STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355082	A. BUILDING _____ B. WING _____	10/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVE MARIA VILLAGE	501 19TH ST NE JAMESTOWN, ND 58401

(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 October 29, 2012 and completed on October 31, 2012 the sample included five (5) residents for complete review, twelve (12) residents for focused review, and three (3) closed records for review. The sample included two (2) additional residents to verify specific concerns during the survey.	F 000	1. For the one resident who was affected, a significant correction MDS assessment was completed and submitted on 11-6-2012. 2. All residents have the potential to be affected.	
F 278 SS=D	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. Clinical disagreement does not constitute a	F 278	3. All nurse managers completing the MDS assessments have been educated on the importance of assessing and coding the MDS to accurately reflect the resident's status and the components necessary to meet the definition of a toileting program. Additionally, all residents will have a review of bowel and bladder function at least annually and PRN as indicated. 4. A QA tool has been developed to monitor coding of the MDS regarding actual toileting programs. A five percent random sample will be obtained for QA as indicated. The QA will be completed monthly x 3 months and quarterly thereafter with results	

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Timothy N. Burchill — TITLE: President / CEO — (X6) DATE: 11/21/12

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that her safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days llowing 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 ays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ogram participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355082	A. BUILDING _____ B. WING _____	10/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVE MARIA VILLAGE	501 19TH ST NE JAMESTOWN, ND 58401

(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 material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual (Version 3.0), and staff interview, the facility failed to complete Minimum Data Set (MDS) assessments which accurately reflected the resident's status for 1 of 2 sampled residents (Residents #4) coded on the MDS for a toileting program. Failure to accurately assess and code the MDS may affect the level of care provided by staff to the residents. Findings include: The Long-Term Care Facility RAI User's Manual, dated April 2012, pages H-5 and H-6, states "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 . . . random assistance with toileting or hygiene." Requirements include, "implementation of an individualized, resident-specific toileting program that was based on an assessment of the resident's unique voiding pattern . . . notations of the resident's response to the toileting program and subsequent evaluations . . ." Review of a facility document "Standards of Care" occurred on all days of survey. The undated document stated, "Each of the following is to be	F 278	reported to the Quality Assurance Team. 5. November 21, 2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355082	A. BUILDING _____ B. WING _____	10/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVE MARIA VILLAGE	501 19TH ST NE JAMESTOWN, ND 58401

(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 provided as routine care by the Nursing Assistants, unless otherwise directed. . . . 15. Follow toileting schedule - upon rising, before and after meals, mid-afternoon and HS [hour of sleep] and as requested by resident. . . ." Review of Resident #4's medical record occurred on all days of survey. Review of Resident #4's Minimum Data Sets (MDSs) identified the resident on a urinary and a bowel toileting program for the MDSs dated 02/26/12, 05/15/12, and 08/06/12. The resident's current care plan and care area assessment, dated 05/17/12, identified the resident to be toileted per the facility's "Standards of Care." Observation on the morning of 10/30/12 at 8:10 a.m., showed Resident #4 used her call light to have staff assist her to toilet. During an interview with a certified nurse assistant (CNA) (#14) at 11:15 a.m., the CNA stated the resident used her call light approximately at 10:15 a.m. to have staff assist her to toilet. During an interview on 10/30/12 at 3:30 p.m., a supervisory nurse manager (#18) stated staff follow the facility's standard toileting program for Resident #4 and was unable to provide rationale for why the MDSs were coded as the resident being on a toileting program and verified the resident's medical record lacked a bladder assessment in the past year. The resident's care plan and information from an interview with a supervisory nurse identified the facility followed their standard of care for toileting Resident #4 which does not meet individualized times specific to the resident's toileting needs.	F 278		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355082	A. BUILDING _____ B. WING _____	10/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVE MARIA VILLAGE	501 19TH ST NE JAMESTOWN, ND 58401

