care as needed . . . SPECIAL NEED: Toilet and assist resident to bed after meals for a rest . . ." On 07/07/15 at 8:55 a.m., a CNA (#3) stated he takes Resident #11 to the bathroom after breakfast and lunch, and stated the resident had the ability to tell staff when she needed to go. The CNA (#3) suggested using the bathroom to the resident, and the resident nodded. The CNAs (#3 and #4) transferred Resident #11 to the toilet with a sit to stand lift, and stated the resident's brief was soiled with urine and stool. The resident voided in the toilet, and the CNAs provided incontinence care and assisted the resident to her bed. On 07/07/15 at 11:08 a.m., the CNAs (#3 and #4) changed the resident's urine soiled brief in bed, transferred the resident to a wheelchair, and	F 315		

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 _____	07/09/2015

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 315	Continued From page 26 assisted her from the room. At 12:55 p.m., the CNA (#3) asked the resident if she wanted to go to the bathroom or to bed, the resident chose the bed, and the CNAs (#3 and #4) assisted her to bed. The staff members checked Resident #11's brief, stated she was dry, finished cares, and left the room. On 07/07/15 at 4:47 p.m., the CNAs (#5 and #6) checked and changed the resident's brief which was wet with urine. The staff members transferred the resident to her wheelchair using a sit-to-stand lift, and assisted the resident from the room. At 5:08 p.m., the CNAs (#5 and #6) stated the resident does not ask to use the bathroom, so they check the resident while in bed for incontinence and change her brief as needed. During an interview on 07/08/15 at 9:05 a.m., a CNA (#3) stated he takes the resident to the bathroom after breakfast and lunch because she voids a lot, and he did not want her to void in her brief. The CNA stated if staff asked, the resident could tell them when she needed to use the bathroom. - Review of Resident #6's medical record occurred on all days of the survey. Review of Resident #6's admission MDS, dated 09/23/14, showed moderately impaired cognition, extensive assistance of two for toilet use, and always incontinent of bowel and bladder. The quarterly MDS, dated 06/16/15, identified severely impaired cognition, extensive assistance of two for toilet use, frequently incontinent of urine, and always incontinent of bowel. Review of the Urinary Incontinence Care Area Assessment (CAA-a further assessment of the	F 315		

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 _____	07/09/2015

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 315	Continued From page 27 MDS) for the 09/23/14 MDS identified the resident had been incontinent of urine, "probably" related to impaired mobility due to a recent hospitalization and deconditioning. The assessment identified an expectation for improvement over time as therapy staff help the resident increase strength, endurance, and independence with ADLs. The assessment identified nursing staff planned to assist with toileting. Review of the resident's current CNA Kardex identified, ". . . * Provide assistance with toileting * Provide incontinent care as needed . . ." On 07/07/15 at 8:31 a.m., a licensed nurse (#2) assisted the resident from the dining room to the resident's room. In the room, the resident stated she wanted to lie down. At 8:34 a.m., two CNAs (#3 and #4) entered the room and assisted the resident to her bed. The CNAs changed the resident's brief in bed and finished cares before leaving the room. Staff did not encourage or cue the resident to use the bathroom. On 07/07/15 at 10:58 a.m., two CNAs (#3 and #4) entered the resident's room and checked the resident's brief, which was dry. The CNAs assisted the resident into her wheelchair and out to the living area without asking if she needed to use the bathroom. On 07/07/15 at 12:33 p.m., a CNA (#3) assisted the resident into bed, reported the resident was incontinent of urine, and changed the resident's brief. Staff did not encourage or cue the resident to use the bathroom. On 07/07/15 at 3:48 p.m., observation showed	F 315		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355024	A. BUILDING _____ B. WING _____	07/09/2015

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 315	Continued From page 28 the resident lay in bed with her feet hanging off the side, pulling at her oxygen tubing. The resident stated she needed to go to the bathroom and continued to attempt to scoot out of bed. A CNA (#5) entered the room, assisted the resident to the bathroom, and reported the resident was incontinent of urine. The resident had a continent bowel movement, and, after providing perineal care, the CNAs (#5 and #6) assisted the resident back to bed. The CNAs both reported they do not take the resident to the bathroom; they check and change her brief. The CNA (#5) stated the resident had never asked him to go to the bathroom before that day. During an interview on 07/08/15 at 9:00 a.m., a CNA (#3) stated the resident sometimes voided and sometimes did not void when taken to the bathroom. The CNA (#3) stated he attempted to take the resident to the bathroom before and after breakfast and after lunch because that was the resident's routine. He stated the resident needed encouragement to go. On 07/09/15 at 10:20 a.m., an administrative nurse (#1) stated most residents, depending on their cognition and physical abilities, have voiding diaries completed on admission to help determine when the resident typically voided and whether a more specific toileting plan would be beneficial. At 12:00 p.m., the administrative nurse (#1) stated she expected care to be consistent by all staff, stated Resident #6 was admitted to the facility with a urinary catheter, and was not appropriate for a voiding diary at that time. At 1:45 p.m., the nurse (#1) stated she could not find an assessment or voiding diary for Resident #6 since the catheter was removed. The nurse (#1) also stated she could not find a voiding diary	F 315		

