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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355092	A. BUILDING _____ B. WING _____	02/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILL TOP HOME OF COMFORT INC	95 HILL TOP DR KILLDEER, ND 58640

(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 February 6, 2012 and completed on February 9, 2012 the sample included two (2) residents for complete review, eight (8) residents for focused review, and one (1) closed record for review.	F 000		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview, and review of professional reference, the facility failed to conduct a comprehensive assessment for 1 of 1 sampled resident (Resident #6) who experienced a hip fracture resulting in a significant change in physical and mental condition. Failure to complete a Significant Change in Status Assessment (SCSA) in response to Resident #6's physical decline and mood changes placed the resident at risk for	F 274	F 274 1. Resident # 6 had an updated MDS assessment on 10/4/11 after a hospital stay. Her assessments and care plan reflect her status and plan of care. 2. Residents with a significant change in their condition have the potential to be affected. 3. The interdisciplinary MDS team will attend morning report which will inform them of changes in resident condition. The team will monitor the resident's condition to identify significant changes. A significant change MDS will be done when indicated and interventions put in place after a significant change was identified. 4. 10% of residents will be reviewed for significant change and	3/15/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 2/21/12

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.

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F 274	Continued From page 1 continued decline and the lack of appropriate interventions to restore or maintain physical and mental function. Findings include: The CMS Long-Term Care Facility Resident Assessment Instrument User's Manual, Version 3.0, October 2011, pages 2-20 through 2-23 states, "Significant Change in Status Assessment . . . A SCSA is appropriate when: There is a determination that a significant change (either improvement or decline) in a resident's condition from his/her baseline has occurred as indicated by comparison of the resident's current status to the most recent Comprehensive assessment and any subsequent Quarterly assessments; and The resident's condition is not expected to return to baseline within two weeks. . . . Decline in two or more of the following: . . . Presence of a resident mood item not previously reported by the resident or staff and/or an increase in the symptom frequency . . . Any decline in an ADL [Activity of Daily Living] physical functioning area where a resident is newly coded as Extensive assistance, Total dependence, or Activity did not occur since last assessment . . . Resident's incontinence pattern changes . . ." Review of the medical record for Resident #6 occurred February 06-09, 2012. Diagnoses included anxiety, and left hip fracture on 09/25/11, followed by surgery for an open reduction internal fixation of the left hip and return to the facility on 09/28/11. Comparison of Resident #6's quarterly Minimum Data Set (MDS), dated 09/17/11, with the next	F 274	appropriate intervention monthly x 3 by the QA Coordinator and/or nursing management. Findings will be reported to the QA Committee. 5. Completion date 3/15/2012.	

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F 274	Continued From page 2 quarterly MDS, dated 09/28/11, showed a decline in the following areas: The facility assessed the resident's mood symptom frequency for the past two weeks: * Mood: "Little interest or pleasure in doing things" increased from "never or 1 day" to "7-11 days (half or more of the days)." * Mood: "Feeling down, depressed, or hopeless" increased from "never or 1 day" to "2-6 days (several days)." * Mood: "Feeling tired or having little energy" increased from "2-6 days (several days)" to "12-14 days (nearly every day)." * Mood: "Poor appetite or overeating" increased from "never or 1 day" to "7-11 days (half or more of the days)." * Mood: 'Total severity score" increased from "03" to "10". The facility assessed the resident's functional status for ADLs in the areas of self performance and staff support for the past seven days: * Functional Status: "Bed mobility" declined from "independent, no physical help" to "extensive assistance of two+ [plus] persons physical assist." * Functional Status: "Walk in room" declined from "independent, no physical help" to "ADL activity itself did not occur during the entire period." * Functional Status: "Walk in corridor" declined from "extensive assistance of one person physical assist" to "ADL activity itself did not occur during the entire period." * Functional Status: "Locomotion on unit" and "Locomotion off unit" declined from "independent, no physical help" to "extensive assistance of one person physical assist." * Bladder and Bowel: Bowel continence declined from "always continent" to "frequently	F 274		

