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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355031	A. BUILDING _____ B. WING _____	03/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES	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 03/23/15 and completed on 03/25/15, the sample included four (4) residents for complete review, nine (9) residents for focused review, and three (3) closed records for review. The sample included sixteen (16) additional residents to verify specific concerns during the survey.	F 000		
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment	F 164	F 164 SS=D 483.10 PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS: Staff nurses caring for residents #22 and #23 were educated on the right to privacy Residents residing at the facility have the potential to be affected by this practice. Education will be provided by the ADNS or designee regarding the patient's right to privacy, completing patient specific conversations in a private area where they cannot be overheard, and safeguarding medical information.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 4-20-15

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, the facility failed to ensure confidentiality of residents' clinical information for 2 random residents (Resident #22 and #23). Failure to ensure confidentiality of residents' clinical information is an infringement on the residents' rights. Findings include: - Observation on 03/23/15 at 5:15 p.m. identified a medication cart located in the corridor of the north wing on the 2nd floor. A vitals/neurological assessment flowsheet for Resident #23, which included confidential information, sat face up on the top of the medication cart and was visible to anyone near the medication cart. - Observation on 03/24/15 at 9:00 a.m. showed a nurse (#5) talking to Resident #22's family member near the nurse's station and resident TV lounge. The nurse (#5) discussed the resident's change in condition and current health status with the family member, along with other confidential/identifying information, within hearing distance of other residents, staff, and visitors.	F 164	Visual and Auditory Audits of patient information and Nurse Resident/Family conversations will be completed three times weekly for four weeks then monthly for three months. Results of audits will be forwarded to QAA committee for review and recommendations. Date of compliance is April 29, 2015	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide	F 225		

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F 225	Continued From page 2 registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and resident and staff interview, the facility failed to report an alleged incident of abuse for 1 of 1 sampled resident (Resident #12). Failure to report an injury, per facility policy, placed Resident #12	F 225	F 225 SS=D 483.13 INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS For resident's #12, the allegation of abuse has been investigated and concerns addressed. Residents who receive an injury while care is being provided have the potential to be affected by this practice. Nursing staff will be educated regarding investigating injuries at the time they are first observed, document them, and report them per facility investigation tools. CNAs will be educated to report all skin tears timely so they can be investigated. Skin Alteration / Skin assessment reporting tools will be Audited weekly for 4 weeks, then monthly for 3 months for policy compliance. Results of audits will be forwarded to the QAA committee for review and recommendation. Date of compliance is April 29, 2015.	

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F 225	Continued From page 3 and other residents at risk for mistreatment and/or abuse, and did not allow the facility to investigate the injury and implement appropriate corrective action. Findings include: Review of the facility's abuse policy occurred on 03/25/15. This policy, not dated, stated, ". . . REPORTING . . . The center must ensure that all alleged violations involving mistreatment, neglect or abuse, including injuries of unknown source, and misappropriation of resident property are reported immediately to the administrator of the facility and other officials in accordance with state law through established procedures (including to the state survey and certification agency). . . ." Review of Resident #12's medical record occurred on March 24-25, 2015. Diagnoses included congestive heart failure, diabetes, and protein-calorie malnutrition. The quarterly Minimum Data Set (MDS), dated 02/06/15, identified the resident as cognitively intact. The current care plan stated, ". . . Focus: ADL [activities of daily living] Self care deficit as evidenced by weakness related to hx [history] of hip fracture, compression fractures . . . Interventions . . . Transfer with 1 staff assist with gait belt . . ." The current "Tasks" (certified nurse aide care guide) stated, "ADLs/RESTORATIVE CARE: ADL Assist- 1 person assist with dressing/ADLs . . ." During the group interview on 03/23/15 at 3:15 p.m., Resident #12 stated an unidentified Certified Nurse Aide (CNA) transferred her in a "rough" manner last week during the night shift	F 225		

