STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355116	A. BUILDING _____ B. WING _____	04/12/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSIDE LUTHERAN HOME	501 3RD AVE W 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 April 9, 2012 and completed on April 12, 2012 the sample included two (2) residents for complete review, seven (7) residents for focused review, and one (1) closed record for review. The sample included two (2) additional residents to verify specific concerns during the survey.	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 record review, and staff interview, the facility failed to complete a Significant Change in Status Assessment (SCSA) for 1 of 1 sampled resident (Resident #4) who experienced a significant change (improvement) in Activities of Daily Living (ADLs). Failure to conduct the SCSA limited the facility's ability to assess, care plan, and implement approaches regarding changes in	F 274	F 274 An annual Resident Assessment Instrument (RAI) for resident #4 will be completed on 5/15/12. The resident assessments for all other residents were reviewed to ensure no other Significant Change Status Assessments (SCSA) were omitted. All residents have the potential to be affected should the facility fail to ensure accurate completion of resident assessments. An audit form to check accuracy of (RAI) completion was developed. The Director of Nursing or designee will audit all resident assessments completed for the next 90 days. If 100% accuracy is achieved audits will be completed on 10 charts per quarter. Results of said audits will be reported at the quarterly QA committee meeting by the Director of Nursing.	5/16/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	5/10/12

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 Resident #4's status. Findings include: Review of Resident #4's medical record occurred on all days of survey and included a diagnosis of hip replacement. A SCSA, dated 08/29/11, identified Resident #4 required extensive assistance of one person for bed mobility, transfer, toilet use, and locomotion off the unit; limited assistance of one person for walk in room/corridor and locomotion on the unit. A quarterly Minimum Data Set (MDS), dated 11/15/11, identified the resident as independent with bed mobility, transfers, ambulation in the room/corridor, locomotion on/off the unit, eating, and toilet use. During interview, on 04/11/12 at 9:45 a.m., a nursing staff member (#2) confirmed Resident #4's improvement in status on 11/15/11 required the completion of a SCSA.	F 274		
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	F 278	F 278 Resident #5 had a Resident Assessment Instrument (RAI) completed on 3/15/12 which does accurately reflect the resident's status, hence no Significant Change Assessment is necessary at this time. Resident #9 was discharged from the facility on 4/19/12, thus no corrections to prior RAI's are possible.	5/15/12

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F 278	Continued From page 2 assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual (Version 3.0) dated October 2011, and staff interview, the facility failed to complete Minimum Data Set (MDS) assessments which accurately reflected the residents' status for 2 of 9 sampled residents (Resident #5, and #9). Failure to accurately assess and code the MDS may affect the level of care provided by staff to the residents. Findings include: - Review of Resident #9's medical record occurred on April 11-12, 2012. The resident was admitted on 10/12/11 with a diagnosis of left hip fracture. An admission MDS, dated 10/24/11, at M0210 indicated the resident had no pressure	F 278	(F 278 Continued) On 5/9/12 the MDS Nurse and Wound Care Nurse were inserviced on proper coding and definitions of the Long Term Care Facility RAI user manual. All residents have the potential to be affected should the facility fail to ensure assessment accuracy/ coordination. The Director of Nursing or designee as part of RAI audit (refer to F274 Plan of correction) will audit the accuracy of coding H 0200 and toileting plans in conjunction with M 0210 and current wound status. The Director of Nursing or designee will audit all resident assessments completed for the next 90 days. If 100% accuracy is achieved, audits will be completed on 10 charts per quarter. Results of said audits will be reported at the quarterly QA committee meeting by the Director of Nursing.	

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F 278	Continued From page 3 ulcers. Review of Resident #9's Interdisciplinary Progress Notes (IDP) stated the following: * 10/13/11 1:30 p.m., ". . . [no] edema in [left] leg. Noted 0.5 centimeter [cm] area on back of heel nonfluid filled blister. Noted res [resident] rubbing heel on bed . . ." * 10/15/11 10:00 p.m., ". . . 1.5 cm blister on R [right] heel soft drsg [dressing] applied pressure relieving boot applied . . ." * 10/17/11 9:15 a.m., "Skin assessed - cont. [continue] [with] fluid filled blister. Blister 0.8 cm, intact [no] redness around. Noted blister on back of R heel . . ." * 10/23/11 2:30 p.m., ". . . Blister on [arrow up] back R heel. Dried et [and] intact. . . ." * 11/05/11 2:00 p.m., "R heel blister 0.8 cm remains intact, fluid absorbed . . . " During an interview on 04/12/12 at 9:20 a.m., an administrative nurse (#4) stated, she did not consider it a pressure ulcer but "a blister from rubbing" her right foot. The Long-Term Care Facility RAI User's Manual stated on: * Page M-4 "Definitions Pressure Ulcer . . . as a result of pressure, or pressure in combination with shear and/or friction." The Long-Term Care Facility RAI User's Manual stated on: * Page H-6, ". . . Toileting (or trial toileting) programs refer to a specific approach that is organized, planned, documented, monitored, and evaluated . . . A toileting program does not refer to:	F 278		

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F 278	Continued From page 4 - simple tracking continence status, - changing pads or wet garments, and - random assistance with toileting or hygiene." - Review of Resident #5's medical record occurred on all days of survey. Review of a Significant Change in Status Assessment, dated 03/01/12, indicated extensive assist of two people for toilet use, occasionally incontinent of urine, and on a current toileting program. Resident #5's most recent care plan stated, ". . . Toilet sched [schedule] Q [every] 2-3 [hours] & [and] PRN [as needed] w/assist [with] of 2 . . ." A "Bladder Assessment" form, dated 04/10/12, stated, ". . . "Recommend for scheduled toileting plan: Yes proposed schedule [every] 2-3 [hours] & PRN . . ." The lack of adequate assessment, establishment of an individualized toileting schedule based on the assessment and the lack of implementation and monitoring of the toileting program failed to support the accuracy of Resident #5's above referenced MDS.	F 278		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed	F 280	F 280 The Careplan for resident #7 was revised on 4/16/2012 to reflect the use of a pressure redistribution air mattress. Care plans of all residents deemed to be at risk for a decrease in skin integrity based upon clinical assessment to include, but not limited	5/16/12

