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

PRINTED: 04/14/201
FORM APPROVE
OMB NO. 0938-039

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 _____	R 03/31/2011

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

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{F 000}	INITIAL COMMENTS An on-site revisit was conducted March 30-31, 2011 to determine compliance with the deficiencies identified during the February 8-10, 2011 survey. The revisit sample included 6 residents for focused review of the areas of non-compliance	{F 000}	1.The Care Plans and nurse aide Assignment sheets were reviewed and revised for Residents #4, #6, #3, and #7 to reflect current resident status and interventions that are being utilized. Direct care staff were informed of changes and	
{F 280} SS=E	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 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: Based on observation, record review, staff interview, and review of the North Dakota Department of Health; Division of Health Facilities provider files, the facility failed to review and revise the comprehensive care plans for 2 of 4	{F 280}	interventions related to standing lifts and assistive devices for Residents #4, #6, #3, and #7 were done. 2. All residents utilizing any mechanical and/or assistive devices have the potential to be affected by this practice. 3. Direct care staff were informed of survey findings including the importance of proper body positioning and interventions to be utilized to safely meet resident needs including everyone's responsibility to change and implement interventions needed to safely meet resident needs, and reporting these changes and/or need to review and revise assignment sheets to the charge nurse. Professional nursing staff were informed of the need to utilize nursing care plans in the provision of care, the necessity to review and revise the nursing care plan, if applicable, to reflect the current interventions and tasks to	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Cathy Swenson	CEO	4/24/2011

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 280}	Continued From page 1 sampled residents (#4 and #6) who required transfers using a stand lift and for 1 of 2 sampled residents (Resident #3) and 1 supplemental resident (Resident #7) transported by staff in wheelchairs without foot pedals. Failure to review and revise the residents' care plans limited the staff's ability to communicate the care needs of the residents and to ensure continuity of care for the residents. Finding include: Review of the facility's Plan of Correction (POC), identified a completion date of 03/14/11, occurred on 03/30/11. The POC stated, ". . . All residents utilizing both standing and Hoyer lifts were assessed by therapy with recommendations received. . . . Care plans and assignment sheets reflect current transfer methods. . . . " - Resident #4's medical record, reviewed March 30-31, 2011, identified diagnoses including probable Alzheimer's dementia-cognitive impairment, anxiety, history of near-syncopal episodes, osteoarthritis, degenerative joint disease, and obesity. The resident's quarterly Minimum Data Set (MDS), dated 02/05/11, identified total dependence on two persons for transfers. Resident #4's current care plan, dated 01/21/11, identified, "Problem: Res needs assist [with] all ADL's [activities of daily living] - due to impaired mobility and cognitive status . . . Approaches: OT [Occupationaly Therapy] - to provided safest and best transfers for res. . . . (dated 01/19/11) OT recommends use of body lift due to poor L/E [lower extremities] wt [weight] bearing [and] c/o of U/E [upper extremity] pain [with] transfers. . . .	{F 280}	be completed based on the residents current status. Direct care staff 's requirement to provide information related to the charge nurse, and the charge nurse's responsibility to document changes in the IPN's, on the working nurse kardex care plan to monitor and determine if this change is significant/reflects a change in the overall status of the resident requiring a change in their plan of care and/or is a one time event, to make the appropriate changes on the nurse assignment sheets, and provide that information during the change of shift report X 72 hours to verify all staff have been informed. A review of all work assignment sheets by the nursing assistants was completed to verify accuracy and interventions being used. The nursing care plans were then reviewed by the DON and professional nursing staff to ensure they are current and reflect the same information. Revisions to both were made, as applicable. All residents who utilize wheel chairs to ambulate were observed and assessed for foot pedal placement. Interventions related to proper use of mechanical devices were	