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 _____	07/09/2015

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 315	Continued From page 29 or assessment of Resident #11's continence or toileting abilities.	F 315	F 322 SS=D 483.25 (g)(2) NG TREATMENT /SERVICES RESTORE EATING SKILLS	
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that -- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to administer medications and feedings per facility policy for 1 of 3 sampled residents (Resident #3) with a gastrostomy tube (G-tube). Failure to follow G-tube procedures for feeding and medication administration has the potential to cause complications, including infections, for the resident.	F 322	Resident #1 did not have any ill effect related to this observation of delivery care. Skills validation for management of enteral tube was completed with nurse who provided care to resident #1 Residents who receive medications through enteral tubes or who receive enteral feedings have the potential to be affected by this practice. ADNS or designee will provide education to licensed nurses regarding validation of enteral tube placement, administration of medication via enteral tube, administration of nutritional formula through enteral tube, and performing skills in a manner that ensures safe delivery of care. ADNS or designee per TC c adm 8/11/15 dl. Audits will be completed three times weekly for four weeks and then weekly for three months. Results of audits will be forwarded to QAPI committee for review and recommendations. Date of compliance is August 13, 2015.	

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 _____	07/09/2015

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 322	Continued From page 30 Findings include: Review of the facility policy titled "ENTERAL TUBES: MEDICATION ADMINISTRATION" occurred on 07/09/15. This policy, dated 2012, stated, ". . . PROCEDURE: . . . 5. . . . Verify that tablets/capsules are approved for crushing . . . *Keep medication separate. . . . 11. Verify enteral tube placement . . . 13. Instill each medication separately; flushing between each medication with a minimum of 5-10 ml [milliliters] of water to prevent tube occlusions . . . 16. Rinse reusable syringe, allow to air dry, and store separately in labeled clean plastic bag . . ." Review of the facility policy titled "ENTERAL TUBES; INTERMITTENT (PUMP) FEEDINGS" occurred on 07/09/15. This policy, dated 2009, stated, ". . . PROCEDURE: . . . 12. Verify enteral tube placement and residual checks per physician order . . . NOTE: When tube feedings are not being administered, distal end of enteral tube and tube feeding set are capped, maintaining clean disconnects. 17. Rinse reusable syringe, allow to air dry and store separately in clean labeled plastic bag. . . ." Review of Resident #1's medical record occurred on all days of survey. Diagnoses included dysphagia. The record identified a G-tube for feeding and medication administration. Physician's orders included fluoxetine (an antidepressant), metoclopramide (for treatment of heartburn), 2CAL HN (name brand of a formula) 300 ml over one hour every day at 3:00 p.m.; 2CAL HN 65 ml continuous from 7:00 p.m. until 845 ml infused; and check residuals every shift and hold if greater than 300 ml for four hours.	F 322		

STATEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355024	A. BUILDING _____ B. WING _____	07/09/2015

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 322	Continued From page 31 Observation on 07/07/15 at 3:33 p.m. showed a nurse (#30) placed two medications (fluoxetine and metoclopramide) in a cup of approximately 30 ml of water after crushing/opening the capsule. The nurse then entered Resident #1's room and placed the medication on the night stand. The nurse connected a new tubing set to a bottle of formula in Resident #1's room and attempted to connect the tubing to the resident's G-tube, but discovered it needed an adapter. Resident #1 asked for the tubing and he also tried to connect it to his G-tube. The nurse took the tubing from the resident, looped it over the intravenous (IV) pole, and left the room. The nurse (#30) returned with an adapter and connected it to the tubing but failed to clean the end of the tubing. The nurse removed the protective cap from the adapter, placed it on a hooked end on top of the IV pole, primed the tubing, and placed the protective cap back on the adapter. The nurse (#30) placed a syringe into the end of Resident #1's G-tube, flushed the tube with 30 ml of water, administered the two medications via the G-tube, and flushed the tube with another 30 ml of water. The nurse (#30) failed to check for tube placement before administering the medications and failed to keep the medications separate. The nurse removed the cap from the adapter, connected the tubing to Resident #1's G-tube, and began the tube feeding, but failed to check for residual before she began the tube feeding. The nurse (#30) rinsed and dried the syringe used to administer the medications and placed it in a plastic bag attached to the IV pole. The nurse failed to allow the syringe to air dry. Observation on 07/08/15 at 3:30 p.m. showed the	F 322		

STATEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355024	A. BUILDING _____ B. WING _____	07/09/2015

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 322	Continued From page 32 nurse (#30) checked for placement of Resident #1's G-tube by injecting 10 ml of air into the tube. Observation showed the nurse placed the ear pieces of the stethoscope in her ears backwards. She checked for residual, flushed the G-tube with 30 ml of water, removed the protective cap from the tubing and placed in on top of the IV pole, and started the feeding. The nurse (#30) rinsed and dried the syringe (instead of allowing it to air dry) and placed it in a plastic bag attached to the IV pole. Observation at 4:50 p.m., the nurse (#30) returned to Resident #1's room, disconnected the tube feeding and recapped the tubing with the cap on top of the IV pole. The nurse flushed the resident's G-tube with 30 ml of water, rinsed and dried the syringe with a paper towel, and placed it back in the plastic bag attached to the IV pole. The nurse (#30) failed to clean the protective cap before placing it back on the tubing and failed to allow the syringe to air dry. During an interview on the afternoon of 07/09/15, two administrative nurses (#1 and #7) agreed the nurse (#30) failed to follow facility policy related to the administration of medications and feedings via G-tube.	F 322		
F 327 SS=D	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by:	F 327		