(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 The facility lacked monitoring of the resident's bladder and bowel habits on an on-going basis to allow for a toileting schedule to be developed according to patterns of incontinence.	F 278		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of the facility's Standards of Care, and staff interview, the facility failed to provide services to restore as much normal bladder function as possible for 1 of 13 sampled residents (Resident #12) requiring extensive assistance with toileting. Failure to provide toileting in accordance with the resident's care plan could result in increased episodes of incontinence and/or skin breakdown. Findings include: Review of a facility document "Standards of Care" occurred on all days of survey. The undated document stated, "Each of the following is to be provided as routine care by the Nursing Assistants, unless otherwise directed. . . . 15.	F 315	1. For the one resident who was affected, all staff who work on the Lane were educated on the importance of following toileting schedules and facility toileting protocol. 2. Any resident who requires assistance with toileting has the potential to be affected. 3. All nursing staff have been educated on the importance of following toileting programs and facility toileting protocols. Professional nursing staff were educated on November 15, 2012 and Certified Nursing Assistants were educated in groups or individually by 11-21-2012 4. A QA tool has been developed to monitor toileting programs and facility toileting protocols across all shifts. A 5 % random	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355082	A. BUILDING _____ B. WING _____	10/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVE MARIA VILLAGE	501 19TH ST NE JAMESTOWN, ND 58401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 4 Follow toileting schedule - upon rising, before and after meals, mid-afternoon and HS [hour of sleep] and as requested by resident. . . ." Resident #12's medical record, reviewed on all days of survey, identified a diagnosis of presenile dementia. A quarterly Minimum Data Set, dated 09/09/12, identified the resident as severely impaired for decision making, required extensive assistance with toileting, and occasionally incontinent of bowel and bladder. Resident #12's current care plan, dated 02/01/12, identified a focus "Urinary incontinence r/t [related to] dementia. . . ." Interventions included, "Toilet per AMV [Ave Maria Village] protocol. Toilet on request." Another focus, dated 02/01/12, stated, "I have a communication problem r/t dementia. I verbalize very little." Interventions included, "I am able to answer simple yes/no questions at times. Anticipate and meet needs. . . ." Observations during the survey identified the following: * 10/29/12 at 3:45 p.m. - Observation showed Resident #12 resting in bed. Two Certified Nursing Assistants (CNAs) (#9 and #10) checked the resident's brief and found it dry. The CNAs then assisted Resident #12 into the wheel chair and transported her to the nurses' station without offering or providing toileting. * 10/30/12 at 9:30 a.m. a CNA (#5) assisted Resident #12 to walk from the dining room to her room following breakfast. As they approached the resident's room, another CNA (#7) joined them. The CNA (#5) asked the resident if she wanted to use the bathroom. The resident did not respond. Without attempting toileting, the CNAs assisted	F 315	sample will be obtained as indicated. The QA tool will be done monthly on an ongoing basis with results reported to the Quality Assurance Team. 5. November 21, 2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355082	A. BUILDING _____ B. WING _____	10/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVE MARIA VILLAGE	501 19TH ST NE JAMESTOWN, ND 58401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 5 Resident #12 into bed and changed her wet brief. * 10/30/12 at 1:05 p.m. - Two CNAs (#3 and #5) assisted Resident #12 from the dining room to her room in her wheel chair. The CNAs assisted the resident to the bathroom. Observation showed the resident's brief dry. The resident voided and had a bowel movement. One CNA (#5) stated she had toileted the resident just before dinner and the resident was dry and voided. * 10/30/12 at 3:55 p.m. - Observation showed Resident #12 resting in bed. Two CNAs (#4 and #6) checked the resident's brief and found it dry. The CNAs then assisted Resident #12 into a wheelchair and transported her to the nurses' station without offering or providing toileting. An interview occurred with an administrative nurse (#2) on 10/31/12 at 8:00 a.m. When informed of the above observations, the nurse stated staff should have toileted Resident #12 in accordance with the facility's Standards of Care. Although observation showed Resident #12 voided when staff provided toileting, staff failed to consistently implement the facility's Standards of Care for toileting.	F 315		
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.	F 323	1. For the one resident who was affected, staff have been educated to use gait belt for transfers, new slippers have been acquired, and fall mat is removed prior to any transfers. A Physical Therapy evaluation has also been completed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355082	A. BUILDING _____ B. WING _____	10/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVE MARIA VILLAGE	501 19TH ST NE JAMESTOWN, ND 58401