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F 274	Continued From page 3 incontinent." Observations of Resident #6 showed the following declines remained: 02/06/11 at 3:11 p.m., two certified nurse aides (#1 and #2) assisted the resident with bed mobility by assisting her from a lying position to a seated position on the side of the bed. 02/07/11 at 9:50 a.m., a CNA (#3) assisted the resident with mobility off the unit by transporting the resident in her wheelchair from her room to the activity room. During an interview on 02/08/12 at 4:15 p.m., an MDS staff nurse (#4) stated she had not completed a SCSA because she anticipated Resident #6 would get better. This same nurse (#4) stated she had not considered it would take Resident #6 more than 14 days to recover from a hip fracture and acknowledged a SCSA should have been completed for Resident #6.	F 274		
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.	F 278	F278 1. Residents #1, 3, 5, 7, and 10 will be evaluated for appropriateness of individualized toileting plans. Residents not appropriate will be placed on normalized toileting. 2. All residents that need toileting assistance have the potential to be affected.	3/15/12

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F 278	Continued From page 4 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: Based on record review, review of facility policy, review of professional reference, and staff interview, the facility failed to complete Minimum Data Set (MDS) assessments which accurately reflected the residents' status for 6 of 10 sampled residents (Resident #1, #3, #5, #7, #8, and #10). Failure to accurately assess and code the MDS may affect the level of care provided by staff to the residents. Findings include: The Centers for Medicare and Medicaid Services Revised Long-Term Care Facility Resident Assessment Instrument User's Manual, Version 3.0, July 2010, stated, " . . . 1. Review the medical record for evidence . . . showing that the following three requirements have been met: implementation of an individualized, resident-specific toileting program that was based on an assessment of the resident's unique	F 278	3. We will reassess all residents currently on toileting plans. Toileting plans will be modified as needed to reflect level of care required. Policy # 7052 Management of Urinary Incontinence will be revised to reflect the appropriate procedure for individualized toileting. ADL flow sheets will be updated to accurately reflect the resident's toileting plan. 4. The QA Coordinator and/or nursing management will audit 10% of resident's toileting plans for appropriate intervention monthly x 3. Findings will be reported to the QA Committee. 5. Completion date 3/15/2012. Deleted via telephone conversation c MDS Coordinator on 2-27-2012 J.C.	

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FORM APPROVED
OMB NO. 0938-0391

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F 278	Continued From page 5 voiding pattern, evidence that the individualized program was communicated to staff and the resident (as appropriate) verbally and through a care plan, flow records, and subsequent evaluations, as needed, notations of the resident's response to the toileting program and subsequent evaluations, as needed. . . . 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. . . ." Review of the facility policy, "Management of Urinary Incontinence," occurred on 02/09/12. This policy, dated 10/04/99, stated, ". . . Behavioral Techniques: . . . 3. Scheduled Toileting/Habit Training: Beneficial to residents with moderate to severe mental/physical dysfunction. Variable toileting schedule based on resident need and history of voiding. Regular toileting intervals* [include] Upon arising. From the time the resident gets out of bed in the morning until the resident goes to or receives breakfast. After breakfast. From the time the resident completes breakfast until 10 AM. Before lunch. 10 Am until the resident goes to or receives lunch. After lunch. From the time the resident completes lunch until 2 PM. Mid afternoon. 2 PM to 4 PM. Before supper. 4 PM until the time the resident goes to or receives the evening meal.	F 278	F278 1. Residents #1, 3, 5, 7, and 10 will be evaluated for appropriateness of their toileting plans. The MDS will be coded appropriately for each resident. If a resident is on an individualized toileting program, all components of the program will be in place prior to coding. 2. All residents that need toileting assistance have the potential to be affected. 3. Toileting plans will be modified as needed to reflect level of care required. Policy # 7052 Management of Urinary Incontinence will be revised to reflect the appropriate procedure for individualized toileting. ADL flow sheets will be updated to accurately reflect the resident's toileting plan. MDS's at the time of the survey that have not already been corrected or modified will be in compliance and submitted to CMS and state agencies prior to 3/15/12. The MDS will be coded appropriately for each resident. If a resident is on	3/15/12