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F 225	Continued From page 4 which resulted in her hitting her leg on her wheelchair and tearing her skin. During an interview on 03/25/15 at 8:10 a.m., Resident #12 stated, she received the skin tear on her left leg when a night CNA transferred her from the bed to the wheelchair. "He swung me so hard that I got a sore that was bleeding bad on my leg". She said her leg got caught on the wheelchair and she reported the incident to a different CNA and a nurse right away. Review of the March 2015 progress notes identified the following: * 03/13/15 at 12:47 a.m.: "Resident is comfortable without s/s [signs or symptoms] of pain. Resident upon transfer to wheel chair obtained skin tear 3/4" [three fourths of an inch] on left upper shin. Skin tear is flushed with saline and taped after edges were appropriated. Md [medical doctor] notified and family will be notified 3/13/15 on am shift. time of skin tear is 12.20 am (NOC) [night]." * 03/13/15 at 10:12 a.m.: "Daughter, [name of Resident #12's daughter], notified of skin tear, upper left shin @ [at] 10:15 a.m." * 03/13/15 at 3:20 p.m.: ". . . new orders . . . Apply paper tape to skin tear left upper shin until resolved. . . ." During an interview on 03/24/15 at 5:30 p.m., an administrative staff member (#3) stated he/she was unaware of Resident #12's allegation of being cared for in a rough manner. This staff member (#3) stated staff also failed to report this recent allegation so it could be investigated.	F 225		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY	F 241		

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F 241	Continued From page 5 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, review of facility policy, and resident interview, the facility failed to provide care in a manner that enhanced dignity/privacy for 3 of 13 sampled residents (Resident #1, #4, and #9), 2 supplemental residents (Resident #22 and #24), and 2 interviewable residents (Resident A and B). Failure to ensure dignity and respect during personal cares does not recognize the individuality of each resident or enhance the quality of life for each resident. Findings include: Review of the facility policy titled "Call Light" occurred on 03/25/15. This policy, dated December 2009, stated, ". . . 2. Knock on door and wait for response prior to entering room. . . ." - Observation on 03/24/15 at 12:15 p.m. showed a nurse (#4) knocked and immediately opened Resident #9's door. Observation showed Resident #9 in the bathroom visible from the door receiving assistance with personal cares. The nurse (#4) failed to wait for a response and permission prior to entering Resident #9's room. - During an interview on 03/24/15 at 8:50 a.m., Resident A stated staff do not knock on her door prior to entering her room. - Observation on 03/23/15 at 5:25 p.m. showed a	F 241	F 241 SS=E 483.15 DIGNITY AND RESPECT OF INDIVIDUALITY For resident's #1, 4, 9, 22, 24, facility staff have been trained regarding knocking on doors and waiting for a response. Residents residing at the facility have the potential to be affected by this practice. ADNS or designee will provide training to facility staff regarding the need to respect the dignity and privacy of the resident by knocking, waiting for a response, and then entering the resident's room. Facility Managers will be assigned areas to observe policy compliance. Audits will be completed three times weekly for 4 weeks, then monthly for three months. Results of audits will be forwarded to QAA committee for review and recommendations. Date of compliance is April 29, 2015.	

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F 241	Continued From page 6 nurse (#5) entered Resident #22's room without knocking and waiting for permission to enter. - Observation on 03/24/15 at 7:47 a.m. showed a nurse (#6) entered Resident #24's room without knocking and waiting for permission to enter. - During an interview on 03/23/15 at 5:00 p.m., Resident B stated staff do not always knock prior to entering the room. - Observation on 03/24/15 at 7:40 a.m. during morning cares showed an unidentified CNA and a nurse (#12) knocked and immediately entered Resident #4's room. The CNA and nurse (#12) failed to wait for permission prior to entering the room.	F 241		
F 244 SS=E	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, review of Resident Council Meeting Minutes, and group, resident, and staff interview, the facility failed to ensure timely response to call lights for 10 of 16 (A, B, C, D, E, F, G, H, I, J) residents identified as interviewable by the facility and interviewed during the survey and for 1 supplemental resident (#25). Failure of facility	F 244		

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F 244	Continued From page 7 staff to answer call lights timely resulted in resident incontinence and falls per resident interview. Findings include: Review of the facility policy titled "Call Light" occurred on 03/25/15. This policy, dated December 2009, stated, ". . . 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. . . ." - Observation on 03/24/15 at 11:36 a.m. showed Resident #25's call light on. An unidentified CNA answered the call light at 11:56 a.m. (20 minutes later). - Review of Resident Council Meetings Minutes from September 2014 through February 2015 occurred on the afternoon of 03/23/15 and identified the following concerns regarding call lights: *09/26/14 - ". . . call light wait times long 6-8 p.m. (not enough staff)." *10/24/14 - "Call light wait times." *11/24/14 - "Call lights are better but can still be a long wait at times mostly after meals." *12/31/14 - "CNAs come in turn call lights off say 'I'll be right back' and don't return . . . takes a long time to answer call lights mostly after supper. . ." *02/16/15 - "Some concerns by 1st floor resident regarding long call lights [sic] waits." - A group interview of residents occurred on 03/23/15 at 3:15 p.m. During the group interview, 10 of 16 residents stated the following regarding the length of time the residents waited for staff to	F 244	F 244 SS=E 483.15 LISTEN/ACT ON GROUP GRIEVANCE RECOMMENDATION Residents/Family attending group activities were interviewed as a group regarding call light concerns and informed of facility plan to address concern. Residents residing in the facility have the potential to be affected by this practice. ADNS or designee will provide education to facility staff regarding call light response. CNA assignments will be reviewed and adjusted as necessary to meet timely response times. Call light audits conducted during all shifts before and after meals will be completed three times weekly for four weeks then monthly for 3 months. Activities will follow company policy and report all concerns from Resident Council meeting to Administrator who will report to QAA. Results of audits will be forwarded to QAA committee for review and recommendation. Date of compliance is April 29, 2015.	

