| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 355052 | A. BUILDING _____ B. WING _____ | 01/16/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| NELSON COUNTY HEALTH SYSTEM CARE CENTER | 108 E NYHUS AVE MCVILLE, ND 58254 |

| (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 |
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| F 000 | INITIAL COMMENTS<br><br>For the standard Medicare/Medicaid recertification survey started on 01/14/13 and completed on 01/16/13, 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 one (1) additional resident to verify specific concerns during the survey. | F 000 | | |
| F 278 SS=E | 483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED<br><br>The assessment must accurately reflect the resident's status.<br><br>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.<br><br>A registered nurse must sign and certify that the assessment is completed.<br><br>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.<br><br>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.<br><br>Clinical disagreement does not constitute a | F 278 | 1. All residents who were incorrectly marked as having an individualized toileting schedule have had a corrected MDS submitted as of 2/13/13.<br>Resident #2 – her assessment was re-evaluated. She is now a check and change for urine with a schedule in place for bowel.<br>Resident #3, #4, #5, #8, #9 – were re-evaluated and now have individualized toileting plans in place.<br><br>2. All residents have the potential to be affected so were reviewed. Those who were incorrectly marked as having an individualized toileting schedule have had a corrected MDS submitted. Their toileting assessments were reviewed and an individualized toileting schedule put into place for them.<br><br>3. The MDS Coordinator has educated herself using the RAI manual as to the appropriate coding of section H. She also received from the state MDS Coordinator and the survey team some tip sheets to assist her in the proper coding. The Resident Care Coordinator, who completes the toileting evaluations, has been educated regarding the | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Beverly Swenson, CEO | CEO | 2/12/13 |

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 278 | Continued From page 1<br>material and false statement.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual (Version 3.0), resident interview, and staff interview, the facility failed to implement an individualized, resident-specific program based on an assessment of the residents' unique voiding patterns for 7 of 8 sampled residents (Resident #2, #3, #4, #5, #6, #8, and #9) coded on the Minimum Data Set (MDS) as having a toileting program in place. Failure to implement individualized, resident-specific toileting programs based on assessment and accurately code the MDS may effect the level of care provided by staff to the residents.<br>Findings include:<br><br>The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, April 2012, page H-6 states, ". . . Toileting (or trial toileting) programs refer to a specific approach that is organized, planned, documented, monitored, and evaluated that is consistent with the nursing home's policies and procedures and current standards of practice. A toileting program does not refer to:<br>* simply tracking continence status,<br>* changing pads or wet garments, and<br>* random assistance with toileting or hygiene . . ."<br>Page Z-6 states, ". . . The importance of accurately completing and submitting the MDS cannot be overemphasized. The MDS is the basis for the development of: | F 278 | need for a toileting schedule that is individualized to the resident's toileting pattern. She will be analyzing the 3-day toileting diary results as to whether the resident is appropriate for an individualized bladder and/or bowel toileting schedule and will write the schedule in her plan. The policy for 'Habit Training/Scheduled Voiding' was rewritten to reflect the need for an individualized plan. The individualized plan will be in the resident's care plan and on the worksheet each CNA has. The sheet with the generic schedule used previously in the resident rooms for recording resident toileting episodes has been eliminated. The toileting episodes will be recorded on the CNA worksheet until they can be transferred onto the CNA documentation sheet for each resident.<br><br>4.<br><br>5. A QA was devised that will track the toileting evaluation that contains the toileting plan to assure it is accurately used to determine the responses to section H on the MDS. The QA will also track that the toileting plan follows through to the care plan, the CNA worksheet and the documentation by the CNA that the toileting was completed. This will be completed by the DON weekly starting 2/25/13 until the documentation is being completed as it should be, then monthly. Each resident's toileting assessment will be reviewed quarterly and PRN, then updated as necessary. | 2/16/13 |

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| F 278 | Continued From page 2<br>* an individualized care plan<br>* The Medicare Prospective Payment System<br>* Medicaid reimbursement programs<br>* quality monitoring activities . . .<br>* the data-driven survey and certification process<br>* the quality measures used for public reporting . . ."<br><br>Observation on all days of survey showed a toilet schedule affixed to the inside of the bathroom door for Resident #2, #3, #4, #5, #6, #8, and #9's. This schedule identified eight columns for staff members to document the residents' continence or incontinence. The times identified were: 12:00 a.m., 4:00 a.m., upon waking, before dinner, after dinner, before supper, after supper, and bedtime (HS).<br><br>- Review of Resident #2's medical record occurred on all days of survey. The current MDS, dated 12/29/12, identified always incontinent of urine, occasionally incontinent of bowel, and on a scheduled urine and bowel toileting program. Resident #2's "Urinary Continence Evaluation," dated 12/04/12, stated, "Res [resident] [with] decline mental & physically - rarely cont. [continent] [with] urine anymore - 5-6 x/24 [hours] [incontinent 5 to 6 times in 24 hours]." The "Evaluation of Bowel" stated, Res on toilet schedule [with] occ incont of BM [bowel movement]."<br><br>Resident #2's current care plan stated, "Resident occ [occasionally] incont [incontinent] B & B [bowel and bladder] - expect this to increase [with] decline in condition . . . Toilet 2 AM et [and] PRN [as needed] b/4 [before] meals/after meals & [and] b/4 HS [bedtime] . . ." The "Schedule | F 278 | | |

