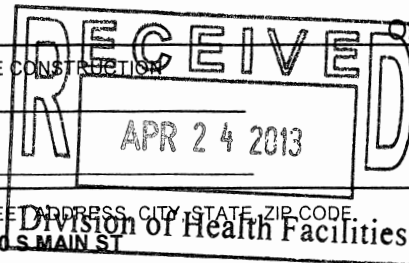


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355031	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/07/2013
NAME OF PROVIDER OR SUPPLIER MANOR CARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 600 S MAIN ST MINOT, ND 58701		
(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 March 4, 2013 and completed on March 7, 2013, the sample included five (5) residents for complete review, thirteen (13) residents for focused review, and three (3) closed records for review. The sample included two (2) additional residents to verify specific concerns during the survey.	F 000			
F 164 SS=C	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment	F 164	Manor Care strives to provide personal privacy and confidentiality for each patient. Patients who reside at Manor Care are at risk to be effected by this practice. General staff meetings as well as nursing meetings were held the week of 4/15/13 to review the importance of privacy and confidentiality. ADNS or designee will complete audits of medication administration records 3 times weekly x 4 weeks, to ensure patient privacy and confidentiality. Findings will be reported to the QAPI committee weekly for review and recommendation. ADNS or designee is responsible for ensuring ongoing compliance.	4/22/2013	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

[Signature]

TITLE

Administrator

(X6) DATE

4/22/13

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 164	Continued From page 1 contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the privacy and confidentiality of the residents' clinical records on 2 of 2 nursing units (Unit One and Two). Failure to maintain confidentiality of residents' clinical records could allow residents' medical information to be viewed by unauthorized individuals. Findings include: Observation showed on Unit Two the medication administration record (MAR) opened and unattended at the following times on the following carts: * Medication Cart #1 on 03/05/13 at 12:30 p.m., 4:55 p.m., and 5:15 p.m. * Medication Cart #2 on 03/05/13 at 11:45 a.m., and 12:05 p.m., and 03/06/13 at 10:00 a.m. * Medication Cart #3 on 03/05/13 at 11:30 a.m., 1:01 p.m., 5:35 p.m.; 03/06/13 at 3:50 p.m.; and 03/07/13 at 7:50 a.m. The MAR contained confidential resident information including their name, prescribed medications, and diagnoses - Observation on 03/06/13 at 3:30 p.m. showed a nurse (#3) administering medications from a medication cart to residents residing on the south end of Unit One. On 03/06/13 at 5:10 p.m. another nurse (#4) administered medications from a medication cart to residents residing on the north end of Unit One. Both nurses (#3 and #4) left the MARs open while they passed	F 164			

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F 164	Continued From page 2 medications and left the carts unattended. While the MARs remained open, residents' confidential information was visible to anyone near the medication carts. During an interview on 03/07/13 at 10:40 a.m., an administrative nurse (#1) stated she expected facility staff to close the MAR when left unattended.	F 164			
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure the most recent life safety code survey results were available for examination for 3 of 4 days (March 5-7, 2013) of survey. Findings include: Observation on March 5-7, 2013 showed the results of the previous health survey, conducted on 04/11/12, in a binder in a display case in the hallway on first floor. The results of the life safety	F 167	The last life safety code results were posted during the time the surveyors were here. The facility will post the survey results in the binder when survey is complete and plan of correction is accepted. Administrator or designee will complete audits of the posting of the survey on a quarterly basis for 6 months. Information gathered from audits will be forwarded to QAA Committee for further review and recommendations	4/22/2013	

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F 167	Continued From page 3 code survey were not present in the binder.	F 167			
F 241 SS=D	During the facility environmental tour on 03/07/13 at 9:20 a.m., the two administrative staff members (#34 and #35) confirmed the facility failed to post the life safety code survey results. 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the dignity of 1 of 1 sampled resident (Resident #2) observed in a hospital gown while in highly visible areas of the facility. Failure to ensure staff assisted Resident #2 to dress in her own clothes appropriate to the time of day, even on her shower day, does not promote the resident's dignity. Findings include: Observations on 03/06/13 identified the following: *8:00 a.m. - Resident #2 dressed in a hospital gown with a bath blanket wrapped around her, eating breakfast in the dining room with the other residents. *9:10 a.m. to 10:30 a.m. - Resident #2 remained in a hospital gown with a bath blanket on her lap and sat in her wheelchair in the Unit One TV area. At any given time, 5 to 10 residents also sat in the TV area and numerous other	F 241	Manor Care strives to promote and maintain each patient's dignity and respect. Resident #2 was dressed fully after her shower. Patients who receive assist with showers/whirlpool have the potential to be affected by this practice. Education provided in general staff meetings and in nursing staff meetings the week of 4/15/13 on maintaining patient dignity. ADNS or designee will complete audits 3 times weekly x 4 weeks then Monthly X 3 months then as part of the QAA committee ongoing monitoring activities. on patients waiting for showers for proper attire.	4/22/2013	

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F 241	Continued From page 4 residents, staff, and visitors passed by this main area. *At approximately 9:30 a.m. - Resident #2's hospital gown was loosely tied in the back. Observation showed the resident's back exposed to everyone in the area and anyone walking by. *At approximately 10:35 a.m. - A CNA (#5) showered Resident #2 and dressed her in a clean blouse and pants. During an interview on 03/06/13 at 9:25 a.m., a CNA (#6) stated residents sleep in their own pajamas or a hospital gown, whichever they prefer. On bath/shower days, the CNA (#6) stated staff leave the residents in their night clothes and place a robe, sweater, or blanket on them until their bath/shower. After their bath/shower staff dress the residents for the day.	F 241			
F 246 SS=E	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 04/11/12. Based on observation; record review; review of facility policy; and family, staff, and resident interview, the facility failed to provide reasonable	F 246	Manor Care will provide services that reasonably accommodate the needs of patients in the facility's care. No adverse effects noted on patients #9, #10, #17 & #22 from this practice. Patient #19 is no longer a resident. Patients who reside at Manor Care have the potential to be affected by this practice. Staff education was provided the week of 4/15/13 at all staff meeting and nursing staff meetings on call light expectations and call lights being in reach. The facility policy on answering call lights was distributed.	4/29/2013	

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F 246	Continued From page 5 accomodation of needs regarding call lights for 3 of 18 sampled residents (Resident #9, #10, and #17) on 2 of 2 units, 1 supplemental resident (Resident #22), and 1 closed record (Resident #19). Failure to answer call lights in a timely manner may result in falls, avoidable incontinence, increased behaviors, and a decreased quality of life. Findings include: Review of the facility policy titled "Call Light" occurred on 03/07/13. This policy, dated December 2009, stated, "... PROCEDURE: 1. Answer all call lights in a prompt, calm, courteous manner. All staff, regardless of assignment, answer call lights ... 4. Turn off call light - light should not be turned off until request is met 5. Respond to request or, if unable to do so, refer to appropriate staff member immediately ... " - Review of Resident #10's medical record occurred on all days of survey. Diagnoses included osteoarthritis, a history of self-transfers and falls, and a history of left fibula fracture. The current Minimum Data Set (MDS), dated 12/27/12, identified intact cognition, makes self understood and understands others, and extensive assistance from two or more people for transfers. Nurses' notes showed the following: *03/04/13: "... Resident on floor by toilet. resident trying to get up without assistance. slipped of [sic] edge of toilet. ..." *03/01/13: "... resident became combative @ 2100 [9:00 p.m.]. striking out and trying to kick the cna/s [certified nursing assistant]. biting [sic] at	F 246	ADNS or designee will conduct random call light audits 10 times weekly for four weeks. Audits will consist of direct observation of staff response to patient triggered call lights as well as random audits of call lights triggered by staff member from a patient room or bathroom as part of the audit tool task. Findings of these audits will be reviewed weekly during the facility QAA process. Audits will then be conducted 10 times monthly for three months then monthly for 9 months. ADNS or designee will conduct patient/family interviews at least 3 times a week for one month related to call light response. Audits will then be completed on a monthly basis for two months then monthly or as per QAPI committee recommendation as part of ongoing monitoring.		

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F 246	Continued From page 6 them. and pinching. nsg [nursing] calmed resident down and help [sic] transfer to bed. resident upset due to it being late and wanted to go to bed earlier. resident calm and quiet after putting to bed. . . ." *01/20/13: ". . . Bathroom call light on, [Resident #10] sitting on the floor in bathroom between toilet and wheelchair and leaning on the wall for support. . . . Was re-instructed not to attempt to stand or transfer self. . . ." *01/08/13: ". . . Staff answered B/R [bathroom] call light and had found [Resident #10] holding onto the railing and wedged in between his foot pedals on the w/c [wheelchair]. . . . States 'I couldn't wait for staff.' Incontinent of both B&B [bowel and bladder]. . . ." A physician's consultation report, dated 01/09/13, identified a left fibula fracture. Observation on 03/06/13 at 9:58 a.m. showed Resident #10 activated his call light. An unidentified staff member entered the room and turned off the resident's call light. Resident #10 stated he needed to use the bathroom. The staff member stated, "The girls will be here in a few minutes. They're just making their way down the hall." The staff members returned at approximately 10:25 a.m. (25 minutes later) to assist Resident #10 to the bathroom. An interview occurred with Resident #10 on 03/06/13 at 10:05 a.m. During the interview, the resident stated the following: *He has fallen twice waiting for someone to answer his call light. *He "waits and waits" for someone to help him on the toilet, and for someone to help him off. *He fell "a couple days ago" in the bathroom. He	F 246			

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F 246	Continued From page 7 was alone and put his call light on, but no one came, so "I decided to do something about it." He attempted to transfer himself and fell. The resident stated he did not hit his head but hurt his left ankle during the fall. *He broke his left leg in January. He went into the bathroom after supper, "about 6:15" and put on his call light, but "they [staff] can't come, they're in the dining room." He "got tired of waiting" and attempted to transfer himself. The resident fell and x-rays later showed a left fibula fracture. *He feels the facility is short-staffed, "There's no one to help us after supper," and "Evenings are the worst." Refer to F323. - During an interview on 03/05/13 at 5:10 p.m., Resident #9 voiced concerns regarding how long it takes to get help after supper. Resident #9 reported a few residents wait a long time in the dining room after supper, they ring the bell on the table, but no staff are available to assist them. - During an interview on 03/06/13 at 3:40 p.m., Resident #17 voiced concerns regarding staff leaving her on the bedside commode for one hour and fifteen minutes. The resident reported she could not reach her call light and yelled to get help. - Review of Resident #19's record occurred on 03/07/13 and diagnoses included a history of a pelvic fracture, congestive heart failure, and osteoarthritis. The admission MDS, dated 01/16/13, identified intact cognition; extensive assistance from staff for transfers, locomotion, and toileting; and occasional urinary incontinence.	F 246			

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F 246	Continued From page 8 Review of a care plan progress note, dated 01/23/13, stated, "Patient Care Conference Held: Patient and family present as well as social services, therapy, nursing, and dietician . . . Patient does report concerns regarding call light taking too long . . ." - During an interview on 03/05/13 at 1:05 p.m., Resident #22 (Room 196) stated he turned on his call light for staff to lay him down but "someone shut it off and then no one came." Observation showed the resident's call light was off and during the interview with the resident, two staff members came with a mechanical lift to assist the resident. - Observation revealed staff failed to answer the following call lights in a timely manner: * 03/05/13 - Room 190 from 8:50 a.m. to 9:06 a.m. (16 minutes) * 03/06/13 at 9:58 a.m. to 10:09 a.m., (11 minutes) showed an illuminated and audible call light in a resident room located on the end of Unit 2. * 03/06/13 - Room 190 from 10:45 a.m. to 10:57 a.m. (12 minutes) * 03/06/13 - Bathroom light in Room 190 from 11:00 a.m. to 11:17 a.m. (17 minutes) - On 03/06/13 at 4:40 p.m., a random observation from the nurse's station showed the call light on in Room 196. Staff turned the call light off at 4:45 p.m., however, staff did not enter the room to provide care until 4:47 p.m. The staff failed to provide assistance to the resident in Room 196 prior to turning the call light off. During a confidential interview on 03/05/13, a	F 246			

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F 246	Continued From page 9 resident's family member (A) stated it "doesn't do any good" to put on the call light after supper because there is no one around to help. The family member indicated there were several occurrences in which no staff were available after supper to assist the resident to the bathroom, so the family member assisted the resident. The family member stated, "You look down the hallways after supper and you don't see a soul." During a confidential interview on 03/05/13, a resident's family member (B) stated, "There are not enough CNAs. Things get done, but you wait for over an hour. I watch the clock, and stand in the hall trying to get someone's attention . . . from supper to 10:00 p.m. there are two CNAs running from room to room." During interviews on 03/06/13 at 3:00 p.m. and 5:25 p.m., an administrative nurse (#1) and a managerial nurse (#21) stated facility staff are expected to answer call lights "right away, as soon as possible, promptly." During an interview on 03/07/13 at 9:30 a.m., an administrative nurse (#1) stated, "The last call light audit I completed was in January and the longest time before a call light was answered was 7 minutes and 18 seconds." When asked about her expectations she stated, "I have not given the CNAs a specific time," in which to answer a call light.	F 246			
F 248 SS=E	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and	F 248	Manor Care will provide an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental and psychosocial well-being of each resident.		4/22/2013

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F 248	Continued From page 10 the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, record review, family and staff interviews, the facility failed to develop and implement an individualized activity program for 5 of 8 sampled residents (Resident #2, #3, #5, #7, and #15) dependent on staff for activities. Failure to implement an individualized activity program to respond to the interests and current capabilities of the residents has the potential to affect their physical, cognitive, and emotional health. Findings: Review of the facility policy titled "Activity & Recreation Service Manual" occurred on 03/07/13. This policy, dated January 2013, stated, "... GROUP PROGRAMS, Group programs involve a number of people in physical, mental and social interactions. By providing group programs, the center maximizes resources, encourages cohesiveness and promotes socialization ... ONE-TO-ONE PROGRAMMING, A one-to-one program is provided for patients unable or unwilling to participate in large group settings, meeting some or all of the following criteria: * health and or disease status limits participation in group activities * isolation status; medically related or self-imposed isolation limits exposure to other patients * behavioral symptoms that limit tolerance and participation in group settings	F 248	Residents #2, #3, #5, #7, and #15 have been <i>re-evaluated</i> & reviewed; care plans updated to better meet their past & current leisure interests and social needs to create an individualized activity plan of care. Residents are evaluated/assessed upon admission, quarterly & annually regarding individual leisure needs and interests. Creating a resident centered care plan, focusing on each resident's individualized interests, preferences and current capabilities; identifying residents who are dependent on staff for activities, identified on activity evaluation & reviewed annually. Activity staff will focus on quality and accuracy of activity attendance charting; ensuring compliance by gathering room to room for group activities, facilitated by activity staff; based upon residents individual leisure needs & preferences. Activity staff attended an in-service the week of 4/15/13 regarding the expectations of program attendance charting; this will be reviewed bi-annually at department meetings. All staff was in serviced on the importance of activities the week of 4/15/13.		