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{F 280}	Continued From page 2 Problem: Res has hx [history] of pain - related to arthritis and had bad leg injuries yrs [years] ago . . . Approaches: . . . Transfers [with] mech. [mechanical] lift (OT recommends body lift to [decrease] pain). . . ." The Staff Assignment Sheets, undated, identified, ". . . [Resident #4] . . . Assist with cares . . . Standing lift for transfer . . ." Observations revealed the following: * On 03/30/11 at 4:45 p.m., two Certified Nurse Assistants (CNAs) (#7 and #8) transferred Resident #4 from her wheelchair to the bathroom using the stand lift. * At 5:00 p.m., two CNAs (#8 and #9) transferred Resident #4 from the bathroom to her wheelchair using the stand lift. * On 03/31/11 at 9:07 a.m. and at 9:20 a.m., the CNA (#10) transferred Resident #4 from her wheelchair to the bathroom, and back again, using the stand lift. During an interview on 03/30/11 at 3:30 p.m., a nursing staff member (#6) agreed the care plan and assignment sheets provided staff with conflicting information/instruction. When asked why the forms did not provide the same information, she stated, "It must have been missed." (Refer to F323) Failure of the facility to revise/update Resident #4's care plan/staff assignment sheet to reflect her current lift transfer needs has the potential for the resident to experience an fall, injury and/or pain related to facility staff's lack of direction on the proper mode of transfer. - Resident #6's medical record, reviewed March	{F 280}	reviewed and observed to verify accuracy related to the assignment sheets and care plans. Interventions related to the proper use of mechanical devices and accuracy of resident's correct interventions along with proper positioning and use of the mechanical lifts were again reviewed. Observations were made of the direct care staff by the DON re: same. Communication methods were reviewed along with responsibilities for documentation related to resident status changes, changes in nursing interventions, care plans and assignment sheets. A nurses working care plan Kardex has been implemented to provide an easily accessible location to document such changes, and to utilize during report. This will also serve as a reminder to document in the resident's IPN notes which will be dated and indicate when the changes occurred, and provide the information required for the MDS coordinator to update the master care plan if this is an ongoing intervention/change and verify MDS requirements related to number of days this event occurred. The 24 hour nursing report form was changed to also	

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{F 280}	Continued From page 3 30-31, 2011, identified diagnoses including multiple sclerosis (MS). The resident's quarterly Minimum Data Set (MDS) dated 03/07/11, identified extensive assistance of two persons required for toileting, transferring, and personal hygiene. Review of Resident #6's current care plan dated 02/01/11 occurred on 03/30/11. The care plan stated, "Problem: Res [resident] needs assist with ADL's [Activities of Daily Living] due to MS [multiple sclerosis] dx. [diagnosis]. . . . Approaches: . . . 2. use standing lift for transfers. d/c [discontinued] 03/07/11. . . . 6. limited use of R) [right] arm and hand - near total loss of L) [left]. . . . 03/07/11, OT eval [evaluate] for lifting system, OT recommends Hoyer, resident refuses - continue to use S [stand] lift and assess as changes in condition." The CNA assignment sheet, not dated, for Resident #6 stated, "under special equipment-standing lift for transfer. . ." (see notes below) The resident's therapy treatment note, dated 02/08/11, stated; OT evaluation, "Inpatient plan of treatment . . . assessed stand lift transfers - with staff. Education, improved technique for safer transfers. Plan to reassess in 3-6 months." * 03/08/11 ". . . Reassessed stand lift this am. as resident is strongly opposed to using a full body sling. Became extremely upset and crying as a concern regarding her mental state and negatively associated with the Hoyer and MS progression will continue to trial [name of stand] stand (type of mechanical lift to aid in standing) to determine if stand lift can remain an option. Consulted at length with staff and DON [director of nursing], full body sling on hold." * 03/09/11 stated; "assessed res. [resident] and	{F 280}	include a change in the plan of care, and provides an ongoing method for the DON to identify any changes made – providing a source to verify accuracy of the nursing care plans and the assignment sheets as a monitor for the QA program. Resident rights along with monitoring for safety risks during the implementation and use of any assistive and mechanical device will be ongoing through observation and documented on the resident's IPN's as concerns and or changes occur. 4. The DON/designee will monitor the accuracy of the NCP's and assignment sheets to verify changes and appropriate documentation as applicable at least 4 times/week or as often as needed to verify compliance. Once compliance is achieved, monitoring of same will occur at least weekly X2 and then monthly monitors and reporting to be ongoing to verify continued compliance. Administration will complete at least one monitor after being informed of initial changes made and implemented to verify compliance. Monitors will be reported on monthly to the QA committee/med staff mtgs. 5. April 25, 2011	

