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 _____	C 11/29/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY ELDERCARE CTR	2900 14TH 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 and complaint survey started on November 26, 2012 and completed on November 29, 2012 the sample included five (5) residents for complete review, twenty-two (22) residents for focused review, and three (3) closed records for review. The sample included four (4) additional residents to verify specific concerns during the survey.	F 000		
F 278 SS=E	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED 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.	F 278	F 278 It is the policy of Valley Eldercare Center that each resident receive an accurate assessment by staff that are qualified to assess resident care and are knowledgeable about the resident's status. All residents have the potential by this deficient practice. On December 03, 2012 all the care coordinators were instructed of the changes necessary for the coding of the toileting schedules on the MDS. In order to code a toileting schedule on the MDS it must be individualized with specific times that assist the resident to maintain continence. Resident #2 is no longer in the facility. Resident #11 was reassessed for Incontinence/continence, it was Determined that she did maintain some Continence so specific times for Toileting were determined as 6am, 8am, 10am, 1pm, 3pm, 7pm and check on rounds at night. This latest assess-ment was completed and care planned on 12-08-2012. Continued on page 2	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Brad Hanson — TITLE: Pres./CEO — (X6) DATE: 12/20/12

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

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 _____	C 11/29/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY ELDERCARE CTR	2900 14TH 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 278	Continued From page 1 Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual (Version 3.0), the facility failed to implement an individualized, resident-specific program based on an assessment of the resident's unique voiding pattern for 6 of 7 sampled residents (Resident #2, #11, #16, #18, #19, and #23) coded on the Minimum Data Set (MDS) as on a toileting program. Failure to implement individualized, resident-specific toileting programs based on assessment does not meet the requirement for coding a scheduled toileting program on the MDS. Findings include: The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, April 2012, page 2-1 states, ". . . The RAI process is the basis for the accurate assessment of each nursing home resident . . ." Page H-6 states, ". . . Toileting (or trial toileting) programs refer to a specific approach that is organized, planned, documented, monitored, and evaluated that is consistent with the nursing home's policies and procedures and current standards of practice. A toileting program does not refer to: * simply tracking continence status, * changing pads or wet garments, and * random assistance with toileting or hygiene . . ." Page Z-6 states, ". . . The importance of	F 278	Continued from page 1 Resident #18 toileting schedule was discontinued as this resident is a hoyer lift now and on comfort cares. This was changed on 11-27-2012. The coding will be changed with her next assessment. Resident #19 On her most recent MDS quarterly assessment on 12-04-2012 the coding was changed to reflect she is no longer on a toileting schedule. Resident #16 She is no longer on a toileting schedule so her code will change. She is on our routine toileting schedule but not on an individualized schedule. Resident #23 She was reassessed based on continence/incontinence, it was determined that specific times would be care planned at 7am, 10am, 1pm, 4pm, 7pm, then first and last rounds at night. Charts and MDS's will be audited for accuracy in coding of toileting schedules by ADON/DON monthly times 6 months, then quarterly times 6 months. If no issues are noted we will do an annual audit for accuracy. Staff will attend an in-service regarding all changes on 12-27-2012. Compliance date is January 03, 2012	Addm 12/28/12 E Carol Smorthand DON at 10:30am CDeyro, RN 01-03-13

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 _____	C 11/29/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY ELDERCARE CTR	2900 14TH 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 278	Continued From page 2	F 278		

accurately completing and submitting the MDS cannot be overemphasized. The MDS is the basis for the development of:
* an individualized care plan
* The Medicare Prospective Payment System
* Medicaid reimbursement programs
* quality monitoring activities . . .
* the data-driven survey and certification process
* the quality measures used for public reporting . . ."

- Review of Resident #11's medical record occurred on all days of survey. The annual MDS, dated 11/18/12, identified Resident #11 as frequently incontinent of bladder and on a current toileting program.

The current care plan identified staff should toilet Resident #11 every two to three hours while awake and on demand at night.

- Review of Resident #23's medical record occurred on November 28-29, 2012. The quarterly MDS, dated 10/16/12, identified Resident #23 as frequently incontinent of bladder and on a current toileting program.

The current care plan identified staff should toilet Resident #23 every two to three hours while awake and as needed at night.

- Review of Resident #16's medical record occurred on all days of survey.
A quarterly MDS, dated 09/08/12, identified Resident #16 as frequently incontinent of bladder and on a toileting program.

