STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355067	A. BUILDING _____ B. WING _____	11/18/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY ELDERCARE CTR	2900 74TH AVE S GRAND FORKS, ND 58201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey started on 11/15/09 and completed on 11/18/09, the sample included 5 residents for complete review, 17 residents for focused review, and 3 closed records for review.	F 000		
F 278 SS=D	483.20(g) - (j) RESIDENT ASSESSMENT The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by:	F 278	It is the policy of Valley Eldercare Center that each resident receive an accurate assessment by staff that are qualified to assess relevant care areas and knowledgeable about the resident's status needs, strengths and areas of decline. Following a discussion with the state surveyors and their helpful interpretation of guidelines in the RAI manual regarding assessments we have changed our methods used for completion of the MDS. We discontinued our practice of using the bowel/bladder diary (72 hour assessment) as a toileting schedule. This was used as a schedule for Resident's #9, #23, and #24. We changed our practice before the survey team exited on 11/18/09. All our care coordinators were informed of this change of practice on 11/18/09. At no time did any care coordinator believe they were falsifying a medical record. The way they completed and coded the MDS was based on how they interpreted the RAI manual. Charts/MDS's will be audited for accuracy in coding of toileting schedules by ADON/DON monthly times six (6) months, then quarterly times six (6) months. If no issues are noted we will do an annual audit for accuracy. Staff will attend an inservice regarding all the changes on 12/16/09.	12/23/09

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Greg Hanson	President/CEO	12/14/09

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 278	Continued From page 1 Based on observation, record review, staff interview, review of facility policy and professional literature, the facility failed to accurately complete the scheduled toileting plan compoenent of the comprehensive Minimum Data Set (MDS) for 1 of 1 sampled resident (Resident #9) and 2 of 2 closed records (Resident #23 and #24). Failure to accurately complete the MDS for each sampled resident did not allow each resident's comprehensive assessment to reflect care provided consistent with their individual needs, problems, and strengths. Findings include: The Centers for Medicare and Medicaid Services Revised Long-Term Care Facility Resident Assessment Instrument User's Manual, Version 2.0, December 2008, stated, ". . . There are 3 key ideas captured in Item H3a: 1) scheduled, 2) toileting, and 3) program. The word 'scheduled' refers to performing the activity according to a specific, routine time that has been clearly communicated to the resident (as appropriate) and caregivers. The concept of 'toileting' refers to voiding in a bathroom or commode, or voiding into another appropriate receptacle (i.e., urinal, bedpan). Changing wet garments is not included in this concept. A 'program' refers to a specific approach that is organized, planned, documented, monitored and evaluated. A scheduled toileting program could include taking the resident to the toilet, providing a bedpan at scheduled times, or verbally prompting to void. If the scheduled plan is recorded in the care plan and staff are actually toileting the resident according to the multiple specified times, check Item H3a. If the resident also experiences breakthrough incontinence, this would be a good	F 278		

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time to reevaluate the effectiveness of the current plan by assessing if the resident has a new, reversible condition causing a decline in continence (e.g., UTI, [urinary tract infection] mobility problem, etc.), and treating the underlying cause. Also determine whether or not there is a pattern to the extra times the resident is incontinent and consider adjusting the scheduled toileting plan accordingly. For residents on a scheduled toileting plan, the care plan should at least note that the resident is on a routine toileting schedule. A resident's specific toileting schedule must be in a place where it is clearly communicated, available to and easily accessible to all staff, including direct care staff. If the care plan is the resource used by staff to be made aware of resident's specific toileting schedules, then the toileting schedule should appear there. Facility staff may list a resident's toileting schedule by specific hours of the day or by timing of specific routines, as long as those routines occur around the same time each day. If the timing of such routines is not fairly standardized, specific times should then be noted. Documentation in the clinical record should evaluate the resident's response to the toileting."

The facility's policy, "Bladder and Bowel Assessment," revised December 2006, stated: "Policy: it is the policy of that the facility will ensure that each resident who is incontinent of bladder and/or bowel is identified, assessed and offered the opportunity to achieve continence or restore as much normal bladder and/or bowel function as possible through appropriate treatment and services will be offered to restore as much function as possible. . . . Procedure: 1. Implement Bladder and Bowel (B&B) assessments on all residents noted to be

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F 278	Continued From page 3 incontinent at the time of admission . . . 2. Record resident bladder and bowel patterns for at least 72 hours using the Bladder and Bowel Diary. . . . 3. following completion of the 72 hour Bladder and Bowel Diary, the Bladder and Bowel Assessment . . . will be completed. . . 4. If deemed appropriate, scheduled toileting of bladder retraining and bowel toileting or retraining program will be implemented. . . " - Review of Resident #9's medical record occurred November 16-17, 2009, and showed the facility admitted the resident on 08/17/09. The record included Resident #9's admission Minimum Data Set (MDS) completed 08/30/09. The MDS identified Resident #9 as incontinent of bowel and bladder all/almost all the time, and participating in a scheduled toileting plan. The incontinence Resident Assessment Protocol (RAP), completed 08/28/09, stated, "Resident does not use toilet and staff check and change him 2-3 times per shift. Observation showed certified nurse assistants (CNAs) provided Resident #9 care at 1 p.m. on 11/16/09 (CNA #5 and #7), at 5:05 p.m. on 11/16/09 (CNA #6 and #8), and at 8:10 a.m. on 11/17/09 (CNA #5 and #7). During each observation the CNAs checked Resident #9's brief for incontinence, changed the brief if wet/soiled, and provided no toileting assistance for the resident. During interviews with the CNAs (#5 and #7) at 1 p.m. on 11/16/09, and the CNAs (#6 and #8) at 5:05 p.m. on 11/16/09, the CNAs indicated they did not provide toileting assistance for Resident #9, but rather checked and changed the resident's brief during their shifts. The CNAs	F 278		

