

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

PRINTED: 05/18/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355024		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/20/2016	
NAME OF PROVIDER OR SUPPLIER MANOR CARE HEALTH SERVICES				STREET ADDRESS, CITY, STATE, ZIP CODE 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			F 000			
F 244 SS=E	For the unannounced complaint survey conducted April 19-20, 2016, the sample included four sampled residents, three supplemental residents, and two closed records for review. The complaint issues regarding abuse and assessments following a change in condition could not be substantiated. The complaint issue regarding call lights was substantiated. 483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by: Based on information provided by the complainant, review of "Resident Council Minutes," review of incident reports, resident interviews, and staff interviews, the facility failed to ensure action upon and resolution of grievances from residents and families regarding call light response times for 5 of 5 (A, B, C, D, E) interviewable residents interviewed during the survey (April 19-20, 2016). Failure of staff to answer call lights in a timely manner may affect the quality of life/care provided to all the residents. Findings include: Information provided by the complainants			F 244	F244 1. No Residents were identified by the State due to confidentiality. Random interviews and a meeting with the Resident Council has been done to let residents know how we will better respond to their concerns. 2. Residents residing at the facility who are able to voice concerns have the potential to be affected by the practice. Interviews with Resident Council and interviews with random residents were done to discuss call light response and improvement of the process		5/25/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

05/11/2016

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 244	Continued From page 1 indicated call lights are not being answered in a timely manner. Review of the August 2015-March 2016 "Resident Council Minutes" occurred on the morning of 04/20/16 and identified the following concerns: * 08/26/15 - "... Center lights long wait times. . ." * 09/30/15 - "... Call lights still slow on Center. . ." * 10/28/15 - "... Call lights are better, always room for improvement. . ." * 12/31/15 - "... long wait time for call lights especially after meal times. . ." * 01/28/16 - "... Long call light times. . ." * 02/24/16 - "... Long call light wait times. . ." * 03/29/16 - "... Communication is horrible. CNAs [certified nursing assistants] don't come back. . ." Review of incident reports identified the following: * 08/13/15 - "... During res. [resident] care conference it was reported that a CNA . . . waits excessively long to help her to the BR [bathroom] when she puts on her call light and leaves her in there for great lengths of time. The res. stated that she often puts on her light to help her roommate and the CNA gets mad. . ." * 01/26/16 - "... The res. states she yelled for help once she was completed with the bed pan . . . She ended up taking herself off the bedpan . . ." Five residents identified as interviewable by the facility were interviewed during the survey. The residents stated the following regarding the length of time they have waited for staff to respond to their call lights:	F 244	3. The Administrator, Department Directors or Department Managers provided education to staff on the Concern Reporting process and response to call lights. The Resident Concern Process was reviewed with the Resident Council; staff is providing timely response to Resident concerns including call light response. Resident Council meetings are held monthly and concerns expressed during the meeting are documented and reported by the Activities Director or designee to the Administrator. Administrator assigns specific department managers to follow-up each resident concerns and resolve to the extent possible Activities Director reviews the resolution of the concerns at the next resident Council Meeting. The Administrator or designee reviews new concerns daily at the IDT meeting and assigns them to Department Managers for completion. Resolutions of new concerns (not reported at Resident Council) are to be addressed with the resident directly for satisfaction to the extent possible. 4. The Social Service worker or designee(s) conduct call light audits 2 times weekly for 4 weeks, 1 time weekly for 4 weeks and then 1 time monthly for 8 months. The Administrator or designee reviews results of audits at IDT meeting. Outstanding resident concerns are assigned to Department Managers to obtain resolution. Audits and concern		

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F 244	Continued From page 2 * On 04/19/16 at 5:33 p.m., Resident A stated, "I've had to wait for a long time, over 30 minutes." * On 04/19/16 at 5:11 p.m., Resident C stated the following: - "Last Tuesday [04/12/16] I had a doctor appointment at eight o'clock in the morning. I woke up at seven o'clock. I put my call light on, a CNA entered the room, I requested a bed pan, but the CNA left the room without giving me a bedpan. I ended up wetting myself waiting for a CNA to come and give me a bedpan. I called the front desk and told them I was wet now and needed someone to come to the room. Another CNA came to the room with a nurse who started arguing in my room on the other side of my curtain about who was going to help clean me up. A different CNA came into the room and ended up helping me get cleaned up." - "Monday night [04/18/16] at seven forty-five I turned on the call light, a CNA came to the room at eight, I told her I needed a bed pan, she said she would get another CNA to do it. At eight thirty no one had come to the room to give me a bed pan. I called the front desk at eight thirty and told them no one is coming to help me. Around eight forty CNAs came to the room, put me on the bed pan, and then when they went to remove the bed pan my sheets got all wet. These CNAs said they would be right back to change the sheets. They never came back to my room. At nine o'clock a different CNA came to my room during her rounds and I told her about my wet sheets. This CNA then changed my sheets and my clothes. I was so upset and crying I needed Tramadol and Xanax for my anxiety." - "Last Friday night [04/15/16] a CNA gave me the bed pan. When I was finished I put on my call light around nine to nine thirty. A nurse came to	F 244	response log is reviewed by QAA committee monthly for recommendations. 5. Date of Compliance May 25th, 2016		

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F 244	Continued From page 3 my room and ended up spilling my bed pan all over my bed because I could feel I was getting all wet. She said I will be right back and never came back. I had my light on the whole time, it was not till around eleven o'clock that another CNA came into my room after the change of shift at ten and saw me and cleaned me up." * On 04/20/16 at 1:36 p.m., Resident B stated, "I have waited up to a half hour for call light to be answered." * On 04/20/16 at 1:40 p.m., Resident D stated, "I have sat on the pot for fifteen to twenty minutes, they never answered the call light so I have to yell out into the hallway for someone to come and help me. They could be better with answering the call light, but average from fifteen to twenty minutes wait time. They often say they will be right back and never come back to help." * On 04/20/16 at 1:45 p.m., Resident E stated, "They sometimes take up to five minutes to . . . once I waited up to two hours. I usually need help with the bathroom every day around three o'clock. I will put my call light on but they do not come into my room until four thirty. It happens a lot with the change of shift. It takes them a long time to answer the light at which time I am watching my clock for the time. I would have accidents in my brief because I wait too long." Review of Resident C's as needed (PRN) electronic Medication Administration Record (eMAR) for April, 2016 identified frequent use of both the Tramadol and Xanax medications for frequent episodes of anxiety. During an interview on 04/20/16 at 2:00 p.m., an administrative nurse (#2) stated she expected call lights to be answered between three to five	F 244			

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F 244	Continued From page 4 minutes. She acknowledged answering call lights in a timely manner has been an ongoing issue. During an interview on 04/20/16 at 3:30 p.m., two administrative staff members (#1 and #2) confirmed awareness of the residents' concerns regarding call lights and are in the process of addressing those concerns.	F 244			