The current care plan identified staff should toilet

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 _____	C 11/29/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY ELDERCARE CTR	2900 14TH 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 278	Continued From page 3	F 278		

Resident #16 every two hours while awake and every four hours at night.

- Review of Resident #18's medical record occurred on all days of survey. A quarterly MDS, dated 09/01/12, identified Resident #18 as occasionally incontinent of bladder and on a toileting program.

The current care plan identified staff should toilet Resident #18 every two to three hours while awake and on demand at night.

- Review of Resident #2's medical record occurred on all days of survey. A quarterly MDS, dated 10/26/12, identified Resident #2 as frequently incontinent of bladder and on a toileting program.

Resident #2's current care plan stated, ". . . Help me to use the toilet every 2-3 hours when I am awake and as I ask at night. . . ."

- Review of Resident #19's medical record occurred on November 28-29, 2012. An annual MDS, dated 09/04/12, identified Resident #19 as frequently incontinent of bladder and on a toileting program.

Resident #19's current care plan stated, ". . . My toileting schedule was restarted at the institance [sic] of my family even though I am still mostly incontinent. The staff will attempt to put me on the comode [sic] only if I am wide awake. . . ."

The facility failed to implement individualized, resident-specific toileting programs, periodically evaluate the effectiveness of these specific

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 _____	C 11/29/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY ELDERCARE CTR	2900 14TH 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 278	Continued From page 4 toileting times, and make revisions to the program, if needed, based on an assessment of Resident #2, #11, #16, #18, #19, and #23's unique voiding pattern.	F 278		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES 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 by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON DECEMBER 22, 2011 Based on observation, record review, review of facility policy, and resident/staff interviews, the facility failed to provide adequate supervision and assistive devices for 1 of 1 sampled resident (Resident #3) with a history of falls transferred without a mechanical stand lift and 2 of 2 sampled residents (Resident #2 and #23) observed transferred without a gaitbelt. Failure of facility staff to ensure proper use of assistive devices (gaitbelts and/or stand lifts) has the potential to cause residents unnecessary pain and places them at risk for possible accident and/or injury. Findings include:	F 323	F323 It is the policy of Valley Eldercare Center that we ensure that the resident's environment remain as free of accidents/hazards as possible and that each resident receives adequate supervision and assistive devices to prevent accidents. Resident #3 continues to reside here. She is a Standing PAL transfer with assist of two. She continues to be followed by PT/OT for strengthening and safe transfer. The hoyer lift is available prn for transfer if the resident is too weak to bear weight during transfer, which could happen on dialysis days. This is care planned and followed by staff. Resident #12 continues to reside here. She is assist of one using a gait belt during the day. At night she is a two person assist prn. This is care planned for safety. Resident #17 continues to reside here. Staff continue to remind her to use her call light for assist, even though she is often non-compliant and will self transfer. The call light must be within her Reach at all times when she is on the Recliner/chair. This is care planned for safety. Continued on page 6	

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 _____	C 11/29/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY ELDERCARE CTR	2900 14TH 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 323	Continued From page 5 Review of the facility policy titled "TRANSFERRING THE RESIDENT TO AND FROM BED TO CHAIR" occurred on 11/29/12. This policy, revised April 2010, stated, ". . . A. Transfer from Bed to Chair or to Ambulate: . . . a. Gait belt is always used in transfers with 1-2 staff members. . . ." Review of Resident #3's medical record occurred on all days of survey. Diagnoses included chronic kidney disease, diabetes, neuropathy, failure to thrive, muscle weakness, history of falls, L1 [lumbar spine], L2, L3, L4 compression fractures and hip/ankle fractures. The quarterly Minimum Data Set (MDS), dated 11/13/12, identified intact cognition, total assistance of two or more persons required for transfers and locomotion on/off the unit, and history of falls. The current care plan stated, ". . . Problem: I have ESRD [end stage renal disease] and need hemodialysis . . . Interventions: . . . I am usually pretty weak [after] dialysis [and] need more assist - I've been cleared to use the PAL [stand lift] [with] 2 assist, but if I'm too weak a total lift may be needed. 11/26/12 . . . Problem: I have a hx [history] of falling and fx [fracture] my hip and ankle . . . Interventions: . . . I have to use 2 [and] Pal until therapy oks the staff to transfer me differently. 11/26/12 . . ." The "Resident Information Sheet," dated 11/26/12, stated, "Hoyer lift for transfers, transfers per therapy - [two] [and] lift." The "Resident updated Information Sheet," dated 11/27/12, stated, "transfer per therapy assist of 2 [and] PAL, lowered to floor at 4:30 a.m. on 11/27, [No] injuries, fall follow up [at] 12:30 p.m., transfer	F 323	Continued from Page 5 Residents #23 continues to reside here. She is assist of one person using a gait belt for transfers. This is care planned for safety. All residents have the potential to be affected by this deficient practice. All staff will receive education and in-service training on December 27, 2012. Topics to be covered will be proper transfer techniques using gait belts and standing/full body lifts, proper positioning of call lights. We continue to do resident transfer audits where a nurse evaluates a transfer by staff in the morning, evening and assess resident bed mobility at night. Each resident will have an audit completed one time per month using the same schedule the units use for care plan review. On December 12 –13, 2012 there was an inservice training completed by Corinne Johnson, RN Staff Development Nurse, Cassidy Robles, PTA and Dennis Benson, SMT, Volaro lift representative. Training was provided on gait belt use, call light placement, all mechanical lifts, devices used for proper positioning. Transfers and use of assistive devices will be audited monthly times 6 months then quarterly by ADON/Staff Development Nurse. Compliance date is January 03, 2013	01-03-13