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F 280	Continued From page 5 within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON MAY 25, 2011. Based on observation, record review, and staff interview, the facility failed to revise the plan of care of 1 of 5 sampled residents (Resident #7) with a history of pressure ulcers. Failure to revise the plan of care as Resident #7's status changed had the potential to affect the staff's understanding of the resident's problems/concerns, required interventions, and may lead to lack of or inconsistency in cares provided. Findings include: Review of Resident #7's medical record occurred on April 11-12, 2012. Resident #7's Weekly Pressure Ulcer Record showed:	F 280	(F 280 continued) to: medications, diagnosis, disease process, hydration status or a history of a decrease in skin integrity, were reviewed to ensure interventions were care planned appropriately. A standardized temporary skin care plan was developed so appropriate interventions could be implemented for new admissions, hospital readmissions or residents who have acquired a change in condition placing them at risk for a decrease in skin integrity. These interventions will be reflected on the residents individual care plan. These temporary care plans will be utilized until further assessment is completed by the Wound Care Nurse or Skin Care Team. The skin Care Team will meet monthly to review care plans and treatment plans of all residents identified being at risk for a decrease in skin integrity. The Director of Nursing or designee will review 6 charts per month with the wound care nurse from the list of residents at risk of a decrease in skin integrity to ensure interventions are appropriately care planned and accurate. Results of the reviews will be reported by the Director of Nursing to the QA committee on a quarterly basis.	5-23-12 Per TC E SNF- Dan for the next year HY

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F 280	Continued From page 6 *08/16/11 - Stage 1 pressure ulcer to the right outer ankle, preventive treatment/intervention of gel socks while in bed. This pressure ulcer resolved on 08/22/11. *10/17/11 - Stage 2 pressure ulcer to right outer ankle, preventive treatment/intervention of applying a DuoDerm. On 10/23/11, the facility placed an air overlay mattress to Resident #7's bed. Resident #7's November 2011 Treatment Record identified this pressure sore resolved on 11/04/11. Review of Resident #7's care plans, dated 06/20/11 and 09/15/11 (in place at the time the resident exhibited the above pressure sores) failed to identify a problem, approach(es) and goal to help manage and treat the resident's actual problem of impaired skin integrity. Observation on 04/11/12 identified the presence of an air overlay mattress on Resident #7's bed. Resident #7's current care plan, dated 02/22/12, for potential/actual skin impairment failed to identify the approach of the air overlay mattress on her bed. During interview 04/12/12 at 10:00 a.m., administrative nurse (#4) stated Resident #7 does not have any open or redden areas. This nurse stated the continued use of the air overlay mattress "is to prevent any further" breakdown and expected this to be listed/identified on the resident's current plan of care.	F 280		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES	F 314		

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F 314	Continued From page 7 Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON MAY 25, 2011. Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide necessary treatment and services to aid in the prevention of and promote the healing of pressure ulcers for 2 of 2 sampled residents with facility acquired pressure ulcers (Resident #1 and #2) and for 1 of 3 sampled residents with a history of pressure ulcers (Resident #8). Failure to adequately assess residents upon admission or re-entry into the facility, reposition residents, and properly use pressure relieving air mattresses contributed to the development of Resident #1 and #8's bilateral heel pressure ulcers; the need for surgical procedures to assist with healing of the pressure ulcers for Resident #1 and #8; avoidable heel pain for Resident #1; and placed Resident #2 at risk for continued skin breakdown and worsening of an existing pressure ulcer. Findings include:	F 314		

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F 314	Continued From page 8 Review of the facility policy titled "Pressure Sores-General" occurred on 04/11/12. This policy, dated 05/27/11, stated, "POLICY: It is the policy of Parkside Lutheran Home to provide care to residents in order to prevent the occurrence of pressure sores or any other open areas. A resident who has pressure sores will receive the necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. PROCEDURE: Routine skin checks will be done on all residents at admission, during cares and on bath days . . . 3. For prevention, utilize pressure redistribution devices as indicated . . . 7.a. Any reddened or open areas are to be documented by the licensed staff in the resident's record including size, location, action taken . . . ESSENTIAL POINTS: If a resident is at risk for developing a decubitus, open a problem on the care plan indicating the resident is at risk . . . Licensed nurse are to notify physician and apply treatments as ordered by physician and record. Pressure ulcers will be measured weekly by charge nurse or wound care nurse. Wound care nurse or Charge nurse will initiate and document wound care progress on pressure ulcer . . . ." On the afternoon of 04/09/12, the facility provided written documentation to the survey team which identified the presence of facility acquired pressure ulcers involving two residents (Resident #1- bilateral heels and Resident #2- Stage 3 to the coccyx). - Review of Resident #1's medical record occurred on April 09-12, 2012. Resident #1 sustained a fall at a basic care facility on	F 314	F 314 For residents #1, #2 and #3 the skin care team reviewed care plans as well as course of treatment. Interventions remain in place to promote healing and prevention of further pressure ulcers. All residents could be at risk should the facility fail to provide necessary treatment and services to aid in the prevention or promote healing of pressure ulcers. facility policy "Pressure Sores-General" was reviewed and revised on 5/7/2012. The facility policy "Skin Team Policy and Procedure" was reviewed and revised on 5/7/2012. All licensed nurses were in-serviced on said policies on 5/7/2012. The skin team members were reassigned to include multiple disciplines. The team shall meet monthly to review care plans and treatment plans of all residents identified to be at risk for a decrease in skin integrity. An in-service on skin care, skin assessment and proper skin care interventions will be presented to all CNA staff on 5/16/2012. The facility policy on change of shift rounds was created on 5/9/2012, and all CNA's will be in-serviced on said policy on 5/16/2012	5/16/12