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

STATEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355024	A. BUILDING _____ B. WING _____	07/09/2015

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 327	Continued From page 33 THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 05/22/14. Based on observation, staff interview, record review, and policy review, the facility failed to offer fluids to 1 of 4 sampled residents (Resident #11) who needed extensive assistance with eating. Failure to ensure sufficient fluid intake may result in dehydration and urinary tract infections. Findings include: Review of the facility policy titled "HYDRATION PROMPTS" occurred on 07/09/15. This undated policy stated, "Prompting patients to consume fluids and hydrate themselves is the single most effective approach in maintaining fluid balance. Patients, regardless of cognitive status, often respond to prompts to drink fluids. Depending on the individualized care plan, some patients may require more frequent and scheduled prompting. Prompting fluid intake can be paired with other scheduled interactions such as: *'water in-water out' - prompting to drink fluids is paired with toileting activities *'sip 'n go' - any staff person entering a patient room while the patient is awake, offer fluids or prompts to drink *'TAPS' - 'turn and position, sip' where fluids are offered with each position change . . ." Review of Resident #11's medical record occurred on all days of the survey. The annual Minimum Data Set (MDS), dated 03/30/15, identified moderately impaired cognition and extensive assistance of one person for eating. The comprehensive care plan identified, "Risk for alteration in hydration related to times of forgetfulness/confusion, diuretic medication, decreased vision, receives assistance at times	F 327	F 327 SS=D SUFFICIENT FLUID TO MAINTAIN HYDRATION Resident #11 did not have any untoward effects related to observations. Care plan and task list were updated to include assistance with fluid intake. Residents who are identified as requiring assistance with meals (fluid intake) have the potential to be affected by this practice. ADNS or designee will provide education to nursing staff regarding offering fluids at meals and with cares and following guidelines for hydration management. ADNS or designee per TC c adm 8/11/15 dl Audits for compliance with assistance with fluid intake at meals and with cares will be completed three times weekly for four weeks and then weekly for three months. Results of audits will be submitted to QAPI committee for review and recommendations. Date of compliance is August 13, 2015.	

STATEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355024	A. BUILDING _____ B. WING _____	07/09/2015

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 327	Continued From page 34 with meals, disease process/conditions . . . Encourage and assist patient with fluids at and between meals as needed . . ." Observation on 07/7/15 at 8:55 a.m. showed a Certified Nurse Assistant (CNA) (#3) suggested the resident use the toilet and the resident nodded. Two CNAs (#3 and #4) assisted the resident to use the bathroom, and then at 9:24 a.m., assisted the resident to lie down in bed. The CNA (#3) pushed the bedside table up next to the resident, telling the resident she had a mug of water on it, and left the room without assisting/encouraging the resident to drink. Observation on 07/07/15 at 11:08 a.m. showed two CNAs (#3 and #4) provided perineal care and assisted the resident from the bed to the wheelchair, and then out to a living room table without offering fluids. Observation on 07/07/15 at 11:45 a.m. showed the resident received a plate of food, a mug of hot cocoa with a plastic lid on it, and a plastic glass of milk with a lid on it. At 12:14 p.m., the resident picked up the milk and took a sip of it, then set the milk down. The resident lowered her head, and remained with her head lowered and eyes closed until 12:28 p.m. A CNA (#4) asked if the resident was finished with her meal, how it tasted, and pushed the resident from the dining room. At that time, a CNA (#3) stated it looked like the resident didn't drink any of the milk or coffee, then picked up an unused plastic cup from the table, and reported he thought the resident probably drank cranberry juice. At 12:55 p.m., a CNA (#3) assisted the resident to her room and into bed. Staff failed to offer fluids prior to leaving the room.	F 327		

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 _____	07/09/2015

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 328 F 328 SS=D	Continued From page 35 483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, review of professional reference, and staff interview, the facility failed to provide the necessary care and services for 3 of 6 sampled residents (Resident #2, #6, and #11) with orders for oxygen. Failure to provide oxygen as ordered has the potential for residents to experience complications and/or hospitalization related to oxygen saturation levels. Findings include: Review of the facility policy titled, "Respiratory: Oxygen Administration" occured on 0709/15. This policy, dated 01/2011, stated, ". . . Record oxygen administration on Treatment Administration Record. . . ." Berman, A.T., and Snyder, S. (2012). "Kozier & Erb's Fundamentals of Nursing: Concepts, Process, and Practice," (9th ed).	F 328 F 328	F 328 SS=D 483.25 (k) TREATMENT/CARE FOR SPECIAL NEEDS Physician orders for residents #2, #6, and #11 were reviewed and clarified or revised when indicated. MARs/TARs were updated to reflect current orders. Care plans and task lists were updated when indicated for these residents. Residents who use supplemental oxygen have the potential to be affected by this practice. Oxygen orders were reviewed and clarified or revised as indicated for like residents with updates completed to MARs/TARs, care plans, and task lists when indicated. ADNS or designee will provide education to licensed nurses and certified nursing assistants regarding supplemental oxygen us. In addition, licensed nurses will be educated on documentation of O2 saturation and supplemental O2 use. ADNS or designee per TR c adm 8/11/15 dl. Audits will be completed three times weekly for four weeks then weekly for three months. Date of compliance is 08-13-15.	