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 _____	C 11/29/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY ELDERCARE CTR	2900 14TH 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 323	Continued From page 6 2 and Pal." The "Resident Care Notes," dated 11/27/12 at 12:05 a.m., stated, ". . . Resident lowered to floor by 2 CNAs [No] injuries able to move all extremities. Resident is quite weak in her legs. . . ." During an interview on 11/28/12 at 2:38 p.m., a managerial nursing staff member (#13) obtained the 11/27/12 "Fall Incident Report" and stated, "The resident was weak, and was lowered to the floor in her room. The two CNAs were getting her ready for dialysis." She described the incident as "avoidable," due to the fact the two CNAs failed to follow the care plan and utilize a PAL lift during the transfer. An interview with Resident #3 [identified by the facility as interviewable] occurred on 11/29/12 at 10:25 a.m. She stated, "I kept telling them I could not transfer. They said, 'The note says you can.' I told them I wasn't comfortable [being transferred without the lift]. They wouldn't listen to me. They tried to get me up [using the gaitbelt], and I went down on the floor, on my butt." When asked if she had had any pain/discomfort or injury, she replied, "Oh no, not with this one." - Review of Resident #12's medical record occurred on all days of survey and diagnoses included spinal stenosis and an abnormal movement disorder. The quarterly MDS, dated 10/09/12, identified the resident transferred with extensive assistance of one staff member. Observation in Resident #12's room on 11/28/12 at 7:50 a.m. identified a nurse (#4) assisted	F 323		

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 _____	C 11/29/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY ELDERCARE CTR	2900 14TH 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 323	Continued From page 7	F 323		

Resident #12 to stand from her wheelchair by lifting up on the back of the resident's pants and under her right arm. Resident #12 held on to her walker while standing and the nurse (#4) applied cream to the resident's buttocks. The resident's legs started to tremor and the resident yelled "I'm falling!" Resident #12's knees buckled and she fell back into her wheelchair seat. The nurse (#4) then assisted Resident #12 to transfer from her wheelchair to the recliner in her room. The nurse (#4) lifted under the resident's left arm and assisted her to stand and pivot to the recliner. The resident took a few unsteady steps before sitting down in the recliner. The nurse (#4) failed to use a gait belt while assisting Resident #12.

- Review of Resident #23's medical record occurred on November 28-29, 2012 and diagnoses included osteoarthritis and dementia. The quarterly MDS, dated 10/16/12, identified the resident transferred and ambulated with extensive assistance of one staff member and showed the resident experienced one fall with no injury.

Observation on 11/29/12 at 8:38 a.m. identified a CNA (#10) assisted Resident #23 to stand from her wheelchair by lifting up on the back of the resident's pants and under her left arm. Resident #23 walked to the bathroom using her walker. After using the toilet, the CNA (#10) assisted the resident off the toilet by lifting under her right arm and the resident walked back to her wheelchair. The CNA (#10) failed to use a gait belt when transferring Resident #23.

During an interview on 11/29/12 at 10:38 a.m., an administrative nurse (#9) stated staff should use

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 _____	C 11/29/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY ELDERCARE CTR	2900 14TH 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 323	Continued From page 8	F 323		

a gait belt when transferring residents who require staff assistance.