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F 314	Continued From page 9 01/18/12, which resulted in a left hip fracture. The facility admitted the resident on 01/24/12. Medical diagnosis included open reduction internal fixation (ORIF) of left hip, osteoarthritis, anxiety, congestive heart failure, diabetes mellitus, and a history of cerebral vascular accident. Resident #1's admission Minimum Data Set (MDS), dated 02/05/12, identified the resident displayed severe cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 7; required extensive two person physical assistance with bed mobility, transfers, dressing, toilet use and personal hygiene; received PRN (as needed) pain medications and non-medication interventions during the 5-day look back period; the frequent presence of pain, rated as "06" on the 00-10 Numeric Rating Scale; two Stage 2 pressure ulcers identified on 02/01/12; pressure reducing devices for her chair and bed, turning/repositioning schedule, nutrition/hydration interventions, and pressure ulcer care. Resident #1's Nursing Care Assessment Areas (CAAs), dated 02/06/12 stated, ". . . Triggers ADL [Activities of Daily Living] Function d/t [due to] needs extensive assist with cares . . . Res [resident] isn't ambulating at this time . . . Triggers Pressure Ulcers d/t has break down . . . Res has 2 Stage II areas, one on each heel. Res is followed [sic] the Wound Nurse and Physician, treatment to change as needed. Precautionary items in place to prevent further break down . . . Proceed to care plan . . . ." Resident #1's 60-day MDS, dated 03/20/12, remained the same in all areas identified above	F 314	(F314 continued) The Wound Care Nurse will do a random audit of 3 residents per week from the at risk list to ensure interventions are being implemented properly, should improper use of interventions be discovered the Wound Care Nurse will immediately correct the issue and will retrain the individual responsible for that residents care. Results of the audits will be reviewed monthly by the Skin Care Team and further education or training if necessary will be recommended by the Skin Care Team. Findings of the Skin Care Team's monthly meeting will be reported by the Director of Nursing at the quarterly QA meeting attended by the Medical Director.	

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F 314	Continued From page 10 except this MDS identified Resident #1 exhibited four unstable pressure ulcers due to slough and/or eschar and identified the presence of necrotic (eschar) tissue. Resident #1's care plan identified a problem, dated 01/24/12, of "Alteration in Skin Integrity R/T [related to] ORIF [and] heel breakdown and approaches of "Repos [reposition] Q [every] 2 [hours]. The facility added approaches of "float heels when in bed," and heel lift boots to bilateral feet at all times on 02/22/12, almost one month later. The surveyor noted a discrepancy, with the date of 01/24/12 on the care plan, which identified the implementation of the problem of "Skin Integrity R/T . . . heel breakdown," as the Interdisciplinary Progress Note (IPN) of 01/30/12 is the first time facility staff documented and addressed the presence of Resident #1's heel pressure ulcers. Resident #1's physician orders included a copy titled "Standing Orders," signed by the physician on 10/13/08, which stated, "SKIN ASSESSMENT: Within 7 days of admission . . . Decubitus Care: 1. Decube/Pressure relief mattress on admission. 2. Pressure relief cushions/gel socks when indicated. 3. Apply hydrocolloidal when indicated. Notify doctor or PA [Physician Assistant]. Change q [every] 3 days and PRN. If wound shows no improvement in 2 weeks or if s/s [signs/symptoms] of infection notify MD or PA immediately . . . ." Resident #1's "Admission Nursing Assessment" form, dated 01/24/12, showed facility staff assessed and documented the skin condition (at the time of admission to the facility) to include "IV	F 314		

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F 314	Continued From page 11	F 314		

[intravenous] site bruises" to the right arm and hand, a "fluid filled ecchymotic area" to the left anticubital area, a "birthmark" to her lower back, a "reddened" area to left lower back, and a "bandage and staples" to the left hip. This Admission Nursing Assessment failed to document the presence of any redness or bogginess to Resident #1's bilateral heels.

Review of Resident #1's IPNs from January 24-29, 2012, lacked documentation of any redness or bogginess to the resident's bilateral heels.

An IPN, dated 01/30/12 at 9:30 a.m., stated, "Noted resident [left] heel fluid filled blister 3.8 (L) [length] x 2 cm [centimeters] (W) [width]. Blister intact - area surrounding heel spongy et [and] dusky in color. [Right] heel 7.5 (L) x 4.5 cm (W) fluid filled blister intact [with] dk [dark] color area in middle measuring 2.5 (L) x 2 cm (W). Blister intact. Heel spongy, pink surrounding blister . . . Gel heel socks applied to feet bilaterally. Also, pressure relieving mattress put on bed. Resident also to wear heel lifter boots while in bed."

Further IPNs, dated January 31-April 10, 2012, show evidence of facility staff assessing and monitoring Resident #1's bilateral heel pressure ulcers, applying a pressure relieving mattress to her bed and other interventions to promote the off loading of pressure to her heels, the implementation of dietary interventions to aid in the healing of the pressure ulcers, and wound care as ordered by the medical provider.

Review of the facility form titled, "Hourly Flow Record," showed the facility implemented an

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every two-three hour repositioning schedule for Resident #1 on February 1, after the discovery of her bilateral heel blisters. Resident #1's medical record lacked evidence the facility initiated, reminded, or assisted Resident #1 with frequent repositioning/turning from January 24-January 31, 2012.

Resident #1's Weekly Pressure Ulcer Records stated:
Left heel - 01/30/12 - Stage 2 measuring 3.8 x 2.0 cm (L x W) with an intact blister. Treatments/Comments of: "heel gel socks applied, air mattress to bed, heel lifter boots in bed."

- 02/01/12 - Stage 2 measuring 2 x 7 cm with an intact blister. Treatments/Comments of: "Heel elevator boots on at all times."
- 02/08/12 - Stage identified as "intact blister" measuring 3 x 6 cm.
- 02/15/12 - Stage identified as "[not] intact blister" measuring 3 x 7 cm.
- 02/22/12 - Stage identified as "unstageable" measuring 3 x 7 cm with "dried blacked epidermal tissue." Treatments/Comments of: "Appt [appointment] to be seen for debridement of epidermal tissue." The medical provider debrided Resident #1's left heel pressure ulcer on 02/23/12.
- 02/23/12 - Stage 2 - measuring 3.5 x 0.4 cm, depth of 0.2 cm with a "red and blood" wound bed.
- 02/28/12 - Stage "unstageable" measuring 3.5 x 0.4 cm, depth of 0.2 cm with a "black and dry" wound bed.
- 03/07/12 - Stage "unstageable" measuring 4.0 x 1.2 cm, with a "tan and yellow" wound bed. Treatments/Comments of: PolyMem