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F 278	Continued From page 6 After supper. From the time the resident completes the evening meal until 7 PM. At HS [hour of sleep]. Prior to going to bed. "Interval resident is toileted will be individualized. It is not required that residents be toileted at every interval listed. . . . ." - Review of Resident #1's medical record occurred on all days of survey. Medical diagnoses included dementia with psychosis, and legal blindness. Resident #1's annual MDS, dated 12/20/11, identified Resident #1 required extensive one person physical assistance with toilet use, frequently incontinent of urine, and on a urinary toileting program. Resident #1's current care plan, stated, ". . . frequently incontinent of bladder . . . assist resident with toileting as per ADL [Activities of Daily Living] Flowsheet." Resident #1's February 2012 Certified Nursing Assistant (CNA)/ADL Tracking/Flowsheet identified the resident on a "toileting schedule" and the times identified as "upon rising, after breakfast, before and after lunch, mid afternoon, before and after supper, at HS." A "Mini B&B [Bladder and Bowel] Assessment", dated 12/20/11, identified Resident #1's voiding pattern as "frequently incontinent of bladder, continent of bowel." The facility determined the resident would benefit from "Toileting assistance upon request" and "Scheduled toileting." This assessment failed to identify specific individualized times for staff to toilet Resident #1. - Review of Resident #8's medical record occurred on all days of survey. Medical diagnoses	F 278	an individualized toileting program, all components of the program will be in place prior to coding. See Below 4. The QA Coordinator and/or nursing management will audit 10 MDS's for appropriate coding of toileting plans at 3 months. Findings will be reported to the QA Committee. 5. Completion date 3/15/2011. 3.) Continued CNAs were provided education on 2/14/12. CN were provided education on 2/16/12 deficient practice. POC will be Reviewed at March meetings.	

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F 278	Continued From page 7 included chronic renal insuffiencey, diabetes, and anxiety. Resident #8's quarterly MDS, dated 01/18/12, identified Resident #8 required extensive one person physical assistance with toilet use, frequently incontinent of urine, and on a urinary toileting program. Resident #8's current care plan failed to identify specific times facility staff are to toilet the resident. Resident #8's February 2012 Certified Nursing Assistant (CNA)/ADL Tracking/Flowsheet identified the resident on a "toileting schedule" and the times identified as "upon rising, after breakfast, before and after lunch, mid afternoon, before and after supper, at HS;" and "check [and] change Q [every] 2-3 hrs [hours] unless otherwise stated." A "Mini B&B Assessment", dated 01/18/12, identified Resident #8's voiding pattern as "frequently incontinent of bladder, occasionally of bowel." The facility determined the resident would benefit from "Scheduled toileting." This assessment failed to identify specific individualized times for staff to toilet Resident #8. The MDSs for Resident #1 and #8 identified an individualized toileting plan, but the bladder and bowel assessments, care plans, and CNA/ADL Tracking/Flowsheet identified facility staff failed to assist the residents with toileting in response to their unique voiding patterns. - Review of Resident #5's medical record occurred February 06-09, 2012. Diagnoses included Alzheimer's dementia, and history of urinary tract infection. An annual MDS, dated 11/17/11, identified Resident #5 required	F 278		

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F 278	Continued From page 8 extensive assist of one person for toileting; frequently incontinent of urine; always incontinent of bowel; and on a current toileting program. Resident #5's current care plan, stated, ". . . frequently incontinent of bowel and bladder . . . assist resident by toileting as per ADL schedule." Resident #5's February 2012 "CNA-ADL Tracking Form [ADL schedule]" identified the resident is on a "Toileting Schedule" and the times identified as "Upon Rising, After Breakfast, Before and after Lunch, Mid Afternoon, Before and After Supper, [at] HS." Resident #5's "Mini B&B Assessment", dated 11/17/11, identified a voiding pattern of "Frequently incontinent of bladder. Always of bowel." The facility determined the resident would benefit from "Scheduled toileting." This assessment failed to identify specific individualized times for staff to toilet Resident #5. - Review of Resident #7's medical record occurred February 06-09, 2012. A significant change MDS, dated 11/04/11, identified Resident #7 required extensive assist of two persons for toileting; frequently incontinent of urine; continent of bowel; and on a current toileting program. Resident #7's current care plan, stated, ". . . continent of bowel and frequently incontinent of bladder . . . assist resident by toileting as per ADL schedule." Resident #7's February 2012 "CNA-ADL Tracking Form" identified the resident is on a "Toileting Schedule" and the times identified as "Upon Rising, After Breakfast, Before and after Lunch, Mid Afternoon, Before and After Supper, [at] HS."	F 278		