2. Based on observation, record review, and staff interview, the facility failed to provide a safe environment for 1 of 1 sampled resident (Resident #17) with a history of falls with injury and who lacked availability of the call light. Failure to place the resident's call light within reach increases the chance for falls and further injury when the resident needs to call staff for assistance with activities of daily living (ADLs).

Findings include:

- During an observation on 11/27/12 at 4:30 p.m., a certified nursing assistant (CNA) (#7) knocked and entered Resident #17's room and asked the resident if she needed to use the bathroom, the resident stated, "I took myself." The CNA (#7) stated, "you have to call and we will help you." Observation showed the resident was sitting in the recliner with the call light located on the bed, out of Resident #17's reach.

An observation on 11/28/12 at 10:40 a.m., showed Resident #17 sitting in her room in the recliner with her call light located on the bed. The resident could not reach the call light from this position.

During an observation on 11/29/12 at 8:05 a.m., a CNA (#8) applied a gait belt around Resident #17's waist and helped her transfer from the wheelchair to the recliner in her room. As the CNA (#8) left the room, she reminded the resident to call if she needs help. Observation showed the resident's call light located on her bed

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 _____	C 11/29/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY ELDERCARE CTR	2900 14TH 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 323	Continued From page 9	F 323		

and out of the reach of the resident.

Review of Resident #17's record occurred on all days of survey and included of diagnoses chronic vertigo, hyponatremia (low sodium which can cause confusion and muscle weakness), falls, and history of stroke.

A quarterly Minimum Data Set (MDS), dated 10/17/12, identified Resident #17 experienced one fall with no injury and 2 or more falls with injury, balance during transitions/walking as not steady and only able to stabilize with staff assistance, and extensive assistance of two persons for transfer and toilet use. This MDS identified the resident as cognitively intact.

Review of Resident #17's Resident Care Notes stated the following:
* 08/16/12 9:20 p.m., "Resident put call light on, found sitting on her bottom between chair & [and] bed. States she went to stand to get to bed & fell. . . ."
* 09/08/12, "At 625 [6:25 a.m.] CNAs called nurses to room. [Resident's name] was under her bed lying on R [right] side head against the wall. W/C [wheelchair] was in BR [bathroom] . . . Called placed for EMS [emergency medical services] . . . This nurse suggested use of spine board because of position [resident's name] was found in and extreme pain to back head [sic] . . . "
* 09/15/12, "Data: Resident found on floor next to recliner. Resident was transferring self from recliner to wheelchair. Resident had call light. Resident has been needing extra help with transfers due to increase weakness and confusion. . . ."

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 _____	C 11/29/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY ELDERCARE CTR	2900 14TH 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 323	Continued From page 10 Review of a physician's progress note, dated 09/10/12, stated, ". . . Fall over the weekend resulting in considerable pain neck, back, legs and left ankle, and all x-rays were negative in the ER [emergency room]." Review of Resident #17's current care plan states the following; "PROBLEMS/STRENGTHS - I NEED ASSISTANCE WITH MY ADL'S . . . I ALSO HAVE DIZZY SPELLS AND HX [history] OF SYCOPE [sic]. I HAVE HX OF FALLS AND MY BALANCE IS POOR. I DO NOT ALWAYS LIKE TO CALL OR WAIT FOR ASSISTANCE. . . INTERVENTIONS. . . I WILL USE THE CALL LIGHT FOR ASSISTANCE WITH MY ADL'S AS NEEDED . . . SAFETY DEVICES: . . . REMIND TO CALL AND WAIT FOR ASSISTANCE WITH ALL TRANSFERS AND AMBULATION. IS RELUCTANT AT TIMES TO CALL OR WAIT FOR ASSISTANCE. . . ." During an interview on 11/28/12 at 1:00 p.m., a staff nurse (#4) stated that prior to the fall on 09/08/12, Resident #17 had been independent with transfers in her room and did not have a bed alarm. During an interview and observation of Resident #17's room on 11/29/12 at 8:30 a.m., an administrative staff nurse (#9), agreed that the resident's call light should be available for the resident when she is sitting in her recliner.	F 323		
F 332 SS=E	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater.	F 332	F 332 It is the policy of Valley Eldercare Center that we ensure that we are free of medication error rates of five per-cent or greater. Continued on page 12	