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F 278	Continued From page 4 stated they had "never assisted [Resident #9] to the toilet or provided the resident with a urinal or bedpan." Review of Resident #9's "Bladder Diary," completed August 20-23, 2009, showed during the bladder assessment period, staff did not provide toileting assistance via bathroom, urinal, or bedpan. The Bladder Diary showed only the status of Resident #9's continence/incontinence (wet or dry) at times checked. The above referenced observations, review of the resident's "Bladder Diary, and the interviews with the CNAs providing care to Resident #9 showed the facility had inaccurately identified Resident #9 as participating in a scheduled toileting plan/program during completion of the resident's admission MDS on 08/30/09. - Review of Resident #23's Medical record occurred 11/18/09 and showed the facility admitted the resident on 11/21/08. The resident's admission MDS, completed 12/02/08, identified Resident #23 as continent of bowel and bladder and participating in a scheduled toileting plan. Nurses notes, as well as Resident #23's Bladder Diary completed November 24-27, 2008, showed the resident remained continent of bladder, and requested assistance for toileting when the resident recognized the need to void. Resident #23's plan of care lacked any evidence of a individualized planned toileting program/plan for the resident. - Review of the medical record for Resident #24 occurred November 17-18, 2009. The record showed the facility admitted the resident on	F 278		

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F 278	Continued From page 5 05/14/09. The resident's admission MDS, completed 05/27/09, identified Resident #24 as occasionally incontinent of bowel, continent of bladder with the use of a catheter, and participating in a scheduled toileting plan. The facility "Bladder Assessment Form," dated 05/20/09, did not identify a toileting plan for Resident #24. The facility "Bowel Assessment Form," dated 05/20/09, stated, "Res [resident] is very confused. Has dementia. Check [and] change 2 to 3 [times per] shift for bowel. Has F/C [Foley catheter] for bladder." The Resident Assessment Protocol, completed 05/27/09, in conjunction with the admission MDS stated, "ADL [activities of daily living] Function/Urinary Incontinence/F/C: ". . . She requires assist of one for dressing, toileting, bathing, and pericare. . . . Res has a Foley catheter for urinary retention. She is incontinent of bowels with a check and change 2 to 3 times per shift. . . ." The care plan, dated May 2009, stated, "Toileting: Requires assist of 1 with toileting. Res is continent of bladder (has F/C for urinary retention) continent of bowel. (Occasionally incontinent) Wears a brief, and assist with pericares as needed." The care plan lacked an identified toileting schedule for Resident #24. During an interview on the morning of 11/17/09 with an administrative nursing staff member (#4), the staff member indicated the facility identifies the residents as participating in a scheduled toileting plan/program, based on the facility's completion of the 72 hour "Bladder and Bowel Diary" during the MDS assessment period. The	F 278		

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F 278	Continued From page 6 staff member indicated the facility interpreted the 72 hour assessment as "a scheduled toileting plan" even though the residents and are not a candidate for an individualized scheduled toileting plan to improve continence/bladder function, and an individualized toileting shchedule is not in place for the resident.	F 278		12/23/09
F 311 SS=D	483.25(a)(2) ACTIVITIES OF DAILY LIVING A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy/procedure, and staff interview, the facility failed to provide the appropriate treatment and services to maintain continence for 1 of 2 sampled residents (#22) who experienced a decline in bowel and bladder continence while on a scheduled toileting program. Failure to provide these services may have hindered this resident's ability to restore as much bowel and bladder function as possible. Findings include: Review of the facility policy titled "Bladder and Bowel Assessment Policy & Procedure" occurred on 11/18/09. This policy, revised 12/06, stated, "POLICY: It is the policy of Valley Memorial Homes that the facility will ensure that each resident who is incontinent of bladder and/or bowel is identified, assessed, and offered the opportunity to achieve continence or restore as much normal bladder and/or bowel function as possible through appropriate treatment and	F 311	It is the policy of Valley Eldercare Center to provide maintenance and restorative programs that will not only maintain, but improve, as indicated by the resident's comprehensive assessment to achieve and maintain the highest practicable outcome. Resident #22 was assessed by Care Plan Coordinator on 12/01/09. A Bowel & Bladder assessment was completed on 12/01/09. It is determined that the resident benefited from being on a Toileting Schedule for urinary incontinence as partial continence was maintained. Resident's plan of care was reviewed on 12/01/09. Staff will be inserviced on Plan of Correction on 12/16/09 which will include education on proper documentation on Toileting Flow Sheets and Valley Eldercare Center Bowel and Bladder assessment policy and procedure. It is Valley Eldercare Center policy that each resident that is incontinent of bowel and bladder is identified, assessed and offered the opportunity to achieve continence or restore as much normal bladder and/or bowel function as possible through appropriate treatment and services. Continued on Page 8 of 30	