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F 278	Continued From page 9 Resident #7's "Mini B&B Assessment", dated 08/04/11, identified a voiding pattern of "Frequently incontinent of bladder, continent bowel." The facility determined the resident would benefit from "Toileting assist upon request" and "Scheduled toileting." This assessment failed to identify specific individualized times for staff to toilet Resident #7. - Review of Resident #10's medical record occurred February 08-09, 2012. A quarterly MDS, dated 01/24/12, identified Resident #10 required extensive assist of one person for toileting; frequently incontinent of bladder and bowel; and on a current toileting program. Resident #10's current care plan, stated, ". . . has dribbling incontinence of bladder. Continent of bowel . . . assist resident by toileting as per ADL schedule." Resident #10's February 2012 "CNA-ADL Tracking Form" identified the resident on a "Toileting Schedule" and the times identified as "Upon Rising, After Breakfast, Before and after Lunch, Mid Afternoon, Before and After Supper, [at] HS." Resident #10's "Mini B&B Assessment", dated 08/04/11, identified a voiding pattern of "Frequently incontinent of bladder [and] bowel." The facility determined the resident would benefit from "Toileting assist upon request" and "Scheduled toileting." This assessment failed to identify specific individualized times for staff to toilet Resident #10. - Review of Resident #3's medical record occurred on all days of survey. Diagnoses	F 278		

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F 278	Continued From page 10	F 278		

included dementia, anxiety and urinary tract infection. The most current MDS, dated 11/15/11, indicated the resident required extensive assistance of one person for toilet use, occasionally incontinent of urine, and on a current toileting program.

Review of Resident #3's current care plan stated, ". . . resident is occasionally incontinent of bladder and frequently incontinent of bowel . . . nursing to assist resident by toileting as per ADL schedule. . . "
The "CNA-ADL Tracking Form" (a CNA care plan) for the months of October, November, December of 2011 and January, and February of 2012, indicated the resident is on a "Toileting Schedule." The form further defines a toileting schedule as "Upon Rising, After Breakfast, Before and after Lunch, Mid Afternoon, Before and After Supper, @ [at] HS [hour of sleep]."

A "Mini B&B [Bladder and Bowel] Assessment," dated 11/15/11, identified Resident #3's voiding pattern as "occasionally incontinent of bladder, frequently [sic] bowel." The facility determined the resident would benefit from "Toileting assistance upon request" and "Scheduled toileting." This assessment failed to identify specific individualized times for staff to toilet Resident #3.

The MDSs for Resident #3 identified an individualized toileting plan but the bladder and bowel assessments, care plans, and CNA/ADL tracking form identified facility staff failed to assist the residents with toileting in response to their unique voiding patterns.

During interview on 02/08/12 at 3:10 p.m., an

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F 278	Continued From page 11 administrative nurse (#4) stated the times staff assist Residents #1, #3, #5, #7, #8, and #10 to toilet are based on generalized times (upon awaking, before and after meals, and before bed), not on an individualized toileting plan. The lack of a complete and accurate assessment does not provide a means of determining Residents #1, #3, #5, #7, #8, and #10's overall continence performance and does not provide accurate data to develop an individualized plan to allow the resident to improve/maintain bladder continence.	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, staff interview, and review of facility policy and procedure the facility failed to ensure residents received appropriate treatment and services to prevent urinary tract infections for 2 of 5 sampled residents (Resident #3 and #5) with a history of urinary tract infections (UTI) and currently incontinent of bowel and/or bladder. Failure to	F 315	F315 1. Residents # 3 and # 5 will have pericares provided per policy. 2. Residents requiring assistance with toileting have the potential to be affected. 3. The CNA's have reviewed ADL policies and procedures including peri-cares. At the 2/14/12 CNA meeting. Each CNA was also provided a written copy of the policies. Additional training will be provided at the March CNA meeting. Reminders have been placed in the CNA log books.	3/15/12

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	355092	A. BUILDING _____ B. WING _____	02/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILL TOP HOME OF COMFORT INC	95 HILL TOP DR KILLDEER, ND 58640

(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 12 provide incontinent cares following incontinence of bowel and/or bladder increases the residents risk for UTI, skin break down, and a loss of dignity and comfort. Findings include: Review of the facility policy/procedure titled "Toileting [and] Providing Perineal Care" occurred on 02/09/12. This policy, dated 02/22/10, stated, "1. Perineal care will be provided after incontinence episodes, after toileting a resident, and as part of AM [morning] and H.S. [hour of sleep] cares. . . . 4. Cleanse perineal area. Always wash front to back toward anus. Female: separate labia and wash downward on each side using different part of the washcloth or wipe. Male: Retract foreskin. Wash penis from urethral opening down, then scrotum. Wash and replace foreskin." - Review of Resident #5's medical record occurred February 06-09, 2012. Diagnoses included Alzheimer's dementia, and history of urinary tract infection. An annual Minimum Data Set (MDS), dated 11/17/11, identified Resident #5 required extensive assist of one person for toileting; frequently incontinent of urine; always incontinent of bowel; on a current toileting program; and received treatment for a UTI in the last 30 days. Resident #5's medical record showed the facility treated Resident #5 for UTIs in July 2011; October 2011; November 2011; and December 2011. Resident #5's current care plan, stated, ". . . frequently incontinent of bowel and bladder. . . Will be clean, dry, and free from odors. . . Nursing	F 315	Management will monitor for compliance (see below). 4. The QA Coordinator and/or nursing management will audit 25% of CNA's who are providing peri-cares for appropriate technique bi-weekly x2 and at 2 and 3 months. Findings will be reported to the QA Committee. 5. Completion date 3/15/12.	