(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 This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of a professional standard, review of the facility's Standards of Care, and staff interview, the facility failed to ensure each resident received assistance devices to prevent accidents for 1 of 2 sampled residents (Resident #12) requiring extensive assistance with transfers and observed transferred without a gait belt. Failure to use the appropriate assistance device contributed to Resident #12 experiencing tripping and falls and could result in an injury. Findings include: Review of a facility document "Standards of Care" occurred on all days of survey. The undated document stated, "Each of the following is to be provided as routine care by the Nursing Assistants, unless otherwise directed. . . . Transfer/Locomotion . . . B. Use gait belt with all assisted transfers and ambulation unless otherwise specified . . . D. Assist with ambulation, transfers, and locomotion per Routine Care Sheet [a sheet on the resident's bathroom door with specific instructions for that resident's care]. . . ." Kozier and Erb's Fundamentals of Nursing Concepts, Process, and Practice, 9th edition, Pearson, Boston, page 1158 stated, "Transferring Clients: Many clients require some assistance in transferring . . . Before transferring any client, however, the nurse must determine the client's physical and mental capabilities to participate in the transfer technique. . . . A gait belt provides the greatest safety. A gait belt is a safety device used	F 323	2. Any resident who requires assistance with transferring has the potential to be affected. 3. All nursing staff have been educated to assess environment for safety of both equipment and personal items prior to any transfer. A gait belt shall be used for all transfers. 4. A QA tool has been developed to monitor use of gait belt with all transfers as well as personal and environmental safety. A 5 % random sample will be obtained. The QA tool will be completed monthly on an ongoing basis, with results reported to the Quality Assurance Team.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355082	A. BUILDING _____ B. WING _____	10/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVE MARIA VILLAGE	501 19TH ST NE JAMESTOWN, ND 58401

(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		

for moving or transferring a client. . . . It can also be used when assisting a client to ambulate. . . ."

Resident #12's medical record, reviewed on all days of survey, identified a diagnosis of presenile dementia. A quarterly Minimum Data Set (MDS), dated 09/09/12, identified Resident #12 had short and long term memory problems, severe impairment with decision making, required extensive assistance with transfers and walking in the room and corridor, and experienced a fall with injury since the prior assessment. Section G300 of the MDS identified Resident #12 as "not steady, only able to stabilize with staff assistance" when moving from seated to standing position, walking, turning around, moving on and off toilet, and surface to surface transfer (transfer between bed and chair or wheelchair).

Resident #12's current care plan, dated 02/01/12, identified a focus "At risk for falls r/t [related to] dementia. An intervention, dated 06/15/12, stated, "Res [resident] sits on floor & [and] lays on floor frequently. This is not a fall as she does this intentionally. Family is aware & they prefer her to be left alone." Another focus, dated 02/01/12 stated, "I have an ADL [Activities of Daily Living] Self Care Performance Deficit r/t dementia. Interventions included, "I can ambulate with 1-2 staff assist, hand in hand . . . I require extensive staff participation with transfers . . . (handwritten and dated 10-3-12): I do not use a gait belt."

The resident's Routine Care Sheet, revised 10/03/12, stated, "Additional Instructions: . . . Refuses gait belt, if she allows it to be put on, it may be used. Fall Prevention: 6-15-12 At times will intentionally sit down on floor, this is not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355082	A. BUILDING _____ B. WING _____	10/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVE MARIA VILLAGE	501 19TH ST NE JAMESTOWN, ND 58401

(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		

considered a fall. 8-23-12 Use w/c [wheelchair] when aggressive rather than walking."

Progress notes identified the following:
* 08/23/12 at 9:50 p.m. - "[CNA name] was ambulating resident back from the dining room hand in had [sic] as resident is careplanned [sic] that way. Resident started getting aggressive when they reached her room, started pushing staff away and swinging her arms out. Resident lost her balance and fell to the floor. Did bump her head on her bedside table."
* 10/30/12 at 11:30 a.m. - "Resident ambulating hand to hand with staff to DR [dining room] for lunch and started to sit was lowered to floor . . . Intervention: Will have second staff follow with wheelchair while ambulating from now on."

