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Division of Health Facilities

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 355064 | A. BUILDING _____ B. WING _____ | 06/03/2010 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| BENEDICTINE LIVING CENTER OF GARRISON | 609 4TH AVE NE GARRISON, ND 58540 |

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| F 000 | INITIAL COMMENTS<br><br>For the standard Medicare/Medicaid recertification survey started on June 1, 2010, and completed on June 3, 2010, the sample included 3 residents for complete review, 9 residents for focused review, and 1 closed records for review. In addition, 12 residents were added to the sample to verify specific concerns during the survey. | F 000 | This plan of correction is this facility's allegation of compliance with applicable regulatory requirements. | |
| F 224 SS=G | 483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN<br><br>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, and staff interviews, the facility failed for 1 of 1 sampled resident (Resident #6) who exhibited wandering and aggressive behavior to:<br>1. Adequately assess resident behaviors, including monitoring for patterns/trends, causative factors, including time, place, persons involved, happenings prior to and at time of behavior, etc, and implement appropriate interventions to prevent behaviors from escalating.<br>2. Monitor the effectiveness of interventions and revise interventions as appropriate.<br>3. Implement an interdisciplinary approach to addressing behaviors which have the potential for resulting in resident to resident abusive situations.<br><br>Failure to adequately assess/monitor Resident | F 224 | F-224<br><br>1) Resident #6 care plan was reviewed on 7/2/10 and was updated to adequately reflect his cares and interventions, especially with his wandering and behavioral issues. The care plan was then placed in the report book to be reviewed at all shift reports for one week to ensure staff are up-to-date with interventions.<br><br>2) All aggressive/combative events will be reviewed weekly at IDT meeting to assure appropriate interventions have been put in place and follow-up done. All aggressive behaviors will be tracked and trended utilizing "Behavior Profile". (See attached exhibit) | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| [signature] | CEO | 7/20/10 |

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 224 | Continued From page 1<br>#6's ongoing behavior(s) and implement appropriate interventions to prevent further behavior(s) resulted in: Resident #6 entering Resident #15's room uninvited, and pushing Resident #15 to the floor resulting in a fracture of Resident #15's lower extremity; as well as fear and physical abuse for other residents.<br><br>Findings include:<br><br>- Observation on 06/02/10, at the noon meal, showed Resident #6 sitting at the dining table, within reach of Resident #19. Observation showed Resident #19 talking loudly, in a manner that could be perceived as yelling. Resident #6 made two attempts to stand while seated at the table. Resident #19 made statements of not liking the food served. A staff member (#14) stood between Resident #6 and Resident #19 visiting with Resident #19 to determine another meal choice, with Resident #19 speaking loudly. Resident #6 stood suddenly and swung at Resident #19 trying to reach around the staff member (#14). Resident #19 stated, "He hit my nose." The staff member (#14) indicated Resident #6 did not make contact with Resident #19. The staff member (#14) moved Resident #6 to another table, and Resident #6 completed the meal without further incident. Staff failed to provide a seating arrangement, which could have prevented this incident by not putting Resident #6 in a position where he sat next to a resident who spoke loudly.<br><br>Resident #6's medical record, reviewed June 1-3, 2010, identified the facility admitted the resident to the Sunflower unit in September of 2008. The resident's current diagnoses included Alzheimer's disease, persistent mental disorder-terminal | F 224 | 3) With each aggressive/combative incident the Resident incident form will be implemented for follow up after the incident. All facility staff have just completed Silverchair training on abuse during the month of June. Just in Time training will be given to all charge nurses on the Resident incident form. All staff were assigned "Managing Challenging Behaviors" per Silverchair to be completed by 7/21/10. All nursing staff educated by Just In Time training on the policy and procedure for behavior tracking.<br><br>4) QA will be completed on all aggressive/ combative events through Oct 31, 2010 to ensure compliance/ competency on the new form. QA will be reevaluated November 1, 2010. Dependent on frequency of events and compliance of policy, QA will then be conducted on 2 random events every month. QA will be conducted by Sunflower neighborhood leader. QA will be conducted on 2 random staff members per month by the DON related to abuse to cover forms of abuse and reporting procedures.<br><br>5) Date certain will be 7/21/10 | 7/21/10<br><br>7/21/10 |

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| F 224 | Continued From page 2<br>dementia, senile dementia with depression and dementia with behavioral disturbances. The resident's current Minimum Data Set (MDS), dated 04/14/10, identified Resident #6 has short and long-term memory problems, and exhibited wandering and socially inappropriate/disruptive behavioral symptoms daily. The MDS also identified Resident #6 as displaying verbally abusive behavioral symptoms, physically abusive behavioral symptoms, and resistive to care; one to three times in the last seven days, all three not easily altered. The current MDS documentation indicated Resident #6 is a resident of an Alzheimer's or dementia special care unit.<br><br>Resident #6's medical record identified the following:<br>* 07/08/09 - Resident #6 identified as "chasing" another resident in the hallway. Staff found the Resident #15 in his room, on the floor, injured, saying Resident #6 pushed him down. This other resident experienced a fracture of a lower extremity.<br>* 12/23/09 - Resident #6 identified as being in Resident #10's room attempting to pull Resident #10's walker away from Resident #10. With staff redirection, Resident #6 released the walker. Resident #10 reported Resident #6 hit her, but staff could not identify an injury.<br>* 12/27/09 - Resident #6 entered another resident's room. The other resident hollered and when staff entered, both residents were hitting each other. Staff did not identify injuries to the residents.<br>* 01/22/10 - Resident #6 threw a glass of water in another resident's face and wandered in and out of residents' rooms.<br>* 06/02/10 - Resident #6 stood at the dining room table attempting to hit another resident sitting next | F 224 | | |

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| F 224 | Continued From page 3<br>to him who was "yelling."<br><br>Review of Resident #6's current care plan addressed the problem of "Neighbor is at risk/potential for behavioral symptoms. Indicators vary based on mood and are not always easily altered." The care plan failed to identify Resident #6's behavioral symptoms including physical altercations with other residents. Resident #6's "Personal Preferences" sheet identified "I get upset when peers yell a lot." Observation (as noted above) showed staff sat Resident #6 next to Resident #19, who talks loudly (documented above as "yelling"), and did not separate the two residents until Resident #6 attempted to hit Resident #19 because she was yelling/talking loudly.<br><br>During an interview, on 06/03/10 at 10:30 a.m., an administrative staff member (#4) identified Resident #6 "cycles" and cannot always be predictable. When this staff member (#4) became aware Resident #6 and Resident #19 were seated at the same dining table, the staff member (#4) identified they should not sit together. | F 224 | | |
| F 250 SS=G | 483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE<br><br>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, review of professional literature, and staff interview, the | F 250 | | |

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| F 250 | Continued From page 4<br>facility failed to provide medically-related social services to respond to the behaviors of 1 of 1 sampled resident identified with suicidal/self destructive behaviors (Resident #3). Failure to identify the causes for the behaviors, implement appropriate interventions, and establish goals to minimize behaviors, limited Resident #3's ability to maintain individuality, and maximum allowable/appropriate control over her day-to-day life, routine and goals. This resulted in the resident ingesting hand sanitizer on four occasions while under the care of the facility, and an emergency room visit with the fourth incident.<br><br>Findings include:<br><br>The Centers for Medicare and Medicaid Services (CMS) requires all facilities provide for the medically related social services needs of each resident. This requirement specifies that facilities aggressively identify the need for medically-related social services, and pursue the provision of these services. "Medically-related social services" means services provided by the facility's staff to assist residents in maintaining or improving their ability to manage their everyday physical, mental, and psychosocial needs. These services might include, for example:<br>o Making referrals and obtaining services from outside entities<br>o Providing or arranging provision of needed counseling services;<br>o Through the assessment and care planning process, identifying and seeking ways to support residents' individual needs and preferences, customary routines, concerns and choices;<br>o Promoting actions by staff that maintain or enhance each resident's dignity in full recognition of each resident's individuality; | F 250 | F-250<br>Social Service Assessment:<br>1) Social Worker that completed MDS/RAPs is no longer employed at Benedictine Living Center as of April 26, 2010. Social Service designee has been completing information in the interim. Erica Gentile, LSW, has been hired. She will be starting 7/19/10. She is registered to attend a 3-day workshop, "MDS 3.0 Training" on Aug 24 – 26, 2010 sponsored by NDDOH. She will not be completing any MDS's until after her training is complete.<br><br>2) MDS/RAPs for all neighbors are completed by Social Service designee with review by interdisciplinary team members.<br><br>3) IDT will review neighbor #3's MDS/RAPs to ensure that all needed revisions occur monthly x 3, then quarterly.<br><br>4) Neighbor #3 MDS/RAPs will be reviewed in depth with SW/IDT monthly x 3.<br><br>5) Date Certain will be 7/21/10. | 7/21/10 |

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| F 250 | Continued From page 5<br>o Finding options that most meet the physical and emotional needs of each resident;<br>o Providing alternatives to drug therapy or restraints by understanding and communicating to staff why residents act as they do, what they are attempting to communicate, and what needs the staff must meet;<br>o Finding options which most meet their physical and emotional needs.<br><br>Review of the Material Safety Data Sheet (MSDS) for the facility product Purell Instant Hand Sanitizer with Moisturers and Vitamin E occurred on 06/03/10. The MSDS, dated October 15, 2007, stated, ". . . Potential Health Effects . . . Ingestion: May cause upset stomach, nausea (Abnormal entry route). . . . FIRST AID MEASURES . . . Ingestion: Do not induce vomiting. Contact a physician or Poison Control Center. . . ."<br><br>- The facility failed to take a proactive approach to prevent Resident #3 from attempts of self-harm by ingesting alcohol based hand sanitizers/alcohol pads on four occasions (02/03/10; 02/07/10; 03/31/10, and 04/01/10); failed to complete behavior tracking to identify the precipitating factors, specific interventions and the resident's response to those interventions; failed to ensure the availability of outside resources to assist in this resident's complex mental health issues, and failed to assess, care plan, implement and evaluate Resident #3's behaviors of anxiety, ingestion of unsafe products, manipulative/attention getting behaviors, and sleeping problems.<br><br>Review of Resident #3's medical record occurred on all days of survey. Resident #3's admission occurred January 18, 2010. The resident's | F 250 | F-250<br>Alcohol issue --<br>1) Resident (neighbor) #3 care plan was revised 7/5/10 to address attempts of self harm with alcohol products in all areas of activity (i.e. clinic visits, passes, and in the facility). The care plan was placed in report book to be reviewed at all shift reports x 1 week to ensure staff are up-to-date with interventions.<br><br>2) All care plans will be reviewed by the IDT, updated, and interventions added if not on the current plan of care.<br><br>3) Alcohol based hand sanitizers/ alcohol pads are now locked in med cart or kept on person. Alert information is highlighted on referral sheets and clearly indicated on envelope with medical information for consultants to communicate to medical personnel neighbor #3's challenges with alcohol based products. Neighbor does not accompany activity staff on shopping trips without 1:1 observation.<br><br>4) Neighbor #3's care plan and neighbor preferences sheet will be reviewed in depth with the IDT monthly x 3 starting 7/5/10, then quarterly for next 9 months.<br><br>5) Date Certain will be 7/14/10. | 7/14/10 |