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280}	Continued From page 4 CNA regarding use of stand lift. Made several suggestions to improve transfer, better foot placement on foot plate and placing sling further down the trunk and holding in place to minimize slipping up the back. This was beneficial and improved standing. . . ." An interview occurred with an administrative staff nurse (#6) on 03/30/11 at 4:30 p.m., confirmed care plans were not updated with pertinent information necessary for safe transfers of Resident #6. Failure of the facility to revise/update Resident #6's care plan/staff assignment sheet to reflect her current lift transfer needs has the potential for the resident to experience an injury and/or fall related to facility staff's lack of direction regarding the OT's suggestions for transfers. Review of the facility's Plan of Correction (POC), identified a completion date of 03/14/11, occurred on 03/30/11. The POC stated, ". . . All residents who do not have foot pedals on their wheelchairs in order to allow them to ambulate independently were reviewed and foot pedals placed, along with interventions to assist them in maintaining their feet on those pedals. Bags were placed on the backs of wheelchairs to place foot pedals for those residents who would still utilize their feet for mobility in their wheelchairs allowing staff to place and remove pedals from chairs as needed when they assist in transfers. . . . Staff assignment sheets indicate need for safety . . . and need to use foot pedals, as applicable and agreed upon by the residents. . ." - Resident #3's medical record, reviewed March 30-31, 2011, identified diagnoses including	{F 280}		

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280}	Continued From page 5 Alzheimer's dementia, vision loss, hearing loss, and history of falls. The resident's significant change MDS, dated 03/05/11, identified total dependence on two persons for locomotion on/off the unit. Resident #3's "Resident with w/c and foot pedals assessment", undated, identified the resident uses his feet to propel his wheelchair at times, and he has a bag for his foot pedals in his room. Resident #3's current care plan, dated 01/21/11, identified, "Problem: Res needs assist [with] his ADL's . . . Approaches: . . . w/c - w/c pressure relief cushion . . ." The current care plan lacked instruction regarding placing foot pedals on the resident's wheelchair. The Staff Assignment Sheets, undated, identified, ". . . [Resident #3] . . . Assist with cares . . . W/C . . ." The Staff Assignment Sheets lacked instruction regarding placing foot pedals on the resident's wheelchair. Observation on 03/30/11 at 1:00 p.m., showed a CNA (#11) transported Resident #3 in his wheelchair from the dining room to the resident's room. The resident's shoes slid along the surface of the floor, catching on the flooring as the CNA (#11) transported him down the hallway. The resident did not lift his feet. - Resident #7's medical record, reviewed March 30-31, 2011, identified diagnoses including Alzheimer's dementia, degenerative joint disease, and osteoarthritis, The resident's significant change MDS, dated 03/05/11, identified extensive assistance from one person for locomotion on the unit and total dependence on one person for	{F 280}		

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: 280}	Continued From page 6 locomotion off the unit. Resident #7's "Resident with w/c and foot pedals assessment", undated, identified the resident uses her feet to propel her wheelchair at times, and she has a bag for her foot pedals in her room. Resident #7's current care plan, dated 01/17/11, lacked instruction regarding placing foot pedals on the resident's wheelchair. The Staff Assignment Sheets, undated, stated, ". . . 21. [Resident #7] . . . Assist . . . W/C . . ." The Staff Assignment Sheets lacked instruction regarding placing foot pedals on the resident's wheelchair. Observation showed the following: * On 03/30/11 at 10:10 a.m., a CNA (#7) transported Resident #7 in her wheelchair from the resident's room to the front activity area. The resident's shoes slid along the surface of the floor as the CNA (#11) transported her down the hallway. The resident did not lift her feet. * On 03/31/11 at 11:00 a.m., a CNA (#7) transported Resident #7 in her wheelchair from the front activity area to the dining room. The resident's shoes slid along the surface of the floor, catching on the flooring as the CNA (#11) transported her into the dining room. The resident did not lift her feet. (Refer to F323) Failure of the facility to revise/update Resident #3 and #7's care plan/staff assignment sheets to reflect their current transport needs (wheelchair foot pedals) has the potential for the residents to	{F 280}		