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 _____	07/09/2015

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 328	Continued From page 36 *Page 1397 stated, "OXYGEN THERAPY . . . Like any medication, oxygen is not completely harmless to the client. Clients can receive an inadequate amount or an excessive amount of oxygen and both can lead to a decline in the client's condition. An inadequate amount of oxygen (hypoxia) will lead to cell death, and if left untreated can ultimately lead to death. Excessive amounts of oxygen can lead to pulmonary oxygen toxicity . . ." - Review of Resident #2's medical record occurred on all days of survey. Diagnoses included chronic obstructive airway disease. Physician's orders included oxygen at two liters per nasal cannula (L/NC). Observation on 07/07/15 at 7:50 a.m. showed Resident #2 lying on his bed watching television and his oxygen at three L/NC. Observation on 07/08/15 at 2:25 p.m. showed Resident #2 asleep on his bed and his oxygen at two and a half L/NC. - Review of Resident #6's medical record occurred on all days of survey. The quarterly Minimum Data Set (MDS), dated 6/16/15, identified the resident used oxygen during the previous 14 days while in the facility. Review of Resident #6's physician's orders for July 2015, identified, ". . .OXYGEN 2L NC AS NEEDED. KEEP SATURATION > (greater than) 90% . . ." Observation during initial tour on 07/06/15 at 1:30 p.m. showed Resident #6 sat in a wheelchair in her room, with a portable oxygen tank strapped to	F 328		

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 _____	07/09/2015

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 328	Continued From page 37 the wheelchair, and a nasal cannula applied to the resident's nose. The tank's gauge needle pointed to empty. Observation at 1:52 p.m. showed the tank remained empty with the nasal cannula still in place. Observation on 07/06/15 at 5:24 p.m., showed the resident sat in the dining room with oxygen applied and flowing at two L per minute. On 07/07/15 at 8:03 a.m., the resident again sat in the dining room with oxygen applied. At 9:03 a.m., after assisting the resident to bed and changing the resident's oxygen from a portable tank to an oxygen concentrator, a Certified Nurse Assistant (CNA) (#3) stated the resident always used oxygen at two liters per minute. On 07/08/15 at 10:07 a.m., a CNA (#4) stated the resident needed oxygen applied at all times, used a concentrator in her room, and switched over to a portable tank when leaving her room. Review of Resident #6's July 2015 Medication Administration Record (MAR) identified, "OXYGEN 2L NC AS NEEDED. KEEP SATURATION > 90%" but staff failed to document the resident received oxygen in July. The MAR did not include any measurements of the resident's oxygen saturation to indicate the need for the oxygen or the effectiveness of having the oxygen applied. During an interview on 07/09/15 at 9:40 a.m., a licensed nurse (#2) stated oxygen use needed needed to be documented on the MAR, and confirmed no one documented the oxygen use in July. On 07/09/15 at 12:00 p.m., an administrative	F 328		

STATEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355024	A. BUILDING _____ B. WING _____	07/09/2015

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 328	Continued From page 38 nurse (#1) stated she expected staff to take the resident's oxygen saturation level prior to applying as needed (PRN) oxygen, and to document the usage of oxygen on the MAR. - Review of Resident #11's medical record occurred on all days of survey. Review of physician's orders for July 2015 identified, ". . . O2 (oxygen) AT 2L PER NASAL CANNULA AS NEEDED . . . KEEP O2 SATS (saturation) > 92% . . ." Observation on 07/07/15 at 9:24 a.m. showed two CNAs (#3 and #4) assisted Resident #11 to lay down in bed and applied oxygen supplied by a concentrator to the resident. The CNA (#3) confirmed the oxygen ran at a rate of two liters per minute. At 4:47 p.m., two CNAs (#5 and #6) removed the resident's oxygen, turned off the oxygen concentrator, and assisted the resident from bed to the resident's wheelchair. On 07/08/15 at 10:07 a.m., a CNA (#4) stated staff applied oxygen at two liters to the resident anytime the resident laid down in bed, and took it off when the resident got up from resting. Review of Resident #11's July 2015 MAR showed, ". . .02 sats to keep > 92% . . ." The MAR had documentation of the resident's oxygen saturation each shift, but did not identify whether the resident had oxygen applied at the time of the reading. The MAR also included, "O2 AT 2L PER NASAL CANNULA AS NEEDED . . ." but staff failed to document the resident received oxygen in July. On 07/09/15 at 9:40 a.m., a licensed nurse (#2) stated she documented Resident #11's oxygen	F 328		

STATEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355024	A. BUILDING _____ B. WING _____	07/09/2015