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F 311	Continued From page 7 services will be offered to restore as much function as possible. PURPOSE: The continence program utilized is a structured Bladder and Bowel Rehabilitation Program designed to help residents progress from incontinence to continence and from constipation to regularity, through guided nursing management. . . . Care will be provided based on the type, severity, and cause of the urinary or bowel incontinence... . PROCEDURE: . . . If deemed appropriate, scheduled toileting or bladder retraining program and bowel toileting or retraining program will be implemented. The following factors will also be evaluated.... The ability of the resident to make decisions and call for assistance to use the toilet. ... Residents on a toileting or retraining program will be reviewed at least quarterly and with a significant change in continence status." Review of Resident #22's record occurred on November 17-18, 2009. The record identified the resident's admission occurred in August 2009. Admitting diagnoses included debility, Parkinson's disease and urinary retention. An admission Minimum Data Set (MDS), dated 09/10/09, identified the resident with a short and long term memory problem, modified independence in daily decision making, extensive assistance of one person for toileting and usually continent of bowel, and frequently incontinent of bladder. The MDS identified the change in urinary continence as "deteriorated." The Resident Assessment Protocol Summary (RAPS), dated 09/10/09, addressed the resident's cognitive loss stating, "... Res [resident] has a STM [short term memory] and LTM [long term memory] loss. He is able to make a decision regarding ADLs [Activities of Daily Living] . . ." The ADL [Activities	F 311	Continued From Page 7 All residents on a toileting or retraining program will be reviewed at least quarterly and with any significant change of status by the R.N. Care Plan Coordinator. The R.N. Care Plan Coordinator will assess the effectiveness of the resident's toileting schedule by using the Valley Eldercare Center Bladder Assessment form. An inservice will be held on 12/16/09 to review our plan of correction. All staff will be educated on proper documentation on Toileting Flow Sheets and on our Bowel and Bladder Assessment policy and procedure. Every resident on a toileting schedule will be evaluated monthly times six (6) months by Assistant Director of Nursing. In addition, our current policy states that each resident on a toileting schedule will be evaluated quarterly and on an ongoing basis by the R.N. Care Coordinator to ensure that residents on toileting schedules are effective. All resident's on a toileting schedule will be audited by the Assistant Director of Nursing monthly times six (6) and then quarterly by the Care Plan Coordinator with their quarterly or annual review. By using the audit tool, each individual's toileting schedule will be reviewed to ensure that staff are following the resident's individual plan of care and our internal policy and procedure for Toileting Schedules and Bladder Assessment.	

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of Daily Living] RAP stated, ". . . Res is continent of bowel and incontinent of bladder at least once or twice daily. Res is on a toileting schedule. He has had a TURP [transurethral resection of the prostate] for urinary retention . . ." An admission nursing assessment identified the resident's elimination patterns as "Bowel . . . Diarrhea @ [at] times. Frequency of stool daily . . . Bladder: No difficulty . . . incont [incontinent] if [doesn't] get to BR [bathroom] soon enough."

Resident #22's current care plan addressed the problem of impaired mobility with an intervention of "Toileting schedule, [every] 2 hours while awake . . ."

On 11/17/09 at 3:30 p.m., a certified nursing assistant (CNA) (#23) stated Resident #22 is toileted when "he puts his light on." At 4:50 p.m., a CNA (#23) responded to Resident #22's call light and ambulated Resident #22 to the bathroom. Observation showed Resident #22's brief saturated with urine as well as the resident incontinent of soft stool into the brief. Observation showed Resident #22's coccyx area reddened. Following the care observation, when interviewed, the CNA (#23) stated toileting last occurred at 2:00 p.m. and reported the resident "knows when he has to go."

Review of Resident #22's "Charting Record . . . Plan of Care - Toileting Flowsheet" identified Resident #22 toileted at noon on 11/17/09. The Flowsheet for November identified toileting of Resident #22 did not occur over a six hour time frame after 1:00 p.m. between November 01-10, 2009, and at that toileting the resident is identified as incontinent. Review of the October 2009 Toileting Flowsheet identified nursing staff

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F 311	Continued From page 9 frequently did not toilet Resident #22 over a six hour time frame after 1:00 p.m. and often identified the resident incontinent with that toileting. The record for September also identified no toileting occurred over a six hour time frame after 1:00 p.m. with incontinence identified on 14 of 30 days. An ADL charting record identified Resident #22 continent of bowel and urine in September; often incontinent of urine, and incontinent of stool on 18 of 31 days in October; and always incontinent of urine, and incontinent of stool on 8 of 17 days reviewed in November. Record review identified Resident #22 receives a diuretic twice daily, therefore may require more frequent toileting. An interview occurred with an administrative staff member (#17) on the morning of 11/18/09. The staff member stated Resident #22 is always incontinent of bladder, but should not be incontinent of bowel. The staff member stated Resident #22 is on a toileting schedule to maintain improved continence as well as mobility, and stated the resident is not cognitively aware enough to determine when he should go to the bathroom.	F 311		12/23/09
F 323 SS=D	483.25(h) ACCIDENTS AND SUPERVISION 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. This REQUIREMENT is not met as evidenced	F 323	It is the policy of Valley Eldercare Center that we ensure the resident's environment remains as free of accidents/hazards as possible and that each resident receives adequate supervision and assistive devices to prevent accidents. Continued on Page 11 of 30	