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{F 280}	Continued From page 7 experience an accident and/or injury.	{F 280}	1.The Care Plans and nurse aide Assignment sheets were reviewed and revised for Residents #4, #5, #3, and #7 to reflect current res- ident status and interventions that are being utilized in the use of mechanical devices. Direct care staff were informed of changes and interventions related to standing lifts and assistive devices for Residents #4, #5, #3, and #7 were done. The use of a total body lift was immediately implemented for Resident #4. A review of Resident #4's pain control regimen was also reviewed with no changes made. Observations of Resident #4 prior/during/after transfers demonstrated adequate pain control. There was no change in Resident #4's combative behavior based on changes implemented. Direct Care staff were again observed re: the correct utilization of mechanical lifts, body positioning, and interventions to be implemented in the use of same. The recommendations by therapy and the type of lift utilized was reviewed with the cognitive residents utilizing same, and family members, if applicable, to verify their understanding of the need to change, the potential risks involved to continue utilizing current lift devices, and the importance of the
{F 323} SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: 1. Based on observation, record review, review of the E-Z Way operator's manual, staff interview, and review of the North Dakota Department of Health; Division of Health Facilities provider's files, the facility failed to ensure safe transfers with mechanical devices for 2 of 4 sampled residents (Resident #4 and #5) observed transferred with a stand lift. Failure to safely use stand lifts placed Resident #4 and #5 at risk of falls, injury and pain. Findings include: Review of the "EZ Way stand Operator's Instructions" manual, revised 03/11/09, occurred on 03/31/11. The manual stated, ". . . The EZ Way stand can also be used for transferring the patient from . . . wheelchair, toilet . . . Patients should be able to bear some weight, have upper body strength (example: be able to sit on the side of a bed unattended), and be able to follow simple commands. If a patient does not meet each of these three criteria, the EZ Lift total body lift must be used. . . . Transferring the patient: Attach	{F 323}		

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{F 323}	Continued From page 8 harness 1) Position the harness around the upper body of the patient so the sides of the harness are between the patient's torso and arm, resting 2-3 inches below the underarm. . . . Raise the patient 1) Position patient's arms on the outside of the harness and have them place their hands on the padded handles. . . . Press the UP button. . . . Stop lifting when the patient is in a standing position. . . ." - Resident #4's medical record, reviewed March 30-31, 2011, identified diagnoses including probable Alzheimer's dementia-cognitive impairment, anxiety, history of near-syncopal episodes, osteoarthritis, degenerative joint disease, and obesity. The resident's quarterly Minimum Data Set (MDS), dated 02/05/11, identified total dependence on two persons for transfers. Review of the facility's Plan of Correction (POC), identified a completion date of 03/14/11, occurred on 03/30/11. The POC stated, ". . . Therapy completed transfer assessment and observations of staff doing transfers for Resident's . . . The care plans for all of these residents were reviewed and updated to reflect this assessment. . . . Resident . . . continues to be combative with cares at time with complete disregard for her environment and personal safety. . . . Staff assignment sheets were reviewed and reflected these findings and methods to transfer. . . ." Resident #4's "Outreach Occupational Therapy Inpatient Plan of Treatment," dated 01/20/11, stated, ". . . Initial Assessment: . . . Resident assessed this a.m. for transfers via stand lift. Res [Resident] c/o [complains of] significant pain with arm movement . . . Res is often difficult to help	{F 323}	assessments used to utilize a method to decrease the potential for any accidents/incidents that could occur as a result of their decreased strength, etc. Resident rights were respected and followed per their choices with interventions also considering the resident's choice to be as independent as applicable and ability to assist with transfers. Ongoing assessments, reviews, and observations will continue and discussed during care plans/family conferences. Assistive devices were placed on the wheelchairs of Resident #3 and #7. The nursing care plan and the nursing assignment sheets were changed to reflect the use of same. Observations of their use and resident's response as well as safety concerns and increased behaviors as a result of these changes will continue to be monitored and documented by the nursing staff. 2. All residents utilizing any mechanical and/or assistive devices have the potential to be affected by this practice. Any intervention has the potential to be a safety risk. 3. Direct care staff were informed of survey findings including the importance of proper body positioning and interventions to be utilized to	