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| F 250 | Continued From page 6<br>admitting diagnoses included idiopathic normal pressure hydrocephalus, alcohol dependence, history of multiple addictions, mononeuritis (inflamed condition of a single nerve), anorexia nervosa, bulimia nervosa, personality disorder, anxiety, depression and obsessive-compulsive disorder.<br><br>Review of a clinic note, dated 01/12/10 (prior to the resident's admission), identified the above diagnoses and stated, ". . . possible nursing home placement. . . . She is suffering from neuropathy. She is in a wheelchair. She is incontinent. She is having issues with her bladder control. . . ."<br><br>Review of Resident #3's admission Minimum Data Set (MDS), dated 01/26/10, quarterly MDS, dated 02/09/10, and significant change MDS, dated 04/22/10, identified the resident with no long or short term memory problems, moderate impairment of daily decision making, and no difficulty understanding others or being understood. Each MDS identified Resident #3's "INDICATORS OF DEPRESSION, ANXIETY, SAD MOOD" included making negative statements, repetitive questions, persistent anger with self or others, repetitive anxious complaints/concerns, and insomnia. Each MDS identified these indicators not easily altered "by attempts to 'cheer up', console, or reassure the resident" during the previous seven day assessment period. The admission MDS identified the resident's change in mood had "Deteriorated" and the two subsequent MDS identified the resident's mood had not changed. The 04/22/10 MDS identified an onset of "Socially inappropriate/disruptive behavioral symptoms" not identified on the previous two MDSs. | F 250 | | |

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| F 250 | Continued From page 7<br>Review of Resident #3's Resident Assessment Protocol Summary (RAPS), for the 04/22/10 MDS, identified, although the resident triggered for cognitive loss, mood state, and behavioral symptoms, the facility failed to summarize and define whether this resident needed a referral and/or further evaluation by other health professionals. The Activities of Daily Living [ADL] /Functional Rehabilitation Potential RAPS stated, "Significant change MDS due to decline in several areas of ADLS, bowel incontinence and noted socially inappropriate behaviors, overall decline. . . . is alert and oriented . . . she is often not compliant and it is difficult to determine if her decline is related to her choosing not to comply and or do for herself, attention seeking, or an actual decline. . . . Multiple mood indicators and some behaviors present and they are not easily altered. Staff have actually seen neighbor place herself on the floor and then call out for help stating she fell. She has a HX [history] of Alcoholism and will drink anything with alcohol in such as hand sanitizer etc so staff have been informed to ensure she does not get a hold of any. She also can be physically and verbally aggressive toward her caregivers although she did not display any of these behaviors during this assessment period. . . ." The Psychosocial Well-Being RAPS, dated 04/21/10, stated, ". . . able to establish her own goals . . . does not go to as many out of room activities as she did in the past, but does enjoy staying in her room and watching TV. . . . She continues to seek attention through some behavioral episodes. . . ."<br><br>Review of Resident #3's current care plan, dated 01/18/10, identified the following problems:<br>* ". . . risk for skin breakdown . . ." with an approach including "2/16 Neighbor does use | F 250 | | |

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| F 250 | Continued From page 8<br>planned position changes for attention seeking behavior. 4/26 Staff have noted her to put her self on floor and then state she fell."<br>* ". . . risk for falls due to my weakened condition. . . ."<br>* "I like to be called [name preference] . . . 4-30-10 At this time I need lots of encouragement to come out of my room. I do like to watch TV and rest. . . . However do not give me alcohol. . . ."<br>The care plan did not include approaches for preventing the resident from obtaining alcohol in all areas of activity, i.e. clinic visits, passes, etc.<br>* "I am new to [facility], I live in . . . a private room per request. . . ." with approaches of not addressing the resident with terms of endearment, "Encourage visits with neighbors. . . . participation in activities . . . reminders/cues for meals, activities, and daily routine . . ."<br>* Effective 02/03/10: "Although my memory is good, I do not always make good decisions especially regarding my health . . ." with approaches including "Establish a daily routine . . . Repeat instructions several times prn [as needed] . . . Medication as ordered - and monitor for effectiveness . . . Use positive tones. Do not set negative limits."<br>* Effective 02/03/10: "I do get depressed. I am not afraid to tell you what I am feeling and when I am down. I am on medication and need you to monitor that I take it effectively. Please offer me reassurances/redirection. . . ." with approaches including "Validate neighbors feeling of depression, anxiety, sad mood; Acknowledge reality of situation as neighbor perceives it; Acknowledge feelings as expressed - use listening, reflection-refer to social worker for counseling; Encourage neighbor to participate in activities; Offer . . . simple choices-encourage decision making . . . Encourage neighbor to | F 250 | | |

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| F 250 | Continued From page 9<br>develop friendships with other neighbors; Medications as ordered . . . Approach neighbor in warm, friendly manner in calm low tones."<br><br>Review of a history and physical (H & P), dated 01/26/10, written by a practitioner, stated, ". . . currently at the . . . nursing home. . . . is very overwhelmed and apparently quite frustrated with the care she is receiving . . . . She is attempting to negotiate for other placement, other than being in the nursing home. . . . PLAN . . . We will obtain psychiatric testing. . . . Again this is somewhat concerning for possible malingering disorder. . . . She will be evaluated by [psychiatrist] . . . It is unsure if this will be short lived if patient does not get her way . . ."<br><br>A second H & P report, dated 01/26/10, written by a psychiatrist, identified the resident was transferred from the facility to the local hospital within her first 10 days at the facility and then to an inpatient psychiatric unit. The history presented stated, ". . . was at the nursing home and she started complaining of depression and anxiety and being at the end of her rope. She was working on ways to kill herself. She did not have a plan. . . . She has essentially lost her life and misses her activity level. . . . She also is having difficulty tolerating the stressors at the nursing home because socially she feels isolated there. PAST PSYCHIATRIC HISTORY: She had 10 suicidal gestures in her life and she had 1 attempt and that was with pills. . . . PAST MEDICAL HISTORY . . . history of 1. Eating disorder . . . 2. Sleeping disorder . . . SOCIAL HISTORY . . . She states most of her family wants her tucked away and out of sight. . . MENTAL STATUS EXAMINATION . . . Her mood is 'it has been real bad for a long time.' Affect is despondent . . . She | F 250 | F-250<br>Suicidal Ideation<br>1) Neighbor #3's care plan was updated to include threats of intention to do self harm.<br><br>2) All neighbors will have Cornell Depression Scale or Geriatric Depression Scale completed on admission, annually and with any significant change MDS. Any neighbor with self harm or suicidal ideation will have depression scale completed and physician notification. Care plans will be initiated and updated dependent on findings. All staff have completed "Preventing Suicide" Silverchair training and are aware of what to look for, report and appropriate interventions to initiate in event any neighbors, including Neighbor #3, would present with suicidal signs or symptoms. (Refer to F224 to behavioral tracking and trending profile)<br><br>3) IDT to review care plan monthly x 3, then quarterly thereafter.<br><br>4) ) RN neighborhood coordinator will review consultation reports and Spiritual Care Director notes weekly x 4, and monthly thereafter to monitor for changes in behaviors.<br><br>5) Date Certain will be 7/21/10 | 7/21/10 |

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| F 250 | Continued From page 10<br>also stated she had no suicidal ideation at the current time. . . . Review of symptoms shows her sleeping 'not good.' . . . She feels worthless, hopeless, and helpless and these have been long-standing. She feels guilty. Her self-esteem is very poor. . . . DIAGNOSTIC IMPRESSION . . . Major depression, recurrent . . . Anxiety disorder . . . Psychosocial Stressors: Severe. The patient has problems related to primary support network. . . . She also does not relate well to the patients at the nursing home, who are much older than she is. . . . She has economic problems. . . . ASSESSMENT . . . comes to the clinic with 2 weeks of worsening behaviors, some of this is due to her declining medical situation. . . . It is the feeling of the examiner that this patient has multiple diagnoses. She has an anxiety diagnoses, a mood diagnosis . . . PLAN: The patient is on many medications so we have to exercise caution with the choice of medications. . . . The patient is not drinking now. . . . because she is not drinking, 1 mg [milligram] of Klonopin [Clonazepam] [anticonvulsant, also used for panic disorders, and neuralgias] a day will not hurt her. Extreme caution has to be exercised with the choice of a mood stabilizer. . . ." On 01/27/10, the psychiatrist dictated, ". . . The patient states . . . she would like a sleeping pill. PLAN . . . We will triage for a sleeping pill, perhaps we will try doxepin [Sinequan - an antidepressant] at a low dose. . . ."<br><br>A physician progress note, dated 02/04/10, stated, ". . . seen today for evaluation. . . . is going to be started on her Antibuse [sic] [an adjunct to management of alcohol abstinence]. She did drink one container of hand sanitizer yesterday. Her Antibuse [sic] had been discontinued a few weeks ago. . . ." | F 250 | F-250<br>Insomnia<br>1) Neighbor #3 care plan reviewed and updated to include sleep concerns. Sleep monitor study to be completed x 1 week to analyze sleep patterns. Insomnia event and sleep assessment to be completed in Matrix system.<br><br>2) Insomnia event and sleep assessment to be completed in Matrix prior to introduction of medication as sleep aid or prior to dosage changes. Sleep monitor study will be completed x 1 week for all neighbors before introduction or change in medications for insomnia<br><br>3) ) IDT will review neighbor #3's care plans to ensure that all needed revisions occur monthly x 3, then quarterly. Nursing staff educated regarding sleep log and policy and procedure per Just In Time Training. (See attached sleep log and sleep measures p/p)<br><br>4) ) RN neighborhood coordinator will review consultation reports and Spiritual Care Director notes weekly x 4, and monthly thereafter to monitor for changes in sleep pattern.<br><br>5) Date Certain will be 7/21/10 | 7/21/10 |