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F 323	Continued From page 10 by: Based on observation, record review, review of facility policy/procedure, review of manufacturer's guidelines, and staff interview, the facility failed to ensure the safe transfer of 2 of 8 sampled residents (#2 and #20) observed transferring with a gait belt, and 2 of 4 sampled residents (#3 and #5) observed transferring with a stand lift. Failure to use assistive devices according to facility policy/manufacturer's recommendations placed these residents at risk of falls and injury. Findings include: Review of the facility procedure titled "Ambulation, Gait Belts, Use of" occurred on 11/18/09. This procedure, revised 04/09, stated, "PURPOSE: Gait belts are provided to assist staff to safely transfer or ambulate residents. . . . A gait belt will be used as indicated by . . . nursing assessment or nursing personnel. Potential indications for use of gait belt would include but not limited to: a. Unsteady gait/transfer. . . . c. Unpredictable behavior with ambulating/transferring." Review of the manufacturer's instructions on the Professional Assistance Lift (PAL) (mechanical lift used to stand and transfer a person) occurred on 11/18/09. These instructions stated " .. . **IMPORTANT** ONCE PATIENT OR RESIDENT STARTS LIFTING, SNUG SAFETY RESTRAINT STRAP. WHEN THE TORSO STRAIGHTENS, THE STRAP WILL LOOSEN.. . . APPLYING BUTTERFLY SLING TO PERSON . .. lean the person slightly forward just enough to insert the sling behind the back. NOTE: Place the sling as far down as you can. Position the wings of the sling under the arms and make sure they	F 323	Continued From Page 10 C.N.A.'s and Licensed Nursing staff have already been inserviced on proper transfers using the gait belts and proper use of equipment for transfers requiring the standing PAL Lift. This was held on 12/01/09. Resident #2 and #20 have already had audits completed tracking gait belt use during transfers and ambulation. Audits have been completed to evaluate equipment use on transfers of Resident #5 and Resident #3. During the observation and evaluation, different size slings were used to promote safer transfer techniques. Other slings have been ordered to accommodate appropriate, safe transfers. Resident #3 agreed to use the Hoyer lift for transfer until a different sling is obtained to accommodate safe transfer with the standing PAL. We will use the new sling if appropriate otherwise we may have to change the plan of care to use the Hoyer full body lift for safety Resident #5 is now using a smaller size sling to promote safe transfer and help with proper position. Audits will be completed by our staff development nurse weekly times twelve (12) weeks, then quarterly times six (6) months and then annual audits. The audits will cover both gait belt use and proper transfer/proper equipment, done randomly on all residents using this equipment. Continued on Page 12 of 30 per T.O. to DON Carol Snortland 12/17/09 at 1630 QL.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 11 are centered. Secure buckle as low as possible around the lower abdomen. Fasten the buckle and pull snug. . . . As a person stands, the abdomen will become more narrow: therefore you must tighten the security strap as you lift the person. This procedure will help keep the strap in proper alignment." - Review of Resident #2's medical record occurred on all days of survey. Resident #2's medical diagnoses included peripheral neuropathy, macular degeneration and legal blindness. Resident #2's "Resident Care Notes," dated 09/21/09 at 6:10 p.m., identified a fall. The note stated, "... CNA [certified nursing assistant] came to report. Res [resident] had been in B/R [bathroom] & [and] was walking out when her knees buckled & she caught her preventing fall to the ground. States Res said she'd hit her head into the wall - On exam noted lg [large] hematoma - [right] frontal area of head measuring 4 cm [centimeters] in circumference. Res denies discomfort ..." A "Falls Assessment" identified the fall on 09/21/09 and included a notation dated 10/03/09, which stated, "Res is declining. She has a bad heart & looses [sic] her balance at times. Will cont [continue] to monitor ..." Review of Resident #2's quarterly Minimum Data Set (MDS), dated 09/03/09, and annual MDS, dated 06/03/09, identified Resident #2 required limited assistance of one person with transfers and walking in the room, and extensive assistance of one person with toileting. The 09/03/09 MDS identified the resident with an unsteady gait. A Resident Assessment Protocol Summary (RAPS), dated 06/03/09, for falls	F 323	Continued From Page 11 All staff will be inserviced on 12/16/09. Use of gait belts, proper equipment appropriate for transfer suing the standing PAL or other mechanical lifts. Information will be presented by Staff Development nurse and a member of the Safety and Safe Lift committee. Additional training will occur on 01/12/10. This is for all staff regarding "Safe Lift". This will be provided by an Occupational Therapist from Altru Health Systems. Included in the training will be safe lifting, ergonomics, and gait belt usage. Deleted per T.O. Carol Snortland, DON on 12/17/09 at 1630.	

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F 323	Continued From page 12	F 323		

stated, ". . . Res is blind and needs assist of one to ambulate and to toilet . . . She is at risk for fall related [sic] to medication and her physical condition. Fall risk assessment = 13 . . ." A fall risk score of 10 or above identifies residents at risk for falls.

Resident #2's current care plan identified the problem of "Self care deficit manifested by need for assist with ADLs [Activities of Daily Living] . . ." with interventions which included ". . . Transfers: Transfers with assist of 1. Ambulation: Ambulates with assist of 1 with use of FWW [front wheeled walker], distance as tolerated . . . Toileting: Requires assist of 1 with toileting . . ."

Observations of direct care staff, specifically certified nursing assistants (CNAs), ambulating Resident #2 in her room to and/or from her recliner to her bathroom occurred on four occasions on 11/16/09. On two of four occasions, the direct care staff assisting, did not utilize a gait belt to ambulate the resident into and/or out of the bathroom. On all occasions the resident utilized her FWW. The observations of staff not utilizing the gait belt occurred at the following times:

* 10:00 a.m.: a CNA (#15) responded to the resident's call light from the bathroom. The CNA (#15) ambulated Resident #2 from the bathroom, to her sink in her room for handwashing, and then to the resident's recliner. Observation showed no gait belt utilized by the CNA.

* 5:10 p.m.: a CNA (#16) ambulated Resident #2 from her recliner to the bathroom, then from the bathroom to the sink counter in her room for handwashing, and back to her recliner, without utilizing a gait belt.

An interview with a supervisory staff member

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F 323	Continued From page 13 (#17) occurred on 11/17/09 at 5:20 p.m. The staff member stated "assist of 1" on the care plan means nursing staff should utilize a gait belt at all times. The staff member agreed a gait belt should be utilized during all transfers /ambulation /toileting of Resident #2. - Observation on 11/18/09, at 9:30 a.m., showed Resident #20 transported to his room per wheelchair for toileting by two Certified Nursing Assistants (CNAs) (#1 and #2). The CNA (#1) transferred Resident #20 from the wheelchair to the toilet by lifting the resident under his arms to assist him to stand. After Resident #20 voided in the toilet, the CNA (#1) assisted him to stand by lifting under his arms to transfer him back to the wheelchair. The CNAs (#1 and #2) failed to utilize a gait belt. Resident #20's medical record, reviewed on November 17-18, 2009, identified a history of falls. The quarterly Minimum Data Set (MDS), dated 10/02/09, identified Resident #20 required extensive assistance of one for transferring, unsteady gait, and falls in the past 30 days and 31-180 days. Resident #20's Resident Assessment Protocol (RAP) for Falls, dated 07/08/09, stated, "Res [Resident] is at risk for falls related to weakness and unsteady gait. . . . He is confused and questionable understanding of safety. Fall risk assessment = 10. This places resident at high risk for falls.. . " Resident #20's care plan stated, ". . . POTENTIAL FOR INJURY, FALLS M/B [manifested/by] fall risk R/T [related to] DEMENTIA, RECENT UTI [urinary tract infection], MEDICATION USE . . .	F 323		