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F 244	Continued From page 8 answer a call light: *Resident A - stated she waits "so long" for staff, it resulted in incontinence - waits the longest during the night shift - staff will come in and turn off the call light and leave without providing assistance *Resident B - waits "a long time" for staff assistance *Resident C - stated she waits the longest for staff to answer her call light during the evening shift - stated she waited two hours "last Thursday or Friday evening" for staff to assist her with toileting which resulted in incontinence *Resident D - stated her light will be on up to an hour and she gets frustrated and just attempts to take care of herself *Resident E - has to wait "too long" for staff assistance *Resident F - stated she has to wait "a long time" for staff assistance - identified staff will enter her room, shut her call light off, and say "I'll be right back" and either don't come back at all or come back after an extended amount of time. She stated staffs' delay in meeting her needs resulted in incontinence, falls from self-transferring, and a sore bottom from being left on the toilet for an extended period of time. She identified she sees and hears staff gathered in the corridor laughing when her light is on for assistance. *Resident G - stated often staff take 45-60 minutes to answer her call light - identified the night shift is usually the worst *Resident H - stated she "has to wait" for staff assistance *Resident I - stated she waited two hours for staff to answer her call light on one recent occasion- identified "7 out of 10 times has to wait over 30 minutes [for staff assistance after turning	F 244		

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F 244	Continued From page 9 on call light]." She stated staff turn the call light off and then leave the room without always coming back to provide assistance. *Resident J - stated he waits an extended period of time before and after meals for staff to provide assistance - During an interview on 03/23/15 at 3:30 p.m., Resident F's family member (#1) stated last week she visited the facility and upon leaving, Resident F turned on her call light for staff assistance. Resident F called her family member (#1) at 5:00 p.m. (1.5 hours later) and staff had not yet answered her call light or provided assistance. - During an interview on 03/23/15 at 5:00 p.m., Resident B stated a couple of weeks ago he heard four staff members standing outside his door talking and laughing while he had his call light on waiting for assistance. - During an interview on 03/23/15 at 5:00 p.m., Resident D stated she waits so long, often an hour, for staff to provide assistance with cares, especially in the evening/night shift. Resident D stated she experienced pain in her shoulders from trying to wash herself up before bed and has experienced falls and incontinence from self-transferring after waiting an extended period of time for staff assistance. - During an interview on 03/24/15 at 8:52 a.m., Resident A stated staff take up to thirty minutes to answer her call light, especially during the night, and experienced incontinent episodes while waiting for staff. - During an interview on 03/24/15 at 10:00 a.m., Resident C stated staff take up to an hour to	F 244		

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F 244	Continued From page 10 answer her call light, especially after supper. Resident C pointed to a clock on the wall and identified that is how she knows how long it takes. Resident C said she experienced incontinent episodes while waiting for staff to answer her call light and also stated staff will come into her room in the evening, shut off the call light, say they will be back in a minute, and return about 30 minutes later. During an interview on the morning of 03/25/15, an administrative staff member (#3) stated he/she expected all staff in all disciplines to answer call lights and not turn the call light off until staff meet the resident's need. The staff member (#3) stated staff should meet the residents' needs within 15 minutes after they turned on their call light.	F 244		
F 246 SS=D	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: Based on observation, record review, and staff interview, the facility failed to meet the individual needs for 3 of 13 sampled residents (Residents #8, #9, and #11) observed requiring assistance with adaptive needs. Failure to ensure availability and access of Resident #9's hearing aides, utilization of a wedge cushion for Resident #8,	F 246		4/29/15