Observations during the survey identified the following:
* 10/30/12 at 9:30 a.m. - A CNA (#5) ambulated Resident #12 from the dining room to her room (a distance greater than 100 feet). The CNA (#5) did not use a gait belt, but stood in front of the resident and walked backwards down the hall leading Resident #12 by holding her hands. Resident #12 walked with a shuffling gait and took small steps. The CNA (#5) and Resident #12 ambulated past a bed, in the hallway. The resident attempted to sit on the bed and the CNA, with some coaxing, redirected the resident to continue walking. Another CNA (#7) joined them when they reached Resident #12's room. The CNAs ambulated Resident #12 to her bed with one CNA (#7) holding the resident under her right arm and the other (#5) holding her left arm. As they approached the bed, Resident #12 tripped on the fall mat next to the bed and her knees

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355082	A. BUILDING _____ B. WING _____	10/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVE MARIA VILLAGE	501 19TH ST NE JAMESTOWN, ND 58401

(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		

buckled. The CNAs (#5 and #7) lifted the resident under her arms and legs and assisted her to bed. Observation showed the edge of the fall mat curled up against Resident #12's chair.
* 10/30/12 at 1:05 p.m. - Two CNAs (#5 and #8) ambulated Resident #12 from her bathroom to her bed. The CNAs did not use a gait belt, but held the resident under her arms as they ambulated her across the room.
* 10/30/12 at 3:55 p.m. - Two CNAs (#4 and #6) assisted Resident #12 out of bed. When the CNAs put on Resident #12's slippers, one CNA (#4) stated, "they have holes in them." Observation showed the right slipper torn at the toe extending into the sole of the slipper, creating a tripping hazard. The CNAs (#4 and #6) did not change the slippers, and without applying a gait belt, held Resident #12 under her arms and transferred her to the wheelchair.
** The CNAs failed to attempt to utilize a gait belt or allow the resident to refuse its use.

An interview occurred with an administrative nurse (#1) on 10/30/12 at 3:30 p.m. regarding transfers for Resident #12. The nurse stated she would look for the assessment. At 4:05 p.m. the nurse (#1) stated a Physical Therapy (PT) evaluation had been attempted after the resident's admission on 12/09/11. She stated the resident did not cooperate, so the PT did not complete the evaluation. Record review lacked evidence staff attempted to perform the PT evaluation at a later date.

An interview occurred with an administrative nurse (#2) on 10/31/12 at 8:00 a.m. The nurse confirmed the facility did not complete an assessment prior to determining staff should not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355082	A. BUILDING _____ B. WING _____	10/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVE MARIA VILLAGE	501 19TH ST NE JAMESTOWN, ND 58401