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F 323	Continued From page 14 RESIDENT WILL HAVE SAFE TRANSFERS WITH ASSIST OF 2 . . . " During an interview on 11/18/09 at 9:37 a.m., a nursing staff member (#3) confirmed the CNAs should utilize a gait belt when transferring Resident #20. - Review of the Resident #5's medical record occurred on November 16-18, 2009. The resident's diagnoses included left hemiplegia (half of the body is paralyzed) following a cerebral vascular accident (stroke). Review of Resident #5's, quarterly MDS, dated 10/21/09, identified the resident required total assistance with transfers and toilet use. During interview on 11/16/09 at 10:45 a.m., a CNA (#18) identified Resident #5 returned from an appointment after 10:00 a.m. and requested to use the toilet. Observation on 11/16/09 at 10:45 a.m., showed two CNAs (#18 and #19) assisting Resident #5 from the commode using a stand lift. When CNA (#18) raised Resident #5 from the commode to a semi-standing position, her legs remained bent at an approximately 90 degree angle and the lift sling pushed up under the resident's right arm causing her shoulder to shrug upward and her right elbow to bow outward above her shoulder. Resident #5 stated "Ooh, Ooh, it hurts, I'm shaky, I can't stand, Oh, Oh arm sore." The CNAs continued to provide pericare and then transferred the resident to her wheelchair. -Review of Resident #3's medical record occurred on November 16-18, 2009. The resident's diagnoses included cerebral vascular accident (stroke) with right-sided hemiplegia (paralysis). Review of Resident #3's Minimum Data Set	F 323		

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F 323	Continued From page 15 (MDS), dated 09/11/09, indicated the resident required extensive assist with transfers and toilet use. Observation, on 11/16/09 at 2:45 p.m., showed a CNA (#31) placed a mechanical lift sling behind Resident #3's back and connected the safety support strap around the resident's torso. This CNA connected the sling to the stand-up lift, assisted the resident to hold onto the left handle with her left hand, and stood the resident up with the lift. The sling slid up under the resident's axillae and the safety strap slid up under her breasts. Resident #3's left arm raised above her head and her elbow above her shoulder. The CNA (#31) transported the resident into the bathroom and lowered her onto the toilet. In transferring off the toilet, the CNA (#31) raised Resident #3 up with the mechanical lift. The sling pulled up on the resident's arms causing her left arm and elbow to raise above her head. Observation, on 11/17/09 at 9:20 a.m., showed a CNA (#20) placed a mechanical lift sling behind Resident #3's back and buckled the safety support strap around the resident's torso. This CNA connected the sling to the stand-up lift, assisted the resident to hold onto the left handle with her left hand, and stood the resident up with the lift. The sling slid up under the resident's axillae and the safety strap slid up under her breasts. Resident #3's left arm raised above her head and her elbow above her shoulder as she held on. Her right elbow and forearm (paralyzed limb) raised just above her right shoulder. Observation showed Resident #3's body at an angle to the lift with her shins not contacting the knee rest and her feet planted on the platform. The CNA (#20) then transported the resident into	F 323		

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F 323	Continued From page 16 the bathroom with the lift and lowered her onto the toilet. In transferring the resident off the toilet, the CNA (#20) raised Resident #3 up with the mechanical lift in the same manner. An interview of therapy staff members (#21 and #22) occurred on 11/17/09 at 3:10 p.m. A therapy staff member (#21) stated residents transferred using a stand lift should not be positioned with their "buttocks low" and their "elbows above their shoulders" A therapy staff member (#22) stated the strap around the resident's waist "should be tight."	F 323		12/23/09
F 371 SS=F	483.35(i) SANITARY CONDITIONS The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, professional literature review, and staff interview, the facility failed to prepare food in a safe and sanitary manner in 1 of 1 main kitchen. Failure to follow safe food sanitation practices placed residents, who eat food prepared in the facility, at risk of foodborne illness. Findings include: Review of the 2005 Food Code, published by the	F 371	It is the policy of Valley Eldercare Center to procure, provide, store, prepare, distribute and serve food under sanitary conditions. This will be further accomplished by the institution of Policy #1200.1 (*Attachment A*) and Policy #1200.2 (*Attachment B*) and a three (3) day emergency menu plan (*Attachment C,D,E*). Dietary staff will be inserviced on 12/17/09 on safe food handling and prevention of foodborne illness related to the incident that occurred on 11/15/09. Date changed per Carol Swartland, DON - per T.O. 12/17/09 at 1650 AL 12/22/09 On 12/15/09 and ~~12/30/09~~ dietary staff will also be inserviced on Policy #1200.1 and Policy #1200.2 to train dietary staff on how to react to a sewer back-up situation and how to follow an emergency menu. Audits (*Attachment F*) of actual sewer back-up incidents will be conducted and reviewed by the administrator and facility safety committee. Audits will be conducted 100% of the time for one (1) year for compliance.	