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| F 278 | Continued From page 3<br>Specifications" posted on the resident's bathroom door stated, "Toilet 12am & [and] 2am & PRN [as needed] Assist b-4 and after meals and HS [hour of sleep]."<br><br>Review of the "Nurse Aide Charting" from November 2012 through January 15, 2013 identified Resident #10 as always incontinent during the hours of 11:00 p.m. to 7:00 a.m. Even though the bowel and bladder assessments and CNA charting identified the resident's increased incontinence, the facility failed to re-evaluate her current toileting schedule and voiding patterns and develop an individualized toileting program.<br><br>- Review of Resident #5's medical record occurred on all days of survey. The current MDS, dated 12/05/12, identified frequent urinary incontinence and on a scheduled urinary toileting program. The "Urinary Continence Evaluation," dated 12/04/12, identified the resident as incontinent of urine two to three times in 24 hours and to continue with the toileting schedule.<br><br>Resident #5's current care plan stated, "Frequently incont of urine - occ [occasionally] of bowel . . . toilet per schedule (See CNA [certified nursing assistant] book) . . ." The "Schedule Specifications" posted on the resident's bathroom door stated, "Toilet at 5:30 a.m., after bfst [breakfast], b-4 [before] and after meals."<br><br>Review of "Nurse Aide Charting" from November 2012 through January 15, 2013 identified Resident #5 as always incontinent of urine during the hours of 11:00 p.m. to 7:00 a.m. The facility failed to re-evaluate the resident's voiding patterns and develop an individualized toileting | F 278 | | |

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| F 278 | Continued From page 4<br>program.<br><br>- Review of Resident #6's medical record occurred January 14-16, 2013. A quarterly MDS, dated 11/13/12, identified the resident as always incontinent of urine, occasionally incontinent of bowel, and on a scheduled toileting program for bladder and bowel. Resident #6's "Urinary Continence Evaluation," dated 08/01/11, stated, "Res on toilet schedule for BM's [bowel movements]. Urine cont (4-5 x/24 [hour] incont)." A quarterly evaluation, dated 08/04/12, stated," On toilet schedule [after] B/F [breakfast], [after] dinner, b/4 supper. Remains incont of urine 5-6 x/24 [hours]."<br><br>Resident #6's care plan, dated 12/01/12, stated, "Problem/Need Bowel &Bladder Resident is incont. of urine. Occ incont of bowel. Has toileting plan - helps [with] bowel continence . . . toilet after breakfast, noon meal & b/4 supper [check] [every] 2-3 [hours] during nite [sic]." The "Schedule Specifications" affixed to the resident's bathroom door stated, "Toilet after bfast [breakfast], after noon meal, and before supper. Check every 2-3 hrs [hours] prn during NOC [night] shift."<br><br>Review of the "Nurse Aide Charting" from October 2012 through January 15, 2013 identified an increase in Resident #6's incontinence. The facility failed to re-evaluate her current toileting schedule and voiding patterns and develop an individualized toileting program.<br><br>- Review of Resident #9's medical record occurred 01/14/13. A significant change MDS, dated 10/29/12, identified the resident as | F 278 | | |