(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 use a gait belt when transferring Resident #12. She stated staff do not use a gait belt because Resident #12 would not walk unless staff held her hands. The MDS, dated 09/09/12, identified Resident #12 as "unsteady" during transfers and ambulation. The record identified Resident #12 had falls on 08/23/12 and 10/30/12 while staff ambulated her without a gait belt. The facility's failure to evaluate the risk of transferring and ambulating Resident #12 without an assistance device placed the resident at risk for an injury. Staff members walking backwards down the hall while ambulating a resident diminishes the staff member's awareness of hazards/obstacles in the hall which may result in the resident and/or staff member tripping and/or falling and sustaining an injury. Holding the resident under her arms while ambulating/transferring does not ensure stability and has the potential for a resident and/or staff member to experience an injury.	F 323		
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by:	F 371	1. The facility has replaced all attached straw spill-proof cups with straight-sided mugs with detachable lids to facilitate thorough cleaning. 2. All residents have the potential to be affected. 3. a. Mugs and lids will be washed in the facility dishwashing machine, at proper temperatures and pressure. b. Debris specks left on clean mugs and lids will be avoided by careful examination done by dietary aide on clean end of the dishwashing machine as mugs and lids are removed to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355082	A. BUILDING _____ B. WING _____	10/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVE MARIA VILLAGE	501 19TH ST NE JAMESTOWN, ND 58401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 11 Based on observation, review of policy and procedure, and staff interview, the facility failed to distribute and serve food under sanitary conditions for 2 of 5 residents (Resident #14 and #22) who were served supplements in sipper cups; and failed to clean, sanitize, and store sipper cups in a safe and sanitary manner in the main kitchen. These practices placed residents using sipper cups at risk for contamination of beverages which may result in foodborne illness. Findings include: Review of the facility policy titled "Loading of Dish Washer" occurred on 10/31/12. This policy, dated 08/19/11, stated, ". . . 5. Place cup [sic], glasses, in their own racks. When washed, check to see if they are clean. Always rewash if dirty, never wipe dirt off. . . " Observation during a kitchen tour on 10/31/12 at 9:45 a.m. identified the following: - 3 clear plastic sipper cups upside down and drying on the clean side of the dish room. (The sipper cups have a straw attached at the base of the cup which contains curves.) The sipper cups contained brown residue inside of them including inside the straw component. - 1 clear plastic sipper cup with a lid on it on a snack cart in the dry storage area. The sipper cup contained brown residue and water inside of the container. During the above observation, a supervisory dietary staff member (#11) stated the facility will soak the sipper cups to get out the brown residue and will throw around eight sipper cups a week. Two supervisory dietary staff members (#11 and	F 371	be stored. If mugs and lids have debris left on them, they will be removed, sent back to the dirty end, pre-washed by hand and sent through dishwashing machine again. If debris specks continue to appear, employee and management will try to determine reason. Dishwashing will stop, the dishwashing machine will be drained, the interior sides and arms spray rinsed, and the strainer basket removed and spray rinsed. The dishwashing machine with be reassembled and restarted. The process will be repeated as needed. By 11/21/12 all dietary staff will be trained on how to catch debris specked mugs before they are stored away, rewash them, and clean the dishwashing machine. **4.** The dietary director or the dietary supervisor will monitor for debris specks on spill proof mugs and lids once a week for 4 weeks. After 4 weeks, monitoring will continue on a monthly basis. Results will be recorded on a newly developed and implemented QA form, reported to the QAM,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355082	A. BUILDING _____ B. WING _____	10/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVE MARIA VILLAGE	501 19TH ST NE JAMESTOWN, ND 58401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 12 #12) removed the mugs to be washed. Observation in residents' rooms on 10/31/12 showed the following: * at 12:15 p.m. in Resident #14's room, a sipper cup contained a partially consumed supplement. The cup contained brown residue on the inside of the clear plastic cup and inside of the straw. * at 12:20 p.m., a staff nurse (#15), removed the lid to Resident #14's sipper cup, poured out the remaining supplement, and while gloved the nurse reached inside of the cup and scraped some of the brown residue off the inside of the cup with her finger. * at 12:30 p.m. in Resident #22's room, a sipper mug contained a partially consumed supplement. The cup contained brown residue on the cup and inside the straw. During an interview at 12:20 p.m., a supervisory dietary staff member (#12) identified Resident #14 had "Vanilla Ensure" in the cup with nothing added to it. This staff member provided a list of 5 residents who use the sipper cups. After the above observations, interviews with two CNAs (#13 and #14) identified Resident #14 and Resident #22 received the supplements during morning snack pass at approximately 10:15 a.m.. The CNA's stated the residents did not receive food with their supplements, and received the sipper cups from the kitchen on the snack carts. When asked if Resident #22's sipper cup had spots inside of it prior to use during an interview at 12:30 p.m., one of the CNA's (#13) stated she didn't notice but, ". . . Sometimes it's stained in there . . ." referring to the straw part of the cup. This CNA confirmed the staff did not add anything	F 371	and presented at the quarterly QA meeting. A random sample of 5% of the residents who use spill proof mugs will be selected for the QA. If found to be out of compliance, appropriate measures will be taken to immediately correct, and the dietary staff retrained 5. 11/21/12.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355082	A. BUILDING _____ B. WING _____	10/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVE MARIA VILLAGE	501 19TH ST NE JAMESTOWN, ND 58401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 13 to Resident #22's supplement at snack pass. Failure to ensure proper cleaning of the sipper cups resulted in Resident #14 and Resident #22 being served supplements from dirty cups on the morning of 10/31/12.	F 371		