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| F 250 | Continued From page 11 | F 250 | | |

A psychiatric evaluation, dated 02/05/10, stated, ". . . Most recently she has been reprimanded for procuring hand sanitizer from the nurses and drinking it under the guise that she was trying to keep her self sanitary so she wouldn't get any more infections. She was then placed on Clonazepam because of her anxiety and says that it is working but certainly not taking care of the anxious problems she continues to have, and she calls 'panic attacks' where she thinks she's going to go out of her mind and do something to herself. PAST MEDICAL HISTORY: She has overdosed on Clonazepam, Lorazepam [anti-anxiety medication] and Trazodone in the past [anti-depressant] . . . This is a very complicated psychiatric case. . . . She is very manipulative but capable and has seemed to resigned [sic] herself to be helpless all of her life. . . We'll increase her Clonazepam to 0.5 mg [milligrams] TID [three times a day] with a prn [as needed] [every] 12 hrs [hours] prn. . . . Suggestion we have a psychotherapist visit with her, someone who feels fairly comfortable working with borderlines. . . ."

A physician progress note, dated 04/19/10, stated, ". . . she has since had a relapse in her drinking, which had her evaluated in the emergency department because of unresponsiveness secondary to drinking hand sanitizer. . . ."

Review of Resident #3's progress notes, written by various disciplines, stated the following:
* 01/26/10 at 8:21 a.m. [Activities]: "[Resident] reported to therapist this morning that she if [sic] feeling really depressed. On a scale of 1-10 she stated that she is a 9. She is requesting to see someone for her depression. I will contact the nsg

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| F 250 | Continued From page 12<br>[nursing] staff to set something up." An activities staff member entered this progress note.<br>* 01/26/10 at 11:00 a.m.[Nursing]: ". . . Pastoral care was asked to visit with her. Neighbor did express suicidal thoughts to pastoral care. Both the DON [Director of Nurses] and myself also visited with neighbor and she expressed suicidal thoughts with a plan to either cut herself (she said she did have a razor in her room) or to wheel herself out into the street into traffic. Neighbor was further questioned and she did at one point say that she was crying out for help but that she doesn't want to feel like this anymore and that she was increasingly hopeless and helpless [sic]. She informed staff that she used to be on Klonopin and that was 'the only thing that helped' her anxiety. Informed her that she had Hydroxyzine [anti-anxiety drug] prn but neighbor stated that was worthless. . . ."<br>* 01/26/10 at 12:20 p.m. [Nursing]: ". . . left per w/c [wheelchair] by facility driver to [facility name] ER [emergency room] for psych [psychiatric hospital] admission."<br>* 02/01/10 at 11:33 a.m. [Nursing]: "Neighbor has been c/o [complaining of] anxiety attacks and wanted staff to call doctor and get her a prescription for ativan [anti-anxiety drug]. Called [local physician] and he would not give her an order . . . neighbor . . . was very upset. She walked away from me and would not talk to me."<br>* 02/03/10 at 11:28 a.m. [Nursing]: ". . . was admitted to [psychiatric hospital] on 1/26 due to increased behaviors. . . ." At 2:35 p.m.: "[Resident] was caught drinking a 1/2 bottle of hand sanitizer. . . . Poison control center was called and active ingredient is ethyl alcohol and won,t [sic] harm her but will need to be seen for psych problems." At 3:00 p.m.: "Met with [resident] who admits to consuming 1/2 bottle | F 250 | F-250<br>Supportive Consultation<br>1) Neighbor #3 received consultation from Dr. Bell prior to survey date and follow up on 7/2/10. Spiritual Care Director is providing 1:1 supportive visits 3x/wk.<br><br>2) Monthly in-house visits by Dr. Bell provided for all neighbors as needed. Registered nurse schedules consultation services on monthly visit by physician.<br><br>3) In-house consultation scheduled on as-needed basis.<br><br>4) RN neighborhood coordinator will review consultation reports and Spiritual Care Director notes weekly x 4, and monthly thereafter to monitor for changes in behaviors.<br><br>5) Date Certain will be 7/14/10. | 7/14/10 |

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| F 250 | Continued From page 13<br>hand sanitizer. She states she is miserable and needed 'relief'. Discussed at length her request for clonopin [sic], she became very agitated during discussion, and hit this writer across rt [right] jaw with closed fist. She was told that her behavior was completely inappropriate and not acceptable." At 3:19 p.m.: "Call placed to [psych hospital] and talked with SW [social worker] who connected me with [resident's inpatient psychiatrist]. Discussed at length situation . . . and neighbor requested to be continued on the Clonazepam [Klonopin]. He did consent after about 20 min [minute] conversation to order the clonazepam as she had received in the hospital, until 2/5/10 when neighbor can be evaluated by [facility consulting psychiatrist]."<br>* 02/04/10 at 12:10 p.m. [Nursing]: "No problems noted from drinking hand sanitizer. . . . left for her appt [appointment] in Bismarck with [physician's name] accompanied by staff and per van. . . ."<br>* 02/05/10 at 1:12 a.m.: "No ill effects from drinking hand sanitizer. All products containing alcohol are kept locked up."<br>* 02/07/10 at 8:26 a.m. [Nursing]: "Neighbor was very out of it this morning, not making any sense. Staff went in her room and found several products containing alcohol in them. All products were removed from her room and locked up. Questioned neighbor about consuming any alcohol and she denied taking any. [DON] was made aware of the situation." At 11:29 a.m. [Nursing]: "Neighbor was going into the den and became unsteady on her feet claiming to have an anxiety attack. She was assisted to the den by staff. Neighbor was requesting that she needed medication for anxiety. Currently neighbor is on clonazepam."<br>* 02/11/10: "SS [social services] Admission MDS completed. [Resident] came to live with us from | F 250 | | |

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| F 250 | Continued From page 14<br>assisted living . . . no memory impairment . . . Indicators of depression, anxiety, sad mood e/b [evidenced by]: neighbor makes negative statements . . . repetitive anxious concerns, insomnia/change in usual sleep patterns. Indicators present are not easily altered. . . ."<br>* 02/17/10 at 12:28 p.m. [Nursing]: ". . . Neighbor was in bingo . . . requesting bingo to be stopped to serve coffee. Staff in attendance watched her put herself on the floor, and neighbor was upset that bingo was not put on hold while she was getting up. Neighbor will be planned position change for attention seeking behaviors."<br>* 02/21/10 at 4:19 a.m. [Nursing]: "[Resident] c/o of instability while standing or ambulating . . . She would like a foley [sic] catheter inserted . . . She states she has a bladder infection and urinated on the floor of her room stating that was the cause and to make her point. She was standing in her room without difficulty and was well balanced. . . ."<br>* 03/03/10 at 1:11 p.m. [Nursings]: ". . . continues on antabuse and sees [physician's name] for psych issues."<br>* 03/11/10 at 12:55 p.m. [Nursing]: "Neighbor seen by [local physician] regarding c/o not sleeping well. Orders received to d/c [discontinue] Ambien [sleeping pill] and start Lunesta [sleeping pill]. . . . Neighbor has increased balance problems that may be due to her hydrocephalus. . . ."<br>* 03/19/10 at 2:44 p.m. [Nursing]: "Neighbor was seen by staff trying to open east medcart. When asked what she was doing, she stated 'she needed some alcohol pads.' Staff notified nurse, and nurse informed neighbor she could not give her any alcohol pads. Neighbor became up set [sic] and went to her room."<br>* 03/30/10 at 9:34 a.m.: "Neighbor out on pass | F 250 | | |

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| F 250 | Continued From page 15<br>with Activities on shopping trip . . . Left at 0900 [9 a.m.]." At 3:45 p.m., the neighbor returned from the shopping trip.<br>* 03/31/10 at 9:36 a.m. [Nursing]: "Neighbor seen by staff putting hand sanitizer in mouth. Not our brand of sanitizer, neighbor went out shopping on 3-30-10. Nursing staff discussed issue with neighbor. Neighbor stated it was an impulse buy." At 4:48 p.m.: "Neighbor was very down today. states life not worth living. admits [sic] to licking hands with hand sanitizer, and also bought some 'chewing tobacco' yesterday and ate some of that in attempt to 'make me sick'. She admits she is not 'serious' about harming herself just wanting 'attention'. we [sic] did have long discussion about getting 'positive' attention, and she was told to just say to the girls. I am lonely or feeling blue, can you visit with me for awhile. Denies any suicidal thoughts."<br>* 04/01/10 at 1:38 p.m. [Nursing]: "Neighbor left for appointment in Bismarck . . . via van and BLC [Benedictine Living Center] staff." At 2:17 p.m.: "Nurse from Human Performance Center called and stated that [resident] asked for hand sanitizer and she gave her a bottle. Fifteen minutes later she asked for more hand sanitizer and the nurse squirt some on her hands. [Resident] licked the sanitizer off of her hands. [Resident] is now lethargic and they are sending her over to the ER room . . ." At 4:37 p.m.: ". . . nurse called . . . stated labs were done and [resident] had a small amount of alcohol in her system but everything else checked out normal and she will be coming back in the next two hours."<br>* 04/27/10 at 2:55 p.m. [Activities]: ". . . At times when attending activities she does display attention seeking behaviors. . . ." At 4:41 p.m.: "1st Quarter social services assessment. No significant changes have been noted this review | F 250 | | |

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period. . . . continues to exhibit the following behaviors; negative statements . . . repetitive questions, persistent anger with self and others, unrealistic fears, repetitive health complaints, insomnia/change in sleep . . . withdrawal from activities . . . She exhibited repetitive anxious complaints almost daily. She does state that she wants to go home but no discharge plans are planned at this time."
* 05/07/10 at 12:08 p.m. [Nursing]: "Scheduled for a psych f/u [follow-up] today but was not seen as she was at an appt . . . Will add her to next month's list."