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F 246	Continued From page 11 and proper seating in a wheelchair for Resident #11 has the potential to affect the quality of each resident's life. Findings include: - Review of Resident #9's medical record occurred on March 23-25, 2015. The resident's diagnoses included dementia, depression, anxiety, and psychotic disorder with hallucinations. Resident #9's current quarterly Minimum Data Set (MDS), dated 01/12/15, identified minimal ability to hear with use of a hearing aide. Resident #9's care plan identified ". . . ADL [activities of daily living] self care deficit . . . has bilateral hearing aides. . . . Difficulty communicating as evidenced by difficulty hearing conversations related to hearing loss/deafness . . . Maintain and use bilateral hearing aides . . . Observe for and report any changes in communication abilities/efforts . . ." Observation of personal cares on 03/23/15 at 4:30 p.m. showed a certified nursing assistant (CNA) (#8) repeating instructions to Resident #9 while providing assistance. Observation of personal cares on 03/24/15 at 8:20 a.m. and 12:15 p.m. showed a CNA (#9) repeating instructions to Resident #9 while providing assistance. All observations of Resident #9 on March 23-25, 2015 showed the resident not wearing his bilateral hearing aides. During an interview on 03/24/15 at 3:30 p.m., a	F 246	F 246 SS=D 483.15 REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES Resident #8 Hospice is providing better pain control, Abductor pillow has been discontinued. Resident # 9 Family has requested to not use Hearing Aides anymore as Resident constantly removes and damages them. Resident #11 an OT evaluation of chair and positioning for bolster cushion was completed. The bolster was discontinued for this resident. Residents who require adaptive equipment have the potential to be affected by this practice. Task lists for those residents who use adaptive equipment were reviewed and updated when indicated. ADNS or designee will provide education to facility staff regarding updating of Care Plan Task Lists to reflect the accommodation of needs, providing resident specific interventions, and specialized services. Education will also be provided to direct care givers regarding accommodation of needs.	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355031	A. BUILDING _____ B. WING _____	03/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES	600 S MAIN ST MINOT, ND 58701

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F 246	Continued From page 12 nursing staff member (#6) stated facility staff store the hearing aides in the medication cart at night. This staff member (#6) stated she had not seen Resident #9's hearing aides when she worked over a two week period and another staff member (#10) was unaware Resident #9's hearing aides were missing. A progress note, dated 03/24/15 at 8:37 p.m., identified, "Resident hearing aids [sic] missing. Concern form will be completed. Resident family (wife) contacted and 3 time [sic] room check done." During an interview on 03/25/15 at 8:20 a.m., a nurse supervisor (#12) stated if a hearing aide is lost, staff will check different areas for its location i.e. under his bed, dietary, and laundry. If the hearing aide is not located, facility staff will fill out a "Concern Form" and send it to the Director of Care Delivery. Facility staff had not completed this form for Resident #9's hearing aides before 03/24/15 at 3:30 p.m. The concern form, dated 03/24/15, stated, " . . . Individual initiating concern . . . (nursing staff member #10) . . . [resident] did not have hearing aides in ears, bilaterally. . . . Called wife . . . to see if maybe she took them home or for repairs she replied, "No, they should be at Manorcare. . . ." During an interview on 03/24/15 at 5:30 p.m. and 5:45 p.m., when asked about having to repeat himself when providing personal cares for Resident #9, a CNA (#8) stated Resident #9 's hearing is not the best so have to keep repeating. Later, when asked about Resident #9's hearing aides, this staff member (#8) stated the resident	F 246	Audits consisting of visual observation for compliance with the use of adaptive equipment will be completed weekly for four weeks, then monthly for 3 months. Results will be forwarded to the QAA Committee for review and recommendations. Date of compliance is April 29, 2015	

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F 246	Continued From page 13 pulls his hearing aides out and drops them; then it takes staff one to two days to find them. The CNA (#8) had not verified the placement/function of Resident #9's hearing aides and/or reported to nursing staff that the aides were missing. During an interview on 03/24/15 at 5:40 p.m., a CNA (#9) who provided morning cares for Resident #9 stated she hadn't seen Resident #9's hearing aides since Saturday, 03/21/15. This staff member (#9) stated the night nurse places Resident #9's hearing aides in his ears and she never usually places them in his ears. (The night nurses failed to complete a concern form.) When asked about having to repeat herself with personal cares, the staff member (#9) stated sometimes Resident #9 does not understand and sometimes he does not hear. The CNA (#9) had not verified the placement/function of Resident's #9's and/or reported to nursing staff that the aides were missing. During an interview on 03/25/15 at 8:20 a.m., a nurse supervisor (#12) stated the CNAs place Resident #9's hearing aides into the resident's ears in the morning and give the hearing aides to the nurses in the evenings. This staff member (#12) stated everyone who has a hearing aide stored in the medication cart has an entry on their Medication Administration Record (MAR) and the nurse should record the hearing aides as checked in or out. Review of Resident #9's MARs since his admission on 10/14/14 lacked an entry for tracking of hearing aides. Failure to ensure the availability (and security) of Resident #9's hearing aides limits the resident's ability to understand others, to be understood, and communicate needs. This may result in an	F 246		