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| F 278 | Continued From page 5<br>frequently incontinent of urine and on a toileting program. Resident #9's "Urinary Continence Evaluation," dated 08/01/11, identified the resident experienced persistent incontinence classified as "Mixed (stress incontinence with urgency);" identified the most appropriate intervention for the resident as "Habit training/scheduled voiding program;" and stated "Res uses call lite [sic] [at] noc for bedpan & usually incont x1/shift [one time per shift]. Toileted during AM [morning] cares, [after] meals, & HS - prn (4-5x/24 hours incont)." A quarterly evaluation, dated 08/04/12, stated, "No [changes]. Remains incont. of urine."<br><br>Resident #9's care plan, dated 12/16/12, stated, "Problem/Need Bowel & Bladder Resident incont. of bladder . . . Approaches . . . Toileting schedule - (see master schedule)." The "Schedule Specifications" affixed to the resident's bathroom door stated, "Toilet during AM cares, before and after meals and HS. Resident calls for bedpan at night. Check & change prn or as product indicates during NOC."<br><br>Review of the "Nurse Aide Charting" from October 2012 through January 15, 2013 identified an increase in Resident #9's incontinence. The facility failed to re-evaluate her current toileting schedule and voiding patterns and develop an individualized toileting program.<br><br>During an interview on 01/16/13 at 12:10 p.m., a nursing staff member (#1) stated she intended Resident #6 and #9 to be on a toileting program for bowel, not bladder.<br><br>During an interview, on 01/16/13 at 2:03 p.m., two | F 278 | | |

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| F 278 | Continued From page 6<br>administrative staff members (#4 and #6) agreed Resident #6 and #9's toileting schedule did not meet the MDS guidelines for a toileting program.<br><br>- Review of Resident #4's medical record occurred on all days of survey. The most recent MDS, dated 01/05/13, identified the resident as frequently incontinent of urine and on a scheduled urine toileting program. Resident #4's Care Area Assessment (CAA), dated 01/09/13, for Urinary Incontinence/Catheter, stated, ". . . has extensive assist [with] toilet needs and is frequently incont [incontinent] of bladder . . . T. [toileting] schedule in place . . . She can ring for assist as needed. . . ." Resident #4's "Urinary Continence Evaluation," dated 12/03/12, stated, ". . . Res completed 3 day incontinence assessment. No specific pattern obs [observed] . . . for now res will be toileted [before] and [after] meals and HS."<br><br>Resident #4's current care plan stated, ". . . Assist to toilet and check and change prn T. schedule. See schedule in CNA book. . . ." The CNA book schedule stated, "[Before] and after meals and HS - prn." The "Schedule Specifications" affixed on the resident's bathroom door stated, "Toilet before and after meals and HS - prn."<br><br>Review of the "Nurse Aide Charting" from November through December 2012 identified an increase in Resident #4's incontinence. The facility failed to re-evaluate her current toileting schedule and voiding patterns and develop an individualized toileting program.<br><br>- Review of Resident #8's medical record occurred on January 08-09, 2013. The most recent MDS, dated 10/08/12, identified the | F 278 | | |

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| F 278 | Continued From page 7<br>resident as frequently incontinent of urine and on a scheduled toileting program. Resident #8's "Urinary Continence Evaluation," dated 12/03/12, stated, "Res will cont on toilet program. Res states 'unable to hold urine - just comes.' Res [with] urinary incont and rarely cont of urine."<br><br>Resident #8's current care plan stated, "Resident has frequent stress incontinence . . . Toilet schedule and prn . . ." The "Schedule Specifications" affixed on the resident's bathroom door stated, "Encourage toilet before and after meals and HS - prn during noc [night]."<br><br>During an interview on 01/16/13 at 1:10 p.m., Resident #8, identified as cognitively intact on her most recent MDS, stated, "I know when I have to go. Have to call them [facility staff] for help [with toileting]."<br><br>- Review of Resident #3's medical record occurred on all days of survey. The most recent MDS, dated 01/02/13, identified the resident as occasionally incontinent of urine and on a scheduled toileting program. Resident #3's "Urinary Continence Evaluation," dated 12/04/12, stated, "Res cont on toilet schedule - cont. of urine past wk [week]."<br><br>Resident #3's current care plan stated, "Resident has problems [with] [bowel] and [bladder] incontinence" . . . "Toilet Schedule - assist of one q [every] 2 to 3 [hours] and prn [before] and after meals." The "Schedule Specifications" affixed on the resident's bathroom door stated, "Toilet before and after meals." The facility failed to re-evaluate her current toileting schedule and voiding pattern and develop an individualized | F 278 | | |