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 328	Continued From page 39 saturation each shift with the resident on room air. The nurse indicated the MAR failed to identify whether the resident received PRN oxygen and staff failed to document whether oxygen was in use when taking oxygen saturation levels. The nurse (#2) stated she did not know the aides applied oxygen when the resident laid down. On 07/09/15 at 12:15 p.m., an administrative nurse (#1) stated she expected staff to take the resident's oxygen saturation level prior to applying PRN oxygen, and to document the usage of oxygen on the MAR.	F 328		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to ensure 1 of 3 sampled residents (Resident #8) receiving nebulizer treatments remained free of a significant medication error. Failure to administer Atrovent nebulizer as ordered resulted in the resident incorrectly receiving approximately 23 doses of DuoNeb nebulizer. Findings include: Review of the facility policy titled "Medication and Treatment Administration Guidelines" occurred on 07/09/15. This policy, dated December 2014, stated, ". . . Medication and Treatment Orders: . . . * The licensed nurse noting an order is	F 333	F 333 SS=D RESIDENTS FREE OF SIGNIFICANT MED ERROR Resident #8's order was clarified on 06-28-15 and MAR updated to reflect correct order. Resident #8 received the correct medication once the transcription error was noted. Residents who have new orders have the potential to be affected by this practice. Monthly physician order sheets were audited prior to August 1st and updated when indicated to reflect current orders. Transcription of orders to MAR and TAR were validated during this process.	

STATEMENT OF DEFICIENCIES / PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355024	A. BUILDING _____ B. WING _____	07/09/2015

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 333	Continued From page 40 responsible for accurate transcription and initiation of orders . . . Medication Administration: * Medications are administered in accordance with the following "rights" of medication administration . . . right medication, . . ." Review of Resident #8's medical record occurred on all days of survey. Diagnoses included chronic obstructive pulmonary disease (COPD) and history of pneumonia. A medication order, dated 06/23/15, stated, "Change Atrovent to give every 4 hours while awake and every 6 hours PRN [as needed]." Resident #8's June 2015 Medication Administration Record (MAR) showed the following: * 06/23/15 - Staff discontinued PRN Albuterol and Atrovent nebulizers * 06/23/15 - DuoNeb (Albuterol and Atrovent combination) every 4 hours while awake. On 06/27/15, staff wrote "Wrong Med D/C [discontinued]" in the column dated 06/28/15. * 06/23/15 - DuoNeb every 6 hours PRN. Staff wrote "Wrong Med D/C" by this entry, but did not date the entry. * 06/27/15 - Atrovent every 4 hours while awake and every 6 hours PRN The transcription error by the facility on 06/23/15 resulted in Resident #8 receiving the wrong nebulizer (DuoNeb) for four days.	F 333	ADNS or designee will provide education to licensed nurses on transcribing and validating new orders. ADNS or designee will c Adm 8/11/15 dl. Audits will be completed three times weekly for four weeks and then weekly for three months. Results of audits will be forwarded to QAPI committee for review and recommendations. Date of compliance is August 13, 2015	
F 334 SS=E	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization,	F 334		

STATEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355024	A. BUILDING _____ B. WING _____	07/09/2015

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 334	Continued From page 41 each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and	F 334	F 334 SS=E 483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS Residents #9 and #11 tolerated second dose of influenza vaccine without ill effects. Following survey, residents #4,#5, #7, #9,#10, and #11 and/or their responsible parties were notified that influenza immunizations had been given during the 2014-2015 influenza season. Resident #9's pneumococcal immunization status was validated and medical chart updated to reflect current status. Residents who are admitted and do not have documentation regarding pneumococcal immunization and those residing at the facility during influenza season have the potential to be affected by this practice. The ADNS was educated during survey on the process for patient immunizations. The ADNS or designee will provide education to licensed nurses on the process for obtaining consents, documenting immunizations, and monitoring residents following immunizations.	

STATEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355024	A. BUILDING _____ B. WING _____	07/09/2015

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 334	Continued From page 42 (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to assess each resident's immunization status for 6 of 16 sampled residents (Resident #4, #5, #7, #9, #10, and #11). Failure to provide education to the residents and/or legal representatives regarding the benefits and potential side effects of receiving the influenza and/or pneumococcal vaccine; obtain consents for the influenza and/or pneumococcal vaccines; offer the pneumococcal vaccine; and document the vaccine administration in the residents' medical record resulted in the administration of the influenza vaccine twice to two residents (Resident #9 and #11) and does not allow residents and/or their	F 334	ADNS or designee per TC F adm 8/11/15 dl. Audits of new admissions will be completed three times weekly to validate pneumococcal consents or declinations were obtained at admission. Audits will then be completed weekly for three months on immunizations for new admissions and for residents residing at the facility during the 2015-2016 influenza season. Results of audits will be submitted to the QAPI committee for review and recommendation. Date of compliance is August 13, 2015.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355024	A. BUILDING _____ B. WING _____	07/09/2015

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 334	Continued From page 43 legal representatives to make a choice regarding the immunizations. Findings include: Review of the facility policy titled "Influenza Immunization Plan" occurred on 07/08/15. This policy, dated May 2013, stated: ". . . The influenza immunization guidelines include systems to: *screen *distribute educational handouts *obtain signed consent forms *track acceptance and declinations . . . *maintain documentation . . . The screening process identifies: . . : *recommendations of administering the immunization *reasons for refusal Contraindications for immunization include: *vaccinated in current flu season . . ." Review of the facility policy titled "Pneumococcal Immunization Plan" occurred on 07/08/15. This policy, dated May 2013, stated: ". . . The pneumococcal immunization guidelines include process to *screen patients . . ." Review of the facility policy titled "MEDICATION AND TREATMENT ADMINISTRATION GUIDELINES" occurred on 07/08/15. This policy, dated December 2014, stated, ". . . DOCUMENTATION: Medications and treatments administered are documented immediately following administration or per state specific standards . . ." On 07/08/15, upon request, an administrative nurse (#1) provided an immunization report with	F 334		

STATEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355024	A. BUILDING _____ B. WING _____	07/09/2015

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 334	Continued From page 44 the names and dates of the residents who received an influenza vaccine in May 2015. The list included 20 residents. Review of Resident #4, #5, #7, #9, #10, and #11's medical records occurred July 06-09, 2015. INFLUENZA IMMUNIZATION - Resident #9's medical record identified he received the influenza vaccine on 12/10/14 while in the hospital and Resident #11's medical record identified he received the vaccine in October 2014. Both residents received the vaccine again in May 2015. The records failed to identify if the residents or their legal representatives were screened, educated, or signed consents for the influenza vaccine administered in May 2015. - Resident #5 received the influenza vaccine in October 2014 and the medical record failed to identify if the resident or legal representative were educated and signed a consent for the vaccine. - Resident #4, #7, and #10's medical record identified they refused the influenza vaccine in October 2014. All three residents received the vaccine in May 2015. The records failed to identify if the residents were screened, if they or their legal representatives were educated, and if consents were signed for the vaccine. The facility staff failed to document in the resident's medical record, the date, location (i.e. left or right deltoid), and the lot number and expiration of the influenza vaccine administered to Resident #4, #7, #9, #10, and #11. During an interview on 07/08/15 at 5:50 p.m., an	F 334		

STATEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355024	A. BUILDING _____ B. WING _____	07/09/2015

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 334	Continued From page 45 administrative nurse (#1) stated the facility administered the influenza vaccine in May 2015 to those residents who were missed in October 2014. An administrative nurse (#7) confirmed this statement on 07/09/15 at 1:00 p.m. and stated the facility had some influenza vaccine left over from the flu season and decided to use it up before it expired. Neither nurse (#1 and #7) could explain how the 20 residents were chosen. PNEUMOCOCCAL IMMUNIZATION - Resident #9's medical record identified an admission date of 12/15/14. The record failed to identify if the facility screened, offered, and documented acceptance or refusal of the pneumococcal immunization.	F 334		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format.	F 356	F 356 No residents were identified as being affected. All residents and Families may be affected Education provided by Administrator / Designee to Staffing Coordinator and Licensed nurses to complete Staffing sheets daily and update hours at beginning of shift. Administrator or Designee will monitor posted hour sheet for shift updates 3X per week for 4 weeks, monthly for 3 months for deficiencies. Audit Findings will be forwarded to the facility QAPI committee for review and recommendations. Facility will be in compliance August 13, 2015	

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 _____	07/09/2015

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 356	Continued From page 46 o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to post the total and actual hours worked by licensed and unlicensed nursing staff directly responsible for resident care on 4 of 4 days (July 6-9, 2015) of survey. Findings include: Observation of July 2015 staffing hours worked identified the facility staff fail to update the actual staffing hours worked for that day. The facility failed to provide current staffing information for July 2015. During an interview on 07/09/15 at 8:25 a.m., an office staff member (#28) stated she makes up the staffing schedules daily, posts them for that day, and the next day will correct the hours to show the actual hours of licensed and unlicensed nursing staff worked. She confirmed the schedules posted each day do not show the actual hours nursing staff worked.	F 356		
F 371	483.35(i) FOOD PROCURE,	F 371		

STATEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355024	A. BUILDING _____ B. WING _____	07/09/2015

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 371 SS=F	Continued From page 47 STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and review of facility policy, the facility failed to prepare and serve foods under sanitary conditions in 1 of 1 kitchen. Failure to effectively sanitize dishes and sanitize dining room tables may result in food borne illness, and failure to restrain facial hair may result in foreign objects getting into resident food. These issues have to potential to affect all residents who consume food prepared from the kitchen. Findings include: - Review of the facility policy titled "Dishwasher Operation - High Temperature Machine" occurred on 07/09/15. This policy, dated September 2014, stated, ". . . 8. Check and record temperatures of wash and rinse water. . . .Wash temperatures are to be . . .160F [Fahrenheit] for conveyor type machines. Rinse temperatures must be at least 180F. Temperatures should not exceed 170F for wash or 200F for rinse. Do not start washing dishes if temperatures are below minimum requirements. . . . 10. Record wash and rinse	F 371	F 371 No residents were identified as being affected. Residents who receive food through the kitchen are affected Food Service Manager / Designee provided education to food service staff on verifying the water temperatures. and notifying supervisor if temperatures are not in range. Staff educated on proper method to sanitize dining room tables, and use of Manufacturers sanitizing test strips. In addition, Hair and beard, if appropriate, nets to be used by all who enter Kitchen area Food Service Manager / Designee to complete audits 3X per week for 4 weeks, monthly for 3 months for deficiencies. Audit findings will be forwarded to the facility QAPI committee for review and recommendations. Facility will be in compliance August 13, 2015	