On 06/03/10 at 8:00 a.m., an administrative staff nurse (#4) provided the following information in an interview:
* Facility staff "search her [Resident #3's] room constantly"
* Facility staff did not know how Resident #3 obtained the hand sanitizer on the 03/30/10 shopping pass as she was supervised by a volunteer. The staff member stated the resident is no longer offered to go on outings because of this event. The staff member stated family members and the resident's visitors know not to bring her hand sanitizer.
* On April 1, 2010, a facility staff member reported to the receptionist at the clinic Resident #3 was not to have hand sanitizer, and this communication did not get relayed to the nurse, resulting in the resident obtaining the hand sanitizer and going to the ER. The facility has since added this to each clinic referral form. Review of the April 1, 2010, referral form, however, lacked this written notation.
* Provided a copy of "Just In Time Training," dated 02/03/10, to staff members which stated, "We need to keep all alcohol containing products

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| F 250 | Continued From page 17<br>off of the Prairie Rose & Dakotah [sic] med carts. We have a neighbor actively seeking alcohol and who is willing to & has recently drank hand sanitizer. Keep your hand sanitizer in your pocket. The red tub of wipes for the glucometers are in the bottom drawers of the med carts . . . If you see hand sanitizer out in the open, pick it up & put it in a secure place!"<br><br>Resident #3's record review identified the resident's physician ordered Ambien Controlled Release (extended release) 12.5 milligrams, a sleeping pill, on an as needed basis, for the resident on admission. Six days later, the physician changed the order to daily at bedtime. On 03/11/10, the physician discontinued the Ambien and ordered Lunesta (a sleeping pill) 2 mg at bedtime for the resident. On the morning of 06/03/10, a supervisory staff nurse (#15) stated resident's sleeping problems are addressed by informing the physician/provider so they can prescribe them "something." The staff nurse stated the facility did not have a system to assess resident's sleeping problems or implement measures to address these problems. On the afternoon of 06/03/10, an administrative staff member (#4) stated she was not aware why Resident #3 was put on the Ambien; said it was changed from prn to scheduled due to her using it daily; and changed to Lunesta because the Ambien wasn't working. She referred to the 03/11/10 progress notes.<br><br>On 06/03/10 at 9:40 a.m., two administrative staff members (#1 and #4) stated the licensed social worker was responsible for completing Resident #3's cognitive loss, mood state, and behavioral symptoms RAPS in April, and was not completing this duty and other duties and that was the reason | F 250 | | |

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| F 250 | Continued From page 18<br>the facility is currently seeking a different social worker.<br><br>In an interview with an administrative staff nurse (#4) on the afternoon of 06/03/10, the nurse stated Resident #3 has never seen a psychotherapist, as suggested by the psychiatrist on her 02/05/10 evaluation, as the facility does not have a psychotherapist available. The nurse stated she had been given permission to have pastoral care see the resident, however this did not occur. The staff nurse also stated, when asked, no one from Alcoholics Anonymous (AA) has seen Resident #3. | F 250 | | |
| F 279 SS=E | 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS<br><br>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.<br><br>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.<br><br>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). | F 279 | F-279<br><br>1) Resident #13 is no longer in the facility. Resident #3, #5, and #6 care plans were reviewed and updated as appropriate.<br><br>2) All care plans will be reviewed by the Interdisciplinary team and updated. Interventions currently in place will be added if not on the current plan of care.<br><br>3) All neighbor care plans and neighbor preference sheets will be reviewed in depth with the IDT. Thereafter, all neighbor care plans will be reviewed monthly x 2 per IDT. Starting 10/10 IDT will review 2 random care plans per month in conjunction with the MDS schedule. Staff will review care plan monthly as per schedule at all shift reports. Staff educated per Just In Time related to policy on updating care plans. (See attachment Care Plan Change & Update)<br><br>4) Beginning 10/10 two random care plans will be audited for accuracy and appropriate interventions by DON. August and September review will be initialed by each IDT member as reviewed and appropriate.<br><br>5) Date certain will be 7/21/10. | 7/21/10 |

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| F 279 | Continued From page 19<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, review of facility policy, and staff interview, the facility failed to develop and/or review and revise the residents' comprehensive plan of care to address specific problems identified for 3 of 12 sampled residents (Resident #3, #5, and #6), and one closed record (Resident #13). Failure to develop, review and revise the residents' care plans limits the staff's ability to communicate changes in the residents' status and care, and to ensure continuity of resident care.<br><br>Findings include:<br><br>Review of a facility policy titled INTERDISCIPLINARY CARE PLAN AND CONFERENCE occurred on 06/03/10. The policy, undated, stated, "The purpose of the Interdisciplinary Care Planning Conference is to initiate, develop, review and update the Care Plan for each resident through a collaborative effort. PROCEDURE: 1. Members of the Care Plan team should include: Nursing . . . Social Services . . . 3. Functions and Responsibilities of the Care Plan Team . . . Complete prior to Care Conference, written assessment and evaluation of each resident to be reviewed. Collaborate with the other members to initiate, develop, review and update each resident's individualized Care Plan . . . 4. . . . at a minimum . . . the following areas are addressed . . . Overall physical status . . . Activity participation. Socialization and Psychosocial skills. . . . Discharge status . . ."<br><br>- Review of Resident #3's medical record occurred on all days of survey. Resident #3's admission occurred January 18, 2010. The | F 279 | | |

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| F 279 | Continued From page 20<br>resident's admitting diagnoses included idiopathic normal pressure hydrocephalus, alcohol dependence, history of multiple addictions, mononeuritis (inflamed condition of a single nerve), anorexia nervosa, bulimia nervosa, personality disorder, anxiety, depression and obsessive-compulsive disorders.<br><br>Review of Resident #3's current care plan identified the following problems, dated 01/18/10:<br>* ". . . risk for skin breakdown . . ." with an approach including "2/16 Neighbor does use planned position changes for attention seeking behavior. 4/26 Staff have noted her to put her self on floor and then state she fell."<br>* ". . . risk for falls due to my weakened condition. . . ."<br>* "I like to be called [name preference] . . . 4-30-10 At this time I need lots of encouragement to come out of my room. I do like to watch TV and rest. . . . However do not give me alcohol. . . ."<br>* "I am new to [facility], I live in . . . a private room per request. . . ." with approaches of not addressing the resident with terms of endearment, "Encourage visits with neighbors. . . . participation in activities . . . reminders/cues for meals, activities, and daily routine . . ."<br>* Effective 02/03/10: "Although my memory is good, I do not always make good decisions especially regarding my health . . ." with approaches including "Establish a daily routine . . . Repeat instructions several times prn [as needed]. . . Medication as ordered - and monitor for effectiveness . . . Use positive tones. Do not set negative limits."<br>* Effective 02/03/10: "I do get depressed. I am not afraid to tell you what I am feeling and when I am down. I am on medication and need you to monitor that I take it effectively. Please offer me | F 279 | | |

| ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| **3ENEDICTINE LIVING CENTER OF GARRISON** | **609 4TH AVE NE GARRISON, ND 58540** |

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| F 279 | Continued From page 21<br>reassurances/redirection. . . ." with approaches including "Validate neighbors feeling of depression, anxiety, sad mood; Acknowledge reality of situation as neighbor perceives it; Acknowledge feelings as expressed - use listening, reflection-refer to social worker for counseling; Encourage neighbor to participate in activities; Offer . . . simple choices-encourage decision making . . . Encourage neighbor to develop friendships with other neighbors; Medications as ordered . . . Approach neighbor in warm, friendly manner in calm low tones."<br><br>Resident #3's care plan failed to address the following problems and/or approaches:<br>* The problem and approaches to address the resident's suicidal history/tendencies, including accessing and ingestion of alcohol based hand sanitizer, which occurred on four occasions (02/03/10; 02/07/10; 03/31/10, and 04/01/10). Record review identified the resident accessed hand sanitizer within the facility on two occasions, while on pass with a volunteer, and when taken to an appointment accompanied by a staff member.<br>* The resident's behaviors, including attempts of self-harm, including ingestion of hand sanitizer, potential intentional falls, daily feelings of anxiety, manipulative/attention seeking behaviors, and other indicators of depression, anxiety and sadness.<br>* The resident's sleep disorder, and attempts to improve the resident's sleeping patterns without medication management, which has the potential to further contribute to the resident's fall risk, falls and subsequent injury.<br>* The resident's problem/need for available outside resources to address her complex mental health issues as addressed by her psychiatrist. Refer to F 250. | F 279 | | |

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| F 279 | Continued From page 22<br><br>On 06/03/10 at 11:45 a.m., an administrative staff nurse (#4) stated staff should make care plan entries, including problems identified and approaches, when the problem is identified.<br><br>- Resident #5's medical record, reviewed June 1-3, 2010, identified the facility admitted the resident on 04/28/08 and transferred the resident to the Sunflower unit in May of 2008. The resident's current diagnoses include persistent mental disorder. The resident's current Minimum Data Set (MDS), dated 04/18/10, identified Resident #5 exhibits wandering daily; socially inappropriate/disruptive behavioral symptoms, one to three times in the last seven days, both not easily altered; resistive to care, one to three times in the last seven days, easily altered; and a resident of an Alzheimer's or dementia special care unit.<br><br>Resident #5's medical record identified the resident exiting the unit on four different occasions on the following dates: 08/26/09; 09/02/09; 05/16/10; and 05/24/10. Refer to F 323.<br><br>Review of Resident #5's current care plan identified the problem "Risk for elopement [related to] [history] of actual elopement, attempts to go outside looking for his car, repetitive verbalizations about going home and impaired cognitive status," with approaches of Resident #5 utilized a wanderguard bracelet, staff check the function of the wanderguard bracelet each shift, and if the resident refuses to wear the wanderguard bracelet staff are to check on Resident #5 every fifteen minutes. This care plan also identified if staff cannot account for the resident, the charge nurse is to implement the | F 279 | | |