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| F 278 | Continued From page 8<br>toileting program.<br><br>During an interview on the afternoon of 01/16/13, an administrative nurse (#6) confirmed the toileting plans for Resident #2, #3, #4, #5, #6, #8, and #9 were not individualized scheduled toileting programs. | F 278 | | |
| F 309 SS=G | 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING<br><br>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, and staff interview, the facility failed to provide the necessary care and services to minimize the pain for 1 of 1 sampled resident (Resident #3) who experienced pain/behaviors with perineal care. Failure to provide Resident #3 with perineal care according to the recommended plan of care resulted in pain, discomfort, and aggressive behaviors.<br><br>Findings include:<br><br>- Review of Resident #3's medical record occurred on January 14-16, 2013. Diagnoses included anxiety with psychosis with reactive confusion, Alzheimer's dementia, atrophic vaginitis (an inflammation of the vagina and outer | F 309 | 1. Resident #3 – The behaviors exhibited by this resident can be directly linked to pain caused when she has pericares. The appropriate approach to preventing her pain is to use a warm washcloth for pericares and to pat, not rub, while completing them. This approach is now being communicated to the CNAs on the CNA worksheet provided to them to assist them to provide care. She is also being given a second tub bath every week. She was also seen by Dr. Berg, her primary care provider on 2/4/13. He checked her peri area. Orders were received.<br><br>2. This has the potential to affect all residents who have behaviors. Behaviors are communicated shift-to-shift through report. Social Services is initiating a new behavior reporting sheet which we will use to identify behaviors so that approaches can be initiated.<br><br>3. We will correct this deficiency by initiating better means of communication. The behavior sheet that will be started by Social Services will list the specific behavior and possible interventions from the care plan. Interventions will be reviewed for effectiveness and new | |

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| F 309 | Continued From page 9<br>urinary tract), and lichens sclerosis (a chronic long-term skin condition mostly affecting the genitals that causes thin patches on the skin which can easily tear and bleed).<br><br>Resident #3's most recent Minimum Data Set (MDS), dated 01/02/13, identified short-term and long-term memory problems; usually understands others and makes self understood; behaviors including inattention, disorganized thinking, altered level of consciousness, and rejection of care on 4 to 6 days; extensive assistance with toileting and personal hygiene.<br><br>Resident #3's Treatment Administration Record (TAR), dated 11/02/12, stated, "Clobetasol crm [cream] [a topical corticosteroid] to labia 2X [times] wkly [weekly] X 2 mo [months]."<br><br>A nursing assessment on the back of the TAR, dated 01/14/13 at 8:00 p.m., stated, "Periarea [perineal area] red in color, small dark reddened area in center of vaginal opening that measures 1.5 cm [centimeters] in diameter [no] odor. Small amt [amount] of yellow drainage noted cont. [continue] to receive clobetasol cream 2X's wkly."<br><br>Resident #3's current care plan, dated 12/23/12, stated, "Physical and verbal abuse during pericares [perineal care] . . . Do pericares [with] warm wash cloth - don't rub - pat [with] wash cloth. . . . Toilet schedule assist of 1 - q [every] 2 to 3 [hours] and prn - before and after meals. . . ."<br><br>Observation on 01/14/13 at 5:00 p.m. showed a certified nursing assistant (CNA) (#10) assisted Resident #3 with toileting. When the CNA began | F 309 | interventions initiated, if necessary. An inservice for all nursing staff will be held on 2/13/13 to train them to use the new sheet. To enhance communication we started having the CNA who is assigned to the resident on the day of the resident's care plan attend the meeting. This was started on 1/29. The care plan is read to review and update it during that meeting. The CNA who is attending is asked for their input regarding things they have found that will make care for the resident better for both the resident and the staff.<br><br>4.<br><br>5. A QA will be done by Social Services that follows any resident who has a behavior problem identified on the MDS to be sure they have the behavior problem on the care plan along with interventions and a behavior sheet communicating those interventions to other staff members. The QA will also monitor if the listed interventions are effective and that other interventions are tried if they are not. This QA will be done weekly starting 2/12/13. | 2/16/13 |

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| F 309 | Continued From page 10<br>using a disposable wipe to provide perineal care after a bowel movement, Resident #3 stated, "Ooh, Ooh, Oh my goodness hurts, Ouch, Quick, never is. Sorry, I cry all the time. It hurts, Ooh." After the CNA completed perineal care, the resident voiced no further complaints of pain.<br><br>During an interview on 01/15/13 at 9:20 a.m., a CNA (#11) stated, "Resident #3's bottom is sore, so I wet toilet paper with warm water to wipe her. The resident doesn't like anything cold so she seems to do better [with warm water]."<br><br>On 01/15/13 at 5:20 p.m., a CNA (#5) stated "No one had taken her." and assisted Resident #3 from the dining room to assist her with toileting. The CNA identified Resident #3 as incontinent of urine. When the CNA used a disposable wipe to provide perineal care after the resident voided, Resident #3 cried, "Oww, that's where it's sore. No, Don't, [I'm] not coming to this place anymore." After the CNA completed perineal care, the resident voiced no further complaints of pain.<br><br>Observation on 01/16/13 at 9:45 a.m. showed a CNA (#11) assisted Resident #3 with toileting. The CNA identified the resident did not void, but indicated she would provide perineal care anyway. The CNA wet toilet paper with warm water to provide perineal care. When using this method, Resident #3 had no negative reaction to perineal care. The CNA stated, "I wet toilet paper with warm water because she doesn't like anything cold and her bottom is a little sore."<br><br>Review of Nurses' Notes identified the following: *10/06/12, 6:00 a.m. - ". . . hollared [sic] out while | F 309 | | |