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F 314	Continued From page 13 as ordered. Will update Dr [doctor] [with] request to consider changing treatment." - 03/14/12 - Stage "unstageable" measuring 3.5 x 1.0 cm, depth 0.2 cm, with a "yellow and wet" wound bed. Treatments/Comments of: PolyMem d/c [discontinued] on 03/08. Tender-Wet [dressing] started daily. - 03/21/12 - Stage "unstageable" measuring 2.0 x 1.6 cm, depth 0.2 cm, with yellow slough to the wound bed. - 03/28/12 - Stage "unstageable" measuring 2.8 x 1.0 cm, depth 0.2 cm, with "90% white slough, 10% granulation" to the wound bed. - 04/04/12 - Stage 3 measuring 0.5 x 2.0 cm, depth of 0.2 cm, wound bed as "pink [with] 15% white slough." - 04/11/12 - Stage 3 measuring 0.5 x 2.0 cm, depth of 0.2 cm, wound bed as "pink [with] 10% white slough." Right heel - 01/30/12 - Stage 2 measuring 7.5 x 4.5 cm with an intact blister. Treatments/Comments of: "Heel gel socks, heel lifter boots in bed." - 02/01/12 - Stage 2 measuring 4.5 x 7.0 cm with an intact blister. Treatments/Comments of: "Heel elevator boots on [at] all times." The surveyor identified a discrepancy in the measurement from 01/30/12, as recorded by the licensed nurse two days prior. - 02/07/12 - Stage as "unstageable" measuring 1.0 x 2.2 cm, wound bed "black." - 02/15/12 - Stage as "unstageable" measuring 0.5 x 2.0 cm, wound bed "black." - 02/22/12 - Stage as "unstageable" measuring 0.5 x 2.0 cm, with "black" wound bed. Treatments/Comments of: "Appt for	F 314		

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F 314	Continued From page 14 debridement." The medical provider debrided Resident #1's right heel pressure ulcer on 02/23/12. - 02/23/12 - Stage 2 - measuring 4 cm (did not indicate if this is a length or width measurement), with a "red and bloody" wound bed. - 02/28/12 - Stage "unstageable" measuring 4 cm (did not indicate if this is a length or width measurement), with a "black and dry" wound bed. - 03/07/12 - Stage "unstageable" measuring 3.3 x 2.5 cm, with a "pink/red/tan/dry" wound bed. - 03/14/12 - Stage "unstageable" measuring 2.7 x 2.5 cm, depth 0.1 cm, with a "yellow and wet" wound bed. Treatments/Comments of: "Will fax update to Dr. re: [regarding] yellow/wet wound bed if [change] in treatment recommended." - 03/21/12 - Stage "unstageable" measuring 2 cm (did not indicate if this is a length or width measurement), with "green/yellow slough" to wound bed. - 03/28/12 - Stage "unstageable" measuring 2 cm (did not indicate if this is a length or width measurement), with 90% yellow slough, 10% granulation" to wound bed. - 04/04/12 - Stage "unstageable" measuring 2 cm (did not indicate if this is a length or width measurement), wound bed as "80% slough - 20% granulation." - 04/11/12 - Stage "unstageable" measuring 2 cm (did not indicate if this is a length or width measurement), wound bed as "80% slough - 20% granulation." A Physician Progress Note, dated 02/08/12,	F 314		

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stated, ". . . The patient did come back from the hospital with blister on the heels . . . ." (However, Resident #1's record lacked evidence of the presence of any blisters, redness or boggy heels based on her skin assessment at the time of her admission to facility on 01/24/12.) This progress note identified the resident has a "blister to the right heel which quite significant . . . does measure at least 3 cm in diameter . . . ." The medical provider recommended "continue with avoiding any extra pressure to the heels. Monitor quite closely. Continue with pain pill as needed. Patient will continue with physical therapy."

A Physician Progress Note, dated 02/23/12, stated, ". . . The patient has ulcers of both heels that have started to peel and are blackened in color and it was requested by nursing staff to have these debrided . . . On examination of the heels, the right heel has a large area of blackened tissue that does flake off easily. A #15 blade scalpel was used to debride the wound and there is pink tissue noted on the sides of the heel and on the very posterior aspect of the heel there is an ulceration that is noted that does have slight amount of blood oozing from it that looks to be about a Stage 2 ulcer through the superficial layers of the skin . . . On examination of the left heel there is some darkened black skin that flacks off easily with using a 15-blade scalpel to debride the area. These is an ulceration of about 4 mm [sic] by 3.5 cm on the lateral side of the left heel as well as a smaller ulceration noted on the posterior aspect of the heel grade Staging 2-3. On the ulceration of the posterior aspect of the heel there is a yellowish discharge overlying this and a culture was taken . . . no erythematous tissue or swelling is noted. No bleeding is noted .

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. . ." The medical provider recommended a Flexigel dressing be placed to the bilateral heels and for the dressing to be changed daily and await final culture results. On 02/25/12, the final culture report showed "normal skin flora."

On 02/29/12, the medical provider documented the size of the Resident #1's left heel ulcer as "about 2 cm in length and 1 cm in width," and the right heel ulcer "right in the middle which measures about 1.5 cm in diameter as well as length." The medical provider attempted to once again perform ulcer debridement to the bilateral heel pressure ulcers, but discontinued the procedure due to "the patient complained of too much pain." The medical provider recommended Resident #1 be seen at the clinic for debridement of the heel ulcers under local anesthetic.

Review of Resident #1's Treatment Records from February-April 2012 identified the following dressing changes in response to the resident's bilateral heel ulcers:

*02/01/12 - Tegaderm to open blister area right medial foot, change every third day and PRN.

*02/09/12 - Check both heels daily - dressing change daily PRN to both heels.

*02/23/12 - Flexigel dressing to both heels - change daily.

*03/02/12 - PolyMem to bilateral heel ulcers - change daily, update the provider in one week, and foam boots to bilateral lower extremities.

*03/08/12 - Continue PolyMem to right heel ulcer - change daily. Tender-Wet dressing daily to left heel ulcer. Foam boots on while sitting in recliner or wheelchair at while lying in bed.

*03/15/12 - Tender-Wet dressing to right heel

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ulcer - change daily.
*03/20/12 - DuoDerm to right heel, change daily.

Upon admission to the facility, the medical provider initiated an order Physical Therapy (PT) and Occupational Therapy (OT) services for Resident #1. Review of OT Daily Flowsheets from March 2012 identified Resident #1 stated on March 14 ". . . [Bilateral] heels are still painful," on March 15 stated "Hip doesn't hurt today. Heels do hurt still," and on March 19 states "heels are painful . . . ." PT Daily Flowsheets from April 03-10, 2012 identified Resident #1 complained of heel pain on four days (April 03, 04, 09, and 10). On April 04, the PT note stated, "Pt [patient] appeared less attentive than normal today. Mentions poor sleep due to feet."