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| F 279 | Continued From page 23<br>missing resident protocol, and Resident #5 resided on the Sunflower unit.<br><br>The care plan failed to address Resident #5's elopement out a window and an outside door within the secured unit.<br><br>- Resident #6's medical record, reviewed June 1-3, 2010, identified the facility admitted the resident to the Sunflower unit on September 2008. The resident's current diagnoses include Alzheimer's disease, persistent mental disorder-terminal dementia, senile dementia with depression and dementia with behavioral disturbances. The resident's current MDS, dated 04/14/10, identified Resident #6 exhibited wandering and socially inappropriate/disruptive behavioral symptoms daily, verbally abusive behavioral symptoms, physically abusive behavioral symptoms, and resistive to care, one to three times in the last seven days, all three not easily altered, and a resident of an Alzheimer's or dementia special care unit.<br><br>Resident #6's medical record identified wandering and physically aggressive behaviors with other residents on: 07/08/09; 12/23/09; 12/27/09; 01/22/10 and 06/02/10. Refer to F 224.<br><br>Review of Resident #6's current care plan addressed the problem of "Neighbor is at risk/potential for behavioral symptoms. Indicators vary based on mood and are not always easily altered," failed to identify Resident #6's behavioral symptoms included physical altercations with other residents. The "Personal Preferences" sheet for Resident #6 identified "I get upset when peers yell a lot." | F 279 | | |

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| F 279 | Continued From page 24<br>During an interview, on 06/03/10 at 11:50 a.m., with three administrative staff members (#1, #4, and #5), a staff member (#5) identified the facility had not completed an elopement risk assessment for Resident #5. An administrative staff member (#4) stated staff removed the cranks off the window the resident exited, as well as his room, after the May elopement incident; and placed a movable screen in front of the glass door Resident #6 eloped from in May. The two staff members (#4 and #5) identified the care plan lacked those interventions implemented. These staff members (#1, #4, and #5) identified when a resident can be physically aggressive to another resident, the care plan should identify the possibility of potential/actual physical aggression from the resident.<br><br>Failing to implement measures, and care plan those measures, does not ensure consistency in the care provided for residents.<br><br>- Review of Resident #13's closed medical record, on 06/03/10, identified the facility admitted the resident on 06/08/09 and discharged the resident on 12/21/09. Admission diagnoses included persistent mental disorder and hypotension. Resident #13's Minimum Data Set (MDS), dated 12/01/09, identified persistent anger with others, expressions of unrealistic fears, and wandering daily, which was not easily altered.<br><br>Resident #13's medical record identified the following:<br>*07/05/09 - The resident left the facility unattended, the door alarm sounded, and the staff assisted the resident to return to the facility.<br>*07/08/09 - The resident left the facility unattended, the door alarm sounded, and the | F 279 | | |

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| F 279 | Continued From page 25<br>staff assisted the resident to return to the facility.<br>*08/21/09 - The resident became unresponsive, remained unresponsive, and the local ambulance service transported the resident to the local hospital emergency department. The resident returned to the facility that day with a diagnosis of possible narcolepsy and physician orders for Depakote 250 milligrams, each day. Depakote is an anticonvulsant medication.<br>*10/04/09 - The resident entered Resident #2's room, uninvited. Resident #2 attempted to get Resident #13 to leave her room. Resident #13 pushed Resident #2 who fell and experienced a fracture of the upper extremity. The facility staff contacted Resident #13's family and physician and received consent and orders for admission to the facility's secured unit.<br><br>Review of Resident #13's Resident Assessment Protocol Summary (RAPS) written after the above incidents, dated 12/02/09, failed to identify the incidents of leaving the facility unattended; failed to identify the incidents of unresponsiveness and potential diagnosis of narcolepsy; and, failed to identify the incident of aggression towards Resident #2 which resulted in injury to Resident #2, and Resident #13's admission to the secured unit.<br><br>Review of Resident #13's care plan, dated 12/02/09, identified the use of a wanderguard but failed to identify other interventions or approaches implemented to ensure the resident did not leave the facility unattended. The resident's care plan failed to identify Resident #13's unresponsive episodes and approaches or interventions by staff regarding these episodes. The resident's care plan failed to identify Resident #13's aggression towards other residents and approaches or | F 279 | | |

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| F 279 | Continued From page 26<br>interventions by staff regarding this behavior.<br><br>During interview, on 06/03/10 at 10:00 a.m., an administrative staff member (#1) reported, after the episodes of 07/05/09 and 07/08/09, the staff began escorting Resident #13 on walks out of the facility. Resident #13's RAPS and care plan failed to identify this intervention.<br><br>The facility staff identified Resident #13's behaviors and wandering on the MDS and in the medical record. The facility staff provided interventions of emergency care, medication, and escorted walks. Failure to include these changes in the resident's care plan limited the continuity of care by the facility staff and may have limited the consistent use of interventions for the resident's behaviors. Lack of consistent interventions may have contributed to the incident between Resident #13 and Resident #2 resulting in injury to Resident #2 and Resident #13's admission to the secured unit. | F 279 | | |
| F 323 SS=E | 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br><br>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>This REQUIREMENT is not met as evidenced by:<br>1. Based on record review and staff interview, the facility failed to provide supervision, assistance, or implement necessary interventions to prevent | F 323 | F-323<br>1) Section 1 – Resident #5 care plan was revised and elopement risk completed.<br>Section 2 – During survey period when lack of gait belt was noted the two staff members were counseled and "just in time" training was initiated.<br>Section 3 – Knife was removed and locked up during survey process.<br><br>2) Section 1 – All current neighbors were assessed for elopement risk. All new neighbors will be assessed at time of admission for risk of elopement. Risk of elopement will be reviewed for all neighbors quarterly.<br>Section 2 – All residents could potentially be affected by lack of gait belt usage.<br>Section 3 – Knife has been locked up, and cupboards searched again for sharps and other hazardous materials. | |

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| F 323 | Continued From page 27<br>elopement of 1 of 2 sampled residents (Resident #5) who left the facility unattended. Failure to assess elopement risk and implement interventions to prevent elopement has the potential to cause physical and/or psychosocial harm to residents leaving the facility without supervision.<br><br>Findings include:<br><br>- Resident #5's medical record, reviewed June 1-3, 2010, identified the facility admitted the resident on 04/28/08 and transferred the resident to the Sunflower unit (special care unit) in May, 2008. The resident's current diagnoses included persistent mental disorder. The resident's current Minimum Data Set (MDS), dated 04/18/10, identified Resident #5 has long and short-term memory problems. The MDS identified the resident exhibited wandering daily; socially inappropriate/disruptive behavioral symptoms one to three times in the last seven days, both not easily altered; resisted care one to three times in the last seven days, easily altered; and resided on an Alzheimer's or dementia special care unit.<br><br>Resident #5's medical record identified the following:<br>* 08/26/09 - The resident left the facility unattended from an outside door on the Sunflower unit. The door alarm sounded and staff assisted the resident back into the facility.<br>* 09/02/09 - The resident left the Sunflower unit unattended going into another area of the facility. The door alarm sounded and staff assisted the resident back into the Sunflower unit.<br>* 05/16/10 - Staff observed the resident go into another resident's room, when Resident #5 did not come out of the room staff investigated. Staff | F 323 | 3) Section1 – IDT will review elopement assessments and care planning on 7/7/10. Staff will receive elopement training through Silverchair module by 7/14/10. Care plans will be initiated or updated with elopement event.<br>Section 2 – All nursing staff were assigned the "Resident Lifting and Transfers" Silverchair module related to proper transfer techniques. Staff reeducation was done during survey process at all change of shift. This involved "Just in Time" training with review of policy and procedure for transfers.<br>Section 3 – Staff inserviced via Just in Time training related to proper storage of sharps and other hazardous materials to be followed throughout entire home.<br><br>4) QA will be performed by DON related to elopement assessment being completed with initiation of all wanderguards, with discontinuation of current wanderguards and also all new neighbors x 6 months. Starting January 2011 a random audit of 2 neighbors per month will be completed. QA will be performed by RN related to transfer techniques. Neighbor #3 will be included in the monthly QA. | |

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| F 323 | Continued From page 28<br>identified Resident #5 had opened the window, pushed out the screen and climbed out a window on the Sunflower unit. Staff found the resident approximately three blocks from the facility and had difficulty redirecting him back to the facility. Resident #5's wanderguard was in place but did not sound as he went out a window and not an alarmed door.<br>* 05/24/10 - The resident left the facility unattended from an outside door on the Sunflower unit. The door alarm sounded and staff assisted the resident back into the facility.<br><br>The record identified no evidence of assessment of Resident #5's elopement risk, i.e. patterns/trends, behavior prior to leaving/attempting to leave, etc.<br><br>Review of Resident #5's current care plan identified the problem, "Risk for elopement [related to] [history] of actual elopement, attempts to go outside looking for his car, repetitive verbalizations about going home and impaired cognitive status." Approaches for this problem include a wanderguard bracelet, staff check the function of the wanderguard bracelet each shift, and if the resident refuses to wear the wanderguard bracelet staff are to check on Resident #5 every fifteen minutes. Another intervention is if staff cannot account for the resident, the charge nurse is to implement the missing resident protocol; and the resident resided in the special care unit. The care plan failed to address Resident #5's most recent elopements on 05/16/10 and 05/24/10. The plan of care included no approaches regarding monitoring the effectiveness of approaches, nor did the plan of care include specific individualized approaches based upon an assessment of | F 323 | QA will be performed by Sunflower neighborhood coordinator weekly in secure (Sunflower) neighborhood and all other neighborhoods to ensure compliance with sign off sheet through December, 2010 and then 2x/month thereafter.<br><br>5) Date Certain will be 7/21/10. | 7/21/10 |