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{F 323}	Continued From page 9 with washing underarms due to refusal to move and overall rigidity. . . . Res does not fully bear weight on LE's [lower extremeties] was lifted to partial standing. . . . Staff reports she is treated for arthritis pain daily but still is a difficult transfer and often demonstrates negative behavior ie: hitting when she is moved. . . . Functional Goals: . . . Staff education/instruction for use of Hoyer lift to minimize arm pain. . . ." A second entry, dated 02/17/11, stated, ". . . Progress Report/Summary: . . . Recommend hoyer lift vs [versus] stand lift, too much weight from hanging vs standing appropriately is likely adding to shoulder/arm discomfort. Hoyer will decrease this." Resident #4's current care plan, dated 01/21/11, stated, "Problem: Res needs assist [with] all ADL's [activities of daily living] - due to impaired mobility and cognitive status . . . Approaches: OT - to provided safest and best transfers for res. . . . (dated 01/19/11) OT recommends use of body lift due to poor L/E wt [weight] bearing [and] c/o of [sic] U/E [upper extremity] pain [with] transfers. . . . Problem: Res has hx [history] of pain - related to arthritis and had bad leg injuries yrs [years] ago . . . Approaches: . . . Transfers [with] mech. [mechanical] lift (OT recommends body lift to [decrease] pain). . . ." The Staff Assignment Sheets, undated, stated, ". . . [Resident #4] . . . Assist with cares . . . Standing lift for transfer . . ." Observations revealed the following: * On 03/30/11 at 4:45 p.m., two Certified Nurse Assistants (CNAs) (#7 and #8) transferred Resident #4 from her wheelchair to the bathroom using the stand lift. The resident did not bear weight and appeared to be in a sitting position as	{F 323}	safely meet resident needs including everyone's responsibility to change and implement interventions needed to safely meet resident needs, and reporting these changes and/or need to review and revise assignment sheets tc the charge nurse. Professional nursing staff were informed of the need to utilize nursing care plans in the provision of care, the necessity to review and revise the nursing care plan, if applicable, to reflect the current interventions and tasks to be completed based on the residents current status. Direct care staff 's requirement to provide information related to the charge nurse, and the charge nurse's responsibility to document changes in the IPN's, on the working nurse kardex care plan to monitor and determine if this change is significant/reflects a change in the overall status of the resident requiring a change in their plan of care and/or is a one time event, to make the appropriate changes on the nurse assignment sheets, and provide that information during the change of shift report X 72 hours to verify all staff have been informed. A review of all work assignment sheets by the nursing assistants was completed to verify accuracy and interventions being used.	

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	355052	A. BUILDING _____ B. WING _____	R 03/31/2011

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{F 323}	Continued From page 10 she hung from the harness. She held onto the CNA's (#8) hand with her left hand, and let her right arm hang at her side. She made no effort to hold onto the handles on the stand lift. As the harness raised upward, her shoulders raised to ear level. The CNAs pushed Resident #4 into the bathroom, at which time the lift caught between the door frame and toilet. The CNAs managed to dislodge the lift after three - four minutes and lowered the resident onto the toilet. * At 5:00 p.m., two CNAs (#8 and #9) provided verbal and hand-over-hand cues; placing the resident's hands on the handles of the stand lift. As the CNAs raised the sling, the resident vocalized "Oh. Oh. Oh." One CNA (#8) stated, "That's hurting her." Resident #4 did not bear weight and appeared to be in a sitting position as she hung from the harness. The CNAs (#8 and #9) provided pericares, adjusted her clothing, and transferred her back to her wheelchair. * On 03/31/11 at 9:07 a.m., the CNA (#10) transferred Resident #4 from her wheelchair to the bathroom using the stand lift. The CNA (#10) provided verbal and hand-over-hand cues; placing the resident's hands on the handles of the stand lift. The resident did not fully bear weight and appeared to be in a reclined position as she hung from the harness. The CNA transferred her into the bathroom and lowered her onto the toilet. * At 9:20 a.m., the CNA (#10) provided verbal and hand-over-hand cues; placing the resident's hands on the handles of the stand lift. Resident #4 did not bear weight and appeared to be in a reclined position as she hung from the harness. The CNA stated, "She doesn't like to be raised really high, cause it hurts her. I don't know why we don't use a full-body lift." The CNA (#10) provided pericares, adjusted her clothing, and transferred her back to her wheelchair.	{F 323}	The nursing care plans were then reviewed by the DON and professional nursing staff to ensure they are current and reflect the same information. Revisions to both were made, as applicable. All residents who utilize wheel chairs to ambulate were observed and assessed for foot pedal placement. Interventions related to proper use of mechanical devices were reviewed and observed to verify accuracy related to the assignment sheets and care plans. Interventions related to the proper use of mechanical devices and accuracy of resident's correct interventions along with proper positioning and use of the mechanical lifts were again reviewed. Observations were made of the direct care staff by the DON re: same. Communication methods were reviewed along with responsibilities for documentation related to resident status changes, changes in nursing interventions, care plans and assignment sheets. A nurses working care plan Kardex has been implemented to provide an easily accessible location to document such changes, and to utilize during report. This will also serve as a reminder to document in the resident's IPN notes which will be dated and	