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 _____	07/09/2015

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 371	Continued From page 48 temperatures on the Dishwasher Temperature Log form. . . . It is suggested that heat sensitive tapes are used periodically to verify sanitizing temperatures." Review of the facility policy titled "Dishwasher Operation - Dishwasher Failure" occurred on 07/09/15. This policy, dated September 2014, stated, "1. When dishwasher temperatures, water supply or chemical concentrations are not at the dishwasher manufacturer's recommended levels, the dishwashing process is stopped immediately and not restarted until the problem is corrected. The problem is reported to the food service director or person in charge of the kitchen operation. . . ." Observation on 07/08/15 at 1:20 p.m. in the main kitchen showed a dietary staff member (#17) recorded wash and rinse temperatures from a gauge located on the outside of the dish machine. The staff member stated the rinse temperature on the gauge had to reach 180 degrees to sanitize the dishes. The staff member stated she looked at the gauge before washing dishes from each meal service, and if the temperature was not high enough, she stopped and told a manager or maintenance staff member. Review of the Dishwasher Temperature Log showed the noon rinse cycle on 07/07/15 read "170" degrees, and the staff member (#17) recorded "160" degrees on 07/08/15. She stated they also had strips available to test the temperature, walked out of the dishwashing room, and spoke with an administrative dietary staff member (#13). The administrative dietary staff member (#13) entered the dishwashing room and stated they had temperature sensitive strips available to test the temperature to ensure the dishwasher sanitized	F 371		

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 _____	07/09/2015

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 371	Continued From page 49 properly. Readings taken from two different brands of temperature sensitive strips at that time revealed the dishwasher did not reach 160 degrees on the dish surface (the temperature needed to effectively sanitize dishes). The staff member (#13) confirmed the reading. At 1:53 p.m., the staff member (#13) stated she had not been notified by staff of any issues regarding the dishwasher temperature before running the temperature sensitive strip through the machine. On 07/08/15 at 1:54 p.m., the dietary staff member (#17) stated she did not notify anyone of that day's reading because the morning's temperature was appropriate (180 degrees). On 07/08/15 at 2:35 p.m., a maintenance staff member (#16) ran a dishwasher cycle and readings from the two different brands of strips revealed the dishwasher did not reach 160 degrees. He drained the dishwasher and attempted the load again. The readings with the second cycle showed the temperature reached 160 degrees. At 4:30 p.m., a distributor representative (#15) stated he checked the dishwasher, and found the heat booster on the dishwasher had shut off at some point and was not providing the hot water the dishwasher needed to consistently reach the proper temperature. - Review of the facility policy titled "Cleaning Procedure - Sanitizing Food Contact and Non-Food Contact Surfaces" occurred on 07/17/15. This policy, last updated June, 2015, stated, ". . . 6. Use test strips to determine when solution needs changing. Change solution when concentration falls below 200 ppm [parts per million] and as needed such as when visibly dirty.	F 371		

STATEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355024	A. BUILDING _____ B. WING _____	07/09/2015

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 371	Continued From page 50 . . ." Observation on 07/07/15 at 1:35 p.m. showed a dietary staff member (#26) cleared the dirty dishes and soiled table cloths from the tables in the Courtyard dining room. The staff member stated he wiped the tables with soapy water from a green bucket first, then wiped the table with sanitizer water from a red bucket. The staff member stated he prepared the sanitizer by filling the bucket half full with hot water and half full with premixed sanitizer and used the same bucket for all 4 dining rooms. The staff member (#26) stated he thought the sanitizer chemical needed to be at a concentration between 400ppm and 500ppm, but when tested, it read between 0 and 150 with dark green spots along the edges of the strip. The dry roll of strips used to test had green spots along the edges (indicating previously activated by sanitizer). The staff member (#26) stated they did not have a case for that roll of strips to protect them from damage. Observation on 07/08/15 at 9:30 a.m. showed a dietary staff member (#31) cleared the dirty dishes from the tables in the South dining room. The staff member stated she wiped the tables with soapy water from the green bucket and then wiped the tables with sanitizer from the red bucket. The staff member stated this was her second dining room and she had two more dining rooms to clean. When asked how often the red bucket is filled with sanitizer, she stated she fills it in the morning and dumps it after cleaning all the tables in all four dining room. This staff member stated the concentration of the sanitizer should measure between 200 and 400 ppm. The staff member (#31) then measured the concentration of the solution in her red bucket and it measured	F 371		

STATEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355024	A. BUILDING _____ B. WING _____	07/09/2015

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 371	Continued From page 51 150 ppm. The staff member dumped the solution and obtained a fresh bucket of sanitizer. During an interview on 07/08/15 at 2:05 p.m., an administrative dietary staff member (#13) stated the kitchen staff used a quaternary (quat) sanitizer for the dining room tables. She expected staff to fill a red bucket with premixed sanitizer solution and add about 1 cup of cold water to lower the temperature for staff comfort, but not to add anymore water than that so as not to dilute the sanitizer. The staff member (#13) stated she expected the sanitizer to read 400, expected staff to change the sanitizer after the first dining room, and after the third dining room to ensure it remained effective. The staff member stated she discarded the strips with green spots because they had gotten wet and damaged. On 07/09/15 at 10:25 a.m., the administrative dietary staff member (#13) stated the information posted in the kitchen identified different concentration levels for the expectation for proper sanitization. The form where staff documented readings read 200, but the poster provided by the distributor read 150 and she would clarify with the distributor. - Review of the facility policy titled "Hair Restraints" occurred on 07/09/15. This policy, dated January 2015, stated, "Hair restraints are worn to keep hair away from food and to minimize touching or handling of hair during food production. Hair is considered to be a foreign object and hair restraints help to avoid hair from falling into food. . . .1. Hair restraints are worn by anyone in the kitchen. . . . 5. Hair restraints include: . . . *beard or facial hair coverings . . ." Observation on 07/08/15 at 12:55 p.m. in the the	F 371		