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| F 323 | Continued From page 29<br>Resident #5's elopement risk.<br><br>During an interview, on 06/03/10 at 11:50 a.m., with three administrative staff members (#1, #4, and #5), a staff member (#5) identified the facility had not completed an elopement risk assessment for Resident #5. The two staff members (#4 and #5) indicated the care plan lacked the approach of removing the cranks off the windows and a movable screen in front of the glass door the resident eloped from.<br><br>2. Based on observation, record review, review of facility policy, and staff interview, the facility failed to ensure 1 of 4 sampled residents (Resident #3) who required transferring assistance with a gait belt, received adequate and appropriate assistance for the prevention of falls. This placed Resident #3 at risk for an accident and subsequent injury.<br><br>Findings include:<br><br>Review of the facility policy titled "TRANSFER BELT USE" occurred on 06/03/10. The policy, dated December 2002, stated:<br>"PURPOSE: The purpose of the transfer belt (gait) is to provide support to Neighbors who may be unsteady on their feet. The belt will protect the Neighbor should they become weak or lose their balance when ambulating or transferring.<br>POLICY: Nursing Staff will use a transfer belt when ambulating or transferring a Neighbor.<br>PROCEDURE;<br>1. Review care plan/assignment sheet for Neighbor ambulation status. . . .<br>6. Grasp transfer belt at Neighbor's side using an underhand grasp. . . .<br>8. Allow Neighbor to get and maintain standing | F 323 | | |

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| F 323 | Continued From page 30 | F 323 | | |

balance. Observe for dizziness or weakness. . . .
9. Grasp transfer belt at Neighbor's back and walk at side of Neighbor, supporting hand and arm if necessary. . . ."

Review of a facility assessment process for the "Tinetti Assessment Tool: Description" occurred on 06/03/10. The description (undated), stated, ". . . Description: The Tinetti Assessment Tool is a simple, easily administered test that measures a patient's gait and balance. The test is scored on the patient's ability to perform specific tasks. . . . Scoring: Scoring of the Tinetti Assessment Tool is done on a three point ordinal scale with a range of 0 to 2. A score of 0 represents the most impairment, while a 2 would represent independence of the patient. The individual scores are then combined to form three measures . . . an overall balance assessment score . . . Interpretation: . . . The maximum score for the balance component is 16 points. . . . In general, patients who score below 19 are at a high risk for fall. . . ."

- Review of Resident #3's medical record occurred on all days of survey. Resident #3's admission occurred in January of 2010. The resident's admitting diagnoses included idiopathic normal pressure hydrocephalus, alcohol dependence, history of multiple addictions, mononeuritis (inflamed condition of a single nerve), anorexia nervosa, bulimia nervosa, personality disorder, anxiety, depression and obsessive-compulsive disorders.

Resident #3's care plan identified the following problem and approaches:
"I am at risk for falls due to my weakened condition. I have fallen in past prior to coming

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| F 323 | Continued From page 31<br>here to live" with approaches including ". . . Monitor resident's ability to ambulate/transfer and provide assistance as needed. Monitor resident's steadiness and balance and report changes. . . ." The resident's current "I" care plan stated, "Personal Preferences . . . I need help [with] transfer to toilet . . . I do need help to move from one surface to another at times. Please help me by: assist [one] . . . I am unsteady on my feet. Please help me by: I use w/c [wheelchair] due to my weakened condition. I am able to stand [with] assist if I have a bar to hold on to. . . . I am not able to walk without problems. Please help me by . . . ambulates [with] assist [one]. uses w/c also . . . I need assist to sit up and lay down. . . ."<br><br>Additional record review included a:<br>* Tinetti Assessment Tool for Balance, dated 04/28/10, which identified Resident #3's overall balance score of 2 which included testing of "The following maneuvers:" unable to arise without help; "Immediate standing balance (first 5 seconds)" as "Unsteady (swaggers, moves feet, trunk sway);" "Standing Balance: Unsteady . . ."<br>* Physical Therapy Progress Report, dated 05/19/10, which stated, ". . . Transfers: General . . . Patient needs moderate assist of 1 for all transfers for safety purposes. . . . Transfers: Sit to Stand . . . The patient requires mod [moderate] assist from sit to stand. Continues to go into excessive extension when first standing. Once she has adjusted to a neutral standing posture she only needs min [minimal] assist of 1 with use of FWW [front wheeled walker] for stabilization. . . . Precautions: Balance is decreased and is a great fall risk. Staff should assist with all transfers, W/C [wheelchair] for mobility at this time. . . . Caregiver Education: Staff is to continue with mod assist for all transfers for patient safety. | F 323 | | |

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| F 323 | Continued From page 32<br>. . . Has continued deficits in transfers and independent ambulation."<br><br>The following observation occurred on 06/01/10:<br>* At 3:00 p.m., a certified nursing assistant (CNA) (#10) moved Resident #3's wheelchair to her bedside, and observed while the resident grasped the grab rail on the bed to sit up and reached across to the arm of the wheelchair to transfer. The CNA provided minimal assistance during this transfer. The CNA transported the resident to the bathroom via the wheelchair, directed the resident to stand utilizing a railing next to the toilet, pulled down the resident's brief and pants, and guided the resident to sit down on the toilet. Upon completion of toileting, the CNA assisted the resident to stand and cued her to hang onto the railing while the CNA provided pericares. At that time, observation showed the resident lose her balance, her knees buckle and her trunk sway against the bathroom wall. The CNA provided support by grabbing the resident's trunk with her hands, and guiding the resident to the wheelchair, grasping the waist line of the resident's pants. The CNA wheeled the resident from the bathroom to her bedside, provided standby assistance to transfer the resident to the bed, and pulled under the resident's arms to pull her up in the bed once the resident sat on the edge of the bed. At no time during the observation did the CNA utilize a gait belt to transfer/assist the resident with standing/repositioning.<br><br>The following observations occurred on 06/02/10:<br>* At 8:10 a.m., a CNA (#11) transported Resident #3 in her wheelchair to the bathroom. The CNA instructed the resident to stand holding onto the railing next to the toilet. The resident stated, "my legs are rubbery today." The resident pivoted | F 323 | | |

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| F 323 | Continued From page 33<br>herself to the toilet and sat on only half of the toilet seat. The CNA lifted under the resident's right shoulder to "scoot you back" on the toilet seat. Upon completion of toileting, the CNA lifted under the resident's arms to assist her to stand. The resident stood independently, hanging onto the railing, while the CNA provided pericares, and pulled up the resident's brief, and pants. The CNA then held onto the waist line of the resident's pants and pivot transferred the resident to the wheelchair. The CNA transported the resident to her bedside via the wheelchair, the resident stood hanging onto the grab bars on her bed, sat onto the bed, and the CNA lifted the resident's legs into the bed. At no time during the observation did the CNA utilize a gait belt to transfer/assist the resident with transferring/standing. Observation showed a gait belt hanging on a hook inside the resident's room door.<br>* At 10:10 a.m., a CNA (#11) informed the surveyor she forgot to use the gait belt on Resident #3 at 8:10 a.m. The CNA now utilized a gait belt to transfer the resident from the bed to wheelchair, stood the resident utilizing the gait belt in the bathroom, and then released her grasp off the gait belt at which time the resident lost her balance and her trunk slid sideways across the bathroom wall before the CNA caught the resident to assist her to the standing position again. Observation showed the resident incontinent of a large amount of semi-liquid stool. The CNA removed the resident's brief with two hands, again releasing her grasp on the gait belt. Upon completion of toileting, the CNA stood the resident by pulling her up under her arms, performed pericares several times to cleanse stool from the resident's periarea, and allowed the resident to stand independently hanging onto the railing next to the toilet. The CNA transported the | F 323 | | |

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| F 323 | Continued From page 34<br>resident to the bedside, assisted the resident with standing utilizing the gait belt, then released her grasp off the gait belt, and guided the resident touching her buttocks while the resident pivot transferred onto the bed.<br>* At 2:30 p.m., a CNA (#10), assisted Resident #3 from her bed to wheelchair by lifting under the resident's shoulders to transfer her. The CNA did not utilize a gait belt The CNA transported the resident via the wheelchair to the bathroom, moved the wheelchair sideways into the bathroom (right wheel blocking the doorway), and while the CNA stood outside the bathroom, told the resident to stand utilizing the railing next to the toilet. The resident stood, lost her balance, and started to fall toward the toilet. The CNA, reaching across the wheelchair, grabbed the resident under her right arm to grasp her, stepped across the front of the wheelchair to enter the bathroom, and assisted the resident onto the toilet seat. The resident sat near the front edge of the toilet, so the CNA pulled under the resident's right arm to sit her back farther on the toilet seat. The CNA then stepped out of the bathroom to obtain supplies out of the resident's closet drawers, and the surveyor advised the CNA to utilize a gait belt for Resident #3's transfers. The CNA stated, "You think so? I am just used to lifting them under the shoulders." The surveyor then notified a supervisory nursing staff member (#4) of the observation and the supervisory staff member stated the CNA "knows better."<br><br>On the morning of 06/03/10, an interview occurred with two nursing administrative staff members (#4 and #5). A staff member (#4) stated if nursing staff are having to put their "hands on a resident," the staff should utilize a gait belt. The staff member stated this would include both | F 323 | | |

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| F 323 | Continued From page 35 | F 323 | | |

standby and limited assistance.

3. Based on observation, review of the secured unit admission criteria, and staff interview, the facility failed to ensure the resident environment remained as free of accident hazards as possible, for 1 of 1 secured unit on 1 of 1 day (06/02/10) of observation. Failure to secure paring knives placed visitors, staff, and all 16 residents of the secured unit at risk of injury.

Findings include:

Review of the facility document, SPECIAL CARE UNIT ADMISSION CRITERIA, undated, occurred on 06/03/10. This document stated "It is the policy of Benedictine Living Center to admit patients to the secure unit who need protection and care due to confusion or wandering, with a diagnosis of any cognitive/neurological impairment such as Alzheimer's disease or similar mental dementia. Admission criteria will include any of the following:
. . .
2. Confused wanderer with documentation of risk or harm to self. . . .
4. Cognitive or neurological impairments that cause destructive or injurious behavior towards self or others requiring close monitoring within confined area."