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| F 309 | Continued From page 11<br>CNA was washing periarea, very red . . ."<br>*10/27/12, 6:00 a.m. - "Periarea excoriated [damaged or removed part of the skin's surface] and to vaginal area. Cleansed [with] soap and water and calmo [calmoseptine a moisture barrier cream that temporarily relieves discomfort and itching] applied. Very tender when washing area - as tearful and stating 'stop.'"<br>*10/27/12, 9:00 p.m. - "Periarea/vaginal area remains irritated. Cleansed [with] soap and water. Calmo applied."<br>*10/30/12, 9:00 p.m. - "Groin red [and] cries out when pericares done - also red near rectal area."<br>*11/02/12, no time - "Res [resident] kicked CNA stomach [with] pericares. CNA report gentle cleansing done."<br>*11/08/12, 8:00 p.m. - "Res cont. [continues] to yell at staff when receiving pericares. Res slapped this writer in face while attempting to wash. Res allowed to calm down and then attempted to wash again."<br>*11/10/12, 8:30 p.m. - "Resident less resistive [with] pericares when laying on bed. c/o [complained of] water being cold and reassurance given and calmed. No physical aggression."<br>*12/14/12, 10:30 p.m. - "Requires two to assist in care - [one] to wash and one to talk to her [and] distract her when pericares done."<br>*12/15/12, 11:00 p.m. - "CNA reports that resident hollars [sic] every morning when pericares are being done."<br>*12/31/12, 1:00 p.m. - "Nursing Assessment . . . Res verbal and physically abusive [with] cares (pericares) . . ."<br><br>During an interview on the afternoon of 01/16/13, an administrative nursing staff member (#6) confirmed staff should provide perineal care | F 309 | | |

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| F 309 | Continued From page 12<br>"according to the care plan." | F 309 | | |
| F 312 SS=D | 483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide proper perineal care for 1 of 3 sampled residents (Resident #2) dependent on staff for perineal care and incontinent of bowel. Failure to cleanse appropriately after a bowel movement placed this resident at risk for skin irritation/breakdown and urinary tract infections.<br><br>Findings include:<br><br>Review of the facility policy titled "PROCEDURE FOR GIVING PERI [Perineal] CARE TO THE FEMALE CLIENT" occurred on 01/16/13. This undated policy stated, ". . . 7. . . . Gently wash the inner legs and outer peri area along the outside of the labia . . . 8. Wash the outer skin folds from front to back. 9. Wash the inner labia from front to back. 10. Gently open all skin folds and wash the inner area from front to back. 11. Rinse the area well, starting with innermost area and proceeding outward. . . ."<br><br>Review of Resident #2's medical record occurred on all days of survey. Diagnoses included | F 312 | 1., 2, This deficiency has the potential to impact all of the residents who are dependent on staff for the completion of cares. All CNAs responsible for pericares have been observed as of 2/13/13 completing pericares on a resident. Obviously, not every resident was being transferred using the standing lift or was incontinent of stool. The question was asked of each of them how they would proceed with pericare if such a situation were to occur. Education was given to those whose answers were doubtful.<br><br>3. An inservice for all nursing staff will be held on 2/13/13. The procedure for pericare will be reviewed during the inservice along with what to do should they be faced with needing to do pericare when a resident is on the lift.<br><br>4.<br><br>5. All CNAs have been monitored since the survey. CNAs will again have their skills monitored, including pericare, annually during their performance review by they DON. Urine culture reports will be monitored as they occur to determine if more frequent monitoring is needed.<br>Per Linda DON (telephone call) 2/14/13 @ 11:30am. 2 CNAs will be observed weekly until NO further problems and then 2 observations monthly for 3 months. Kelly Beechie | 2/16/13 |