Resident #1 verbalized pain and discomfort related to her bilateral heel pressure ulcers and received the following pain medications:
*Tylenol (also known as Acetaminophen, an over- the-counter [OTC] pain medication, ordered on 02/09/12) 650 milligrams (mg) every four hours (hrs) as needed. The resident received the medication twelve times in February (twice on the 16 and 18, four times on the 19, once on 20-22, and on the 25) and twice on April 8.
*Tramadol (also known as Ultram, a narcotic/opoid pain medication, ordered on 02/21/12) 50 mg every six hrs as needed. The resident received the medication five times in February (once on the 23, twice on the 24 and 26). On February 27, the medical provider changed the order to provide the Tramadol twice daily to Resident #1 and continue with the PRN dosing. Record review showed that in addition to

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the scheduled Tramadol, Resident #1 received PRN doses 10 times in March (twice on the 2, once on 3, 7, 10, 11, 23, twice on the 24, and once on the 29) and nine times in April (1-6, and 8-10). On 03/02/12, the provider discontinued the twice daily dosing of Tramadol related to Resident #1 displaying increased confusion.

*Advil (also known as Ibuprofen, an OTC nonsteroidal anti-inflammatory [NSAID] medication, implemented from the facility's standing orders on 03/03/12) 400 mg every four hrs as needed. The resident received the medication 17 times in March (5-6, 8, 10-16, 18-19, 21-22, 24, 27-28).

Observation of Resident #1's bilateral heel pressure ulcers occurred on 04/10/12 at 11:05 a.m. A strong, foul odor was noted upon the removal of the DuoDerm dressing to the right heel pressure ulcer. The old dressing contained yellow drainage. Observation showed the right heel pressure ulcer size as approximately 3.5 cm by 3.5 cm. The left heel pressure ulcer omitted no odor or drainage. Observation showed the left heel pressure ulcer size as approximately 2.5 cm by 1.0 cm.

During an interview on 04/11/12 at 7:45 a.m., an administrative nurse (#4) confirmed Resident #1's bilateral heel ulcers developed after admission to this facility. This administrative nurse stated the facility initially placed a pressure relieving air mattress to Resident #1's bed prior to her admission (on January 24) but "somehow" the air mattress was removed (the exact date is unknown) and facility staff again placed an air mattress on February 1, 2012 (after the bilateral

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F 314	Continued From page 19 heel blisters were identified). Failure of the facility to routinely assess Resident #1's heels during cares as per policy and for six consecutive days (January 24-30) following admission to the facility and ensure the immediate implementation of pressure relieving devices, contributed to the development of bilateral heel pressure ulcers and her verbalizations of heel pain. - Review of Resident #8's medical record occurred on April 11-12, 2012. Resident #8 sustained a fall at the facility on 07/27/11, which resulted in a left hip fracture. Resident #8 was hospitalized from July 27-30, 2011 and returned to the facility on July 30. Medical diagnosis for Resident #8 included open reduction internal fixation (ORIF) of left hip, dementia, bipolar disorder, and history of Stage 2 left heel pressure ulcer. Resident #8's significant change MDS, dated 08/09/11, and quarterly MDS, dated 10/25/11, identified the resident displayed severe cognitive impairment as evidenced by a BIMS score of 3; required extensive two person physical assistance with bed mobility, transfers, dressing, toilet use and personal hygiene; one Stage 1 and one Stage 2 pressure ulcer identified on 08/09/11; and pressure reducing device on the bed, turning/repositioning schedule, and nutrition/hydration interventions. Resident #8's care plan identified a problem, dated 08/01/11, of "Alteration in Skin Integrity R/T fx [fractured] hip and [decreased] activity," the	F 314		

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addition of "Stage 1 on heels" added on 08/08/11 and approaches of "Reposition [every] 2 [hours] or more freq [frequently], gel socks to bilateral heels at all times." The care plan lacked dates of when facility staff actually implemented these approaches.

Review of Resident #8's Interdisciplinary Progress Notes (IPNs) from July 30 (when the resident returned from hospital) through August 04, 2011, lacked documentation of any redness or bogginess to the resident's bilateral heels. These notes stated Resident #8 needed assistance for transfers (with three persons) and repositioning, and complained of pain. On 07/31/11 at 1:45 p.m., an IPN identified facility staff implemented the intervention of repositioning Resident #8 every two hours. Resident #8's IPNs stated:

*08/05/11 at 5:00 a.m. - "Removed socks noted [left] heel darkened [and] spongy . . . ." Further documentation at 10:00 a.m., stated, "Skin assessed. Noted Stage 1 pressure area on [left] heel. [Left] heel off loaded [and] gel socks on bilaterally." Resident #8's medical record identified the facility placed an air mattress on her bed on 08/06/11.

*08/09/11 at 10:00 a.m. - "Noted Stage 1 pressure ulcer on [right] heel. Cont [continued] [with] Stage 2 intact blister on the [left] heel. Cont [with] gel socks bil [bilaterally] . . . Transfers [with] three . . . Repositioned [every] 2 hours."

*08/17/11 at 1:10 p.m. - "Skin assessed. Cont. [with] Stage 2 intact blister on [left] heel. [Right] heel firm [and] blanches well, [no] red areas."

