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

PRINTED: 05/17/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355114	A. BUILDING _____ B. WING _____	05/11/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH DAKOTA VETERAN HOME	1400 ROSE ST LISBON, ND 58054

(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 05/09/11 and completed on 05/11/11, the sample included 2 residents for complete review, 7 residents for focused review, and 1 closed record for review. The sample included 3 additional residents to verify specific concerns during the survey.	F 000		
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.	F 164	**F 164 PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS** 1. Education will be provided to all staff in regards to resident privacy; this will include how to ensure that residents are not subject to the viewing of various medical tasks that they may be uncomfortable seeing. Such tasks include the administration of insulin and performance of blood sugar checks. 2. Same as above 3. The following policies will be updated to include the provision of privacy in regards to the viewing of medical tasks; Medication Administration, Insulin Injections and Blood Glucose Testing. All Nurses and Medication Techs will be given education on the changes and will receive a copy of the updated policies.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Mark B. — Administrator — 6/3/11

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 164	Continued From page 1	F 164	4. Quality Audits for privacy during medical treatments will be completed monthly for three months, then quarterly for one year. 5. Completion Date 06/23/11	

This REQUIREMENT is not met as evidenced by:
Based on observation and review of facility policy, the facility failed to provide privacy for 2 of 2 supplemental residents (Resident #12 and #13) observed receiving an injection or a blood glucose accu-check. Failure to administer injections/perform blood sugar accu-checks in a private location does not honor the residents' right to privacy or protect other residents within view who may be uncomfortable at the sight of blood and/or injections.

Findings include:

Review of the facility policy titled "Medication Administration" occurred on 05/11/11. The policy, dated 10/22/08, stated, "Medications/Treatment's that are administered in a way that could interfere with the dignity of a resident will be offered [in] a private area. Some examples include injections . . .

- On 05/09/11 at 8:50 p.m., observation showed Resident #13 seated at a table in the dining room with another resident. Observation showed eight additional residents seated at different tables in the dining room. A licensed nurse (#2) asked Resident #13 to go with her to his room or another private area to receive his insulin injection. Resident #13 stated, "No, give it here." The nurse proceeded to inject the insulin into Resident #13's upper right arm.

- Observation on 05/10/11 at 5:41 p.m., showed a nursing staff member (#1) performed a blood

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F 164	Continued From page 2 sugar accu-check on Resident #12 in the lounge area by the nurses station. An unidentified resident was seated close by.	F 164	**F 312 ADL CARE PROVIDER FOR DEPENDENT RESIDENTS** 1. Additional set of adaptive silverware has been purchased to ensure availability. Staff has been instructed on the resident's plan of care including use of adaptive silverware and assistance needed at meals. Resident will be assessed by the consulting Occupational Therapist and care plan updated with any changes. 2. Consulting Occupational Therapist has developed an assessment for the nurse/dietician to complete on all residents that will identify any residents having difficulties or potential for having difficulties with meal time. Any residents identified, will be further assessed by the Occupational Therapist. All recommendations will be implemented as appropriate and addressed in the resident's plan of care. Any changes in the plan of care will be	
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation and medical record review, the facility failed to provide set up assistance and assistive devices with eating for 1 of 2 sampled residents (#5) requiring assistive devices for eating. Findings include: Review of Resident #5's medical record occurred on all days of survey. The resident's diagnoses included poor vision with left eye blindness, psychoses, anxiety, and depression. Review of the most recent Minimum Data Set (MDS), dated 04/05/11, identified a Brief Interview for Mental Status score of 04, indicating severe cognitive impairment. The MDS showed Resident #5 required set up assistance with meals and identified a weight loss of eight pounds (3.6%) from 01/26/11 to 04/05/11. Resident #5's care plan, dated 04/12/11, stated, "Problem: Alteration in nutrition related to . . . reduced ability to feed self related to arthritis. . . . Approach: . . . Provide adaptive silverware and plateguard to increase	F 312		

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F 312	Continued From page 3 Res. [Resident's] ability to feed self. . . . Provide set-up assist as needed at meals." Observation on 05/10/11 at 12:20 p.m., showed Resident #5 seated in a wheelchair at a dining room table for dinner. An unidentified staff member placed the resident's dinner tray on the table in front of the resident but failed to provide any set up assistance, built up silverware, or plateguard. The resident attempted to spear a meatball with a fork but was unable to do so. Resident #5 then picked up the meatball with his fingers and ate it. The resident cut up the second meatball by holding the handle of the fork in his right hand and the tines of the fork in his left hand. Resident #5 attempted to open his milk carton for 10 minutes before giving up and pushing the milk carton away. Observation also showed the facility staff failed to provide a plateguard for Resident #5 during the evening meal on 05/09/11. Observation on 05/11/11 at 9:30 a.m., showed Resident #5 seated in the dining room for his morning meal. An unidentified certified nurse aide (CNA) cut the resident's waffle into bite-size pieces. The CNA failed to cut his two sausage links and failed to open his container of milk. The resident's plate did not have a plate guard. Observation showed Resident #5 picked up a sausage link with his fingers and placed it in his mouth. The resident did not attempt to open the carton of milk. The facility's failure to provide set up assistance and assistive eating devices with meals has the potential to affect the resident's feelings of self-worth and may have contributed to Resident	F 312	communicated to staff caring for that resident through assignment sheets and resident review. 3. The above assessment will be completed on all residents upon admission to NDVH. Referral to Occupational Therapist will be done as identified, and further assessment including implementation of an individualize care plan will be completed. Quarterly with the MDS, each resident's plan of care will be reviewed to ensure he/she is receiving appropriate mealtime assistance and assistive devices if needed. 4. Quality Audits to ensure residents are provided with needed assistance/adaptive devices during meal times will be completed monthly for three months, the quarterly for one year. 5. Completion Date 06/23/11	

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F 312	Continued From page 4 #6's weight loss.	F 312		