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F 248	Continued From page 11 * patient chooses not to participate in group activities offered or seldom initiates own activities . . . The one-to-one program format is based upon the comprehensive assessment, interests and the physical, mental and psychosocial needs of the patient. Care plans reflect frequency and types of services provided. Visiting time frames vary according to individual patient needs . . . PROGRAM CONTENT AND GUIDELINES, It is the center's responsibility to provide programming designed to provide patients with choices of meaningful social and therapeutic activities while stimulating interest, meeting needs and connecting with the community. A comprehensive program of group and individual activities enhance the physical, emotional and spiritual well-being of each patient . . ." Review of the March 2013 activity calendar showed "Bingo" on Thursdays as the only evening activity available. Activities on Tuesdays consisted of "Helping Hands (folding towels)," "Catholic Mass," and "Devotionals," which limited the activities available for residents who do not participate in religious activities. Activities for the week of survey included: * March 04 - Monday - 9:30 a.m. Reading Corner, 11:00 a.m. Ring Toss, 2:30 p.m. Bingo, 3:45 p.m. Manicures * March 05 - Tuesday - 9:30 a.m. Helping Hands, 10:30 a.m. Catholic Mass, 2:30 p.m. Devotionals with Pastor * March 06 - Wednesday - 9:30 a.m. Helping Hands, 10:30 a.m. Word Game, 1:30 p.m. One-to-one room visits, 2:30 p.m. Bingo * March 07 - Thursday - 9:30 a.m. Helping	F 248	The Activity Director will complete a monthly audit of program attendance charting to ensure residents are having the opportunity to be involved in activities of interest daily for 3 months then once quarterly for a year. Findings of audits will be forwarded to QAPI for review and recommendations for ongoing monitoring. The Activity Director will observe the scheduled activities of group programs offered and residents targeted for one to one programming needs for two weeks daily, then weekly for three weeks, then randomly thereafter and report findings to QAPI The Monthly Activity calendar will show a variety of resident directed program offerings throughout the day available to residents on both floors and abilities. Implementing a monthly resident "Activity preference committee" will engage residents in sharing their program ideas and being involved in the planning of the monthly activity calendar. This will engage resident input and choice, creating meaningful social and therapeutic activities to stimulate resident interests, needs and community engagement. The Resident Activity Preference Committee will be planned and facilitated on a monthly basis by the Activity Director.		

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F 248	Continued From page 12 Hands, 10:30 a.m. Special Focus (small group discussion), 3:00 p.m. First Lutheran, 3:30 p.m. Social, 7:30 p.m. Bingo - Observations on March 05-07, 2013 showed staff failed to provide meaningful, individualized activities on a consistent basis. Observations at various times of the day showed between 10-20 residents seated in the TV area/lounge on each floor, who were not actively engaged in any type of activity. - Review of Resident #2's medical record occurred on March 05-07, 2013. Diagnoses included dementia, depression, and macular degeneration. The quarterly Minimum Data Set (MDS), dated 01/25/13, identified the resident with highly impaired vision, severely impaired cognition, and extensive assistance for transfers and locomotion. The admission MDS, dated 08/04/12, identified the resident enjoyed music, news, group activities, being outdoors, and religion. The current care plan stated, "... Focus: Enjoys activities such as some music programs, also has coffee & desert [sic] with company almost weekly ... Goals: Will participate in independent leisure activities of choice such as having coffee and desert [sic] with friends and family ... Will participate in activities that promote socialization with peers consistent with likes and interests such as music with [name of volunteer]. If she chooses to come to music, [name of volunteer] visits her ... Interventions: Assist to transport to & from activities of choice ... Encourage participation in group activities of interest ..."	F 248			

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F 248	Continued From page 13 Review of activity participation logs for January-March 6, 2013 showed the following: *January 2013: passive participation in "music/singing in room" and "television" daily; active participation in "socializing" daily; active participation in "newspaper," "reading/writing," "social programs," and "visitors" on two days each; and "spiritual/religious activities" on one day *February 2013: passive participation in "television" daily; active participation in "socializing" daily; active participation in "music/singing in room" on six days; passive participation in "music/singing in room" on 20 days; active participation in "visitors" on six days; active participation in "exercise," "social programs," and "spiritual/religious activities" on one day each *March 2013: passive participation in "music/singing in room" and "television" daily; active participation in "socializing" daily; and active participation in "visitors" on two days Observations on March 05-07, 2013 showed staff failed to provide meaningful and individualized activities specific to Resident #2's physical and cognitive abilities. Observations during survey identified the resident in her wheelchair either in her room, in the corridor, or in the main TV area on the first floor without any activities or stimulation. When placed in the TV area, the resident did not watch the program; and when in her room, the resident sat in silence (contrary to the activity participation logs which identified music in the resident's room). During an interview on 03/07/13 at 9:30 a.m., an activity staff member (#16) stated they try to get the resident to church and music, but she often	F 248			

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F 248	Continued From page 14 refuses or will fall asleep during the group activity. The staff member (#16) stated they do not do one-to-one activities with Resident #2. - Review of Resident #3's medical record occurred on all days of survey. Diagnoses included cerebrovascular disease and aphasia. The current MDS, dated 02/22/13, identified short-term and long-term memory problems, severely impaired daily decision-making skills, and extensive assistance from one person for all ADLs. A "Recreation/Activity Evaluation," dated 11/20/12, identified "Animals/pets" and "Children/intergenerational" as current interests. Resident #3's current care plan stated, ". . . Focus . . . Enjoys activities such as music, animals/pets, outside, low stressed programs, sensory and reality awareness groups. Daughter [sic] visits daily. . . . Goals . . . Will participate in activities that promote socialization with peers consistent with likes and interests such as music. Resident does not like group programs. Staff will invite resident to low stressed programs such as, music, and assist as needed. . . . Interventions . . . Assist to transport to & from activities of choice . . . Encourage participation in group activities of interest . . ." Review of activity participation logs for January-March 6, 2013 showed the following: *January 2013: passive participation in "socializing" and "television" daily, active participation in "visitors" daily, active participation in "music/singing" on two days, and active participation in "off-site outing" on one day. *February 2013: passive participation in "socializing" and "television" daily, active	F 248			

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F 248	Continued From page 15 participation in "visitors" daily, and active participation in "current events," "newspaper," and "reading/writing" (all recorded on the same day). *March 2013: passive participation in "socializing" and "television" daily, and active participation in "visitors" daily. Observation on 03/05/13 showed staff members assisted Resident #3 to lie down between meals and did not offer activities to Resident #3. Observation also showed no organized activities available to residents on the first floor, and no staff members assisting with activities. Observation on 03/06/13 at 9:22 a.m. showed two CNAs (#14 and #15) assisted Resident #3 with toileting. A CNA (#14) asked Resident #3 if she would like to lie down, and the resident shook her head "no." The CNA asked again, and again the resident shook her head "no." The CNA then brought Resident #3 in her wheelchair to the hallway. Observation throughout the morning showed Resident #3 remained in the hallway until lunch time. Observation on 03/06/13 from approximately 2:30 p.m. to 3:30 p.m. showed Resident #3 asleep in her wheelchair in a small dining area near the front entrance. At approximately 3:30 p.m., a nursing staff member (#2) brought Resident #3 to the main TV area on the first floor. Observation throughout the day showed no organized activities available to residents on the first floor. During an interview on 03/07/13 at 9:30 a.m., an activity staff member (#16) stated Resident #3 does not like group activities and staff do not	F 248		

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F 248	Continued From page 16 provide one-to-one activities because her family visits so often. - Review of Resident #5's medical record occurred on all days of survey. Diagnoses included quadriparesis secondary to multiple sclerosis, and depression. The quarterly MDS, dated 01/18/13, identified moderately impaired cognition and total assistance for locomotion. Resident #5's current care plan stated, "... Focus Enjoys activities such as music programs and manicures with a preferred group setting ... some bingo. Family takes her out to church, when possible ... Interventions Assist to transport to [and] from activities of choice. Encourage participation in group activities of interest. Give verbal reminders of activities before activities begins. ... Focus Cognitive loss as evidenced by some forgetfulness ... Interventions Stimulate cognition/memory with participation in activities such [sic] trivia, reminiscence, current events/newspapers." The "Recreation/Activity Evaluation," dated 10/17/12, identified leisure interests including talking, attending parties or socials, interacting with children, watching dramas and baseball on television, listening to country western music, attending religious services, outdoor activities, and going on outings. Review of activity participation logs for January 16-March 5, 2013 showed the following: *January 2013: passive participation in "television" on one day and "reading/writing" on fourteen days, active participation in "reading/writing" on one day, "beauty/barber	F 248			

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F 248	Continued From page 17 shop and bingo" on two days, "visitors" on fourteen days, "socializing" on fifteen days, and independent in "television" on fourteen days. The resident refused "music" on one day and "bingo" on two days. *February 2013: passive participation in "reading/writing" on twenty six days, active participation in "beauty/barber shop and bingo" on two days, "music/singing, off-site outing, social programs, and special/theme events" on two days, "visiting" on eighteen days, "socializing" on twenty six days, and independent in "television" on twenty six days. The resident refused "arts and crafts and music/singing" on one day and "bingo" on four days. *March 2013: passive participation in "reading/writing" on five days, active participation in "socializing and visitors" on five days, and independent in "television" on five days. The resident refused "bingo" on one day. During an interview on 03/06/13 at 11:05 a.m., when asked for a detailed explanation of Resident #5's activity log, an activity staff member (#16) made the following statements: * Beauty: "1:1 nail care. I do her nails a couple times a week." [The log showed "beauty/barber shop" on four days in two months.] * Bingo: "[Resident #7] refuses." * Off-site: "Her family takes her out in their van." * Reading/Writing: "I see her read [the flyer] at the table in the dining room." * Socializing: "She talks to you." * Television: "She's independent." * Visitors: "Her husband and sisters visit daily." During an interview on 03/05/13 at 5:45 p.m., Resident #5's family member (B) stated, "They	F 248			

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F 248	Continued From page 18 [staff] tell me she gets more interaction than most, because her family visits daily and takes her on outings." When asked how she finds out about/is transported to activities, the family member further stated, "She is dependent on staff." Observations showed the following: * 03/05/13 at 7:50 a.m. and 8:08 a.m., Resident #5 lying in bed. * 03/05/13 at 11:40 a.m., 2:40 p.m., 3:30 p.m., 5:15 p.m., 03/06/13 at 9:17 a.m., 10:25 a.m., 10:49 a.m., 11:30 a.m., 3:00 p.m., 3:50 p.m., 4:28 p.m., 4:50 p.m., and 5:00 p.m., Resident #5 lying in bed; with the television on. - Review of Resident #7's medical record occurred on all days of survey. Diagnoses included Creutzfeldt-Jakob disease, encephalopathy, altered mental status, and dementia. The admission MDS, dated 01/22/13, identified severely impaired cognition and extensive assistance for locomotion. Resident #7's current care plan stated, "... Focus Enjoys activities such as music, Catholic Mass, and some socials. He loves to watch movies, and listen to 60's music, in his room ... Interventions ... Assist to transport to [and] from activities of choice, Encourage participation in group activities of interest." The "Recreation/Activity Evaluation," dated 01/21/13, identified leisure interests including watching sports or westerns/action adventure movies on television, listening to 60's music, and attending Catholic services.	F 248			