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 _____	C 11/29/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY ELDERCARE CTR	2900 14TH 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 332	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, review of professional reference, and staff interview, the facility failed to ensure a medication error rate of less than five percent during observation of medication administration for 3 supplemental residents (Resident #31, #32, and #33) who received insulin incorrectly and 1 supplemental resident (#34) who received the wrong dose of a scheduled laxative. Failure to prime insulin pens, eject all excess air from insulin syringes, and administer the correct laxative dose resulted in residents receiving inaccurate doses of medication. Five errors occurred during staff administration of 44 medications, which resulted in an 11 percent error rate. Findings include: Review of the facility policy titled "Injections/Insulin with use of NovoLog Flexpen and Levemir FlexPen" occurred on 11/29/12. This policy, revised February 2011, stated, ". . . Procedure: . . . B. Performing the airshot 1. Turn the dose dial to 2 units. 2. Holding the . . . FlexPen with the needle pointing up, tap the reservoir gently with your finger a few times. 3. With the needle still pointed up, press the push button as far as it will go until you see a drop of insulin at the needle tip. This is called an airshot. . . " Kozier & Erb's "Fundamentals of Nursing,	F 332	.Continued from page 11 Medication passes/insulin administration of the residents affected by this deficient practice will be observed and audited for correct medication administration practices. Other residents having the potential to be affected by the same deficient practice will be identified by observation of medication passes and the auditing of those medication passes. The deficiency will be corrected by inservicing the licensed staff on: 01/02/13 - per Cord Shorthand DON on 12/31/12 at 0902. CDesper A. The proper use of a Novalog FlexPen and the Levemir FlexPen, including priming of the needle with each use per packaging guidelines. B. The drawing up and administration of insulin using a syringe. C. A review of the Valley Memorial Homes policy #107.3a on Performance criteria for Medication Administration, which includes the "6 Rights". D. The licensed staff will be skills validated on the administration of subcutaneous injections and the proper use of insulin pens. This deficiency will be corrected on January 3, 2013. Medication passes will be randomly audited on a weekly basis for a period of six months by the Staff Development/Infection Control Nurse and the Assistant Director of Nursing. These audits will document the following: A. That the "6 Rights" are followed when the medication is administered. B. The correct use of the FlexPens, including priming with each use. C. The correct technique for drawing up and administering insulin per syringe.	01-03-13

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 _____	C 11/29/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY ELDERCARE CTR	2900 14TH 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 332	Continued From page 12	F 332		

Concepts, Process and Practice," 9th Edition, dated 2012, pages 879-880 states, "Preparing Medications from Vials . . . Hold the syringe and vial at eye level to determine that the correct dosage of drug is drawn into the syringe. Eject air remaining at the top of the syringe into the vial. . . . If necessary, tap the syringe barrel to dislodge any air bubbles present in the syringe. . . ."

Review of the facility procedure titled "Medication Administration" occurred on 11/29/12. This policy, dated 05/14/91 and last revised 2/11, stated, "Medication Administration 1. Check Medication Administration Record (MAR) and read each order entirely. 2. Remove appropriate medication from drawer and compare label to MAR when removing from drawer, when dispensing, and when replacing it in the drawer. The following information is assessed: right resident, right medication, right dose. . . ."

- Observation of medication pass on 11/27/12 at 11:00 a.m. showed a nurse (#4) administered insulin to Resident #31. During the observation, the nurse (#4) dialed the dose selector on the resident's NovoLog FlexPen to the number of units prescribed by the provider. Prior to administering the ordered dose of insulin to Resident #31, the nurse failed to "prime" or expel the air from the attached needle with two units of insulin.

- Observation of medication pass on 11/27/12 at 4:42 p.m. showed a nurse (#5) administered insulin to Resident #32. During the observation, the nurse (#5) dialed the dose selector on the resident's NovoLog 70/30 FlexPen to the number of units prescribed by the provider. Prior to

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 _____	C 11/29/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY ELDERCARE CTR	2900 14TH 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 332	Continued From page 13	F 332		

administering the ordered dose of insulin to Resident #32, the nurse failed to "prime" the attached needle with two units of insulin.

- Observation of medication pass on 11/28/12 at 8:34 a.m. showed a nurse (#6) administered insulin to Resident #31. During the observation, the nurse (#6) dialed the dose selector on the resident's Lantus FlexPen to the number of units prescribed by the provider. Prior to administering the ordered dose of insulin to Resident #31, the nurse failed to "prime" the attached needle with two units of insulin.