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| F 312 | Continued From page 13<br>Alzheimer's disease. The quarterly Minimum Data Set (MDS), dated 12/29/12, identified extensive assistance for transfers, toilet use, and personal hygiene; always incontinent of urine; and occasionally incontinent of bowel. Resident #2's current care plan identified occasional incontinence of bowel and bladder and increased incontinence expected related to a physical and mental decline.<br><br>Observation on 01/14/13 at 4:50 p.m. showed a certified nursing assistant (CNA) (#7) utilized the EZ lift (sit to stand mechanical lift) and transferred Resident #2 into the bathroom. The CNA (#7) removed the resident's brief and observation showed feces on her front perineal area and bilateral groin area. The CNA (#7) used several perineal wipes, stood to the side of Resident #2, and wiped with a forward to backward motion, smearing feces through her genital area. The CNA (#7) failed to check the front perineal area to ensure she cleansed it thoroughly. The CNA (#7) applied a clean brief and transferred Resident #2 to her wheelchair.<br><br>During an interview on 01/16/13 at 1:30 p.m., an administrative nurse (#6) stated she expected staff to follow the facility's policy and procedure regarding perineal cares and cleanse the outer-most peri area first to remove the feces. | F 312 | | |
| F 323 SS=E | 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br><br>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. | F 323 | 1., 2. There was a blister that was found on resident #4 during 3/12. The warm packs from the hydrocollator had no identifiable circular areas that may have been the causative agent. Her injury healed without complication. There were no other injuries that can be attributed to the hydrocollator. | |

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| F 323 | Continued From page 14<br><br>This REQUIREMENT is not met as evidenced by:<br>1. Based on record review, resident interview, policy and procedure review, and staff interview, the facility failed to provide a safe environment for 1 of 1 sampled resident (Resident #4) who received a burn from placement of a hot pack. Failure to monitor the use of hot packs resulted in Resident #4 experiencing a burn to her back. Failure to provide staff education regarding the use of hot packs and implement monitoring of hot pack use placed all facility residents using these devices at risk for injury.<br><br>Findings include:<br><br>Review of the facility's policy titled "Safe Use of Hydro collator Packs," occurred on the afternoon of 01/16/13. The policy, dated February 2009, stated, "PURPOSE: The steam Hydro collator pack is placed on a resident for comfort and relief of pain. All residents will be prevented from burns using the Hydro collator pack. PROCEDURE: 1. The unit is equipped with a thermostat to automatically maintain steam packs in water at proper temperature. The temperature should be 170 degrees or lower. . . . 6. Exercise extreme care when applying the steam pack. Know your resident. 7. Explain to the resident what you are doing. Have the resident explain to you if the pack if [sic] too hot. 8. Pull the steam pack out of the water by the tabs and place in Turkish toweling or steam pack cover. The covering should be six or more layers thick. 9. Do not use toweling that is | F 323 | There have been no incidents of injury caused by transferring with the standing lift or from chemicals in the facility. Our efforts will be directed toward prevention.<br><br>3. Hot packs – we elected to take the hydrocollator out of service. We have replaced those hot packs with moist heat packs and a dedicated microwave to warm them in.<br>Sit-to-stand lift – all CNAs have been observed by the DON completing a transfer using this lift. At the completion of the observation they were required to sign the procedure form attesting that they will follow this correct procedure with each sit-to-stand transfer in the future.<br>Chemical storage – all chemicals were removed from the activity room immediately after they were discovered during the survey and have not been replaced.<br><br>4.<br><br>5. Hot packs – each of the hot packs has a strip on it that tells when it is the correct temperature to use so QA will be completed with each use by whoever is using it.<br>Sit-to-stand lift – all CNAs have been observed by the DON. Ongoing observation will be done by the DON during the annual performance review for each CNA.<br>Chemical storage – a QA to monitor that chemicals are appropriately stored will be completed by the DON weekly until no chemicals are found where they can be accessed by residents, then monthly. The first QA was completed 2/7/13. | 2/16/13 |

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| F 323 | Continued From page 15<br>moist from use. 10. Check the temperature of the pack and the resident's skin after applied. 12. NEVER lay one steam pack on top of another. 13. DO NOT lay steam packs over cuts and abrasions. 14. DO NOT use the steam pack in conjunction with skin balms and liniments. 15. NEVER lay the resident on the steam pack. . . ."<br><br>Review of Resident #4's medical record occurred on January 14-16, 2013. Diagnoses included congestive heart failure, cardiomegaly, and acute arthritis. The Minimum Data Set (MDS), dated 01/15/13, identified limited to extensive assist of one person for all Activities of Daily Living (ADLs) except for eating and a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition.<br><br>Resident #4's current care plan stated, "Pain: Resident has potential for pain . . . Assist to reposition to get comfortable - give hot pack, prn [as needed]."<br><br>Resident #4's Nurses' Notes identified the following regarding hot packs:<br>*03/20/12, 8:00 p.m. - "Hot pack to back, pain med [medication] given . . ."<br>*03/21/12, 9:00 p.m. - "Has dime-sized open blister on mid-back (? from warm pack) . . . left open to air [and] observe for signs and symptoms of infection."<br><br>Resident #4's Medication Administration Record (MAR), dated 03/24/12, stated, ". . .TAO [antibiotic ointment] and drg [dressing] to open area, mid-back. Change daily until healed" and, dated 02/28/12, "Heat to L [left] knee tid [three times a day] for 20 min [minutes] and prn. . . ." | F 323 | Per telephone conversation on 2/14/13 @ 11:30a with Linda DON<br>2 CNAs will be observed weekly until no further problems and then 2 observations monthly for 3 months.<br>Kelly Beechie | |