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F 246	Continued From page 14 increase in occurrences of depression, confusion, behaviors, and accidents. - Review of Resident #11's medical record occurred on 03/25/2015. The resident's current diagnoses included hemiplegia and muscle weakness. Resident #11's annual Minimum Data Set (MDS), dated 02/09/15, identified she required extensive assistance of one staff member for bed mobility and transfers. Resident #11's current care plan included the following: * Focus - "Pain to back and knees due to arthritis." . . . Intervention/Tasks - ". . . Encourage/Assist to reposition frequently to position of comfort." * Focus - "At risk for alteration in skin integrity related to long term incontinence, impaired mobility, hemiplegia LUE [left upper extremity] - lifelong status." . . . Intervention/Tasks - ". . . Encourage and assist as needed to reposition frequently." Observations of Resident #11 seated in a wheelchair with a seat cushion, and staff members within view are as follows: * 03/23/15 in the afternoon - resident in the 1st floor television lounge area. Resident leaning into her left armrest. The resident's left axilla rested on the armrest and her left hand touched the floor. * 03/23/15 in the afternoon - resident in the 1st Floor large dining room. Resident leaning into her left armrest. The resident's left axilla (axilla) rested on the armrest and her left hand hung near the floor. * 03/24/15 at 9:20 a.m. - resident in the 1st floor television/small dining room area. Resident	F 246		

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F 246	Continued From page 15 leaning into her left armrest. The resident ate her oatmeal with her right hand while her left axilla rested on the armrest and her left hand hung near the floor. Facility staff members failed to assist Resident #11 with maintaining a proper and comfortable seating position during activities and mealtime. - Observations on 03/23/15 at 4:00 p.m., 03/24/15 at 9:55 a.m. and 3:40 p.m., showed random CNAs turned Resident #8 from side to side, without a pillow abductor wedge, placed between her legs. The resident resisted cares by attempting to hit or push away staff and yelling, "stop, no, get away." Review of Resident #8's medical record occurred on all days of survey. Diagnoses on admission included a recent left hip fracture and rib fracture, dementia with behaviors, pain, arthritis, and osteoporosis. The physician orders, dated 03/09/15, stated, "PILLOW ABDUCTOR WEDGE BETWEEN LEGS FOR TURNING." Failure of the facility to follow physician's orders for an abductor wedge for turning placed Resident #8 at risk for further hip injury and/or pain.	F 246		
F 278 SS=E	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.	F 278		

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F 278	Continued From page 16 A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: MINIMUM DATA SET - DISCHARGE ASSESSMENTS Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual (Version 3.0), and staff interview, the facility failed to ensure the Discharge Minimum Data Sets (MDSs) met the criteria for coding item A0310F=10 for at least 1 of 1 sampled resident (Resident #6), 1 of 1 closed record (Resident #14), and 5 supplemental residents (Resident #28, #29, #30, #31, and #32) discharged to the hospital in the last 6 months. Failure to complete the discharge assessments per the RAI User's Manual	F 278	F 278 SS=E 483.20 ASSESSMENT ACCURACY/COORDINATION/ CERTIFIED MDS coordinator has completed and submitted correction requests for identified residents. For a period from 1/1/15 thru 04/15/15 residents with falls or out of building over 24 hours will be reviewed for possible corrective action. MDS coordinator will review education materials i.e. RAI manual, and ND DHS "Submission of MDS 3.0 assessment Guidelines" regarding accuracy of coding status of residents at discharge and of coding events in section J. Audits of MDS coding will be completed monthly for 3 months of all falls and out of building over 24 hour assessments for accuracy of submission, with results forwarded to QAA committee for review and recommendation. Date of compliance is April 29, 2015	