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F 248	Continued From page 19 Review of activity participation logs for January 16 - March 5, 2013 showed the following: *January 2013: passive participation in "socializing" on three days, "reading writing" on four days, active participation in "bingo, social programs, and special/theme events" on one day, "music/singing and spiritual/religious activities" on two days, "physical activities and targeted therapeutic group" on seven days, "visitors" on ten days, "exercise and socializing" on eleven days, and independent in "television" on fourteen days. * February 2013: passive participation in "bingo, educational, intergenerational programs and socializing" on one day, "reading/writing and socializing" on twenty five days, active participation in "intergenerational programs" on one day, "social programs" on two days, "music/singing and spiritual/religious activities" on five days, "exercise, physical activities, and target therapeutic group" on twenty days, "visitors" on twenty five days, and independent in "television" on twenty six days. * March 2013: passive participation in "bingo" on one day, "reading/writing and socializing" on five days, active participation in "exercise, physical activities, target therapeutic group, and visitors" on three days, and independent in "television" on five days. During an interview on 03/06/13 at 11:05 a.m., when asked for a detailed explanation of Resident #7's activity log, an activity staff member (#16) made the following statements: * Bingo: "[Resident #7] flips the letters. He's not really playing." * Exercise, Physical Activities, and Target Therapeutic Group: "Are checked because he's in	F 248			

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F 248	Continued From page 20 therapy." * Reading/Writing: "He picks things up and looks at it. Oh, he can't write." * Spiritual/Religious Activities: "He likes to listen. He has questionable comprehension and gives nonverbal responses." * Visitors: "Family visit daily." She further stated, "We make sure we bring him [to activities], he's not disruptive." Observations showed the following: * 03/05/13 at 7:50 a.m. and 8:08 a.m., Resident #7 sat in his wheelchair in the hallway. * 03/05/13 at 10:21 a.m., a certified nurse assistant (#19) transported Resident #7 to the church service. * 03/05/13 at 11:40 a.m. and 3:30 p.m., 03/06/13 at 9:15 a.m., 9:25 a.m., 10:25 a.m., 10:49 a.m., 11:30 p.m., 3:00 p.m., 3:50 p.m., 4:10 p.m., 4:50 p.m., 5:00 p.m., 03/07/13 at 10:20 a.m., 10:40 a.m., 11:15 a.m., 3:20 p.m., Resident #7 sat in his wheelchair in the lounge. - Review of Resident #15's medical record occurred on March 6-7, 2013. Diagnoses included altered mental state and psychosis. The admission MDS, dated 01/07/13, identified moderately impaired cognition and extensive assistance for locomotion. Resident #15's current care plan stated, "... Focus Enjoys activities such as reading, music, church. Patient misses her cat (Kitty). ... Interventions ... Assist to transport to [and] from activities of choice, Encourage participation in group activities of interest ..." The "Recreation/Activity Evaluation," dated	F 248			

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F 248	Continued From page 21 01/09/13, identified leisure interests including interacting with animals and children, watching the game shows and the news on television exercising, listening to church music, reading books about religion, attending Lutheran services, and going on outings. Review of activity participation logs for January 01-March 5, 2013 showed the following: *January 2013: active participation in "beauty/barber shop" on one day, "visitors" on eight days, "target therapeutic group" on twenty two days, "exercise and physical activity" on twenty four days, "socializing" on twenty nine days, and independent in "reading/writing" on twenty one days and "television" on twenty eight days. *February 2013: active participation in "arts/crafts, intergenerational programs, off-site outing, social programs, and special/theme events" on one day, "music/singing" on two days, "visitors" on fourteen days, "exercise, physical activity, and target therapeutic group" on twenty days, "socializing" on twenty six days, and independent in "reading/writing and television" on twenty six days. * March 2013: active participation in "off-site outing and visitors" on one day, "socializing" on five days, and independent in "reading/writing and television" on five days. During an interview on 03/07/13 at 11:25 a.m., when asked for a detailed explanation of Resident #15's activity log, an activity staff member (#16) made the following statements: * Exercise, Physical Activities, and Target Therapeutic Group: "Are checked because she's in therapy."	F 248			

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F 248	Continued From page 22 * Intergenerational Program and Music/Singing: "We had a children's program that day." * Music, Social Programs, and Special/Theme Event: "We had a Valentine's Day party." * Off-site: "She went to a doctor appointment with her family." * Reading/Writing: "She reads in her room. She reads on her own." * Television: "She watches [television] on her own." * Visitors: "Family visits." The nurses notes identified the following: * 01/16/13, "... Activity-wise, patient has not attended any group activities due to therapy schedule but her family does visit daily. ..." * 01/21/13, "... She is not attending activities at this time due to her therapy schedule. She does visit with family daily. ..." Observations showed the following: * 03/05/13 at 11:40 a.m., Resident #15 sat in her wheelchair in her room and requested the surveyor's assistance in obtaining her [reading] magnifier. * 03/06/13 at 4:28 p.m., Resident #15 sat in her wheelchair in her room and requested her visitor's assistance in obtaining her glass of water. * 03/07/13 at 10:20 a.m., Resident #15 sat in her wheelchair in her room. * 03/07/13 at 10:30 a.m., Resident #15 slept in her bed, with the television on in the background. * 03/07/13 at 11:15 a.m., Resident #15 sat in her wheelchair in the lounge. During an interview on 03/06/13 at 4:00 p.m., an activity staff member (#20) indicated that activity	F 248			

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F 248	Continued From page 23 hours have been decreased. The activity staff member (#20) stated, they offer an activity one night a week on Thursday that is run by volunteers. When asked about activities for residents that are more dependent or need individual attention, she stated that on Thursday mornings, they do a small group activity with residents that are more dependent and on Saturday and Sunday they do an hour of 1 to 1's. She agreed that it is difficult to provide activities to all residents with decreased activity hours.	F 248			
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEYS COMPLETED IN 2011 AND 2012. Based on observation and family/staff interviews, the facility failed to maintain a sanitary building interior regarding 1) accumulated dust/debris on bathroom exhaust vents, 2) accumulated fecal material on toilets, high-rise toilet seats, a sink, and a wall, 3) odor of fecal material, and 4) accumulated food/debris in a refrigerator on 4 of 4 days of survey. Failure to maintain a sanitary environment has the potential to increase the spread of disease-causing organisms and unpleasant odors throughout the facility. Findings include:	F 253	The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior. The bathroom vents in rooms 169,172,174,236,239,242, 252, 253,254,256, 258,259,260,261,263,and 264 have been cleaned. The sinks, toilets and high rise toilet seats in rooms 169, 238, 240 and 253 have been cleaned. The odor in the first floor (rooms 182-195 and room 255 on second floor) have been cleaned thoroughly and the odor has been investigated and eliminated. The refrigerator in the utility has been cleaned. Nursing staff and housekeeping staff have been in-serviced the week of 4/15/13 on need for surveillance of the toilets and bathrooms. A checklist has been implemented in regard to cleaning of resident rooms. Housekeeping staff has been educated on the checklist and	4/22/2013	

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F 253	Continued From page 24 During the initial facility tour on 03/04/13 at 1:50 p.m., observation showed the following: * Bathroom exhaust vents with moderate to heavy accumulations of dust and lint in resident rooms 169, 172, 174, 236, 239, 242, 252, 253, 254, 256, 258, 259, 260, 261, 263, and 264. * Soiled [with fecal material] toilets, high-rise toilet seats, and one sink in resident rooms 169, 238, 240, and 253. [Rooms 169, 238 and 240 have shared bathrooms.] * Strong odor of urine/fecal material on one unit on the first floor [rooms 182-195] and room 255 on the second floor. Random observations showed the following: * On the afternoon of 03/06/13, dried fecal material on the toilet seat, inside the toilet bowl, and on the wall behind the toilet in Room 176 and on the high-rise toilet seat in Room 183. [Rooms 176 and 183 have shared bathrooms.] * On the morning of 03/07/13, spilled red and yellow liquids and light brown streaks on the bottom shelf of a refrigerator in the Unit One utility room. This refrigerator contained juice and snacks for the residents. During a confidential interview, a resident's family member [who visits daily] stated there is frequently dried fecal material on the toilet high-rise in the resident's bathroom. The family member stated the high-rise remains that way the entire day, and that the resident's bathroom was "really dirty." During an interview on 03/05/13 at 5:45 p.m., Resident #5's family member stated, "The bathroom smells ripe sometimes."	F 253	schedule for cleaning of resident rooms. Utility room refrigerators to be cleaned by nursing staff as scheduled. Environmental Supervisor or their designee will conduct environmental rounds 3 times weekly x 4 weeks to ensure sanitary, orderly and comfortable interior. Audits will continue to be completed twice weekly for an additional 4 weeks, then weekly for one month. Audits will then be completed monthly for three months and then quarterly as part of the QAA committee ongoing monitoring activities.		

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F 253	Continued From page 25 During the facility tour with two administrative staff members (#34 and #35) on 03/07/13 at 9:20 a.m., observation showed the following: * Bathroom exhaust vents with moderate to heavy accumulations of dust and lint in resident rooms 169 and 263. * Soiled [with fecal material] toilets and toilet risers in resident rooms 169, 170, 252, 254, and 256. [Rooms 169, 170, 252 and 256 have shared bathrooms.] * Strong odor of urine/fecal material on one unit on the first floor [rooms 182-195] and room 255 on the second floor. The administrative staff member (#34) stated, "It smells like BM [bowel movement]." During the facility environmental tour on 03/07/13 at 9:20 a.m., the two administrative staff members (#34 and #35) confirmed the moderate to heavy accumulations of dust and lint on the bathroom exhaust vents, the soiled material on the toilets/high-rise toilet seats in the resident rooms, the strong odor on one unit on the first floor and resident room on the second floor, and the accumulation of debris in the refrigerator on the second floor.	F 253			
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	F 280	Manor Care strives to provide care and services that include the resident and family involvement in care planning and the periodic review and revision of care plan by a team of qualified persons after each assessment. Patients #2, #5, #6, #7, #11, #13 & #15 care plans were reviewed and modified. Patient #11 has been discharged.		4/22/2013

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F 280	Continued From page 26 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 record review and staff interview, the facility failed to review and revise comprehensive care plan to reflect the residents' current status for 7 of 18 sampled residents (Resident #2, #5, #6, #7, #11, #13, and #15). Failure to revise the care plans limited staff's ability to communicate care needs and ensure continuity of care for each resident. Findings include: - Review of Resident #2's medical record occurred on March 05-07, 2013. Diagnoses included dementia, osteoarthritis, and macular degeneration. The quarterly Minimum Data Set (MDS), dated 01/25/13, identified the resident with highly impaired vision; severely impaired cognition; extensive assistance for bed mobility, transfers, locomotion, and personal hygiene; and two falls without injury.	F 280	Patients who reside in Manor Care have the potential to be affected by this practice. Licensed nurses were educated on updating care plans with change in condition and quarterly the week of 4/15/13. Care plans will be revised with change in condition and with quarterly assessment. ADNS or designee will complete 10 care plan audits weekly x4 to ensure accurate communication of care. Findings will be reported to the QAPI committee weekly for review and recommendation. Care plan audits will then be completed on a monthly basis or as per QAPI committee recommendations.		

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F 280	Continued From page 27 The current care plan stated, "... Focus: At risk for falls due to unsteady gait ... Interventions: Covered mug in room for liquids (initiated 09/27/12), Dycem to wheelchair ... Fall Matt(s) ... Low bed ... monitor resident more frequently (initiated on 11/23/12) ... Place fall matts under bed when resident NOT in bed (initiated on 01/10/13), Provide assist to transfer and ambulate as needed ..." A report for a fall occurring on 02/16/13 at 3:15 p.m. stated, "resident to be place [sic] in view of staff." The care plan failed to identify this intervention. During an interview on 03/06/13 at 3:45 p.m., an administrative nurse (#2) stated she expected staff to place Resident #2 in main areas within view of staff due to her history of falls and self-transferring. The nurse (#2) agreed this intervention should be on the resident's care plan. - Review of Resident #5's medical record occurred on all days of survey. Diagnoses included quadriparesis secondary to multiple sclerosis, neurogenic bladder [with catheter], and history of [heel]/current [buttocks] pressure ulcers. The quarterly MDS, dated 01/22/13, identified moderately impaired cognition; extensive assistance for bed mobility, transfers, eating, toilet use, and personal hygiene, and total assistance for locomotion on/off the unit, and indwelling catheter. Resident #5's current care plan stated, "... Focus ADL [Activities of Daily Living] Self care deficit ... Interventions ... Oral care and eating as needed ... Toilet patient in the BR [bathroom]	F 280			

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F 280	Continued From page 28 q [every] 2-3 hours and prn [as needed]. Give patient enough time to empty bladder. . . . Focus Open area at right inner buttock Open area to right calf Interventions Encourage and assist as needed to reposition" The nurse's notes identified: * 11/15/12 at 8:01 a.m., " Dependent on staff to offer snack and fluids between meals. . . . " * 12/15/12 at 12:50 a.m., " Patient requires total assistance with feeding. . . . " * 01/17/13 at 9:15 a.m., " Pt has to be fed most of her meals. . . . " Observation showed the following: * On 03/04/13 at 1:50 p.m., a cushion in Resident #5's wheelchair and a pressure relieving mattress on her bed. * 03/05/13 at 7:50 a.m. 8:08 a.m., 11:40 a.m., 2:40 p.m., 3:30 p.m., and 5:15 p.m., Resident #5 lying on her back in bed. * On 03/05/13 at 8:40 a.m. and 1:00 p.m., Resident #5 sitting in her wheelchair at an assisted table in the dining room. Resident #5 took sips of coffee, and a CNA (#33) fed her all the foods requiring the use of utensils. * On 03/06/13 at 9:17 a.m., two certified nursing assistants (CNAs) (#31 and #32) transferred Resident #5 to her bed, checked her brief, and placed heel protectors on her feet. * 03/06/13 at 10:25 a.m., 10:49 a.m., 11:30 a.m., 3:00 p.m., 3:50 p.m., 4:28 p.m., 4:50 p.m., and 5:00 p.m., Resident #5 lying on her back in bed. The facility failed to revise Resident #5's care plan regarding her placement at an assisted table, catheterization/no longer requiring toileting every two-three hours, pressure relieving devices	F 280			