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{F 323}	Continued From page 11 Observation showed staff tranferred Resident #4 using a stand lift on two occasions. The E-Z lift manual indicated a stand lift should not be used with residents who are unable to bear some weight, have limited upper body strength, or are unable to follow simple commands. The Occupational Therapy assessment indicated the resident experiences significant pain with arm movement, does not fully bear weight on her lower extremeties, and is treated for arthritis pain daily. The Occupational Therapist recommended the use of a hoyer lift; indicating hanging in the stand lift would likely add to the resident's shoulder/arm discomfort. The current care plan indicated staff should transfer the resident using a body lift to decrease her pain. Failure to ensure staff responsible for providing direct resident care had accurate information regarding the mode of transfer placed Resident #4 at risk of falls, injury, and pain. - Resident #5's medical record, reviewed March 30 - 31, 2011, identified diagnoses including chronic osteomyelitis, chronic lumbar disease, chronic pain, Parkinson, cerebral vascular accident (CVA), and left foot drop. The resident's quarterly MDS, dated 01/29/11, identified a Brief Interview for Mental Status score of 15 indicating Resident#5 is cognitively intact and the resident required extensive assistance of two persons for transfers and extensive assistance of one person for toileting. Observation on 03/30/11 at 8:35 a.m. and 03/31/11 at 9:35 a.m. showed a certified nurse assistant (CNA) (#3) toileting Resident #5 using an stand lift. As the CNA lifted Resident #5 to a standing position she asked the resident to hold	{F 323}	indicate when the changes occurred, and provide the information required for the MDS coordinator to update the master care plan if this is an ongoing intervention/change and verify MDS requirements related to number of days this event occurred. The 24 hour nursing report form was changed to also include a change in the plan of care, and provides an ongoing method for the DON to identify any changes made – providing a source to verify accuracy of the nursing care plans and the assignment sheets as a monitor for the QA program. Administration discussed family concerns re: residents cognition and previous practices along with shoe purchases to enable "sliding of feet". A review of accidents and near misses was completed with no occurances for Resident # 3 and #7. A review of the skin assessments and foot care was completed for same with no change in condition of intact skin, and no redness noted re: previous use of foot pedals. Ongoing observations will be continue by nursing staff to identify additional safety risks identified due to resident's cognition, and interventions along with family involvement to provide safe care and continued independence of residents utilizing their feet for ambulation at times will continue.	