*08/22/11 at 4:00 p.m. - "Skin assessed. Blister on [left] heel dry [and] intact. Black in color. Noted heel firm, [with] center of blister area

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F 314	Continued From page 21 boggy. Periwound pink [and] blanch well. Will cont [with] gel sock on [at] all times . . . ." *08/27/11 at 1:30 p.m. - "Skin assessed. Noted heel firm under blister area. Blister dried, [and] dk [dark] brown in color. [No] tenderness [with] palpitation." *08/30/11 at 3:30 p.m. - "Skin assessed. Area on [left] heel has blackened hard tissue covering, area unstageable. Area stable, [with] periwound pink [and] blanches well. Heel firm. [No] tenderness to touch." *09/12/11 at 10:00 a.m. - "CNA had nurse look at [left] heel. Nurse noticed clear drainage [with] odor on heel. 6 cm long x 4 cm wide [with] tunneling noticed. No blister present. Resident has appt [with] . . . NP [nurse practitioner] today. No [complaints of] pain at this time. Nurse noticed dark spots around sore." *09/13/11 at 2:00 p.m. - "Noted [two] dk unstageable area on [left] heels . . . [left] heel pink [and] firm. Noted dk hard tissue was debrided from heel. Dry drsg [dressing] applied as ordered. Keflex [an oral antibiotic] given as ordered" *09/20/11 at 1:35 p.m. - "Skin assessed. Unstageable area cont. 0.2 x 0.8 cm stable [left] heel pink [and] blanches well. Cont [with] gel sock on [left] heel [and] float heels when in recliner/bed." *09/29/11 at 7:00 a.m. - "Skin assessed. [Left] heel, blanches well. Unstageable area 0.2 cm. Cont. [with] gel sock on [and] heel floating." *10/11/11 at 1:30 p.m. - "Noted unstageable area on [left] heel open to Stage 2. 0.5 cm x 1 cm. Will have Dr assess on NH [nursing home] rounds." The medical provider ordered a multivitamin, zinc, Opti-Foam dressing to left heel, and an OT consult. On 10/12/11, the occupational therapist recommended	F 314		

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discontinuing the gel sock and use heel suspension boot in bed."

*10/17/11 at 10:00 a.m. - "Skin assessed. Noted Stage 2 0.8 cm x 1.5 cm noted dk areas, drsg scan amount bloody drainage. [Left] heel firm [and] pink. Blanches well." On 10/18/11, the facility made an appointment for Resident #8 to be seen by the medical provider.

*10/19/11 at 4:00 p.m. - "Res returned from appt . . . Continue [with] same tx. Debridement of [left] heel . . . ."

*10/23/11 at 3:00 p.m. - "Skin assessed. Drsg [change] to [left] heel. Noted [two] areas, [one] 0.2 cm on lateral side [and] [one] 0.4 cm on medial side. Both wound bases epithealized. Periwounds pink [with] [left] heel firm [and] blanches well." The medical record identified Resident #8's left heel pressure ulcers healed on 10/27/11.

Resident #8's Weekly Pressure Ulcer Records stated:
Left heel - 08/17/11 - Stage 2 "intact blister," measuring 3.5 x 6.0 cm.
- 08/22/11 - Stage 2 measuring 3.5 x 6.0 cm, wound bed "dry blister."
- 08/30/11 - Stage "unstageable," measuring 3.5 x 6.0 cm.
- 09/07/11 - Stage "unstageable," measuring 3.5 x 6.0 cm, surrounding tissue wound edges "dried." (The medical provider debrided the left heel ulcer on 09/12/11 and ordered an antibiotic.)
- 09/14/11 - Stage "unstageable," measuring 0.2 x 0.8 cm.
- 09/20/11 - Stage "unstageable," measuring 0.2 x 0.8 cm.
- 09/29/11 - Stage "unstageable,"

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F 314	Continued From page 23 measuring 0.2 cm. - 10/05/11 - Stage "unstageable," measuring 0.2 cm. - 10/11/11 - Stage 2, measuring 0.5 x 1.0 cm, wound bed "dk purple/red." - 10/17/11 - Stage 2, measuring 0.5 x 1.5 cm, "bloody" exudate and "dk purple/red" wound bed. The medical provider debrided the left heel ulcer on 10/19/11. - 10/23/11 - Stage 2, "[two] areas measuring "0.2 cm" and "0.4 cm," wound bed "pink." Review of a hand-written Physician Progress Note from a clinic appointment, dated 09/12/11, stated, "No pressure to left heel in bed or in chair. Dry dressing to left heel - monitor daily . . . ." The medical provider debrided the left heel ulcer, ordered laboratory testing and the initiation of Keflex (an oral antibiotic) to treat a suspected left heel ulcer infection. On 09/28/11, Resident #8 returned to the medical provider for a recheck of the left heel ulcer. The medical provider stated, ". . . There is the ulceration on the left heel which is almost heeled [sic] . . . ." The medical provider requested an update of Resident #8's status in two weeks. On 10/19/11, a form titled "Referral and Treatment Request," for Resident #8 stated, ". . . Complaint: [check] area on [left] heel - has gotten bigger compared to last wk [week]. Sm [small] amt [amount] bld [bloody] drainage. [Name of another provider] ordered Optifoam [after] assessing area on 10/11/11. [wondering] if can be debrided . . . ." This form identified the medical provider once again debrided the left heel	F 314		

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	355116	A. BUILDING _____ B. WING _____	04/12/2012

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pressure ulcer and wrote orders to continue with the Optifoam dressing until healed. Resident #8's record identified this left heel pressure ulcer as healed on 10/27/11, (after approximately two months).

Resident #8 re-entered the facility following a hip fracture on 07/30/11. Resident #8's medical record lacked evidence the resident presented on 07/30/11 with any redness or bogginess to her bilateral heels. Resident #8's "Nurses Assistant Flowsheet" identified the facility initiated a consistent repositioning schedule on August 6 (five days after the resident returned to the facility following a hip fracture).

Failure of the facility to routinely assess Resident #8's heels (from August 01-04) following readmission to the facility and failure to ensure the immediate implementation of pressure relieving devices, contributed to the development of this resident's bilateral heel pressure ulcers and the need for surgical debridement (twice) in an effort to aid in the healing of the pressure ulcers.

- Review of Resident #2's medical record occurred on April 09-12, 2012. Medical diagnosis for Resident #2 included insulin dependent diabetes mellitus, Parkinson's, hypertension, and sick sinus syndrome.

Resident #2's quarterly MDS, dated 03/15/12, identified the resident displayed severe cognitive impairment as evidenced by a BIMS score of 2; required extensive two person physical assistance with bed mobility, transfers, dressing, toilet use and personal hygiene; and the absence

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of any pressure ulcers.

Resident #2's physician orders included a copy titled "Standing Orders," signed by the physician on 10/03/08, which stated, ". . . 11. Skin Irritation: . . . . Calmoseptine to affective area bid PRN . . . Decubitus Care: 1. Decube/Pressure relief mattress on admission. 2. Pressure relief cushions/gel socks when indicated. 3. Apply hydrocolloidal when indicated. Notify doctor or PA [Physician Assistant]. Change q [every] 3 days and PRN. If wound shows no improvement in 2 weeks or if s/s [signs/symptoms] of infection notify MD or PA immediately . . . ."