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F 280	Continued From page 29 on her heels and wheelchair, and dependence on staff for repositioning. - Review of Resident #6's medical record occurred on all days of survey. Diagnoses included dementia and senility. Resident #6's current care plan stated, "... Focus [Resident #6] prefers to have medications left next to plate at meals so may take at own pace while eating. ... Interventions Educate/review current order and administration needs with patient demonstrating understanding and ability to perform, Reinforce need to not leave meds [medications] unattended at table, to ensure no other resident has access to meds. ..." During an interview on 03/06/13 at 3:00 p.m., a managerial nurse (#21) confirmed the facility failed to assess Resident #6's ability to self-medicate. Observation on 03/07/13 at 8:40 a.m., showed a nurse (#22) standing next to Resident #6's dining room table, ensuring Resident #6 swallowed all of the a.m. medications she had passed. When asked if and how often Resident #6 self medicates, the nurse (#22) stated, "[Resident #6] never self medicates." The facility failed to revise Resident #6's care plan regarding self administration of medication. - Review of Resident #7's medical record occurred on all days of survey. Diagnoses included Creutzfeldt-Jakob disease, encephalopathy, altered mental status, and	F 280			

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F 280	Continued From page 30 dementia. The admission MDS, dated 01/22/13, identified severely impaired cognition, extensive assistance for transfers, locomotion, toilet use, and personal hygiene, and limited assistance for eating. Resident #7's current care plan stated, "... Focus Indicators of depression/sadness ... Interventions Discuss feeling [sic] of sadness/hopelessness and options of appropriate channeling of these feelings with care givers and social services. ... Focus ADL [Activities of Daily Living] Self care deficit ... Interventions ... Assist with ... eating as needed ... Transfer with one assist with gait belt ... Focus ADL walk pt. [patient] to and from dining room ... Interventions Ambulate pt. to dining room with handheld, two person assist [sic] and gait belt. ... Focus Urinary incontinence ... Interventions ... Remind and assist as needed with toileting at 2-3 hr [hour] increments ... Focus At risk for falls ... Interventions Provide assist to transfer and ambulate as needed." Observation showed the following: * On 03/05/13 at 8:40 a.m., showed Resident #7 sitting in his wheelchair at an assisted table in the dining room. Resident #7 fed himself finger foods, and an unidentified CNA fed him all the foods requiring the use of utensils. * On 03/05/13 at 10:05 a.m. showed a CNA (#19) transporting Resident #7 down the hallway towards his room. An unidentified therapist approached the resident in the hallway and handed him his communication board. Upon reaching Resident #7's room, a second CNA (#23) joined them. Together, the CNAs (#19 and #23) placed a gait belt around	F 280			

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F 280	Continued From page 31 the resident and transferred him onto the toilet. Within minutes Resident #7 became agitated, and the CNAs made three attempts to transfer him back to his wheelchair prior to requesting assistance from a third CNA (#24). The three CNAs (#19, #23, and #24) provided pericare and transferred the resident safely into his wheelchair. * On 03/05/13 at 12:38 p.m., showed Resident #7 sitting in his wheelchair at an assisted table in the dining room. Resident #7 fed himself finger foods and the therapist (#25), who assisted him with all of the foods requiring the use of utensils. * On 03/05/12 at 2:40 p.m., a therapist (#26) and two CNAs (#27 and #28) assisted Resident #7 in the bathroom. The therapist and two CNAs provided pericare and transferred the resident into his wheelchair. During an interview on 03/06/13 at 11:05 a.m., an activity staff member (#16) described Resident #7 as having "questionable comprehension" and communicating through "nonverbal" means. The facility failed to revise Resident #7's care plan regarding his nonverbal attempts to communicate/use of a communication board, need for wheelchair assistance to/from the dining room, placement at an assisted table/preference for finger foods, total dependence on staff for toileting needs, and need for assistance from two-to-three staff members for transfers. - Review of Resident #11's medical record occurred on all days of survey. Review of Resident #11's "Social Work Assessment and History" dated 10/15/12, stated, ". . . She was to begin dialysis 3x/week [times per week] but this was discontinued 10-8-12 . . .	F 280			

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F 280	Continued From page 32 Patient plans to discharge back to her apartment at [name of apartment building] when completion of[sic]rehabilitation of therapies and medically stable . . . " Review of Resident #11's current care plan stated, ". . . Focus - Renal insufficiencies related to: chronic renal failure, Goals - No complications related to dialysis devices or treatment, Interventions - . . . Dialysis 3 times/week . . . " The facility failed to revise the resident's care plan regarding the discontinuation of the resident's and the addition of a focus area for discharge planning. - Review of Resident #13's medical record occurred on all days of survey and diagnoses included right hip fracture on 01/30/13 and a history of falls. Observation throughout the survey identified a scoop/perimeter mattress on the resident's bed. The resident's care plan failed to identify the scoop/perimeter mattress as an intervention to prevent falls. - Review of Resident #15's medical record occurred on March 6-7, 2013. Diagnoses included hearing loss/deafness. Resident #15's current care plan stated, ". . . Focus Difficulty communicating as evidenced by inability to hear related to hearing loss/deafness. . . Interventions Use communication board, Gain individual's attention before beginning to converse, Provide reassurance and patience	F 280			

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F 280	Continued From page 33 when communicating with patient, Repeat information as needed, When talking to patient, use gestures and simple sentences while maintaining eye contact. . . ." The nurse's notes identified the following: * 01/09/13, ". . . She uses a hearing device (amplifier). Patient is hard to communicate with due to deafness . . ." * 01/21/13, ". . . She is also significantly hearing impaired and uses a pocket talker. . . ." * 01/28/13, ". . . [Resident #15] does have a significant hearing loss and uses a pocket talker . . ." * 01/29/13, ". . . HOH [hard of hearing], uses a microphone device . . . to communicate . . ." * 02/26/13, ". . . uses amplifier to help with hearing loss and works well . . ." During an interview on 03/07/13 at 11:25 a.m., an activity staff member (#16) stated, "She is very hard of hearing and has earphones." Observation showed the following: * 03/05/13 at 11:40 a.m., Resident #15 sat in her wheelchair in her room and requested the surveyor's assistance in obtaining her (reading) magnifier. The surveyor had to speak directly into her pocket-talker [amplification device] in order for Resident #15 to hear/understand her. * 03/06/13 at 4:28 p.m., Resident #15 sat in her wheelchair in her room and requested her visitor's assistance in obtaining her glass of water. She wore her pocket-talker throughout the visit. The facility failed to revise Resident #15's care plan regarding her need for an amplification	F 280			

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F 280	Continued From page 34 device.	F 280			
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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. This REQUIREMENT is not met as evidenced by: Based on record review, review of professional reference, and staff/family interviews, the facility failed to provide the necessary care and services for 3 of 3 sampled residents (Resident #5, #15, and #17) regarding high and low blood sugar parameters and treatment of hypoglycemia. Failure to establish high and low blood sugar parameters and treat hypoglycemia has the potential to place all diabetic residents at risk of serious adverse events and resulted in repeated hypoglycemic episodes which required emergency intervention (Glucose Gel and intramuscular [IM] Glucagon) for Resident #5. Findings include: The facility failed to provide a policy and procedure specific to diabetes/blood sugar parameters when requested. The American Medical Directors Association, "Managing Diabetes in the Long-Term Care Setting," Clinical Practice Guideline, 2002, pages	F 309	Manor Care will 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. Patients #5, #15 & #17 had no lasting adverse effects from this practice. Blood Glucose Parameters were obtained for patients #5, #15, & #17. Patients who are diabetic, receiving insulin with blood glucose checks are at risk for being affected by this practice. Charts of patients with blood glucose monitoring were audited and have parameters in place. Patients who receive diabetic snacks have been identified and snacks were passed. Protocol for responding to episodes of hypoglycemia/hyperglycemia was found in current policy books and reviewed by nurse managers. Procedure for obtaining blood glucose checks was found in current policy books and reviewed by nurse managers. Parameters for current diabetic patients with orders for blood glucose monitoring were reviewed and updated in the physician orders when indicated. Licensed nursing staff were educated on policy for obtaining blood glucose,	4-29-13	

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F 309	Continued From page 35 27-29, states, "WHEN TO CALL THE PHYSICIAN . . . Develop protocols that guide first-line care givers (nurses and nursing assistants) in deciding when a prompt physician referral is necessary for a diabetes-related problem. . . TREATING HYPOGLYCEMIA . . . Hypoglycemia is defined as blood glucose level < 60 mg/dl. Symptoms may or may not be present. . . . The same threshold should be used to diagnose hypoglycemia in patients with dementia as in those who are not cognitively impaired. . . . Hypoglycemia is the most feared short-term complication of treatment for diabetes. If not promptly recognized and treated it can result in long-term disability, particularly in cognitively impaired individuals. . . . It is recommended that all long-term care facilities develop and implement a policy and procedures for treating hypoglycemia. . . ." - Review of Resident #5's medical record occurred on all days of survey. Diagnoses included cognitive loss, quadriparesis secondary to multiple sclerosis, and diabetes. The current MDS (Minimum Data Set), dated 01/18/13, identified extensive assistance for activities of daily living (ADLs). The physician orders, dated 02/20/13, identified the following: * 12/04/12: Glucagon 1 milligram (mg) emergency kit IM as needed; low BS [blood sugar] < 80 symptomatic *if not able w [with]/oral glucose * 01/19/13: Novolog 100 units/milliliter (ml) vial; give 6 units with meals plus sliding scale 3 times daily	F 309	identifying parameters for blood glucose monitoring and family/physician notification if blood glucose triggers outside of parameters. Protocols and policies were reviewed with nursing staff. Nursing staff members received education regarding passing and assisting residents with diabetic snacks the week of 4/15/13. ADNS or designee will audit each new admission with blood glucose monitoring orders to ensure parameters are in place. Audits will be ongoing for new admissions. Audits will be completed three times weekly for 4 weeks by ADNS or designee to validate snacks are distributed at designated times to diabetic patients. Results of audits will be forwarded to QAA Committee for review and recommendations. Audits will then be completed monthly for two months and then quarterly or as per QAA Committee recommendations.		

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F 309	Continued From page 36 * 01/26/13: Levemir 100 units/ml vial by injection subcutaneously; 20 units twice a day * 02/09/13: Novolog ss [sliding scale] tid [three times daily]; 141-145 = 1 u [units], 146-175 = 2 u, 176-205 = 3 u, 206-235 = 4 u, 236-265 = 5 u, 266-325 = 7 u, 326-400 = 9 units, > 400 = 12 units" Facility staff check Resident #5's blood sugar at 7:00 a.m., 11:00 a.m., 5:00 p.m., and hour of sleep (hs). The facility failed to establish individualized parameters, and notify the physician when Resident #5 experienced high and low blood sugars, placing her at risk of complications. Resident #5's current care plan stated, ". . . Focus Endocrine System need for monitoring related to: Insulin Dependent Diabetes . . . Interventions . . . Administer medication as per MD [medical doctor] orders . . . Monitor for and report symptoms of hyperglycemia: excessive thirst/urination, hunger, weakness, N/V [nausea/vomiting], acetone breath, Monitor for and report symptoms of hypoglycemia: pallor, diaphoresis, vision changes, change in consciousness . . . Monitor glucometer readings . . . Notify physician . . . of any significant changes. . . . Focus Altered nutrition . . . Interventions . . . snacks as ordered . . . assist as needed to consume foods . . ." The care card further stated, ". . . make sure she gets snacks. . . ." Resident #5's nurses' notes related to blood sugars identified the following: * 09/18/12 at 7:19 p.m., "patient found in dining room diaphoretic blood sugar at 5:00 p [sic] 66, can report she took a couple of bites of burger	F 309			

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F 309	Continued From page 37 then she became unresponsive, skin cold and clammy. removed patient from dining room. insta [sic] glucose given. cont to sweat profusely thru clothing. IM Glucagon shot given to Lft [left] Deltoid. rechecked blood sugar, 248 fed patient, she ate 75% of her dinner. . . ." * 11/21/12 at 10:02 a.m., ". . . BS at 7:00 a.m. noting BS was 45. SN [student nurse] gave pt 4 oz [ounces] of applejuice and recheck BS at 7:30 a.m., BS was 78. Pt. [patient] was going [sic] dining room for breakfast." * 12/01/12 at 5:41 p.m., "Pt. b/s [blood sugar] [at] 4:15 p.m. was 37. Pt. diaphoretic and face red. Pt. [was] given a glass of orange juice and a snack. B/S rechecked at 4:30 and b/s was 55. Pt. [was] given another snack and glass of orange juice. B/S rechecked @ 4:45 p.m. and b/s was 77. Pt. [was] going to dining room for supper. It will be rechecked again after supper." Resident #5's nurse' notes relating to snacks identified the following: * 11/15/12 at 8:01 a.m., ". . . Dependent on staff to offer snack and fluids between meals. Blood sugars are variable. Takes HS [bedtime] snack due to Hx [history] of low am blood sugars. . . ." * 12/15/12 at 12:50 a.m., ". . . Patient requires total assistance with feeding. . . ." * 02/26/13 at 12:23 a.m., ". . . He [husband] does express concern of patient not receiving snacks between her meals to help with blood sugar lows and the CNA's not helping her to eat them, just leaving them on the table." Resident #5's physician notes relating to blood sugars identified the following: * 05/06/12, ". . . Diabetes - - poor control. . . ." * 08/06/12, ". . . Low blood sugar is her greatest	F 309			