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{F 323}	Continued From page 12 onto her incontinent pad to prevent it from falling. The resident complied, reaching behind her with her right hand to hold the pad, causing her to hang on with only her left hand during the transfer to the toilet and back. Failure to have the resident transfer in a safe manner holding on with both hands could result in a fall and or injury. 2. Based on observation, record review, staff interview, and review of the North Dakota Department of Health; Division of Health Facilities provider's files, the facility failed to ensure adequate supervision and assistance devices to prevent accidents for 1 of 2 sampled residents (Resident #3) and 1 supplemental resident (Resident #7) transported by staff in wheelchairs without foot pedals. Failure to ensure staff properly used assistance devices (foot pedals) placed residents at risk for possible accident or injury. Findings include: - Resident #3's medical record, reviewed March 30-31, 2011, identified diagnoses including Alzheimer's dementia, vision loss, hearing loss, and history of falls. The resident's significant change MDS, dated 03/05/11, identified total dependence on two persons for locomotion on/off unit. Review of the facility's Plan of Correction (POC), identified a correction date of 03/14/11, occurred on 03/30/11. The POC stated, ". . . All residents who do not have foot pedals on their wheelchairs in order to allow them to ambulate independently were reviewed and foot pedals placed, along with interventions to assist them in maintaining their feet on those pedals. Bags were placed on the	{F 323}	4. The DON/designee will monitor the accuracy of the NCP's and assignment sheets to verify changes and appropriate documentation as applicable at least 4 times/week or as often as needed to verify compliance. Once compliance is achieved, monitoring of same will occur at least weekly X2 and then monthly monitors and reporting to be ongoing to verify continued compliance. Administration will complete at least one monitor after being informed of initial changes made and implemented to verify compliance. Monitors will be reported on monthly to the QA committee/med staff mtgs. 5. April 25, 2011	

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323}	Continued From page 13 backs of wheelchairs to place foot pedals for those residents who would still utilize their feet for mobility in their wheelchairs allowing staff to place and remove pedals from chairs as needed when they assist in transfers. Staff informed . . . of . . . the need to check and verify proper foot placement when moving wheelchairs. . . . Staff assignment sheets indicate need for safety . . . and need to use foot pedals, as applicable and agreed upon by the residents. . ." Resident #3's "Resident with w/c and foot pedals assessment", undated, identified the resident uses his feet to propel his wheelchair at times, and he has a bag for his foot pedals in his room. Resident #3's current care plan, dated 01/21/11, identified, "Problem: Res needs assist [with] his ADL's . . . Approaches: . . . w/c - w/c pressure relief cushion . . ." The current care plan lacked instruction regarding placing foot pedals on the resident's wheelchair. The Staff Assignment Sheets, undated, identified, ". . . [Resident #3] . . . Assist with cares . . . W/C . . ." The Staff Assignment Sheets lacked instruction regarding placing foot pedals on the resident's wheelchair. Observation on 03/30/11 at 1:00 p.m., showed a CNA (#11) transported Resident #3 in his wheelchair from the dining room to the resident's room. The resident's shoes slid along the surface of the floor, catching on the flooring as the CNA (#11) transported him down the hallway. The resident did not lift his feet. The CNA (#11) failed to ensure the resident's feet cleared the floor during transport, and failed to either remind the resident to lift his feet or place foot pedals on his	{F 323}		

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323}	Continued From page 14 wheelchair. - Resident #7's medical record, reviewed March 30-31, 2011, identified diagnoses including Alzheimer's dementia, degenerative joint disease, and osteoarthritis, The resident's significant change MDS, dated 03/05/11, identified extensive assistance from one person for locomotion on unit and total dependence on one person for locomotion off unit. Resident #7's "Resident with w/c and foot pedals assessment", undated, identified the resident uses her feet to propel her wheelchair at times, and she has a bag for her foot pedals in her room. Resident #7's current care plan, dated 01/17/11, lacked instruction regarding placing foot pedals on the resident's wheelchair. The Staff Assignment Sheets, undated, stated, ". . . 21. [Resident #7] . . . Assist . . . W/C . . ." The Staff Assignment Sheets lacked instruction regarding placing foot pedals on the resident's wheelchair. Observation showed the following: * On 03/30/11 at 10:10 a.m., a CNA (#7) transported Resident #7 in her wheelchair from the resident's room to the front activity area. The resident's shoes slid along the surface of the floor as the CNA (#11) transported her down the hallway. The resident did not lift her feet. The CNA (#11) failed to ensure the resident's feet cleared the floor during transport, and failed to either remind the resident to lift her feet or place foot pedals on her wheelchair. * On 03/31/11 at 11:00 a.m., a CNA (#7)	{F 323}		

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323}	Continued From page 15 transported Resident #7 in her wheelchair from the front activity area to the dining room. The resident's shoes slid along the surface of the floor, catching on the flooring as the CNA (#11) transported her into the dining room. The resident did not lift her feet. The CNA (#11) failed to ensure the resident's feet cleared the floor during transport, and failed to either remind the resident to lift her feet or place foot pedals on her wheelchair. During an interview on 03/30/11 at 2:30 p.m., the nursing staff member (#6) agreed the staff should have ensured the residents feet cleared the floor during transport. She further stated, "If the residents do not lift their feet, I expect the CNAs to go back to their room and get their foot pedals." Failure of the facility to ensure staff properly used assistance devices (wheelchair foot pedals) placed residents at risk for possible accident and/or injury.	{F 323}		
{F 520} SS=E	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.	{F 520}		