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F 315	Continued From page 13 staff to assist resident by toileting as per ADL [activities of daily living] schedule [upon rising, after breakfast, before and after lunch, mid afternoon, before and after supper, and at bedtime]. . . . Observe for S/SX [signs and symptoms] of UTI . . . assist resident with the ADL's that she is unable to do." Observation of care for Resident #5 occurred on 02/07/12 at 9:12 a.m. Two certified nurse aides (CNAs) (#3 and #5) assisted the resident to the bathroom using a standing lift. A CNA (#3) pulled down the resident's pants and removed the brief soiled with loose stool. The CNA (#3) provided peri care to the buttocks prior to the other CNA (#5) lowering the resident onto the toilet. When the CNA (#5) used the lift to assist Resident #5 to stand, the other CNA (#3) again provided peri care to the resident's buttocks and anal area. The CNA failed to provide peri care to the frontal peri area before applying a clean brief. Failure to cleanse all skin in contact with urine and stool can cause skin irritation, odor, and/or UTI. During an interview on 02/09/12 at 9:35 a.m., an administrative nursing staff member (#7) stated perineal care includes cleansing all skin exposed to urine and/or stool and the CNA should have cleansed Resident #5's frontal perineal area. - Review of Resident #3's medical record occurred on all days of survey. Diagnoses included dementia, anxiety and urinary tract infection. The most current MDS, dated 11/15/11, indicated the resident on a current toileting plan, occasionally incontinent of urine, and frequently incontinent of bowel. This MDS also indicated the resident as extensive assistance of one person	F 315		

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F 315	Continued From page 14 for toilet use and personal hygiene. Review of Resident #3's current care plan stated, ". . . resident is occasionally incontinent of bladder and frequently incontinent of bowel . . . observe for S/SX of UTI . . . nursing to assist resident by toileting as per ADL schedule. . . " Review of Resident #3's Interdisciplinary Progress Notes, dated 07/06/11, stated, ". . . UA [urine analysis] returned showing UTI see report MD [medical doctor] notified. . . ." The facility's Infection Control Log for the month of July 2011 indicated the resident had a UTI, no culture obtained, and the treatment as Cipro (an antibiotic) 250 milligrams twice a day for one week. During an observation of care on 02/07/12 at 8:35 a.m., a CNA (#8) assisted Resident #3 to the toilet. Observation showed the resident's incontinent brief wet with urine. When the resident indicated she had finished, the CNA (#8) assisted the resident to stand and performed perineal cares wiping from back to front.	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. This REQUIREMENT is not met as evidenced	F 323	F323 1. Residents # 3 and # 7 will be transferred using gait belts. 2. All residents requiring assistance with transfers have the potential to be affected.	3/15/12

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 323	Continued From page 15 by: Based on observation, review of facility policy and procedure, record review, and staff interview, the facility failed to ensure 2 of 5 sampled residents (Resident #3 and #7) observed being transferred without a gait belt, received adequate supervision and assistance devices to prevent accidents. Failure to use gait belts has the potential for residents to experience falls, injuries, and/or pain. Findings include: Review of the facility policy titled "Resident Transfers" occurred on 02/09/12. This policy, dated 6/21/01, stated, ". . . Procedure: 1. All residents must be transferred as stated in their ADL [activities of daily living] care plan. Assistive devices-gait belts, walkers, . . . will be used according to the ADL care plan. . . . 3. Gait belts will be used by staff with residents requiring weight bearing assistance or assistance with balance and stability during ambulation or transfers. 4. All residents will be monitored and appropriate assistance will be offered in an attempt to prevent falls and injuries. . . ." - Review of Resident #3's medical record occurred on all days of survey. Diagnoses included osteoporosis, osteopenia (low bone mineral density,) compression fractures, right hip fracture, right pelvic fracture, and dementia. Review of Resident #3's MDSs (Minimum Data Sets) dated 11/15/11 and 08/15/11, indicated two or more falls since prior assessment, and extensive assistance of one person for transfers and toilet use. A CAA (Care Area Assessment)	F 323	3. The transfer policy states "Gait belts will be used by staff with residents requiring weight bearing assistance or assistance with balance and stability during ambulation or transfers". Resident transfers will be reviewed by the resident care committee monthly. Gait belts are assigned to the appropriate residents. CNA's will monitor that residents who need a gait belt, will have them available. Continued Next page. 4. The Safety Director or nursing management will audit 20% of CNA's assisting residents with transfers for compliance with care planned transfer assist, use of gait belt, and appropriateness of that level of assist. Gait belt assignment and availability will also be audited. Audits will be completed bi-weekly x 2 and at 1, and 3 months. Findings will be reported to the QA Committee. 5. Completion date 3/15/12.	