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F 371	Continued From page 17 Food and Drug Administration (FDA), Public Health Reasons, page 453, states, "Improper repair or maintenance of any portion of the plumbing system may result in potential health hazards such as cross connections, backflow, or leakage. These conditions may result in the contamination of food, equipment, utensils, linens, or single-service or single-use articles. . . ." Review of "ServSafe Essentials," published by the National Restaurant Association, 5th edition, page 10.10, states, "Sewage and wastewater are contaminated with pathogens, dirt, and chemicals. You must prevent them from contaminating food or food-contact surfaces. If raw sewage backs up in your operation, close the affected area right away. Then fix the problem and thoroughly clean the area. . . ." - An initial tour of the facility's kitchen occurred on 11/15/09 at 1:30 p.m. Observation showed the kitchen floor flooded with approximately one inch of water in all areas of the kitchen, except the main dishwashing area and the dry storage room. When interviewed, a dietary staff member (#9) identified the water to be flowing from all drains (approximately 6 total) in the kitchen. The supervisory dietary staff member (#11) stated an administrative dietary staff member (#10) and maintenance staff had been notified regarding the water flowing from the drains. Observation, showed on 11/15/09 at 1:45 p.m., a dietary staff member (#11) standing in the contaminated water near a food preparation work table. Observation showed two large, uncovered pans of diced roast beef removed from the oven. The dietary staff member (#11) began preparing	F 371		

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F 371	Continued From page 18 beef stew for the evening meal by adding a package of pre-diced potatoes and pans of gravy to the meat, then stirring the ingredients in the pans. Food preparation in areas flooded with wastewater placed the uncovered food at risk for being contaminated. Observation on 11/15/09 at 2:05 p.m., showed an administrative dietary staff member (#10) entered the main dining room to provide direction to unidentified dietary staff members gathered at a table. Observation showed a maintenance staff member (#12) and a plumbing and drain serviceman (#13) attempted to clear the drain pipes from a drain in the main dishwashing area. When interviewed at 2:10 p.m., a maintenance staff member (#12) identified the source of the water as "drain water out of the dishmachine." Observation on 11/15/09 at 4:05 p.m. showed the drain serviceman (#13) attempting to clear the drain pipes from the toilet drain in the kitchen's employee bathroom. Approximately one inch of water remained in the areas of the kitchen previously identified. Observation showed the water blackened near the drains. An administrative dietary staff member (#10) identified the blackened water contained sediment from the drain pipes. Observation on 11/15/09 at 4:10 p.m.,. showed kitchen employees gathered at an entrance to the kitchen and stating their intention to leave the kitchen. This surveyor prompted the administrative dietary staff member (#10) to have each dietary staff member, who had been walking through the wastewater, to sanitize their shoes before exiting the kitchen.	F 371		

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F 371	Continued From page 19 Observation on 11/15/09 at 4:15 p.m., showed an administrative dietary staff member (#10) directed dietary staff to mop the floor of the staff lounge which dietary staff had walked into after walking through the wastewater. This surveyor prompted the administrative dietary member (#10) to mop the dining room where dietary staff had gathered after walking through the wastewater. Observation on 11/15/09 at 5:30 p.m., showed an administrative dietary staff member (#10) directed dietary staff to sanitize surfaces in the kitchen. Observation showed dietary staff did not sanitize dishware stored inverted and uncovered in the kitchen. This surveyor prompted the administrative dietary staff member to wash and sanitize this dishware, used for serving residents, in the dishmachine as these surfaces could recontaminate work and dining surfaces. On 11/15/09 at 5:15 p.m., the drain serviceman (#13) stated "a lot of it [drain blockage] coming from the new addition [of resident rooms]. When interviewed on 11/16/09 at 9:30 a.m., a maintenance staff member (#14) confirmed the drains had been blocked in a resident care area. During an interview on 11/16/09 at 9:00 a.m., an administrative dietary staff member (#10) stated wastewater had backflowed from drains in food preparation areas of the kitchen before and identified the area near two drains where this had occurred. When requested, this staff member identified the facility had no policy/procedure for responding to the backflow of water from kitchen drains. This staff member stated when this had occurred before dietary staff would report it to maintenance staff to clear the drains and clean	F 371		

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F 371	Continued From page 20 the flooded area. Dietary staff would not walk through the wastewater or work in the flooded area as wastewater is contaminated. This staff member identified no direction had been provided to dietary staff upon receiving notification by phone call of the drains backflowing. This staff member stated "yesterday [dietary staff] shouldn't have been doing anything because it kept getting worse." Failure of the facility to develop policies and procedures regarding the backflow of wastewater and the failure to educate staff how to respond to the above situation contributed to dietary staff continuing to operate the facility kitchen and prepare food, which placed the facility residents at risk of contracting a foodborne illness.	F 371		12/23/09
F 441 SS=E	483.65(a) INFECTION CONTROL The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, professional literature, and staff interview, facility staff failed to follow the facility's established infection control practices for 3 of 4 sampled residents (Resident #5, #12, and #18)	F 441	It is the policy of Valley Eldercare Center to establish and maintain an infection control program designed to provide a safe, sanitary and comfortable environment and prevent the development and transmission of disease and infection. R.N. Infection Control nurse will inservice all staff on 12/16/09; and discuss infection control policies regarding: contact isolation practices for residents with MRSA and VRE, hand-washing, protective equipment (gowns, gloves) and sanitizing of mechanical lifts used by these residents. The staff will be informed as to the importance of following policies for the protection of the resident and also protecting themselves against disease. Continued on Page 22 of 30	