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520}	Continued From page 16 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 record review and review of the North Dakota Department of Health; Division of Health Facilities provider files, the facility failed to implement appropriate plans of action to correct deficient practice and ensure compliance with federal requirements. Failure of the facility to effectively utilize quality assurance contributed to the facility's failure to maintain compliance in the area of reviewing and revising care plans and maintaining sanitary conditions. Findings include: The standard survey, conducted February 08-10, 2011, and the revisit survey, conducted March 30-31, 2011, identified the following deficient practices: F 280 Review and revise plan of care	(F 520)		

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{F 520}	Continued From page 17 F 323 Accidents and Supervision F 520 Quality assessment and assurance Refer to those tags for specific findings. Review of the state agency files indicated the facility failed to maintain compliance for deficient practice in the following area, as indicated by a deficiency cited during the last standard survey on 02/10/10: F 280 Review and revise plan of care Review of the facility's QA report titled, "Sanitizing Bucket Monitor" occurred on 03/30/11. This report dated, March 2011, identified when staff fill the sanitizing bucket. The report failed to identify monitoring of sanitizer strengths. An observation of the kitchen/dishwashing room occurred on 03/30/11 at 9:40 am. with a staff member (#1). Observation showed a red bucket of solution on the countertop in the dishwashing room with a wiping cloth emersed in the solution, which the staff member (#1) identified as quaternary ammonia sanitizer (quat) and water. On request, the staff member (#1) tested the chemical concentration of the sanitizer by immersing a test strip in the sanitizer for approximately 10 seconds with a change in color (400 ppm) identified on the strip. The staff member (#1) confirmed the chemical concentration of the sanitizer should be 200 ppm when tested. Observation did not show a quat dispensor installed in the dishwahing room as identified in the facilities Plan of Correction. Failure of the facility to provide effective quality assurance in the above areas resulted in 1) placed residents using stand lifts and/or	{F 520}	1 & 2. As documented in the 2567, refer to the previously documented QA plan for F 280 and F 323 for specific corrections. All residents have the potential to be affected by the concerns addressed related to sanitizer levels. When the vendor changed their date of installation for the quat dispenser , the Dietary manager continued to monitor the sanitizer levels to verify compliance, but did not maintain the documentation to indicate same, and is now aware of the need to notify the survey team of these issues when they occurred and have documentation in hand for review by the survey team when they came onsite.The vendor was contacted and faxed a notice to the Dietary department while the team was onsite to inform them of the new installation date of April 7, 2011 which was used to inform the survey team. To verify appropriate levels while the team was onsite, the Dietary manager completed a monitor to demonstrate the sanitizer levels present at the time of survey continued to be appropriate, and will now document and maintain that documentation for QA reporting	

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{F 520}	Continued From page 18 wheelchairs without foot pedals at risk for accident and/or injury, and 2) placed residents at risk of foodborne illness secondary to nondisinfected food surfaces.	{F 520}	and surveyor review. Administration has added all new monitors and reporting to the Facilities QA plan. 3. Corrections were made to the policy and procedure to indicate same, and education was provided to dietary staff of the updated policy and procedure and monitor. Sanitizing buckets are changed every three hours. Administration verified completion of all monitors identified in the revisit survey and compliance with all areas noted when corrective action was completed within the first week as the first scheduled Administrative monitor for compliance. 4. Sanitizing strength/Quats study will continue to be tested and monitored with the results provided to the QA committee at least quarterly or as often as needed to indicate continued compliance. The dispenser was installed on April 7, 2011 as indicated by the vendor. Administration will continue to do random observations of interventions implemented, and monitors for accuracy and communication at least monthly X2, or as often as needed to verify continued compliance with reporting to the appropriate department manager immediately of any concerns, and reporting to the QA committee in the month the monitors were completed. 5. 04/25/2011	