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F 278	Continued From page 17 instructions affects quality monitoring activities and data. Findings include: The Long-Term Care Facility RAI User's Manual, October 2014, Chapter 2, page 2-1 stated, ". . . The Resident Assessment Instrument (RAI) process is the basis for the accurate assessment of each nursing home resident . . ." Chapter 2, page 2-34 - 2-37 stated, ". . . Discharge assessments consists of discharge return anticipated [DRA] and discharge return not anticipated [DRNA]. These are OBRA [Omnibus Budget Reconciliation Act] required assessments . . . Discharge Assessment-Return Not Anticipated (A0310F=10) Must be completed when the resident is discharged from the facility and the resident is not expected to return to the facility within 30 days . . . Discharge Assessment-Return Anticipated (A0310F=11) Must be completed when the resident is discharged from the facility and the resident is expected to return to the facility within 30 days . . . When a resident had a prior Discharge assessment completed indicating that the resident was expected to return (A0310E=11) to the facility, but later learned that the resident will not be returning to the facility, there is no Federal requirement to inactivate the resident's record nor to complete another Discharge assessment . . . Nursing home bed hold status and opening and closing the medical record have no effect on these requirements . . ." Chapter 3, page Z-6 states, ". . . The importance of accurately completing and submitting the MDS cannot be overemphasized. The MDS is the basis for: * the development of an individualized care plan	F 278		

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F 278	Continued From page 18 * the Medicare Prospective Payment System * Medicaid reimbursement programs * quality monitoring activities, such as quality measure reports * the data-driven survey and certification process * the quality measures used for public reporting * research and policy development." - Discharge Return Not Anticipated assessments, completed for Resident #6, #14, #28, #29, #30, #31 and #32 failed to meet the criteria for coding item A0310F=10 on the MDS. Review of the MDSs identified the following: * Resident #6 - a DRNA assessment, dated 03/17/15, completed due to the resident/family not holding the bed when she went to the hospital. * Resident #28 - a DRNA assessment, dated 10/14/14, completed due to the resident/family not holding the bed when she went to the hospital. * Resident #29 - a DRNA assessment, dated 11/14/14, completed after a DRA assessment, dated 11/12/14, due to the resident/family not holding the bed after he went to the hospital. * Resident #30 - a DRNA assessment, dated 02/01/15, completed due to the resident/family not holding the bed when he went to the hospital. * Resident #14 - a DRNA assessment, dated 01/10/15, completed after a DRA assessment, dated 01/09/15, when the facility learned the resident would not return. * Resident #31 - a DRNA assessment, dated 02/21/15, completed after a DRA assessment, dated 02/17/15, when the facility learned the resident would not return. * Resident #32 - a DRNA assessment, dated 03/09/15, completed after a DRA assessment,	F 278		

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F 278	Continued From page 19 dated 03/06/15, when the facility learned the resident would not return. During an interview on the morning of 03/24/15, an administrative nurse (#1) confirmed DRNA assessments were completed due to the residents/families not holding the bed, and after a DRA assessment when the facility learned the resident would not return. MINIMUM DATA SET - FALLS 2. Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual (Version 3.0), and staff interview, the facility failed to ensure the MDS accurately reflected the resident's status for 1 supplemental resident (Resident #17) who experienced a fall. Failure to accurately code and complete the MDS for this resident limited the facility's ability to develop and implement an individualized care plan consistent with her needs and functional status, and may affect the level of care provided to the resident. Findings include: The Long-Term Care Facility RAI User's Manual, October 2014, Chapter 3, page J-29 - J-30 stated, ". . . Has the resident had any falls since admission/entry or the prior assessment . . . Code 1, yes: if the resident has fallen since the last assessment . . ." - Review of Resident #17's annual MDS assessment dated 01/08/15 revealed the resident experienced no falls since the prior MDS assessment.	F 278		

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F 278	Continued From page 20 Review of a progress note, dated 12/05/14 at 5:47 p.m., revealed staff found the resident sitting on the floor in the resident's bathroom. At that time, the resident reported she attempted to get into her chair, but missed the chair and sat on the floor. The resident received two scratches to her left side from the fall. During an interview at 3:00 p.m. on 03/25/15, an administrative nurse (#1) reviewed the MDS and the resident's progress notes, and reported section J1800 on the MDS did not accurately reflect the resident's fall on 12/05/14.	F 278		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation and review of manufacturer's instructions, the facility failed to meet professional standards of quality for 1 of 2 residents (#26) observed receiving insulin via insulin pen. Failure to consistently prime insulin pens resulted in the resident receiving an inaccurate dose of medication. Findings include: Review of the manufacturer's instructions for NovoLog FlexPen occurred on 03/25/15. This insert stated, ". . . Small amounts of air may collect in the cartridge during normal use. To avoid injecting air and to ensure proper dosing: . . . E. Turn the dose selector to select 2 units. F.	F 281	F 281 SS=E 483.20 SERVICES PROVIDED MEET PROFESSIONAL STANDARDS Review of subsequent blood glucose monitoring of resident #26 was completed with no negative finding associated with the insulin pen not being primed. Nurse was observed with needle pointed up to prime insulin pump with two units prior to administering to resident #26 Residents who receive insulin through insulin pens have the potential to be affected. ADNS or designee will provide nurse education and observation on the proper use of priming and administration of insulin using insulin pens.	