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F 441	Continued From page 21 identified with a current Methicillin Resistant Staphylococcus Aureus (MRSA) infection and/or Vancomycin-Resistant Enterococci (VRE). Failure to follow established infection control practices has the potential to place residents, staff, and visitors at risk of contracting and/or spreading MRSA and/or VRE infections. Findings include: Review of the facility policy titled "Methicillin Resistant Staphylococcus Aureus" occurred on 11/18/09. This policy, dated 04/21/00, stated, "Purpose 1. To provide guidelines for appropriate isolation precautions of residents known or suspected to have MRSA infection or colonization.... Procedure Guidelines ... 2. Residents known or suspected to have MRSA infection or colonization will be placed on Contact Isolation Precautions...." Review of the facility policy titled "Vancomycin Resistant Enterococci" occurred on 11/18/09. This policy, dated 04/21/00, stated, "Purpose 1. To provide guidelines for appropriate isolation precautions of residents known or suspected to have Vancomycin Resistant Enterococci infection or colonization. . . . Procedure Guidelines 1. Residents known or suspected to have VRE infection or colonization will be placed on Contact Isolation Precautions. . . . 4. Wear gloves (clean, nonsterile) when entering the room of a VRE-infected or colonized resident because VRE can extensively contaminate such an environment. When caring for a resident, a change of gloves may be necessary after contact with material that could contain high concentrations of VRE (e.g. stool). 5. Wear a gown (clean, nonsterile) when entering the room	F 441	Continued From Page 21 On 12/02/09 Valley Eldercare Center R.N. Infection Control nurse, did an inservice for staff about cleaning of the lifts using germicidal wipes that are in the isolation carts on the units. Resident #5, #12, and #18 have not developed any other infectious process. Equipment with torn areas has been repaired. Maintenance will have extra upholstery on hand to repair when necessary or lifts will be removed from use until they can be repaired as they are non-cleanable surfaces at that time. The R.N. Infection Control nurse will audit staff in all areas of deficient practice: hand-washing, gown, gloves, and disinfecting of equipment monthly times six (6) months then random audits annually.	

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F 441	Continued From page 22 of a VRE-infected or colonized resident. . . ." Review of the facility policy titled "Handwashing" occurred on 11/18/09. This policy, dated 04/21/00, stated, "Policy Statement [-] Handwashing shall be regarded by this organization as the single most important means of preventing the spread of infections. Policy Interpretation and Implementation [-] 1. All personnel shall follow our established handwashing procedures to prevent the spread of infection and disease to other personnel, patients, and visitors. 2. Appropriate ten (10) to fifteen (15) second handwashing must be performed under the following conditions: . . . j. After removing gloves. . . . 4. The use of gloves does not replace handwashing. . . ." Review of the facility policy titled "Admission/Criteria Related to Infection Control" occurred on 11/18/09. This policy, revision date 12/11/02, stated, ". . . 2. This facility has adopted Standard Precautions as its primary means of reducing risk exposures and the transmission of infectious diseases. This indicates that barriers will be used on all blood, body fluids, excretions, secretions, mucous membranes, and non-intact skin of residents. . . ." The "Common Infections in the Long-Term Care Setting, Clinical Practice Guideline", published by the American Medical Directors Association, 2004, page 13, stated, "Standard precautions should be applied to all patients. They are designed to reduce the risk of transmission of infectious agents in moist body secretions. Standard precautions emphasize handwashing, gloves (when touching body fluids), masks, eye protection, and gowns (when splashing of body	F 441		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 23 fluids is likely) as well as avoidance of needlestick and other sharp injuries." The "North Dakota Recommendations for Control of Drug Resistant Organisms MRSA/VRE" for Long Term Care stated: "Handwashing, Employee: Hands should be washed after direct patient contact or glove removal with an antimicrobial soap . . . for at least 15 seconds. . . . Gowns (clean, nonsterile fluid resistant) should be worn if substantial, contact with the patient or if the patient is incontinent, has diarrhea, has an ostomy, or uncontained drainage or secretions. Gowns should be worn with anticipated contact with environmental surfaces/items. Gowns must be removed prior to leaving the patient. . . . Care of Equipment, . . . Devices to be used on multiple patients (i.e. oxymetry, glucometer, etc.) must be adequately disinfected immediately after use and prior to use on another resident. . . ." - Review of the medical record for Resident #18 occurred November 17-18, 2009. A lab report, dated 04/11/09, identified Resident #18 as positive for VRE in his stool. A lab report, dated 04/23/09, identified the resident as positive for VRE in his urine. Medical diagnoses for Resident #18 included neurogenic bladder. Review of the resident's quarterly Minimum Data Set [MDS], dated 09/08/09, identified Resident #18 required extensive assistance of two staff members for bed mobility and toilet use, extensive assistance of one staff member for personal hygiene, dependent on two staff members for transfers, had an indwelling catheter, is incontinent of bowel, and had a urinary tract infection. This MDS lacked identification of the resident's antibiotic	F 441		

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	355067	A. BUILDING _____ B. WING _____	11/18/2009

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F 441	Continued From page 24 resistant infection. Facility staff revised Resident #18's care plan on 11/17/09, and identified the antibiotic resistant infection as MRSA rather than VRE. Review of CNAs charting of care for Resident #18 occurred on the afternoon of 11/17/09. A form titled "Contact Precautions" identified Resident #18's name and room number and identified the resident has VRE. This form stated, "Contact precautions includes wearing a gown and thicker blue gloves . . . Only those with depressed immune systems will become infected with VRE, so the risk is usually not to the health care worker but to the residents they may spread it to. . ." staff provided bowel incontinence cares to Resident #18 and failed to wear a gown and to use the thicker blue gloves as identified by these precautions. Observation of cares for Resident #18 occurred on 11/18/09 at 3:33 p.m. The CNAs (#24 and #25) wore the yellow/white disposable gloves observed used with other residents. The CNAs' (#24 and #25) uniforms came into contact with the resident's bedding many times during the provision of care exposing their uniforms to potential contamination with VRE. The CNAs (#24 and #25) transferred Resident #18 using a mechanical full body lift, with the resident's legs and feet coming into contact with the upright column of the lift. After transferring Resident #18 to his wheelchair, a CNA (#25) moved the lift out into the hallway, returned to the room, and closed the door, without disinfecting the lift. The CNA (#25) then obtained a graduate to empty the urine drainage bag secured to Resident #18's leg. The close proximity of the CNA (#25) exposed her to potential splash from the urine. The CNA (#25)	F 441		