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F 309	Continued From page 38 risk. . . ." * 10/07/12, ". . . She does continue to have marked fluctuation in her blood sugars. . . . Avoiding hypoglycemia is our main goal. . . ." During an interview on 03/05/13 at 5:45 p.m., when asked for comments/concerns, Resident #5's family member stated, "I do have a concern. Sometimes, the CNAs drop her snack on the bedside table. She's unable to pick it up to feed herself. When I come in the evening, the RN is in a panic, because her [Resident #5] blood sugars are 38-40." During interviews on 03/06/13 at 3:00 p.m. and 5:25 p.m., when asked for information regarding blood sugar parameters, an administrative nurse (#1) and a managerial nurse (#21) stated, "They [nursing staff] would look at each MAR [medication administration record]. The highs and lows are on the MAR if [the resident is] on an insulin sliding scale. It is individualized to each patient." During an interview on 03/06/13 at 5:00 p.m., when asked for information regarding blood sugar parameters, a managerial nurse (#29) stated she could not locate individualized parameters for Resident #5 on either the physician orders or the MAR. She further stated, she did find an "alert on the computer," stating "< 80 or > 400." The facility failed to provide snacks (necessary in regulating her blood sugars), failed to establish individualized parameters, and notify the physician when Resident #5 experienced high and low blood sugars, placing her at risk of complications.	F 309			

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F 309	Continued From page 39 - Review of Resident #15's medical record occurred on all days of survey. Diagnoses included altered mental state, diabetes, and hypoglycemia. Resident #15's current care plan stated, "... Focus Endocrine System related to: Insulin Dependent Diabetes ... Interventions ... Administer medication per physician orders ... Obtain glucometer readings and report abnormalities as ordered ... Report symptoms of hyperglycemia: excessive thirst/urination, hunger, weakness, N/V, acetone breath ... Report symptoms of hypoglycemia: weakness, pallor, diaphoresis, vision changes, change in consciousness ..." The physician note, dated 01/28/13, stated, "... Diabetes - - overly controlled with the blood sugars less than 100 this morning ..." During an interview on 03/07/13 at 8:45 a.m., when asked for information regarding individualized blood sugar parameters, a managerial nurse (#29) stated she could not locate individualized parameters for Resident #15 on either the physician orders or the MAR. The facility failed to establish individualized parameters, and notify the physician when Resident #15 experienced high and low blood sugars, placing her at risk of complications. - Review of Resident #17's medical record occurred on 03/07/13 and diagnoses include diabetes mellitus type II.	F 309			

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F 309	Continued From page 40 Resident #17's current care plan identified, ". . . Focus: Endocrine system related to: Insulin Dependent Diabetes . . . Interventions: . . . Obtain glucometer readings and report abnormalities as ordered . . ."	F 309			
F 312 SS=E	During an interview on the morning of 03/07/13, an administrative nurse (#29) confirmed Resident #17's medical record lacked high and low blood sugar parameters and when to notify the physician for abnormal blood sugar readings. 483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, record review, facility policy/procedure review, and staff interview, the facility failed to ensure 2 of 18 sampled residents (Resident #2 and #7) received the necessary services to maintain good nutrition and personal hygiene, and failed to ensure residents residing on 1 of 2 nursing units (Unit One) received their morning snacks/supplements on 03/06/13. Failure to provide covered mugs for Resident #2's beverages may result in decreased fluid intake and weight loss. Failure to perform perineal cares correctly placed Resident #7 at an increased risk for urinary tract infections. Failure to provide residents with their snacks/supplements placed residents at risk for dehydration and weight loss.	F 312	Manor Care will provide residents who are unable to carry out activities of daily living the necessary services to maintain good nutrition, grooming and personal and oral hygiene. Patients # 2 & #7 had no adverse effects from this practice. Patients who receive supplements/snacks, who need covered cups and incontinent patients are at risk to be affected by this practice. Staff education provided the week of 4/15/13 regarding the importance of following patients' plan of care. Nursing staff educated on proper incontinence cares, need for covered cups and completion of assigned duties (i.e., passing snacks). Staff members providing incontinence care will be observed by nursing management to ensure proper technique.	4-29-13	

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F 312	Continued From page 41 Findings include: Review of the facility policy titled "INCONTINENCE CARE" occurred on 03/07/13. This policy, revised December 2012, stated, ". . . PROCEDURE: . . . 12. Cleanse peri-area and buttocks with cleansing agent . . . Male: . . . Cleanse from the tip of the penis outward. Cleanse down to body including scrotum and skin folds. . . ." - Review of Resident #7's medical record occurred on all days of survey. The admission Minimum Data Set (MDS), dated 01/22/13, identified severely impaired cognition, extensive assistance for toilet use and personal hygiene, and frequently incontinent of urine. Observation on 03/05/13 at 10:05 a.m. showed two CNAs (#19 and #23) transferred Resident #7 onto the toilet and removed his brief wet with urine. Within minutes Resident #7 had a bowel movement, and became agitated. The CNAs (#19 and #23) made three attempts to provide pericare prior to requesting assistance from a third CNA (#24). As two of the CNAs (#23 and #24) assisted the resident to stand, the third CNA (#19) cleansed the resident's buttock area, but failed to cleanse his frontal area. During an interview on the morning of 03/07/13, an administrative nurse (#1) confirmed staff should have provided pericare to both the resident's buttock and frontal area. - Review of Resident #2's medical record occurred March 05-07, 2013. Diagnoses included	F 312	Rounds will be completed 3 times weekly for 4 weeks and then on a weekly basis or as directed by the QAPI committee by nurse management to ensure that patients are receiving supplements/snack and covered mugs. Findings will be reported to the QAPI committee weekly for review and recommendations.		

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F 312	Continued From page 42 weight loss, failure to thrive, dementia, and macular degeneration. The quarterly MDS, dated 01/25/13, identified highly impaired vision, severely impaired cognition, extensive assistance of one staff member for eating, a weight loss of greater than 10% in the last six months, and two falls without injury. The current care plan stated, ". . . Covered mug in room for liquids . . . Altered nutrition r/t [related to] needing assistance with meal set up due to visual impairment, Hx [history] wt [weight] loss varying intakes . . . covered mug for suppl [supplements] at snack time . . ." Resident #2 received her juice supplement in a carton with a straw at the following times during survey: *03/05/13 at 10:35 a.m. *03/05/13 at 3:50 p.m. *03/06/13 - The resident did not receive her morning supplement. *03/06/13 at 3:50 p.m. - Observation at this time showed the supplement sitting upright on the floor with part of the contents on the floor in the resident's room. *03/07/13 at 10:45 a.m. Observation on 03/07/13 at 9:45 a.m. identified the resident's water in a styrofoam cup with a lid and straw on the bedside table. The facility staff failed to ensure Resident #2 received a covered mug for her supplements at snack times and for liquids in her room as care planned. - On the afternoon of 03/04/13, a dietary staff	F 312			

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F 312	Continued From page 43 member (#17) identified staff delivered snacks to the residents daily at 10:00 a.m., 3:00 p.m., and 8:00 p.m. Observations on 03/06/13 from 11:10 a.m. - 12:40 p.m. showed the morning snacks/supplements for 23 residents residing on Unit 1 remained on the snack cart. (Unknown when staff brought the snack cart to the floor.) During an interview on 03/06/13 at 4:25 p.m., a dietary staff member (#18) stated she retrieved the morning snack cart from Unit 1 after lunch and confirmed none of the residents on Unit 1 received their snacks/supplements from the snack cart.	F 312			
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES 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: Based on observation, record review, professional reference, and family/staff interviews, the facility failed to provide the necessary treatment and services to prevent the occurrence and promote the healing of pressure ulcers for 1 of 1 sampled resident (Resident #5)	F 314	Manor Care will provide services to prevent pressure sores unless the resident's clinical condition demonstrates that they were unavoidable; and a resident having a pressure sore receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Patient #5's interventions are in place and the skin care plan was updated. Patients at risk for pressure ulcers were identified after a review of the Braden score. If needed, care plans and interventions were updated to reflect care needs. Patients that are incontinent were identified and random incontinent cares will be observed. Patients who receive snacks were identified and random		4-29-13

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F 314	Continued From page 44 identified with pressure ulcers. Failure to provide timely and appropriate interventions and ensure staff consistently implemented existing interventions resulted in the development of new pressure ulcers and the deterioration of existing facility-acquired pressure ulcers for Resident #5. Findings include: The facility failed to provide a policy and procedure specific to pressure ulcers when requested. The Clinical Practice Guidelines from the Agency for Healthcare Research and Quality (AHRQ) www.ahrq.gov <http://www.ahrq.gov> (Guideline No 15: Treatment of Pressure Ulcers and Guideline No. 3: Pressure Ulcers in Adults: Prediction and Prevention) defined a pressure ulcer as any lesion caused by unrelieved pressure that results in damage to the underlying tissue. Pressure ulcers are staged as follows: * Stage I: Nonblanchable erythema [diffuse redness of the skin] of intact skin. * Stage II: Partial thickness skin loss involving the epidermis/dermis [outermost layer of the skin]. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater. * Stage III: Full thickness skin loss involving damage or necrosis [death of tissue or bone surrounded by healthy parts] of subcutaneous tissue that may extend down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue. * Stage IV: Full thickness skin loss with extensive destruction, tissue necrosis or damage to muscle, bone, or supporting structures.	F 314	observations of residents receiving snack were completed. Protocols and processes for the management of skin conditions were found in existing guidelines for the facility. Training was provided the week of 4/15/13 to nurse managers on skin management and wound rounds. A wound team consisting of licensed nurses with consultations by ARNP, Physical Therapy, and Dietary consultants as needed. Education provided to nursing staff, RD and DSM on skin management interventions and prevention of pressure ulcers. Nursing staff members also received education on incontinence care and assisting patients with snacks. Nursing staff including CNA staff were educated on skin management and reducing the risk for skin breakdown. Educational sessions were held the week of April 15th. ADNS or designee will conduct random audits weekly x 4 of documentation and validation that identified interventions are in place. Audits will be completed weekly x 4 to validate snacks are in place and assistance provided when needed for those residents identified at risk. Incontinent care audits will be completed 3 times weekly x 4. Ongoing monitoring will be completed based upon results of audits, QAPI committee review and recommendation.	

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F 314	Continued From page 45 At risk individuals include those that are bed-/chair-bound or those with impaired ability to reposition, those with incontinence, and those with inadequate dietary intake. Prompt and effective treatment can minimize the deleterious effects of an ulcer and speed recovery. Offer support with eating, and plan/implement a nutritional support/supplementation program. Establish a written repositioning schedule based on the patient's risk for additional ulcers and on the response of the tissue to pressure. The bed-/chair-bound individual should be repositioned at least every two hours. Patients at risk should be turned more frequently. If a patient has a large Stage III or Stage IV pressure ulcer, a low-air-loss bed or air-fluidized bed may be indicated. Limited sitting may be allowed for a patient who has a pressure ulcer on a sitting surface. Reposition the sitting individual so the points under pressure are shifted at least every hour. - Review of Resident #5's medical record occurred on all days of survey. Diagnoses included cognitive loss, quadriparesis [paralysis of all four extremities] secondary to multiple sclerosis, infection, pain, diabetes, catheterization, and history of/current pressure ulcers. The most recent Minimum Data Set (MDS), dated 01/18/13, identified moderately impaired cognition, extensive assistance for activities of daily living (ADLs), has one or more unhealed pressure ulcers, one unstageable pressure ulcer due to slough [light colored tissue] and/or eschar [brown/ black necrotic tissue], one unstageable pressure ulcer with suspected deep tissue injury in evolution, longest length from head to toe: 6.0 centimeters (cm), widest width	F 314			

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F 314	Continued From page 46 side-to-side perpendicular to length: 3.0 cm, necrotic tissue, and receiving skin treatments including: pressure reducing device for chair and bed, turning/repositioning program, nutrition/hydration intervention to manage skin problems, ulcer care, application of nonsurgical dressings, and application of ointments/medications. Resident #5's current care plan stated, "... Focus ADL [Activities of Daily Living] Self care deficit ... Interventions ... Extensive assist with daily hygiene, grooming ... and eating as needed ... Focus Altered nutrition r/t [related to] ... Incr [increased] need with wound ... Intervention ... Diet/snacks as ordered, assist as needed to consume foods, fluids ... Focus Potential for pain related to ... decreased mobility ... Interventions Encourage/assist to reposition frequently to position of comfort ... Focus At risk for alteration in skin integrity related to MS, decreased mobility ... Interventions Encourage and assist as needed to reposition frequently ... Pressure reduction mattress and WC [wheelchair]. ... Focus ... Open area at right inner buttock related to: incontinence of bowels, pressure ... Open area to right calf related to friction ... Interventions Administer treatment per physician orders, Encourage and assist as needed to turn and reposition; use assistive devices as needed ... Use pillows and/or positioning devices as needed ..." The physician orders, dated 02/20/13 identified the following: * Protein powder TID [three times daily] * Holister barrier cream as needed * Polysporin ointment	F 314			