Review of an IPN, dated 03/16/12, for Resident #2 identified an "open area [right] side of coccyx - 0.5 cm in diameter. DuoDerm placed to promote healing. [no] drainage noted."

An IPN, dated 03/21/12, stated, "Skin assessed. Noted 1 cm x 0.2 cm gluteal slit on coccyx [with] 0.2 cm Stage 2 open area to [right] coccyx. Periwound skin moist [and] macerated. Rx [treatment] changed to Calmoseptine ointment bid [twice daily] til healed. Pressure redistribution cushion/recliner. Res repositioned per res request. Res amb [ambulatory] [with] FWW [front wheeled walker] [and] assist . . . ." The application of "Calmoseptine" ointment to an open area contradicts with the identified use of Calmoseptine as stated on Resident #2's standing orders. Facility staff notified Resident #2's medical provider of the Stage 2 open area on 03/21/12 and no additional treatment orders were received from the provider.

An IPN, dated 03/28/12, identified the gluteal slit

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as "healed," but Resident #2's "open area" to the right coccyx remained and progressed to a "Stage 3" pressure ulcer measuring "1 cm x 0.5 cm" with "white slough covering the wound base." The facility placed Resident #2 on a repositioning schedule, (side to side when in bed) and continued to apply Calmoseptine to the opened area on the coccyx. Resident #2's record lacked evidence facility staff notified the medical provider of the progression of the coccyx ulcer to a Stage 3.

Resident #2's care plan identified a problem, dated 03/22/12, of "Alteration in Skin Integrity R/T Potential for Breakdown on her heels [and] coccyx" and approaches of "Gel socks to bilateral feet [and] float heels when in bed." The facility added approaches of "Reposition schedule [every] 2 [hours] or more freq [frequently], lay res [resident] in bed [after] meals [and] reposition side to side till healed" on 03/28/12. The facility added an air mattress to the resident's bed on 03/29/12.

IPN, dated 04/04/12, stated the "Stage 3 open area on coccyx healing well. Area 0.5 cm. Wound base pink [with] white slough noted. Edges pink. Cont [continue] [with] Calmoseptine [and] pressure redistribution devices. Res remains on reposition schedule."

On March 28 and April 04, 2012 facility nursing staff identified Resident #2's right coccyx wound progressed to a Stage 3, but the record lacked evidence the facility contacted the medical provider to request a treatment/order change.

An IPN, dated 04/11/12, identified the Stage 3

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F 314	Continued From page 27 open area on Resident #2's coccyx decreased in size to "0.3 cm" and plan to continue with current interventions and treatments. Observations of Resident #2 on 04/09/12 at 3:05 p.m. and 04/10/12 at 10:15 a.m., showed the resident laying supine in her bed with a bedspread, sheet, and a disposable pad between her and the pressure relieving air mattress and the resident's heels laying directly on the mattress. The presence of multiple layers of bed linens directly on top of the air mattress prevents the airflow components of the mattress from working effectively. Observation on 04/10/12 at 11:40 a.m. showed two certified nurse aides (CNAs) (#7 and #8) assisted the resident to use the toilet. Observation of Resident #2's buttock/coccyx area showed a thick layer of a white ointment covering the upper portion of the buttock area, identified by the CNAs as Calmoseptine. The CNA (#7) stated, "She has an open area here" and pointed to the crevice at the top of the buttock area. During an interview on 04/11/12 at 7:45 a.m., an administrative nurse (#4) stated for the airflow mattress to work effectively, only a sheet and a disposable pad should be between Resident #2 and the mattress and facility staff need to float the resident's heels to prevent breakdown to her heels. During an interview on 04/12/12 at 12:00 p.m., a medical provider (#9) stated Calmoseptine ointment is a preventative or barrier ointment and should not be used on open areas or to treat heel or coccyx pressure ulcers.	F 314		

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F 314	Continued From page 28 Failure to follow the facility's "Standing Orders" for Decubitus Care, failure to utilize the air overlay mattress correctly, and failure to notify the resident's physician when the pressure ulcer progressed from a Stage 2 to a Stage 3 may have delayed the healing of Resident #2's coccyx pressure ulcer.	F 314		
F 354 SS=D	483.30(b) WAIVER-RN 8 HRS 7 DAYS/WK, FULL-TIME DON Except when waived under paragraph (c) or (d) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. Except when waived under paragraph (c) or (d) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on review of the facility nursing staff schedule and staff interview, the facility failed to ensure they provided the services of a registered nurse (RN) for 8 consecutive hours a day, 7 days a week, for 10 of the 103 day period between January 1, 2012 to April 12, 2012. Failure to assure sufficient qualified nursing staff are available on a daily basis has the potential to affect all the residents residing in the facility.	F 354	F354 The facility nursing schedule was revised to ensure that RN coverage of 8 consecutive hours, 7 days per week is maintained. The Director of Nursing or designee shall indicate on the schedule which nurse is the designated RN coverage for each day. The Director of Nursing shall report to the QA committee quarterly if there have been any days of noncompliance.	5/10/12

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F 354	Continued From page 29 Findings include: During the entrance conference, the facility provided a copy of the schedule for RNs and Licensed Practical Nurses (LPNs) working the week of survey (April 9-12) and the week prior. A review of this schedule showed the facility lacked the required RN coverage for 04/01/12. A further review of nursing staff schedules identified 10 days (January 9, 14, 15, February 11, 12, 25, March 24, 25, 31, and April 1) between January 1, 2012 and April 12, 2012 (a 103 day period) that lacked RN coverage. During an interview on 04/11/12 at 7:40 a.m., an administrative nurse (#5) confirmed that the facility lacked an RN working in the facility on 04/01/12.	F 354		
F 386 SS=E	483.40(b) PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure 1 of 2 physicians (Physician A) wrote, signed, and dated a progress	F 386		