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F 441	Continued From page 25 then carried the graduate of urine to the toilet, poured the urine into the toilet, and rinsed the graduate using the sprayer arm, which exposed her to potential splashing of urine. During an interview with CNA (#24) following the above care observation, this CNA (#24) identified staff clean the lifts after use with residents in isolation and she thought the other CNA (#25) had cleaned the lift. When asked, the other CNA (#25) identified she did not clean the lift. The CNA (#24) stated she would clean the lift. The CNA (#24) wiped down the four points of attachment for the sling that supported the resident, the cross bar between the points of attachment and the handles the CNAs (#24 and #25) touched with a sanitizing wipe. The CNA (#24) failed to cleanse the main support column the resident's feet and legs came in contact with. During an interview on 11/18/09 at 9:20 a.m., an administrative nursing staff member (#26) confirmed staff should wear gowns when at risk of exposure during cares, and all surfaces of a mechanical lift which come into contact with a resident in isolation need to be cleaned after use. - Review of the medical record for Resident #12 occurred November 15-18, 2009. A hospital return report, dated 03/20/09, identified Resident #12 as positive for MRSA in his urine. Medical diagnoses for Resident #12 included neurogenic bladder. Review of the resident's annual MDS, dated 09/27/09, identified Resident #12 required extensive assistance of two staff members for transfers and toilet use, extensive assistance of one staff member for personal hygiene, had an indwelling catheter, and had an	F 441		

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F 441	Continued From page 26	F 441		

urinary tract infection. This MDS failed to identify the resident's antibiotic resistant infection. Review of Resident #12's current care plan failed to identify a MRSA infection.

Review of the CNAs charting of care for Resident #12 occurred on the morning of 11/16/09. An untitled form identified Resident #12's name and room number, identified the resident had MRSA in his urine. This form stated, "Contact precautions when providing care for him such as emptying his catheter bag, partial baths, or linen changes. These precautions include wearing gloves, and if splashing is anticipated, eye protection and gowns . . . Only those with depressed immune systems will become infected with MRSA so the risk is usually not to the health care workers but to the residents they may spread it to. . . ." The CNAs (#24 and #25) failed to wear a gown when they emptied the residents catheter bag, a task where splashing can be anticipated, as identified by these precautions.

Observation of cares for Resident #12 occurred on 11/17/09 at 12:35 p.m. and again at 12:50 p.m. During these observations CNAs (#29 and #30) used a mechanical standing lift for transferring Resident #12 from his wheelchair, to the toilet, and back again. Observation showed the padded leg rest on this lift torn, exposing the foam underneath, which does not allow effective disinfecting between residents.

During the observation at 12:50 p.m., a CNA (#29) obtained a graduate and an alcohol pad and emptied the residents catheter bag. The CNA (#29) positioned herself near the catheter bag as the bag drained filling the graduate to within an inch of the top. The CNA (#29) carried this full

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F 441	Continued From page 27 graduate to the toilet, emptied it, and rinsed it using a sprayer arm on the toilet. Each of these steps had the potential to expose the CNA (#29) to splashes of urine, causing contamination of her uniform. During an interview on 11/18/09 at 9:20 a.m., an administrative nursing staff member (#26) confirmed staff should wear gowns when at risk of exposure during cares. This same staff member confirmed the torn surfaces of the mechanical lift used for Resident #12 made it an uncleanable surface. - Review of Resident #5's medical record occurred on November 16-18, 2009. The resident's diagnoses included neurogenic bladder. Review of the resident's quarterly MDS, dated 10/21/09, identified the resident had an indwelling catheter and required total assistance with toilet use. Review of the CNAs charting of care for Resident #5 occurred on the morning of 11/18/09. A form, filed with this charting, contained Resident #5's name/room number and identified the resident as having "MRSA in her urine." The form advised CNAs to "Use CONTACT Precautions when providing direct care for her such as assisting with toileting, changing brief, partial baths, emptying her commode or linen changes. These precautions include wearing gloves, and if splashing is anticipated, eye protection and gowns. HANDWASHING is the most important thing (Both hers and ours). . . . " When interviewed on the afternoon of 11/16/09, a CNA (#20) identified he had emptied urine from Resident #5's catheter bag at approximately 1:00	F 441		

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F 441	Continued From page 28 p.m. Observation of the CNA (#20) emptying Resident #5's catheter bag occurred on 11/17/09 at 12:30 p.m. The CNA (#20) donned gloves from a cart, located outside Resident #5's room, and entered her room failing to gown.With Resident #5 seated in a wheelchair, the CNA (#20) knelt down near the resident's catheter bag on her leg. The CNA's close positioning to the resident's leg bag placed both the resident and the CNA at risk of being splashed with urine while emptying the bag. The CNA (#20) emptied the container of urine into the toilet, again a risk factor. The CNA (#20) then used a lift to transfer the resident to her bed and obtained linen to cover her from a cart in the hallway. The CNA did not wash/sanitize his hands after emptying the container of urine and removing his gloves. The CNA did not wash/sanitize his hands or sanitize the lift before exiting the resident's room. When interviewed on 11/17/09 at 3:45 p.m., a CNA (#20) confirmed the resident had "issues with her urine" and stated it to be "a matter of wearing gloves" and "using universal precautions." During an interview on 11/18/09 at 8:30 a.m., an administrative nursing staff member (#27) agreed CNAs should wash their hands after removing gloves to prevent contaminating other surfaces. When interviewed on 11/18/09 at 9:20 a.m., an administrative nursing staff member (#26) confirmed that gowns should be worn when emptying a catheter bag as there would be a risk	F 441		

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F 441	Continued From page 29 of splashing urine with this procedure. This staff member confirmed if the lift is in contact with a resident, staff should sanitize those areas of the lift using sanitizing wipes. When interviewed on 11/18/09 at 11:00 a.m., an administrative nursing staff member (#26) stated she had received a telephone call in February from Resident #5's unit nurse who indicated a lab result was "suspicious" for MRSA. This staff member stated she had called to clarify the lab results on the morning of 11/18/09 and was informed the resident did not have MRSA. The facility did not provide timely follow-up to determine the continued need for precautions or follow these precautions for a resident who they continued to identify as requiring contact precautions.	F 441		12/23/09