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 _____	07/09/2015

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 371	Continued From page 52 main kitchen showed a dietary staff member (#12) plated food from the steam table for residents to eat. The dietary staff member (#12) had a mustache but no restraint to cover it. At 1:00 p.m., an administrative dietary staff member (#14) walked up to the steam table and stirred food in one of the pans. The staff member (#14) had facial hair, but no restraint covering it. During an interview at 10:25 a.m. on 07/09/15, an administrative dietary staff member (#13) stated she did not have expectations related to restraining facial hair, and the kitchen did not have any beard covers available for use.	F 371		
431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS 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.	F 431	F 431 SS=E 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS A new label was obtained for the insulin bottle for Resident #25 to reflect the current order. Refrigerator temp was adjusted into proper range. per TC & adm on 8/11/15 dl. Residents who receive mediations have potential to be affected. ADNS or designee provided education to licensed nurses and nurse managers on storage of medications, obtaining new medication labels, monitoring and reporting requirements for refrigerator temperatures. ADNS or designee per TC & adm 8/11/15 dl. 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 recommendations. Date of compliance is August 13, 2015.	

STATEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355024	A. BUILDING _____ B. WING _____	07/09/2015

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 431	Continued From page 53 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, record review, review of facility policy, and staff interview, the facility failed to properly store and label medications for 1 of 1 insulin vial (Resident #25), 2 of 3 medication refrigerators (North and Central), and 2 of 6 treatment carts (North 1 and South 1). Failure to store and label medications correctly may result in residents' receiving a wrong dose of medication, may affect the efficacy of medications, and may result in unauthorized access to medications. Findings include: Review of the facility policy titled "MEDICATION AND TREATMENT ADMINISTRATION GUIDELINES" occurred on 07/09/15. This policy, dated December 2014, stated, ". . . Medications are administered in accordance with the following 'rights' . . . right dose . . ." Review of the facility policy titled "Storage and Expiration of Medications, Biologicals, Syringes and Needles" occurred on 07/09/15. This policy,	F 431		

STATEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355024	A. BUILDING _____ B. WING _____	07/09/2015

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 431	Continued From page 54 revised in 2013, stated, ". . . 3. General Storage Procedures: . . . Facility should ensure that all medications and biologicals, including treatment items, are securely stored in a locked cabinet/cart . . . that is inaccessible by residents and visitors. . . . 11. Facility should ensure that medications and biologicals are stored at their appropriate temperatures . . . Refrigeration: 36 [degrees] - 46 [degrees] F [Fahrenheit] . . ." LABELING OF MEDICATION - Observation on 07/07/15 at 8:13 a.m. showed a licensed nurse (#29) obtained Resident #25's insulin vial (Lantus) from the medication cart and filled a syringe with 28 units. The label affixed to the vial stated to administer 30 units. When asked about the discrepancy, the nurse (#29) stated the order changed about a month ago. Review of Resident #25's medical record identified the Lantus dosage changed from 30 units to 28 units on 05/12/15, approximately two months prior. REFRIGERATOR TEMPERATURES - Observation of the Center medication room occurred on 07/09/15 at 11:40 a.m. and revealed the medication refrigerator temperature measured 32 degrees F and a vial of Tuberculin Purified Protein in the refrigerator. Review of the "MEDICATION REFRIGERATOR TEMPERATURE LOG" identified the following: * A note on the logs stated, "Refrigerator temperature should be within 36-46 [degrees]. Notify Manager when temperature exceeds these guidelines. . . ."	F 431		

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 _____	07/09/2015

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 431	Continued From page 55 * July 2015 - the temperature below 36 degrees F six of nine days * June 2015 - facility staff only documented the temperature five of 30 days and the temperature was below 36 degrees F three of the five days - Observation of the North medication room occurred on 07/09/15 at 11:50 a.m. and revealed the medication refrigerator temperature measured 42 degrees F (within normal limits) however, review of the "MEDICATION REFRIGERATOR TEMPERATURE LOG" identified the following: * July 2015 - the temperature below 36 degrees F seven of nine days * June 2015 - the temperature below 36 degrees F 10 of 30 days * May 2015 the temperature below 36 degrees F 16 of 31 days During an interview on the afternoon of 07/09/15, an administrative nurse (#7) stated she expected staff to report a temperature below 36 degrees F. UNSECURED TREATMENT CARTS - Observation on 07/08/15 at 3:25 p.m. showed an unlocked treatment cart in the North One hall and an unidentified resident seated in his wheelchair next to the cart. Observation failed to show a nurse in the area of the treatment cart. - During the tour of the environment on 07/09/15 at 2:00 p.m., observation showed a treatment cart located on the South One hallway unlocked and resident's prescription and over the counter medications in the drawers.	F 431		