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F 314	Continued From page 47 * Monitor reddened area to right lower leg * Pressure reduction mattress The progress notes identified the following: The resident was hospitalized from 09/30/12 to 10/05/12 for urosepsis [infection]. * 10/06/12 at 3:36 a.m., "... Resident is requesting an air mattress, states this bed is ' uncomfortable ' ..." The resident was hospitalized from 10/18/12 to 10/24/12 for pseudo [false]-obstruction of the intestines. * 11/06/12 at 3:04 p.m., "... Noted open area to right buttock and tailbone area. MD [physician] faxed. Calmoseptine applied to area. ..." * 11/07/12 at 3:38 a.m., "new order recieved [sic]/fax for replicare [a hydrocolloid dressing for wounds] to open areas on bottom, * 11/10/12 at 4:51 a.m., "Noted 0.5 cm by 0.5 cm reddened area to right outer heel, heel protectors applied. ..." * 11/13/12 at 2:26 p.m., "Pt. [Patient] with reddened coccyx area with a 2 cm x 2 cm spot that is a hole and is blackened. ..." * 11/13/12 at 8:36 p.m., [Five weeks after Resident #5 first requested an air mattress and one week after a pressure ulcer was identified to her right buttock/tailbone area and reddened area to her right outer heel] "new order recieved [sic]/fax for pressure reduction mattress" * 11/15/12 at 8:01 a.m., "... Diet meets est [estimated] need for calories and pro [protein]. Has red area on bottom r/t [related/to] freq [frequent] BM [bowel movement] when has loose stools. ... Continue to monitor and adjust meals as needed to meet her needs." * 11/26/12, "... The patient is having loose stools 3 times per shift with associated skin breakdown	F 314			

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F 314	Continued From page 48 on her buttocks. . . . Erythema with 1.5 cm area of necrosis on the buttock crease . . . necrotic areas on the right side, loose stool is present. . . . Cut back on laxatives . . . Will use Polysporin and Vaseline gauze to the buttocks. . . ." * 11/28/12 at 1:06 p.m., "Wound rounds completed. [Resident #5] has a boomerang shaped 5.5 x 5.5 cm area to right buttock. 100% slough with erythema around wound. This area started when she [was] frequently incontinent of diarrhea. 2 x 2.4 x .5 cm area to sacrum that is 100% black eschar. Surrounding area erythematous. [Resident #5] reports increased discomfort when up in wheelchair for long periods of time. Instructed CNA's that she should only be up for meals and therapy. . . ." [Three weeks after Resident #5 developed the pressure ulcer to her right buttock/tailbone area] Resident #5's care plan was not revised to include this intervention, * 11/30/12 at 9:54 a.m., "[Resident #5] has an open area on her bottom. . . . Cont [continue] to monitor healing. If no improvement will recommend pro pwd [protein powder]." * 12/02/12 at 2:26 p.m., ". . . Pt [Patient] is up for all meals and then laid down and change [sic] from side to side every two hours to relieve pressure to coccyx area. . . ." * 12/04/12 at 4:50 a.m., ". . . Antibiotic ointment and gauze dressing applied with every BM . . ." * 12/05/12 at 9:56 a.m., "[Resident #5's] wound is not improving faxded [sic] MD [physician] for Pro powder," and at 8:42 p.m., "Orders received for Pro powder TID [three times daily] from [Physician]." [One month after Resident #5 developed the pressure ulcer to her right buttock/tailbone area] * 12/09/12, ". . . The patient has persistent	F 314			

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F 314	Continued From page 49 diarrhea in spite of cutting back on laxatives. . . . Stage III ulcers on the bilateral anal crease. Probable stage IV ulcer measuring 2 x 3 cm up her anal crease which is black in color with most likely a very deep area of necrosis . . ." Failure of facility staff to provide timely perineal care after incontinent episodes resulted in continued skin breakdown for Resident #5. * 12/12/12 at 3:00 p.m., "Wound rounds completed. Open area to sacrum measuring 3 x 2.7 x 0.7. Stage 4 with eschar to outer edges of wound and slough to the center of wound. Previous boomerang shaped ulcer has improved and is now one Coccyx 4 x 2.4 cm stage three with pink tissue surrounding open area. Second are [sic] is to right buttock measuring 0.7 x 3.4 cm stage 3. Currently using ABX [antibiotic] ointment and vaseling [sic] gauze to open area. . . ." * 12/15/12 at 11:49 a.m., ". . . Pt. has sore to coccyx that is red and has a quarter sized necrotic area. Pt anal area is also red. . . ." * 12/17/12 at 10:37 a.m., ". . . has blackened area with slough present rest of wound dark red in color . . ." * 12/19/12 at 5:22 p.m., "Wound rounds completed. Sacral/Coccyx wound has combined into one. 7 x 4.5 x 1 cm. Upper portion (sacral) is stage 4. Lower part is stage 3. Right buttock is healed. . . ." 12/20/12 at 8:38 a.m., ". . . Has increased need for healing open area. . . . Continue to monitor as wound heals. MD [physician] did started [sic] pro pwd for increased protien [sic]. Diet meet [sic] est need for calories. Very limited movement." 12/21/12 at 7:01 p.m., ". . . Wound to coccyx is light green in color with surrounding skin red in color, drainage is dark yellow in color, odor noted. New wound to rt [right] calf that is pink in color	F 314			

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F 314	Continued From page 50 with surrounding skin red in color. no drainage. . . ." 12/22/12 at 3:11 a.m., "[Question] Friction rub noted to RT posterior calf. Site is open to air without drainage. . . ." * 12/22/12 at 2:42 p.m., "Pt seen by [Physician] with new orders for open area on rt calf: clean with ns [normal saline], pat dry, apply TAO [triple antibiotic ointment], cover with nonadhesive dressing, cover with #4 net stocking daily. . . ." * 12/23/12 at 1:46 p.m., ". . . Wound bed is green and yellow in color, drainage is green and red in color, surrounding skin is red in color. . . . rt calf Wound bed is pink in color with light yellow drainage, surrounding skin light red in color. . . ." * 12/31/12, ". . . Buttock - - erythema around the gluteal area, anal crease ulcer which is butterfly shaped and has evolving necrosis. The size is about 4 x 5 cm. The central area is necrotic and sloughing skin. . . . Prognosis is guarded as she will develop a very deep progressive ulcer, most likely. . . ." * 01/03/13 at 5:48 p.m., "Spoke with [family member] last evening . . . He feels like he has to wait to [sic] long for staff to put her to bed after supper and in fact puts her to bed himself using the Hoyer lift. I encouraged him not to transfer him and the risks involved. He reported . . . I'm going to do what I need to do for her. Also asked if we could put her in a Broda chair so that she could recline after eating supper to offload her bottom until staff could transfer her to bed. . . ." Resident #5's current care plan states, "Transfer with 2 assist with Hoyer lift." * 01/13/13 at 10:58 a.m., "Wt [weight] review [Resident #5] continues to have small wt loss. Meal intakes 50-75% or [sic] most meals. Diet meets est need. Given yogurt instead of bread for	F 314			

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F 314	Continued From page 51 added protein. Small wt loss is beneficial but has healing wound so it is not our goal at this time. Wound is improving." * 01/16/13 at 4:08 a.m., "Rt posterior calf wound healed. . . . Decubitus ulcer appears deeper with small amt [amount] of serosanguinous drainage. No odor noted. Vaseline gauze with antibiotic ointment applied to crease. . . ." * 01/17/13 at 3:50 p.m., "Wound note [Resident #5] has improved her intakes at meals. . . . Offered yogurt at meals in place of bread. . . . Diet meets est need for healing. Added protein from Pro pwd TID. . . . Wound increased in size this week. Continue to monitor. . . ." * 01/18/13 at 5:06 p.m., "Stage 4 to coccyx and right buttock. Wound to coccyx measures 6 cm x 3 cm beefy red in color with a scant amount of drainage no odor noted at this time. . . . Wound to rt buttock measures 1 cm x 1 cm beefy red in color with no drainage or odor noted. . . . Interventions: APM [air pressure relieving mattress] mattress, change and reposition every 2 hours. . . ." * 01/22/13 at 4:13 p.m., ". . . received order from [physician] to apply a wet to dry dressing to open area on left lower leg bid till healed. . . ." * 01/25/13 at 10:27 a.m., "Stage 3 to coccyx and right buttock. Wound to coccyx measures 4.5 cm x 2.1 cm beefy red in color with a scant amount of drainage, edges well approximated with no odor noted at this time. . . . Wound to rt buttocks resolved. . . ." * 01/31/13 at 4:44 p.m., "Wound rounds completed . . . Area to right buttocks is healed and completely covered with epithelium tissue [outermost layer of skin]. Wound to sacrum measures 4.1 x 1.4 cm pink red moist granular appearance [pink-red moist tissue that fills an	F 314			

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F 314	Continued From page 52 open wound] no odor present. . . . Continue wound treatment per Provider. . . ." * 02/05/13 at 1:32 p.m., ". . . He [family member] does express concern of patient not receiving snacks between meals . . ." * 02/08/13 at 4:00 p.m., ". . . Wound to sacrum measures 2.3 x 2.1 x 0.1 cm pink shiny tissue, well approximated with no odor. . . ." * 02/14/13 at 4:09 p.m., ". . . Wound to sacrum measures 1 x 0.3 x 0 cm shiney [sic] moist granular appearance no odor present at this time. . . ." * 02/22/13 at 4:39 p.m., ". . . Sacral ulcer now divided in two. Upper wound measures 2 x 1 x 0.1 cm granulation tissue with light exudates. Lower sacral ulcer measures 2.1 x 0.6 cm granulation tissue with light exudates. Dressing continues to be antibiotic ointment with Vaseline guaze [sic]. . . ." * 02/28/13 at 1:07 p.m., "Wound rounds completed . . . Pt has one pressure wound to the Sacral that measures 4.1 x 1.3 x 0 cm shiney [sic] moist granulation tissue with light exudates. Dressing continues to be double antibiotic ointment with Vaseline guaze [sic]. . . ." During an interview on 03/07/13 at 8:45 a.m. and 10:40 a.m., when asked for information regarding pressure ulcer interventions, an administrative nurse (#1) and a managerial nurse (#21) stated the facility provided Resident #5 with a pressure reducing mattress prior to ordering an alternating pressure mattress on 11/13/12. They further stated Resident #5 is "repositioned every two hours per physician order or [per] the nurse's discretion." Resident #5's care plan stated, "Encourage and assist as needed to reposition frequently."	F 314			

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F 314	Continued From page 53 During an interview on 03/07/13 at 3:25 p.m., when asked for information regarding pressure ulcer interventions, a managerial dietary staff member (#36) stated she would "give [the resident] a chance to heal first. If [the resident had] a Stage III or IV [ulcer] that was not healing" she would "make sure they were eating well and getting enough protein" by adding "supplements, protein powder, and multivitamins." She further stated, "There is not support in the literature for [products like] Arginaid or Juven [supplements used to assist wound healing]." During an interview on 03/05/13 at 5:45 p.m., when asked for comments/concerns, Resident #5's family member stated, "Sometimes, the CNAs drop her snack on the bedside table. She's unable to pick it up to feed herself." He further stated, "There are not enough CNAs. Things get done, but you wait for over an hour. I watch the clock, and stand in the hall trying to get someone's attention [to transfer Resident #5 from her wheelchair to her bed] . . . from supper to 10:00 p.m. there are two CNAs running from room to room." Observation showed the following: * 03/05/13 at 7:50 a.m. 8:08 a.m., 9:45 a.m., 11:40 a.m., 2:40 p.m., 3:30 p.m., and 5:15 p.m., Resident #5 lying on her back in bed. * On 03/06/13 at 9:17 a.m., two certified nursing assistants (CNAs) (#31 and #32) transferred Resident #5 to her bed, checked her brief, and placed a pillow behind her back and heel protectors on her feet. * 03/06/13 at 10:25 a.m., 10:49 a.m., 11:30 a.m., 3:00 p.m., 3:50 p.m., 4:28 p.m., 4:50 p.m., and	F 314			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355031	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/07/2013
NAME OF PROVIDER OR SUPPLIER MANOR CARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 600 S MAIN ST MINOT, ND 58701		
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F 314	Continued From page 54 5:00 p.m., Resident #5 lying on her back in bed. One observation [in a two day time span] showed facility staff placed a positioning pillow behind the resident's back and placed heel protectors on her feet. The facility failed to promptly treat Resident #5's pressure ulcer; minimizing the effects of the ulcer, promoting healing, and resulting in the development of a Stage IV pressure ulcer. * Five weeks after Resident #5 first requested an air mattress and one week after she developed a pressure ulcer to her right buttock/tailbone area and reddened area to her right outer heel the facility ordered an alternating pressure mattress. * One month after Resident #5 developed the pressure ulcer to her right buttock/tailbone area, dietary staff requested an order for protein powder. Four days after the request was made, Resident #5's ulcer was reassessed as a Stage IV pressure ulcer. * Family interview revealed the facility failed to ensure Resident #5 consistently received her protein snack and/or feeding assistance. * Three weeks after Resident #5 developed the pressure ulcer to her right buttock/tailbone area and she expressed discomfort, facility staff were instructed to lay the resident down following meals/therapy, however the resident's current care plan only stated, to "Encourage and assist as needed to reposition frequently." Observation showed and family interview confirmed the facility failed to ensure Resident #5 was repositioned every two hours.	F 314			
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident	F 323	Manor Care will ensure that resident environment remains free of accident hazards as is possible; and each resident receives adequate supervision and		4-29-13