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F 323	Continued From page 16 for falls, dated 08/15/11, stated, ". . . is a high fall risk and has occasional falls depite [sic] fall preventions in place. . . balance during transistions [sic] is not steady and only able to stablize [sic] with human assistance is a contributing factor. . . ." Review of Fall Committee Notes and Interdisciplinary Progress Notes for Resident #3 between 04/10/11 to 02/08/12 indicated 15 falls. Review of Resident #3's current care plan listed the problem "High risk for falls related to history of falls." Approaches listed on the care plan included, monitor resident for personal needs, restorative therapy, alarms, and see ADLs for more details. Review of Resident #3's "CNA [certified nurse aide] - ADL Tracking Form"(a type of CNA care plan) listed the following postural supports and safety devices: front wheeled walker, fall strips (strips placed on the floor to prevent slipping) 1/2 side rails, bed alarm, chair alarm, and gait belt. Review of a physician's progress note, dated 12/10/11, stated, ". . . ASSESSMENT 1. . . health problems as documented with severe osteoporosis. At severe risk for fracture from any type of fall." During an observation on 02/07/12 at 8:35 a.m., a CNA (#8), prior to assisting Resident #3, failed to apply a gait belt or lock the brakes on the resident's wheelchair. The CNA lifted the resident by the arm to assist her to stand and sit on the toilet. When finished, the CNA lifted the resident by the arm to assist her to a standing position,	F 323	3) Continued Reviewed gaitbelt policy: use at CNA meeting 2/14/12 and at CN meeting on 2/16/12. POC will be reviewed at March CNA: CN meetings	

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F 323	Continued From page 17 provided perineal care, and adjusted the resident's clothing before assisting her back into the wheelchair. The CNA then transported the resident by wheelchair to her bed, locked the brakes on one side of the wheelchair and lifted the resident by the arm to assist her onto the bed. During an observation on 02/07/12 at 11:35 a.m., a CNA (#8) prior to assisting Resident #3 from the bed failed to apply a gait belt and instead lifted Resident #3 by the arm to assist her to sit in the wheelchair positioned next to the bed. During an interview on 02/08/12 at 4:00 p.m., an administrative staff nurse (#9) stated they should use a gait belt with Resident #3. - Review of the medical record for Resident #7 occurred February 06-09, 2012. Diagnoses included nontraumatic spinal cord injury, incomplete paraplegia, hemiparesis, and spasticity. A significant change MDS, dated 11/04/11, identified Resident #7 requires extensive assistance of two persons for transfers and toilet use; and functional limitation in range of motion on one side both upper and lower extremities. The "CNA-ADL Tracking Form" for Resident #7 identified her as a fall risk and safety devices included use of a gait belt. Nurses notes showed the resident experienced four falls since 08/17/11. Observation of personal cares for Resident #7 occurred on 02/08/12 at 1:35 p.m. Two CNAs (#7 and #8) assisted the resident with toileting. One CNA (#8) stated she assisted Resident #7 to transfer to the toilet, before the observation began. After toileting, the CNAs (#7 and #8)	F 323		

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F 323	Continued From page 18 assisted the resident to transfer to her wheelchair without the use of a gait belt. The second CNA (#7) stated they forgot to use the gait belt during Resident #7's transfers. The first CNA (#8) stated she forgot to apply the gait belt before transferring Resident #7 to the toilet. During an interview on 02/09/12 at 9:35 a.m., an administrative nursing staff member (#7) stated CNAs know to use a gait belt for Resident #7's transfers.	F 323		