Observation of the facility's secured unit kitchenette during the dietary tour, on 06/02/10 at 1:30 p.m., accompanied by a dietary department staff member (#2), identified two paring knives openly stored, immediately inside the door of an unsecured cupboard. Two unidentified secured unit staff members reported they use the knives to slice fruit for residents. Staff member (#2) agreed the unsecured paring knives were a

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| F 323 | Continued From page 36<br>hazard to the unit's residents and locked them in the unit's locked refrigerator freezer.<br><br>During interview, on 06/02/10 at approximately 2:15 p.m., when informed of the observation of the unsecured paring knives in the secured unit, an administrative staff member (#1) and a maintenance management staff member (#3), confirmed this was not an acceptable practice. | F 323 | | |
| F 371 SS=E | 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY<br><br>The facility must -<br>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and<br>(2) Store, prepare, distribute and serve food under sanitary conditions<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, review of policy and procedure, review of the Food and Drug Administration (FDA) 2005 Food Code, and staff interview, the facility failed to store, prepare, distribute, and serve food items under sanitary conditions on 3 of 3 days of observation (June 01-03, 2010) in 3 of 4 areas (kitchen, resident "den," and restorative therapy) regarding the use of unsanitized food thermometers, equipment cleanliness and repair, expired food items, and storage of equipment and staff food in resident food areas. These failures placed facility residents, staff, and visitors who consumed food items prepared in the facility at risk of illness and | F 371 | | |

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| F 371 | Continued From page 37<br>complications related to improper handling and storage of food.<br><br>Findings include:<br><br>The FDA 2005 Food Code states the following:<br>- Preface, page X (ten), ". . . An asterisk * after a tagline . . . indicates that all of the provisions within that section are critical unless otherwise indicated . . ."<br>- Equipment, Utensils, and Linens, page 137, "4-7 Sanitation of Equipment and Utensils . . . 4-702.11 Before Use After Cleaning.* Utensils and Food-Contact Surfaces of Equipment shall be sanitized before use after cleaning. . . ."<br>- Public Health Reasons, Chapter 3, Food, page 374, "3-302.13 Pasteurized Eggs, Substitute for Raw Shell Eggs for Certain Recipes.* Raw or undercooked eggs. . . are particularly hazardous because the virulent organism Salmonella Enteritidis may be present in raw shell eggs. . ."<br>- Public Health Reasons, Chapter 3, Food, page 401, "Manufacturer's use-by dates . . . Manufacturers assign a date to products for various reasons, and spoilage may or may not occur before pathogen growth renders the product unsafe. . . . Although it is a guide for quality, it could be based on food safety reasons. It is recommended that food establishments consider the manufacturer's information as good guidance to follow to maintain the quality . . . of the product. If the product becomes inferior quality-wise due to time in storage, it is possible that safety concerns are not far behind. . . ."<br>- Public Health Reasons, Chapter 6, Physical Facilities, page 466, "6-601.14 Cleaning Ventilation Systems, Nuisance and Discharge Prohibition. Both intake and exhaust ducts can be | F 371 | F 371<br>Outdated Food Items in walk in cooler, in the den cupboard & fridge and therapy refrigerator<br>1) No specific residents were identified for this tag.<br><br>2) All residents who dine have the potential to be affected.<br><br>3) All outdated food items were removed and discarded 6/3/10. Policy developed for cleaning walk-in cooler, walk-in freezer, den refrigerator and cupboard, therapy refrigerator, and Sunflower refrigerator and cupboards. Checklist established for completion of cleaning schedule by dietary staff. Dietary staff to be educated on policy and cleaning schedule July 12, 2010. No staff food items to be stored in any refrigerator other than in staff break room. All staff educated on policy by July 14 2010 through Silverchair module assignment.<br><br>4) Dietary Manager or designee to complete bi-weekly checks x 6 weeks, then cleaning checklist monthly. All food storage/preparation/ serving areas including special care unit, activities (den) and any other areas will be monitored.<br><br>5) Date Certain will be 7/21/10. | 7/21/10 |

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| F 371 | Continued From page 38<br>a source of contamination and must be cleaned regularly. . . ."<br><br>Review of the following facility policies and procedures occurred on 06/03/10:<br>*DIETARY DEPARTMENT SANITATION MONITORING, dated 2000, stated "POLICY, It is the policy of the Dietary department to maintain a sanitary food service operation, which includes the cleanliness of equipment, the department and the personnel. Sanitary and proper food handling techniques shall be used at all times. There will be a comprehensive system for on-going sanitation inspections of the work environment in the Dietary Department.<br>PROCEDURE, 1. The Dietary Director is responsible for monitoring the Dietary Department on a regular basis to assure the department is operated and maintained in a sanitary manner.<br>2. The Dietary Director/designee will accomplish comprehensive sanitation inspections on a monthly basis using the Sanitation Checklist.<br>3. Areas included in the inspections will include at least the following:<br>Storage Areas<br>Refrigerator/Freezer Units<br>Equipment/Utensils<br>Food Preparation Area(s)<br>Dishwashing Area . . .<br>6. Maintenance requests will be completed by the Dietary Director regarding repairs needed or areas previously assigned to Maintenance for cleaning. . . ."<br><br>*CLEANING SCHEDULES, dated 2000, stated "POLICY, The Dietary Department will be maintained in a clean and sanitary condition. Cleaning schedules, with all cleaning tasks listed, will be provided in the department and cleaning | F 371 | F 371<br>Table Fan<br>1) No specific residents were identified for this tag.<br><br>2) All residents who dine have the potential to be affected.<br><br>3) Table fan was removed from the area. No table fan to be used in the dish room, and dietary staff to be educated on July 12, 2010.<br><br>4) Dietary Manager or designee will audit compliance on a monthly basis.<br><br>5) Date Certain will be 7/14/10<br><br>F 371<br>Dust and Debris on motor housing of convection oven, air conditioning unit and air vents<br>1) No specific residents were identified for this tag.<br><br>2) All resident who dine have the potential to be affected.<br><br>3) Motor housing on convection oven, air conditioning unit and air vents air vents were all cleaned. Schedule for monthly cleaning developed and staff to be educated on protocol July 12, 2010.<br><br>4) Cleaning checklist to be completed by dietary staff as assigned. Dietary Manager or designee will audit compliance on a monthly basis.<br><br>5) Date Certain will be 7/14/10 | 7/14/10<br><br>7/14/10 |

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| F 371 | Continued From page 39<br>tasks completed in a timely and appropriate manner. . . ."<br><br>*CLEANING GUIDELINES, undated, stated "A. Refrigerators and Freezers<br>1. Clean refrigerators and freezers regularly. . . .<br>8. Gaskets are to be . . . in good repair at all times. . . .<br><br>B. Storeroom . . .<br>2. Shelving units to be cleaned quarterly or as needed. . . .<br><br>F. Cabinets and Drawers<br>1. Use detergent and warm water. . . . Rinse shelves and drawers with clean sponge and dry. Sanitize at the appropriate strength. . . .<br><br>I. Walls, Ceilings, and Vents . . .<br>2. Walls, ceilings, and vents must be washed thoroughly at least twice a year. Heavily soiled surfaces must be cleaned more frequently and as required. . . .<br><br>CC. Bench Can Opener<br>1. Remove stand from base. Run through dishwasher.<br>2. Wipe base with hot, soapy water. Rinse. Wipe or spray with sanitizer. Let air-dry. . . ."<br><br>- During the initial dietary tour, on 06/01/10 at 9:50 a.m., observation identified a thick layer of ice at the lower portion of the walk-in freezer door and a thin layer of ice covered the floor of the freezer. Observation showed the door seal pulled away from the freezer door and not in contact with the freezer wall.<br><br>- Observation in the facility's kitchen during the | F 371 | F 371<br>Freezer Door<br>1) No specific residents were identified for this tag.<br><br>2) Refrigeration company will assess repair or replacement of the freezer door by 7/9/10.<br><br>3) Dietary staff will be educated to observe to ensure door is sealing properly and no ice build up in evidence in the walk in freezer floor.<br><br>4) Dietary Manager or designee will monitor monthly to ensure door is sealed properly and no ice build up in evidence.<br><br>5) Freezer door will be replaced. New freezer door has been ordered and will be installed as soon as it arrives in the facility (See attached record of purchase)<br><br>F 371<br>Brooms with dirt and debris<br>1) No specific residents were identified for this tag.<br><br>2) All residents who dine have the potential to be affected.<br><br>3) Brooms with dirt and debris were discarded and new brooms were in place 7/2/10. Housekeeping staff to monitor daily for accumulation of debris and clean. Dietary and housekeeping staff will be educated on policy July 12, 2010. | 7/21/10 |

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| F 371 | Continued From page 40<br>evening meal service, on 06/01/10 at 5:10 p.m., identified two dietary staff members (#6 and #7), checked the temperatures of milk poured in glasses and a container of potato salad.<br><br>Observation in the facility's kitchen during the breakfast meal service on 06/02/10 at 7:50 a.m., identified a dietary staff member (#8) obtained a probe type thermometer without a shield from an open plastic cup on a counter. The cup contained a knife, a scissors, a table knife, a teaspoon, and several plastic knives. The staff member inserted the thermometer probe into a stack of pancakes in a steam table pan. The staff member failed to wipe or sanitize the thermometer probe before inserting it into the pancakes. The staff member (#8) then washed the thermometer probe in soapy water, rinsed it, and placed it in sanitizer for approximately one minute before placing it back in the plastic cup.<br><br>During interview, a staff member (#8) reported the facility considers the thermometer sanitized while in the plastic cup and no sanitizing is necessary before checking food temperatures. This staff member (#8) reported the kitchen did not have any alcohol wipes or other sanitizing wipes in the kitchen for use on the thermometer probe. On request, a staff member (#8) discarded the stack of pancakes.<br><br>During interview, on 06/02/10 at approximately 11:20 a.m., a dietary staff member (#7) reported she and a staff member (#6) did not sanitize the thermometer probe before checking the temperatures of the milk and potato salad on 06/01/10. The staff member (#7) stated she used the same procedure to check the milk and potato salad temperatures during the evening meal on | F 371 | 4) Dietary Manager or designee will audit compliance on a monthly basis.<br><br>5) Date Certain will be 7/14/10<br><br>F 371<br>Food Thermometer<br>1) No specific residents were identified for this tag.<br><br>2) All residents who dine have the potential to be affected.<br><br>3) Food thermometer was cleaned, sanitized and moved to an individual closed storage container 6/30/10. Thermometer will be cleaned and sanitized with chemical sanitizer and stored in sanitary closed container after each use. Thermometer will be stored separate from all other items. Dietary Staff to be educated on proper handling and storage of food thermometer on July 12, 2010.<br><br>4) Dietary Manager or designee will complete bi-weekly audits x 6 weeks, and monthly audits thereafter.<br><br>5) Date Certain July 14, 2010. | 7/14/10<br><br>7/14/10 |