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| F 323 | Continued From page 16<br>The MAR lacked a physician's order for placement of heat to Resident #4's back.<br><br>Resident #4's Treatment Administration Record (TAR) identified a treatment initiated 03/22/12, for an "Open blister on back . . . [check] for signs and symptoms of infection." The blister resolved on 04/22/12 (one month later).<br><br>During an interview on 01/16/13 at 11:05 a.m., when questioned regarding the sore on her back, Resident #4 stated, "Only thing I remember was a burn from the heating pad. I didn't feel it until after they told me, then [the burn] was sore.<br><br>During an interview on 01/16/13 at 12:55 p.m., Resident #8, identified by the facility as currently receiving hot packs, confirmed, "It [hot pack] can get very warm if [I] keep it on more than one half hour. If it's too warm, I push it off. I do it myself as the nurses are busy."<br><br>Review of a facility incident report, dated 03/22/12, stated the following:<br>*"Injury of Know Origin"<br>*"Describe the event: had been given a hot pack to her back res [resident] felt stinging sensation; staff observed a dime-sized opened blister. Cause of event: Other. If 'other,' please specify: inadequate padding of hot pack."<br>*"Supervisor Comments: No abuse indicated, resident is aware of how injury happened. Will monitor for healing in tx [treatment] logs."<br>*"Risk Manager Comments: Area identified by noc [night] staff; resident is alert and oriented and unable to indicate how it may have occurred; circular, bed/clothing check with nothing found; wheel chair does not have any actual/potential | F 323 | | |

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| F 323 | Continued From page 17<br>causative item. Did have an incident earlier but nothing identified to be actual/potential cause for same. Order received for drsing [dressing] and AB [antibiotic] ointment; will continue to monitor . . ." The incident report lacked evidence of further investigation of the procedure utilized for placement of the hot pack and staff education to prevent further incidents.<br><br>During an interview on the morning of 01/16/13, an administrative nursing staff member (#6) confirmed the facility lacked evidence of routine monitoring of the temperature of the hydro collator, and the medical record lacked a physician's order for heat to Resident #4's back. She stated staff failed to conduct a complete investigation regarding Resident #4's burn on 03/21/12, as well as provide education on the procedure for safe use of hot packs.<br><br>2. Based on observation, record review, review of facility policy, and staff interview, the facility failed to ensure the safety of 4 of 6 sampled residents (Resident #2, #4, #5, and #9) observed during sit to stand (EZ stand) mechanical lift transfers. Failure to tighten the strap buckled around the residents' waist (Resident #4 and #9) and failure to utilize the shin strap to secure the residents' legs (Resident #2 and #5) has the potential for residents to experience pain and/or injury.<br><br>Findings include:<br><br>Review of the facility's EZ stand operating instructions occurred on 01/16/13. The instructions stated, ". . . Attach harness: 1) Position the harness around the upper body of the patient so the sides of the harness are | F 323 | | |

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| F 323 | Continued From page 18<br>between the patient's torso and arm, resting 2-3 inches below the underarm. . . . 3) Secure the buckle and pull the strap to tighten. . . . Use of Shin Pad Strap: If a caregiver deems it necessary to keep a patient's shins or feet on the foot plate, secure the shin strap around the patient's legs. . . . Raise the patient: 1) Position patient's arms on the outside of the harness and have them place their hands on the padded handles. 2) . . . As the patient is being raised, simultaneously tighten the safety strap buckled around their torso. . . ."<br><br>- Review of Resident #2's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease, arthritis, and fatigue. The quarterly MDS, dated 12/29/12, identified extensive to total assistance for all ADLs. The current care plan stated, "standing lift PRN" for transfers.<br><br>Observation on 01/14/13 at 4:50 p.m., and 01/15/13 at 8:48 a.m., 10:33 a.m., and 3:55 p.m., showed various staff members utilized the EZ lift and transferred Resident #2 to the toilet. The staff members failed to utilize the shin strap for all the transfers. During observation on 01/15/13 at 3:55 p.m., the certified nursing assistant (CNA) (#5) stated, "We don't have to strap her feet in."<br><br>- Review of Resident #5's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease and osteoarthritis. The quarterly MDS, dated 12/05/12, identified extensive to total assistance for all ADLs and two falls without injury during the assessment period. The current care plan identified "potential for falls and history of falls." Interventions included a "standing lift PRN." | F 323 | | |