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F 323	Continued From page 55 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: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 04/11/12. Based on observation, record review, resident interview, and staff interview, the facility failed to provide assistive devices and supervision necessary to prevent accidents for 2 of 4 sampled residents (Resident #2 and #10) with a fall and fracture. Failure to provide Resident #10 with prompt assistance and supervision in the bathroom resulted in multiple falls and a left fibula fracture. Failure to provide Resident #2 with adequate supervision and fall prevention measures may result in avoidable falls and/or injuries. Findings include: - Review of Resident #10's medical record occurred on all days of survey. Diagnoses included osteoarthritis, epilepsy, muscle weakness, bipolar disorder, a history of self-transfers and falls, and a history of left fibula fracture. The current Minimum Data Set (MDS), dated 12/27/12, identified intact cognition, makes self understood and understands others, and extensive assistance from two or more people for transfers and toilet use.	F 323	assistance devices to prevent accidents Patient #2 & #10 were assessed and care plans modified. Patients at risk for falls were identified and care plans were updated to reflect current interventions. Nursing staff members were educated the week of 4/15/13 on call light response times and fall prevention guidelines and interventions. ADNS or designee will randomly audit call light response on all shifts. Audits will consist of direct observation of staff response to patient triggered call lights as well as random audits of call lights triggered by staff member from a patient room or bathroom as part of the audit tool task. Audits will be completed on each shift. Findings of these audits will be reviewed weekly during the facility QAA process. Findings of audits will be forwarded to QAPI for review and recommendations for ongoing monitoring. Nursing rounds will be completed at least 3 times weekly to ensure call lights are within reach and validate fall interventions are in place. ADNS or designee will conduct patient/family interviews at least 3 times a week related to call light response. Audits will then be completed on a monthly basis for two months then monthly or as per QAPI		

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F 323	Continued From page 56 Resident #10's current care plan stated, "... At risk for falls due to new environment, hx [history] of falls, unsteady gait, weakness, use of antipsychotic, use of cardiac meds [medications], anemia, psychiatric d.o. [disorder] ... Interventions ... Assist to toilet resident before and after each meal [initiated 01/09/13] ... Do not leave unattended in bathroom [initiated 01/07/13] ... ADL [activities of daily living] Self care deficit as evidenced by weakness, related to disease process ... Interventions ... Transfer and ambulate with gaitbelt, walker and 2 staff [initiated 01/24/13] ..." Nurses' notes showed the following: *01/08/13 at 6:56 p.m.: "... Staff answered B/R [bathroom] call light and had found [Resident #10] holding onto the railing and wedged in between his foot pedals on the w/c [wheelchair]. ... States "I could'nt [sic] wait for staff." Incontinent of both B&B [bowel and bladder]. ... Two reddened areas noted to both sides of lower back. No other injuries noted at this time. ..." *01/09/13 at 1:46 p.m.: "... To appt [appointment] with [physician name] ... 'I'm going tell [sic] [physician name] I was in an awkward position yesterday & I think I injured by [sic] ankle.' [Resident #10] points to left leg. No redness, bruising or swelling noted to leg/ankle. Able to move leg & foot. Does say 'ouch' when left ankle palpated. Update sent with [Resident #10] paperwork re: [regarding] [Resident #10] report of pain to left ankle. ..." *01/09/13 at 6:45 p.m.: "... [Resident #10] and [one] CNA [certified nursing assistant] returned from F/U [follow up] appointment with [physician's name]. While there [Resident #10] c/o	F 323	committee recommendation as part of ongoing monitoring.	
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F 323	Continued From page 57 [complained of] L) [left] ankle/leg pain. X-rays done in office and findings noted on consultation report. . . . given tramadol 50 mg [milligrams] PO [by mouth] for c/o pain to LLE [left lower extremity] . . ." A physician's consultation report, dated 01/09/13, identified a left fibula fracture. *01/10/13 at 2:00 p.m.: ". . . Up with assist from two staff & gait belt. . . . Medicated for pain to left leg upon request. 'You know I have a broken leg.' Staff propelled [Resident #10] once in w/c. . . ." *01/11/13 at 11:04 a.m.: ". . . C/O pain to left ankle and medicated with tramadol with some relief. . . ." *01/20/13 at 10:13 a.m.: ". . . Bathroom call light on, [Resident #10] sitting on the floor in bathroom between toilet and wheelchair and leaning on the wall for support. . . . Was re-instructed not to attempt to stand or transfer self; [Resident #10] was told 'You need to call us for assist with all transfers and toileting!'. States that he stood up and grabbed ahold of the toilet paper holder instead of the grab bar and the paper holder fell out and was on the floor. . . ." *03/04/13 at 9:14 p.m.: ". . . Resident on floor by toilet. resident trying to get up without assistance. slipped of [sic] edge of toilet. . . ." An interview occurred with Resident #10 on 03/06/13 at 10:05 a.m. During the interview, the resident stated the following: *He has fallen twice waiting for someone to answer his call light. *He "waits and waits" for someone to help him on the toilet, and for someone to help him off. *He fell "a couple days ago" in the bathroom. He was alone and put his call light on, but no one came, so "I decided to do something about it." He attempted to transfer himself and fell. The	F 323			

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F 323	Continued From page 58 resident stated he did not hit his head, but hurt his left ankle during the fall. *He broke his left leg in January. He went into the bathroom after supper, "about 6:15" and put on his call light, but "they [staff] can't come, they're in the dining room." He "got tired of waiting" and attempted to transfer himself. The resident fell and x-rays later showed a left fibula fracture. Review of facility incident reports occurred on 03/06/13 at 4:54 p.m. with a supervisory nurse (#2). The report identified a fall without injury on 03/04/13 at 7:00 p.m. The nurse (#2) stated staff left Resident #10 alone in the bathroom, and the report did not identify if Resident #10 used his call light or not. She stated the report identified "did not ask for assistance," and stated Resident #10 does not always remember to use his call light. She confirmed that staff are not supposed to leave Resident #10 alone in the bathroom. A second incident report identified a fall on 01/08/13 at 7:00 p.m. The nurse (#2) identified that staff reported to Resident #10's bathroom call light and found him "wedged" between his wheelchair foot pedals while holding the bathroom railing. The nurse stated she implemented the intervention of "assist to toilet before and after each meal" after this fall. Resident #10 experienced two falls in the bathroom after supper time (around 7:00 p.m.); one on 01/08/13 (which resulted in a fractured fibula), and one on 03/04/13. During an interview, Resident #10 identified that he activated his call light in both instances. Because staff failed to respond promptly, Resident #10 identified that he attempted to transfer himself and fell. In addition,	F 323			

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F 323	Continued From page 59 the fall on 03/04/13 occurred as a result of inadequate supervision by staff. Failure to provide prompt assistance and supervision in the bathroom resulted in Resident #10 experiencing avoidable falls and a fractured fibula. Refer to F246. - Review of Resident #2's medical record occurred on March 05-07, 2013. Diagnoses included dementia, osteoarthritis, and macular degeneration. The quarterly Minimum Data Set (MDS), dated 01/25/13, identified the resident with highly impaired vision; severely impaired cognition; extensive assistance for bed mobility, transfers, locomotion, and personal hygiene; and two falls without injury. The current care plan stated, "... Focus: At risk for falls due to unsteady gait ... Interventions: Covered mug in room for liquids (initiated 09/27/12), Dycem to wheelchair ... Fall Matt(s) ... Low bed ... monitor resident more frequently (initiated on 11/23/12) ... Place fall matts under bed when resident NOT in bed (initiated on 01/10/13), Provide assist to transfer and ambulate as needed ..." The nurse's notes identified the following falls: * 07/21/12 at 2:00 p.m. - staff witnessed fall as the resident slid out of her wheelchair onto the floor - assessment negative, denied pain, however, on 07/25/13 resident complained of pain to left leg, x-ray revealed fractures to the left hip and right pelvis, hospitalized July 25-28, 2012 * 11/23/12 at 9:00 p.m. - "fall occurred in residents room by bathroom door. resident transferring self from w/c by bed to the bathroom	F 323			

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F 323	Continued From page 60 door. no shoes on just skid slippers. roommate witnessed fall . . . nsg [nursing] found resident on floor on buttocks. resident stated she felt real dizzy and lost balance . . . no bleeding or injuries noted . . ." * 11/27/12 at 6:15 p.m. - "[Resident #2] w/c noticed in hallway next to small D/R [dining room]; Staff found [Resident #2] sitting in upright position next to d/r doorway . . . Denies hitting her head or any injury . . ." * 01/31/13 at 8:07 p.m. - resident witnessed walking from her wheelchair without assistance, staff unable to get to her in time, landed on her left side on the lounge (TV area) carpet, no injury * 01/09/13 at 4:30 p.m. - "[Resident #2] was found on the floor on a falls mat next to her bed. The wheelchair was setting in front of the drawers next to the closet. [Resident #2] could not recall when she fell or why she fell. She was not able to say where she was sitting prior to the fall. [Resident #2] stated she hit her head and that she had a little headache . . . Bed was at lowest position. Neuro checks started . . ." * 02/16/13 at 3:15 p.m. - "resident found by another resident on floor in residents room by bed . . . one small 1 cm [centimeter] rd [round] bruise to left eye brown w/no [with no] other injuries noted at this time . . . resident trying to transfer self from chair to bed . . ." A report for the fall on 02/16/13 at 3:15 p.m. stated, "resident to be place [sic] in view of staff." The care plan failed to identify this intervention. (Refer to F280) Observations of Resident #2 during the week of survey identified the following: * 03/05/13 9:02 a.m. until approximately 11:45	F 323			

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F 323	Continued From page 61 a.m. - sitting in her wheelchair in her room alone until taken to the dining room (except for when staff entered her room to toilet the resident and again to do a treatment to her toes) * 03/05/13 at 2:40 p.m. - sitting in her wheelchair in her bathroom, a CNA (#10) entered the room and found the resident in her wheelchair with stool all over the resident, her wheelchair, the toilet, the bathroom floor, and a large amount of stool in the toilet (it appeared the resident transferred herself onto and off the toilet) * 03/06/13 at 3:50 p.m. - sitting in her wheelchair in her room alone * 03/06/13 at 4:45 p.m. - sitting in her wheelchair in the doorway of her room * 03/07/13 at 9:10 a.m. - sitting in her wheelchair in the corridor next to the small dining room * 03/07/13 at 9:45 a.m. until approximately 11:40 a.m. - sitting in her wheelchair in her room alone until taken to the dining room, fall mat remained flat on the floor next to her bed Observations on March 05-07, 2013 showed staff failed to place Resident #2's between meal liquids in a covered mug as care planned. Observation on 03/06/13 at 3:50 p.m. showed the resident sitting in her wheelchair in her room and her juice supplement spilled on the floor. (Refer to F312) During an interview on 03/06/13 at 3:45 p.m., an administrative nurse (#2) stated she expected staff to place Resident #2 in main areas within view of staff due to her history of falls and self-transfers. The staff failed to place Resident #2 in areas visible by staff, to place her fall mat under the bed	F 323			

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F 323	Continued From page 62 when the resident was out of bed, to frequently monitor the resident, and to utilize covered mugs for liquids in the resident's room, increasing Resident #2's risk for additional falls and injury.	F 323			
F 353 SS=F	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, resident, family, and staff interviews; the facility failed to ensure sufficient, qualified staff were available on a daily basis to meet the residents' needs on 2 of 2 nursing units (Unit 1 and Unit 2). Failure to ensure availability of staff may have contributed to concerns	F 353	Manor Care strives to ensure staffing is sufficient to provide timely and necessary care. Patients #23, #9, #1, #10, #17 were interviewed and have no unmet needs. Patients residing at Manor Care are at risk to be affected by this practice. Staffing patterns were reviewed by Administrator, ADNS, and nurse managers. Staffing meetings are held to review upcoming shifts to ensure adequate staffing is in place. ADNS or designee will conduct resident/family interviews 3 times weekly x 4 weeks to ensure staff is providing timely and necessary care. Findings will be reported to the QAPI committee weekly. Ongoing audits will be completed once weekly for 4 weeks then monthly or as recommended by the QAPI committee.	4-29-13	

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F 353	Continued From page 63 regarding call lights (Refer to F246); lack of activities (Refer to F248); avoidable pressure ulcers (Refer to F314); falls/fractures (Refer to F323); unclean items and odors in the environment (Refer to F253); and residents not receiving snacks/supplements or receiving them late (Refer to F312 and F309). Findings include: - During an interview during the initial tour on 03/04/13, Resident #23 stated she has to "yell" to get ice water as staff failed to consistently bring fresh water. Resident #23 stated the facility doesn't seem to have enough staff. - Observation on 03/05/13 at 10:16 a.m. showed Resident #1, who is capable of accessing liquids when placed within his reach, lacked fluids in his room. - During an interview on 03/05/13 at 5:10 p.m., Resident #9 voiced concerns regarding how long it takes to get help after supper. Resident #9 reported a few residents wait a long time in the dining room after supper, they ring the bell on the table, but no staff are available to assist them. - During an interview on 03/06/13 at 10:05 a.m., Resident #10 stated he feels the facility is short-staffed and "Evenings are the worst." The resident also stated, "There's no one to help us after supper," and he "waits and waits" for someone to help him on and off the toilet. - During an interview on 03/06/13 at 3:40 p.m., Resident #17 voiced concerns regarding staff leaving her on the bedside commode for one	F 353			