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| F 371 | Continued From page 41<br>06/01/10 as reported by staff member (#8).<br><br>Failure to sanitize the thermometer probe before checking the food temperatures resulted in the food potentially being in contact with any organisms present on the other items in the cup or open to the air. It is unknown with what type of materials the items in the cup had been in contact with.<br><br>- Observations during a dietary tour on 06/02/10 at 9:55 a.m. with a dietary staff member (#8) identified the following:<br>*In the kitchen -<br>- 5 plastic plate covers, stacked wet.<br>- a bench can opener with accumulated dry material at the cutting surface.<br>- dust and dried debris on the outside and inside of a metal cabinet containing pots and pans.<br>- wooden cabinets with dried material and a sticky surface texture.<br>- heavy accumulation of dust and debris on the motor housing of a convection oven.<br>Staff member (#8) reported staff should not store the covers wet; staff use the can opener many times a day and she did not know when staff wash it; and, staff should clean the cabinets and motor housing.<br>*In the dishwashing area -<br>- air conditioning unit with heavy accumulation of dust and debris.<br>- air vents with heavy accumulation of dust and debris.<br>- table fan directed towards clean dishes, with heavy accumulation of dust and debris.<br>- two brooms with accumulated dirt and debris in the bristles.<br>A staff member (#8) agreed staff should clean the vents and fan; the brooms do not clean well and | F 371 | F 371<br>Plastic Plate Covers<br>1) No specific resident were identified for this tag.<br><br>2) All residents who dine have the potential to be affected.<br><br>3) Protocols for proper stacking procedures after dishwashing remain in effect. Dietary staff will be reeducated on July 12, 2010.<br><br>4) The Dietary Manager or designee will monitor for compliance with the above protocol bi-weekly for 6 weeks, then as part of monthly sanitation inspection.<br><br>5) Date certain will be 7/14/10<br><br>F 371<br>Bench Can Opener<br>1) No specific resident were identified for this tag.<br><br>2) All residents who dine have the potential to be affected.<br><br>3) Bench can opener was cleaned and sanitized. Can opener will be cleaned and sanitized after every use and cleaned daily in dishwasher by pm dietary aide. Protocol for cleaning can opener to be reviewed with all dietary staff on July 12, 2010. | 7/14/10 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 355064 | A. BUILDING _____ B. WING _____ | 06/03/2010 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BENEDICTINE LIVING CENTER OF GARRISON | 609 4TH AVE NE GARRISON, ND 58540 |

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| F 371 | Continued From page 42<br>staff have ordered new brooms. Observation on 06/03/10 at 2:30 p.m. identified the brooms with dirt and debris remained in place, ready for use.<br>*In a dry store room across the hall from the kitchen -<br>- 6, #10 cans (110 fluid ounces), unlabeled and undated.<br>- 16, #10 cans of assorted corn, beans, and pizza sauce, undated.<br>- 9, 14 ounce cans of condensed milk, use by date of 02/06.<br>- 28, 15 ounce cans organic chicken soup, use by date of 04/05/07.<br>- 19, 14 ounce cans whole kernel corn, use by date of 07/07/07.<br>- 6, 13 to 21 ounce packets powdered pie filling, use by date of 10/24/07.<br>- 27, 8.4 ounce cans sparkling fruit juice, use by date of 09/22/08.<br>- 8, 32 fluid ounce containers mayonnaise with olive oil, use by date of 05/04/09.<br>- 5 boxes strawberry jelly filled cookies, use by date of 10/17/09.<br>- 10, 5.68 ounce boxes cookies and creme cookies, use by date of 01/06/10.<br>- 3 boxes assorted crackers, torn boxes exposing the inside packaging, undated.<br>- Numerous cardboard boxes contained unlabeled and undated canned food items. The lack of labels present limited knowing what was present within the cans.<br>A staff member (#8) reported she rarely enters this room to obtain cooking supplies. She was not aware of any delivery dates for any of the items in this room and reported the activities department used some of the items such as "cookies for bingo prizes." This staff member agreed staff should discard the food items beyond the used by dates or unlabeled. | F 371 | 4) Dietary Manager or designee will complete be-weekly audits x 6 weeks, and monthly audits thereafter<br><br>5) Date Certain will be 7/14/10.<br><br><u>F 371</u><br><u>Storage cabinets</u><br>1) No specific residents were identified for this tag.<br><br>2) All residents who dine have the potential to be affected.<br><br>3) All kitchen cabinets were cleaned. Schedule for weekly cleaning of all kitchen cabinets is made and dietary staff will be educated on cleaning schedule July 12, 2010.<br><br>4) Dietary staff will complete checklist for regular cleaning schedule on a bi-weekly basis. Dietary Manager or designee will review checklist monthly<br><br>5) Date Certain will be 7/14/10 | 7/14/10<br><br>7/14/10 |

| ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 355064 | A. BUILDING _____ B. WING _____ | 06/03/2010 |

| AME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| 3ENEDICTINE LIVING CENTER OF GARRISON | 609 4TH AVE NE GARRISON, ND 58540 |

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| F 371 | Continued From page 43<br>*In the walk-in cooler -<br>- 11, 46 ounce containers of grapefruit juice, use by date of 11/13/09.<br>- 1, 5 pound partially used container of yogurt, use by date of 04/30/10.<br>Staff member (#8) agreed staff should discard these items.<br>*In the walk-in freezer -<br>- A thin layer of ice at the lower portion of the walk-in freezer door and a thin layer of ice covered the floor of the freezer. The door gasket was visibly pulled away from the freezer door and not in contact with the freezer wall.<br>A staff member (#8) reported she slipped on the ice on the floor and cleaned the ice off the freezer door and floor on 06/01/10. She reported the freezer door had been like this for some time and was uncertain if the facility's maintenance department had tried to repair the freezer door.<br>On 06/03/10, at approximately 10:00 a.m., with a maintenance department staff member (#13), observation showed the ice buildup still present on the outside of the freezer door and a thin layer of ice on the floor of the freezer. A staff member (#13) reported the maintenance department did not receive a repair request for this problem.<br>*In the residents' den -<br>- In the cupboard - two, 18.5 ounce cans of soup, use by dates of 05/08/08 and 05/07/09; and one small can of chicken soup, use by date of 04/01/09.<br>- In the freezer - four commercial ice packs, identified for use by therapy services, stored with popsicles.<br>- In the refrigerator - three dozen raw eggs, reportedly belonging to a staff person and obtained from a local individual.<br>A staff member (#8) reported food items in the den cupboard, refrigerator, and freezer are for | F 371 | F 371<br>Unlabeled, outdated or open packing in storage room<br>1) No specific residents were identified for this tag.<br><br>2) All residents who dine have the potential to be affected.<br><br>3) All unlabeled, outdated or items with open packaging were removed and discarded 6/2/10. Policy developed to ensure all food items received for storage in pantry area are checked for appropriate label, expiration date and integrity of packaging. Dietary staff will be educated on policy July 12, 2010.<br><br>4) Staff will review date of all items prior to use. Checklist for review of all foodstuff items stored in pantry area to be completed by dietary staff monthly. Dietary Manager or designee will audit compliance monthly.<br><br>5) Date Certain will be 7/14/10. | 7/14/10 |

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| BENEDICTINE LIVING CENTER OF GARRISON | 609 4TH AVE NE GARRISON, ND 58540 |

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| F 371 | Continued From page 44<br>resident use. The staff member agreed the soups were beyond the use by dates and staff should discard the soups. Storage of the ice packs, used against residents' bodies or clothing, along with the food items potentially contaminates the food items. Staff are not to store personal food items in the refrigerator designated for residents' food items. Raw eggs may have bacteria on the outside of the shell and may contaminate surfaces or food items stored in the refrigerator.<br>*In the restorative therapy refrigerator, observed on 06/03/10 at 8:30 a.m. -<br>- An individual serving container of yogurt, use by date of 03/29/10.<br><br>During these observations, the facility failed to provide cleaning schedules or checklists.<br><br>The facility's dietary service areas included food with use by dates of more than four years prior to the survey or not identified. It is unknown when the facility received many of the food items. Staff members identified the activities department used some of the items. Failure to clean the dietary areas, failure to discard expired food items, and storage of food items, including raw eggs, with cold packs placed the facility's residents at risk of illness related to consuming unsafe food. | F 371 | F 371<br>Therapy Ice Packs<br>1) No specific residents were identified by this tag.<br><br>2) All residents who dine have the potential to be affected by this tag.<br><br>3) Therapy ice packs were removed from freezer in the den refrigerator and moved to freezer in the therapy refrigerator 6/30/10. Therapy ice packs will be stored in freezer of the therapy refrigerator. No food items to be stored in the freezer of the therapy refrigerator. All staff education on policy by July 14, 2010 through Silverchair module assignment.<br><br>4) Checklist developed to ensure no food items stored in freezer of therapy refrigerator to be completed bi-weekly. Dietary Manager or designee to audit checklist monthly.<br><br>5) Date Certain will be 7/14/10 | 7/14/10 |