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| F 323 | Continued From page 19<br><br>Observations on 01/14/13 at 4:45 p.m., and 01/15/13 at 8:25 a.m. and 10:50 a.m., showed various staff members utilized the EZ lift and transferred Resident #5 to the toilet, recliner, or wheelchair. The staff members utilized the shin strap and secured the resident's legs on the platform of the lift. Observation on 01/16/13 at 8:35 a.m. showed the CNA (#2) applied the harness around Resident #5's waist and secured the safety belt. The CNA failed to utilize the shin strap. As the CNA raised the resident to an upright position, the safety belt loosened, and the harness slid upward which caused Resident #5's shoulders to shrug upward. The resident released her grip on the right handle bar and reached for the wall in her room. The CNA (#2) encouraged Resident #5 to hold onto the handle bar, but she refused. The CNA failed to tighten the safety strap.<br><br>During an interview on 01/16/13 at 1:30 p.m., an administrative nurse (#6) stated she expected facility staff to utilize the shin strap for all transfers with the EZ lift and tighten the harness strap as instructed.<br><br>- Review of Resident #4's medical record occurred on January 14-16, 2013. Diagnoses included acute arthritis. The significant change MDS, dated 01/05/13, identified extensive assistance with transfers. The current care plan stated, ". . . standing lift for transfers . . ."<br><br>Observations on 01/15/13 at 9:20 a.m. and 01/15/13 at 4:15 p.m. showed various staff members utilized the EZ lift and transferred Resident #4 from her recliner and the bathroom. | F 323 | | |

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| F 323 | Continued From page 20<br>The staff members failed to tighten the chest strap as they raised the lift. The lift harness slid upward elevating the resident's right elbow to a position level with her shoulder.<br><br>- Review of Resident #9's medical record occurred on 01/14/13. A significant change MDS, dated 10/29/13, identified extensive assistance of one staff member for transfers and toileting. Resident #9's care plan, dated 12/16/12, stated, "Problem/Need Mobility Resident has potential for falls . . . Approaches . . . 2) Full Wt. [weight] bearing standing lift for transfers . . ."<br><br>Observation on 01/16/13 at 1:25 p.m. showed a CNA (#2) utilized the EZ lift and transferred Resident #9 to the toilet. Upon completion of toileting, the CNA (#2) raised the resident to a squatting position. Observation showed the belt around the resident's waist loosened and the harness slide upward into her axilla area and caused Resident #9's elbows to bow outward and her shoulders to shrug upward. The CNA (#2) completed perineal cares, sanitized her hands, and then transferred Resident #9 to her wheelchair.<br><br>3. Based on observation and staff interview, the facility failed to ensure the residents' environment remained as free of accident hazards as possible regarding access to hazardous chemicals in 1 of 1 activity room. Failure to secure hazardous chemicals placed the residents at risk for injury.<br><br>Findings include:<br><br>An environmental tour of the facility occurred on 01/15/13 at 2:00 p.m. with an administrative staff | F 323 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 355052 | A. BUILDING _____ B. WING _____ | 01/16/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NELSON COUNTY HEALTH SYSTEM CARE CENTER | 108 E NYHUS AVE MCVILLE, ND 58254 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 323 | Continued From page 21<br>member (#3). Observation of the activity room showed an unlocked wall cabinet and an unlocked cupboard above the stove, both of which contained hazardous chemicals.<br><br>Review of the Material Safety Data Sheets (MSDS) for the chemicals identified the following warnings:<br>* Oasis 146 Multi-Quat Sanitizer: "Product as sold . . . Causes Digestive tract, eye and skin burns. May cause respiratory tract irritation. Harmful if swallowed. . . . Keep out of reach of Children."<br>* A spray bottle labeled Quat disinfectant: ". . . Avoid contact with eyes. Wash thoroughly after handling. Keep out of reach of children. . . ."<br>* Two bottles of Soft Scrub cleanser: "Keep out of reach of children"<br>* One bottle of bleach: "Keep out of reach of children"<br>* Formula 409 spray cleanser: "Causes moderate eye irritation"<br>* PDI (Professional Disposables, Inc.) Sani-Dex:"Handling and Storage: Store away from heat and sources of ignition"<br>* A long necked butane lighter with the manufacturers' warning "Keep out of reach of children."<br><br>During an interview on 01/16/13 at 12:20 p.m., an administrative staff member (#4) stated she expected staff to lock up chemicals. | F 323 | | |