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F 386	Continued From page 30 note upon the completion of the residents' visits/examinations involving 6 of 9 sampled residents (Resident #3, #4, #5, #7, #8, #9) and 1 closed record (Resident #10) reviewed. Failure to ensure the physician completed a progress note for each resident visit does not ensure the physician's assessment and recommendations regarding the resident's current medical regime and treatment are documented and communicated to all members of the interdisciplinary team. Findings include: Review of Resident #3, #4, #5, #7, #8, #9 and #10's medical record occurred on April 09-12, 2012 and identified the following: - Physician A examined Resident #8 on 08/10/11 and dictated the note for this visit on 01/17/12 (159 days later). Physician A examined Resident #8 on 10/11/11 and dictated the note for this visit on 01/23/12 (103 days later). Physician A examined Resident #8 on 12/02/11 and dictated the note for this visit on 02/08/12 (67 days later). - Physician A examined Resident #5 on 08/10/11 and dictated the note for this visit on 01/07/12 (149 days later). Physician A examined Resident #5 on 11/18/11 and dictated the note for this visit on 02/01/12 (74 days later). Physician A examined Resident #5 on 12/02/11 and dictated the note for this visit on 02/13/12 (72 days later) - Physician A examined Resident #10 on 10/11/11 and dictated the note for this visit on 01/26/12 (106 days later). Resident #10 expired at the facility on 12/11/11.	F 386	F386 All resident records were reviewed by the Medical Records Director on 4/17/2012 to ensure physician assessment progress notes were current. No variances were found at this time. A meeting with Physician A was held on 4/12/2012 to discuss timeliness of dictation. The Medical Records Director will track each resident's physician round date and the date the dictated progress note is received. The Medical Records Director will randomly audit 5 of Physician A's resident charts per month to ensure dictated progress notes are received within 14 days of the physician visit. The results of said audits will be reported by the Medical Records Director at the quarterly QA meeting attended by the Medical Director.	5/10/12

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F 386	Continued From page 31 - Physician A examined Resident #4 on 11/08/11 and dictated the note for this visit on 02/01/12 (84 days later). - Physician A examined Resident #3, #7, and #9 on 11/08/11 and dictated their respective individual progress notes for these visits on 01/26/12 (77 days later). During an interview on 04/11/12 at 4:00 p.m., a medical record staff member (#6) confirmed Physician A does not always complete the dictation on the day of each individual resident visit. This staff member stated she knows it is a problem and continues to monitor and track the turnaround time of receiving the transcribed progress notes from Physician A and reports this information to the facility's quality assurance committee.	F 386		
F 494 SS=D	483.75(e)(2)-(3) NURSE AIDE WORK > 4 MO - TRAINING/COMPETENCY A facility must not use any individual working in the facility as a nurse aide for more than 4 months, on a full-time basis, unless that individual is competent to provide nursing and nursing related services; and that individual has completed a training and competency evaluation program, or a competency evaluation program approved by the State as meeting the requirements of §§483.151-483.154 of this part; or that individual has been deemed or determined competent as provided in §483.150(a) and (b). A facility must not use on a temporary, per diem, leased, or any basis other than a permanent employee any individual who does not meet the	F 494		

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F 494	Continued From page 32 requirements in paragraphs (e)(2)(i) and (ii) of this section. Nurse aides do not include those individuals who furnish services to residents only as paid feeding assistants as defined in §488.301 of this chapter. This REQUIREMENT is not met as evidenced by: Based on information from the state nurse aide registry, facility record review, and staff interview, the facility failed to ensure 1 of 1 direct care staff (Individual A) did not continue to work as a nurse aide for longer than 4 months without successfully completing the competency evaluation program requirements for certification. Failure to ensure certification of direct care staff has the potential to affect resident care. Findings include: Information from the North Dakota nurse aide registry identified on 02/24/12 Individual A, failed a portion of the testing required to become a Certified Nursing Assistant (CNA). Review of information provided by the facility indicated Individual A completed the nurse aide training class in August of 2011. Review of the staff schedule for CNAs for the period of February 25 to March 31, 2012 indicated Individual A worked as a CNA for 24 of the 36 days. This time frame falls outside the 4 month period allowed to work prior to taking and passing	F 494	F494 Individual A successfully completed her CNA testing on 4/17/2012. All CNA's have the potential to have an expired license or fail to complete testing within the required time frames. All newly trained staff will be tracked on the CNA class tracking log. The Education Nurse shall put all newly trained CNA staff information on the said log. The Director of Nursing or designee shall review the log at least monthly to ensure accuracy and verify that newly trained CNA staff remain compliant with testing dates. Should any newly trained CNA's be found to be noncompliant they shall be removed from the schedule and not allowed to work until they become compliant. The Director of Nursing will report any noncompliance issues with said procedure to the QA committee on a quarterly basis.	5/10/12

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F 494	Continued From page 33 the required testing. During an interview on 04/12/12 at 11:00 a.m., an administrative nurse (#3) confirmed Individual A worked as a CNA during the time period listed above.	F 494		
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on review of North Dakota Department of	F 520	F520 The quarterly QA reports were expanded to include not only problems indentified but also include solutions of said problems brought forth by the committee. Each quarterly meeting will include a review of the previous quarters recommendations and status of implementation of remedies to ensure improvements are made in identified areas of concern. Refer to F280 and F14 for specific recommendations of problems already identified.	5/16/12

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F 520	Continued From page 34 Health (ND DoH), Division of Health Facilities provider files, record review, and staff interview, the facility failed to maintain a Quality Assurance (QA) committee which identified and addressed quality issues; and failed to develop and implement appropriate plans of action to correct deficient practice and ensure compliance with federal requirements. Findings include: Review of the state agency files indicated the facility failed to maintain compliance at F 280 and F 314 as indicated by deficiencies cited during the last standard survey on 05/24/11. Refer to F 280 and F 314 for specific findings During an interview on 04/12/12 at 11:00 a.m., an administrative staff member (#1) stated they do monitor areas identified as needing improvement based on the survey completed 05/24/11. The administrative staff member (#1) further stated the facility continues to compile weekly skin reports and these reports are given to the administrator, director of nursing, and discussed at the quarterly QA meetings. When asked how the data, gathered from the weekly skin sheets is utilized, the administrative staff members (#1, #2, #3, and #5) present during the interview, provided no specific information regarding tracking, trending or audits done by the facility's QA program regarding pressure ulcers. Failure of the facility to effectively utilize QA resulted in continued noncompliance in F 280 the area of reviewing and revising care plans. Failure	F 520		

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F 520	Continued From page 35 of the facility to utilize the QA process to assess and implement appropriate interventions regarding pressure ulcers resulted in actual harm to Residents #1, #2, and #8 and continued noncompliance in F 314.	F 520		