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F 353	Continued From page 64 hour and fifteen minutes. The resident reported she could not reach her call light and yelled to get help. - During a confidential interview on 03/05/13, a resident's family member (A) stated it "doesn't do any good" to put on the call light after supper because there is no one around to help. The family member indicated there were several occurrences in which no staff were available after supper to assist the resident to the bathroom, so the family member assisted the resident. The family member stated, "You look down the hallways after supper and you don't see a soul." The family member stated the facility seems short-staffed on evenings and weekends, and on 03/02/13 there were no staff available to assist the resident with bed time cares, so the family member assisted the resident. - During a confidential interview on 03/05/13, a resident's family member stated "There are not enough CNAs. Things get done, but you wait for over an hour. I watch the clock, and stand in the hall trying to get someone's attention . . . from supper to 10:00 p.m. there are two CNAs running from room to room."	F 353			
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:	F 356	Manor Care will post nurse staffing information as per 483.30. Patients residing at Manor Care are at risk to be affected by this practice. Licensed nursing staff and scheduler educated on the nurse staffing information regulation.		4-29-13

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NAME OF PROVIDER OR SUPPLIER MANOR CARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 600 S MAIN ST MINOT, ND 58701		
(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 356	Continued From page 65 - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: - o Clear and readable format. - o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to post the actual hours worked per shift by registered nurses (RNs), licensed practical nurses (LPNs), and certified nurse aides (CNAs) directly responsible for resident care at the beginning of each shift during 3 of 4 days of survey (March 4-7, 2013). Findings include: Observations showed the following: - First floor: * On 03/05/13 at 9:00 a.m., the posting of staff	F 356	ADNS or designee will audit the posted nursing hours for accuracy 3 times weekly x 4 weeks then weekly for 4 weeks and then monthly for two months and then as per QAPI committee recommendations		

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F 356	Continued From page 66 directly responsible for resident care in a display case near the nurses' station. The posting of staff identified the total number of staff and the actual hours worked for the morning, evening, and night shifts. * On 03/06/13, the posting of staff from 03/05/13 remained in the display case until 6:00 p.m., at which time it was updated with the 03/06/13 posting. * On 03/07/13, the posting of staff from 03/06/13 remained in the display case until 1:00 p.m., at which time it was updated with the 03/07/13 posting. - Second floor: * On 03/07/13, the posting of staff from 03/06/13 remained in the display case until 1:00 p.m., at which time it was updated with the 03/07/13 posting. The facility failed to post staffing information for the correct day at the beginning of each shift (days, evenings, and nights). During an interview on the morning of 03/07/13, an administrative nurse (#1) confirmed the posting of staff should be completed each day at the beginning of each shift.	F 356			
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F 431	Manor Care will employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. No residents were identified.	4-29-13	

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F 431	Continued From page 67 Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, review of manufacturer's guidelines, and staff interview, the facility failed to date 6 of 9 multidose vials of insulin on 1 of 2 units (Unit Two) when opened in accordance with manufacturer's guidelines and facility policy, and failed to ensure medications were discarded after the expiration date. This practice may affect the potency and efficacy of the medication.	F 431	Patients residing at Manor Care are at risk to be affected by this practice. Med carts were audited by ADNS or designee to ensure meds were dated and not expired. Licensed nurses were educated the week of 4/15/13 on medication expiration and dating medications by ADNS or designee. ADNS or designee will audit medications for expiration dates weekly x 4 and report findings weekly to QAPI committee for review and recommendation. Ongoing audits will continue monthly or as directed by the QAPI committee by ADNS or designee as part of the routine process of medication management.		

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F 431	Continued From page 68 Findings include: Review of the facility policy titled "Vials and Ampules of Injectable Medications" occurred on 03/07/13. This policy, dated September 2011, stated, " . . . B. The date opened and the initials of the first person to use the vial are recorded on multidose vials . . . F. Medication in multidose vials may be used until the manufacturer's expiration date unless the manufacturer of the medication or standards of practice specify otherwise . . . " The manufacturer's insert for NovoLog insulin stated, "NovoLog in use: Vials, Keep in the refrigerator or at room temperature below 86 [degrees] F [Fahrenheit] for up to 28 days. . . . Throw away an opened vial after 28 days of use, even if there is insulin left in the vial. . . ." Observation of medication administration on 03/05/13 at 11:30 a.m., showed a licensed nurse (#11) obtained a vial of Novolog insulin from medication cart #3 and withdrew two units of insulin. Observation of the insulin box showed a hand written date of 01/11/13. This nurse stated the date is written on the box when opened. Observation showed the Novolog insulin in use for 53 days. The nurse stated the insulin is usually used up before it expires, usually within 30 to 40 days. This nurse called the pharmacist and reported, after opening insulin, it can be used for 28 days. Review of medication cart #3, completed with a licensed nurse (#11), revealed the following in-use vials of insulin: Novolog, dated 1/26/13 (38 days in use), and Novolog, dated 1/19/13 (45	F 431			

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F 431	Continued From page 69 days in use). Review of medication cart #1 on 03/05/13 at 11:40 a.m., showed four in-use vials of insulin lacked a date when opened. Review of medication cart #2 on 03/05/13 at 11:45 a.m., showed two in-use vials of insulin lacked a date when opened. During an interview on 03/07/13 at 10:40 a.m., an administrative nurse (#1) stated she expected staff to date insulin vials when opened.	F 431			
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.	F 441	Manor Care will establish and maintain an infection control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. Patients #2, #3, #11 & #13 had no adverse effects from this practice. Patients at Manor Care are at risk for adverse effects of this practice. Protocols and processes for the proper infection control were found in existing guidelines for the facility. Education was provided the week of 4/15/13 to nursing staff on gloves, hand hygiene, incontinence care, and cleaning of equipment. ADNS or designee will audit random staff 3 times weekly x 4 weeks for proper infection control practices such as gloving, hand hygiene, incontinence care and cleaning equipment. Audits will		4-29-13

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F 441	Continued From page 70 (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 04/11/12. Based on observation, record review, review of facility policy and procedure, and staff interview, the facility failed to follow standard infection control practices for 4 of 13 sampled residents (Resident #2, #3, #11, and #13) observed during toileting/perineal cares and using a bedpan. Failure to follow infection control practices related to glove usage, hand hygiene and cleaning of a bedpan has the potential to cause or spread infection within the facility. Findings include: Review of the facility policy titled "HAND HYGIENE" occurred on 03/07/13. This policy, dated December 2009, stated, ". . . When to wash hands: When hands are visibly dirty or contaminated or are visibly soiled with blood or other body fluids . . . When Clostridium difficile is diagnosed or suspected . . . When to wash hands or use an alcohol-based hand rub: Before	F 441	them be completed weekly for 4 weeks and then monthly for two months. Findings will be reported weekly to the QAPI committee weekly for review and recommendation for ongoing monitoring.		

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F 441	Continued From page 71 applying and after removing gloves, After having direct contact with patient's intact skin . . . if hands are not visibly contaminated, After contact with body fluids or excretions . . . Moving from a contaminated body site to a clean body site during patient care, After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient . . . PROCEDURE: Handwashing: . . . 3. Apply the recommended amount of soap to wash hands. 4. Rub hands vigorously for at least 15 seconds, covering all surfaces of the hands and fingers. 5. Rinse hands with water and dry thoroughly with a disposable paper towel . . ." Review of the facility policy titled "INCONTINENCE CARE" occurred on 03/07/13. This policy, revised December 2012, stated, ". . . 4. Perform hand hygiene. 5. Apply latex free non-sterile gloves . . . 12. Cleanse peri-area and buttocks with cleansing agent wiping from front of perineum toward rectum . . . 16. Remove and discard gloves. 17. Perform hand hygiene . . ." - Review of Resident #11's medical record occurred on all days of survey. A physician's order dated 02/11/13 indicated the resident is currently receiving a medication for the treatment of clostridium difficile (a gastrointestinal infection that produces diarrhea). The last documentation regarding Resident #11's having "loose stools" occurred on 02/17/13. Observation on 03/05/13 at 9:00 a.m., showed a certified nurse aide (CNA) (#19) assisting Resident #11. The CNA (#19) washed her hands and donned a pair of gloves, applied a gait belt around the resident's waist, positioned the	F 441			

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F 441	Continued From page 72 resident's wheelchair next to the toilet, helped the resident stand and sit on the toilet. When Resident #11 said she had finished, the CNA helped her stand, provided perineal cares, helped the resident pull up her pants, assisted the resident to sit in the wheelchair, removed the gait belt, and pushed the wheelchair out of the bathroom and closed the bathroom door. The CNA (#19) then removed her gloves, and washed her hands. The CNA stated the resident voided and had a bowel movement. The CNA failed to remove her gloves after providing perineal cares. - On 03/05/13 at 2:40 p.m., a CNA (#10) entered Resident #2's room and found the resident in her wheelchair in the bathroom. Observation showed a large amount of stool in the toilet bowl, on the toilet seat, on the bathroom floor, on the resident's hands and clothes, and on the armrests and seat cushion of the wheelchair. The CNA (#10) donned gloves, assisted the resident to stand, completed perineal cares, applied a new brief, wiped the first layer of stool off the wheelchair, placed toilet paper over the remaining stool, sat the resident back down, and removed her gloves. Without performing hand hygiene, the CNA (#10) changed the resident's clothes, donned gloves, stood the resident up, and using perineal wipes, finished wiping the stool off the wheelchair cushion and armrests. The CNA (#10) sat the resident down on the wheelchair, changed her gloves, wiped off the resident's hands with perineal wipes, and with her gloves still on, assisted Resident #2 to wash her hands. Without performing hand hygiene, the CNA (#10) removed her gloves, pushed Resident #2 in her wheelchair to the main TV area, went back to the resident's room, donned gloves, and bagged the	F 441			

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F 441	Continued From page 73 garbage and soiled linen. Wearing gloves, the CNA (#10) reached into the toilet to obtain a tube of barrier cream that fell into the toilet from a shelf in the bathroom and then disposed of the tube. The CNA (#10) removed her gloves, took the soiled linen and garbage to the soiled utility room, and washed her hands for the first time during the entire observation, only applying friction to scrub for approximately three to five seconds when washing her hands. The CNA (#10) went back to Resident #2's room, donned gloves, wiped off the toilet seat and bathroom floor with disinfectant, removed her gloves, went back to the soiled utility room with the last bag of garbage, washed her hands only applying friction to scrub for approximately five seconds, then went to the computer to chart. During this observation, the CNA (#10) failed to perform hand hygiene at the following times: after performing perineal cares, prior to assisting Resident #2 to wash her hands, after cleaning up the stool and prior to exiting the room with the resident, and prior to exiting the resident's room the second time after disinfecting the toilet seat and bathroom floor. The CNA (#10) also failed to use disinfectant on the resident's wheelchair cushion and armrest and failed to apply friction for a minimum of 15 seconds when washing her hands. Observation on 03/05/13 at 10:00 a.m. showed two CNAs (#7 and #8) assisted Resident #3 with toileting. The resident was incontinent of urine and stool. A CNA (#8) wearing gloves provided perineal care for the resident. Wearing the same soiled gloves, the CNA placed a new brief and pulled up the resident's pants, assisted the	F 441			

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F 441	Continued From page 74 resident to transfer to the wheelchair, unlocked the wheelchair brakes, and wheeled the resident to her bed. The CNA then removed her gloves and, without performing hand hygiene, assisted the resident to transfer to bed, removed the gait belt, covered the resident with a blanket, and gave her the call light. The CNA then bagged the garbage and left the room without performing hand hygiene. - Review of the facility policy titled "Bedpan/Urinal" occurred on 03/07/13. This policy, dated 12/2009, stated, " . . . 16. Empty bedpan/urinal and disinfect following standard precautions. . . ." Observation on 03/07/13 at 2:47 p.m. showed two CNA's (#12 and #13) assisted Resident #13 off the bedpan. The resident urinated into the bedpan and CNA (#13) dumped the urine into the toilet. The CNA (#13) asked the second CNA (#12) how to clean the bedpan and the CNA (#12) replied we take it to the other room and rinse it. The CNA (#13) covered the bedpan with a plastic bag and placed it in the bathroom. The CNA failed to rinse or disinfect the bedpan. During an interview on 03/07/13 at 10:40 a.m., an administrative nurse (#1) stated she expected the staff to rinse the bedpan with water from the sink or rinse it in the hopper room.	F 441			
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	F 520	Manor Care will maintain a quality assessment and assurance committee that identifies quality care concerns and implements modifications and corrections of facility systems in a timely manner.		4-29-13

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F 520	Continued From page 75 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: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 04/11/12. Based on review of North Dakota Department of 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:	F 520	QA Committee has met to review quality of care concerns and implemented corrections (see Plan of Correction for L1810, F164, F167, F241, F246, F248, F253, F280, F209, F312, F314, F323, F353, F356, F431 and F441) QA meetings will be held weekly for four weeks, then every two weeks for one month and then a minimum of quarterly or as per QAPI committee recommendation.	
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F 520	Continued From page 76 Review of the state agency files indicated the facility failed to maintain compliance at F246, F253, F323, F441, and F520 as indicated by deficiencies cited during the last standard survey on 04/11/12. Refer to F246, F253, F323, and F441 for specific findings. During an interview on 03/07/13 at 9:30 a.m., an administrative staff member (#1) stated they monitor areas identified as needing improvement based on the survey completed 04/11/12. Failure of the facility to effectively utilize QA resulted in continued noncompliance in the following: *F246 accommodation of needs in regard to responding to call lights *F253 housekeeping services *F323 accidents and supervision related to falls *F441 infection control related to hand hygiene and glove use *F520 quality assessment and assurance	F 520			