- Observation of medication pass on 11/27/12, at 11:31 a.m. showed a licensed nurse (#1) withdrawing three units of Novolog Insulin from a multidose vial for Resident #33. As the nurse (#1) drew the insulin into the syringe, this surveyor noted an air bubble in the syringe. This surveyor questioned the nurse about the air bubble while the nurse (#1) still had the needle in the vial of insulin. The nurse (#1) removed the syringe/needle from the vial, turned the needle upwards, looked at the barrel of the syringe, confirmed an air bubble at the base of the needle, and administered the injection to Resident #33.

- Observation of medication pass on 11/28/12, at 8:10 a.m., showed a certified medication aide (CMA) (#2) obtaining medications for Resident #34. The CMA (#2) obtained one gel capsule from a bottle of DocQlace. The label identified each gel capsule contained 100 mg (milligrams) of docusate sodium. The CMA (#2) then administered the medications to Resident #34. Review of the physician order identified Resident #34 should receive 200 mg of docusate sodium.

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 _____	C 11/29/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY ELDERCARE CTR	2900 14TH 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 332	Continued From page 14 Review of the MAR showed the dose as 200 mg. When questioned, the CMA (#2) identified she administered an incorrect dose of docusate sodium to Resident #34. During an interview on 11/28/12, at 12:40 a.m., an administrative nurse (#3) confirmed staff are to prime the needle when using an insulin pen, remove air bubbles from a syringe prior to administration, and administer the ordered dose of medication.	F 332		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community	F 356	F 356 It is the policy of Valley Eldercare Center to post the following information on a daily basis: facility name, current date, total number and actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: Registered nurses, Licensed practical nurses or licensed vocational nurses (as defined under State law), certified nurse aides, and resident census for the day. FTE's are posted by the 200 Unit Charge Nurse before the start of the day shift and updated and posted before the start of the pm shift. The night shift FTE's are updated and posted before the Scheduling Secretary leaves for the day at 4:30p.m. The FTE posting includes: the facility name, current date, total number and actual hours worked by RN, LPN's, and C.N.A.'s and the current facility census. This deficiency was corrected by December 7, 2012. The FTE posting will be audited for a period of 6 months by the DON. All staff will be in-serviced about the changes on December 27, 2012.	see attached amendment CE 12/31/12 01-03-13

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 _____	C 11/29/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY ELDERCARE CTR	2900 14TH 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 356	Continued From page 15	F 356		

standard.

The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.

This REQUIREMENT is not met as evidenced by:
Based on observation and staff interview, the facility failed to post the actual hours worked per shift by registered nurses (RNs), licensed practical nurses (LPNs), and certified nurse aides (CNAs) directly responsible for resident care at the beginning of each shift during 4 of 4 days of survey (November 26-29, 2012).

Findings include:

Observation showed the posting of staff directly responsible for resident care in a display case located by the main entrance of the facility. The posting of staff identified the total number of staff and the actual hours worked for the morning, evening, and night shifts each day.

Observations of the posting of staff on all days of survey identified the following:
*11/26/12 at 1:42 p.m. - posting of staff dated 11/21/12 and filled out for all shifts
*11/26/12 at 4:00 p.m. - posting of staff dated 11/25/12 and filled out for all shifts
*11/27/12 at 8:55 a.m. - posting of staff dated 11/25/12 and filled out for all shifts
*11/27/12 at 5:15 p.m. - posting of staff dated 11/27/12 and filled out for all shifts
*11/28/12 at 7:30 a.m. and 4:40 p.m. - posting of staff dated 11/27/12 and filled out for all shifts

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 _____	C 11/29/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY ELDERCARE CTR	2900 14TH 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 356	Continued From page 16 *11/29/12 at 7:30 a.m. - posting of staff dated 11/27/12 and filled out for all shifts *11/29/12 at 9:50 a.m. - posting of staff dated 11/28/12 and filled out for all shifts The facility failed to post staffing information at the beginning of each shift (days, evenings, nights) and instead posted the information for the entire day. The facility also failed to ensure the correct calendar date was posted. During an interview on 11/29/12 at 10:38 a.m., an administrative nurse (#3) stated the staffing secretary posts the daily posting of staff in the morning for all shifts. On weekends, the nurse (#3) identified a staff member posts the staff information for Saturday and Sunday at the same time she posts the information for Friday.	F 356		
F9999	FINAL OBSERVATIONS Based on observation, record review, and staff interview, the complaint investigated in conjunction with the standard Medicare/Medicaid survey was not substantiated.	F9999		