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F 281	Continued From page 21 Hold your NovoLog FlexPen with the needle pointing up. Tap the cartridge gently with your finger a few times to make any air bubbles collect at the top of cartridge. G. Keep the needle pointing up, press the button all the way. The dose selector turns to zero. A drop of insulin should appear at the needle tip. If not, change the needle, and repeat the procedure . . . ." Observation of medication pass on 03/24/15 at 11:55 a.m. showed a nurse (#10) administered insulin to Resident #26. The nurse (#10) failed to "prime" or expel the air from the attached needle of the NovoLog FlexPen with two units of insulin prior to administering to Resident #26.	F 281	Audits of insulin administration will be completed three times weekly for four weeks and then monthly for 3 months. Results of audits will be forwarded to QAA Committee for further review and recommendations. Date of compliance is April 29, 2015.	
F 312 SS=E	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 record review and observation, the facility failed to ensure staff provided adequate dining assistance for 2 of 6 sampled residents (Residents #7 and #8) and 3 supplemental residents (Residents #18, #19, and #20) observed requiring extensive assistance to maintain adequate nutrition during meal and snack times. Failure to provide adequate assistance and follow Tasks (a certified nursing assistant care guide) with meals/snacks, placed these residents at risk for decreased intake,	F 312		

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F 312	Continued From page 22 choking/aspiration, inadequate nutrition, and weight loss. Findings include: - Review of Resident #7's medical record occurred on all days of survey. Diagnoses included dysphagia. The annual Minimum Data Set (MDS), dated 01/25/15, identified severely impaired cognition and extensive assist of one for eating. The current "Tasks" stated, ". . . * NO STRAWS. . . ." The current meal tray card stated, ". . . "Adaptive Equipment: . . . NO STRAW . . . Beverages: . . . NO STRAWS. . . ." A nutrition assessment, dated 01/26/15 stated, ". . . Functional Problems Affecting Ability to Eat . . . no straw. . . ." Observation on 03/24/15 at 11:35 a.m. showed a certified nursing assistant (CNA) (#9) took a carton of chocolate milk from Resident #7's bedside table, placed a straw in the carton, and held the carton while Resident #7 drank from the straw consuming all of the milk. Failure of staff to follow the residents' "Tasks" and the nutrition assessment, dated 01/26/15 of no straw use for fluids increased the potential for Resident #7 to choke and aspirate on fluids. - Review of Resident #8's medical record occurred on all days of survey. Diagnoses included dysphagia, dementia with behavior, Alzheimer's Disease, and macular degeneration. The admission MDS, dated 01/27/15, identified severely impaired cognition and extensive assist of one for eating. An "Eating & Swallowing Evaluation," dated 01/21/15, identified, ". . . swallowing difficulties are related to severe	F 312	F 312 SS=E 483.25 ADL CARE PROVIDED FOR DEPENDENT RESIDENTS The IDT reviewed seating arrangements for residents #7,#8,#18,#19,and #20 and adjustments were made to seating assignments when indicated to ensure adequate assistance with meal intake. Staff were educated on the need to follow care plans and task lists regarding no straw use for #7 and # 8. Staff were educated on #18, #19, and #20 regarding the need to provide verbal cueing and increase level of assist with meal intake if difficulty with meal intake or refusal of intake is noted. Residents who are not to use straws and residents who require assistance with meal intake have the potential to be affected by this practice. ADNS or designee will provide education to facility staff who assist with intake of food and fluids regarding following resident specific orders that prohibit the use of straws. Education will be provided regarding the need to increase level of assistance when verbal cueing is unsuccessful in increasing oral intake.	

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F 312	Continued From page 23 cognitive impairment . . . and [decreased] ability to comprehend abstract objects (. . . straws. . . .) . . . require . . . [no] straws. . . ." A nutrition assessment, dated 01/26/15 stated, ". . . Functional Problems Affecting Ability to Eat . . . no straw. . . ." The current "Tasks" stated, ". . . Does not use straws. . . ." The current meal tray card stated, ". . . Adaptive Equipment: . . . No Straw . . . Pour liquids into a glass . . . Beverages: . . . No Straw. . . ." Review of Resident #8's progress note, dated 02/16/15, identified, ". . . variable intake that is over all poor . . . UBW [usual body weight] . . . 105-109# [pounds] . . . Current wt. [weight] is 102#. . . ." Observation of the morning's breakfast on 03/24/15 showed staff poured Ensure into a glass without a straw and frequently offered the glass to Resident #8 who drank 100%. That meal intake showed 25% eaten. Observation on 03/24/15 from noon to 12:20 p.m. showed staff sat down to assist the resident, placed straws in a water glass, coffee cup, and an Ensure can, lined the fluids up at the edge of the table in front of the resident, and verbally encouraged and physically offered the fluids containing straws to the resident two or three times during the meal. The resident refused to drink from the straws. Review of the meal intake record showed Resident #8 refused lunch. Failure of staff to follow the recommendations of the resident's "Tasks", eating and swallowing evaluation, dated 01/21/15, the nutrition assessment dated 01/26/15, and the meal tray card of no straw use for fluids may have	F 312	Audits consisting of direct observation of dining room during meal intake to observe level of assistance offered and compliance with prohibited use of straws will be completed three times weekly for four weeks and then weekly for 3 months. Results of audits will be forwarded to QAA committee for review and recommendations. Date of compliance is April 29, 2015.	

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(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 312	Continued From page 24	F 312		

decreased Resident #8's meal intake.

- Review of Resident #18's medical record occurred on 03/25/15. Diagnoses included dementia, dysphagia, and an abnormal weight loss. The quarterly MDS, dated 03/15/15, identified severely impaired cognition and extensive assist of one for eating. The current care plan stated, "Focus * ADL Self care deficit as evidenced by need for assist with ADL's related to physical limitations . . . Interventions . . . Assist with . . . eating as needed . . . Focus * Nutritional status as evidenced by potential for weight loss related to varying intakes. Need for set up and cueing . . . Interventions . . . Encourage or assist as needed. . . ." The current "Tasks" stated, " SPECIAL NEED: . . . Needs assistance with meals. . . ."

Observation on 03/24/15 at 7:55 a.m. in the dining room during breakfast showed a CNA (#21) provided verbal encouragement to Resident #18 from the opposite end of the table. Further observation at 8:15 a.m. showed a therapy staff member (#22) sat at the table and provided verbal encouragement to several residents including Resident #18. The resident remained seated in her wheelchair at the table until 8:40 a.m. Review of the meal intake record showed Resident #18 consumed 0% of her breakfast.

Observation on 03/24/15 at 12:30 p.m. of lunch showed Resident #18 seated at the table, not eating, and no staff present at the table to assist. At 12:35 p.m. observation showed a therapy staff member (#22) sat down at the table and provided verbal encouragement to Resident #18. Review of the meal intake record showed Resident #18 refused lunch. At no time did staff attempt to feed

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	355031	A. BUILDING _____ B. WING _____	03/25/2015

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F 312	Continued From page 25 the resident. - Review of Resident #19's medical record occurred on 03/24/15. Diagnoses included dementia, dysphagia, diabetes, and anxiety. The current care plan stated, "Focus * Altered nutrition r/t [related to] recent wt. [weight] loss. Need for assistance with meal set up due to limited use of hands . . . Increased need for cueing at meals . . . Focus * At risk for constipation . . . Interventions . . . * Encourage and assist as needed to consume all fluids offered at and between meals. . . ." A nutrition assessment, dated 02/05/15, stated, ". . . Cue or assist at meals. . . ." Review of Resident #19's progress note, dated 03/20/15, stated, "Quarterly review . . . Staff set up her meals . . . needs frequent cueing or assistance to eat . . . very limited range of motion in her arms. . . ." Observation on 03/24/15 from 7:55 a.m. through 8:40 a.m. showed a CNA (#21) provided verbal encouragement to Resident #19 from the opposite end of the table. Review of the meal intake record showed Resident #19 consumed 25% of her breakfast. Further observation at 12:30 p.m. during the lunch meal showed Resident #19 arrived at the table at 12:34 p.m. Staff sat with the resident and verbally encouraged her to eat. Review of the meal intake record showed Resident #19 refused lunch. At no time did staff attempt to feed the resident. - Review of Resident #20's medical record occurred on 03/25/15. Diagnoses included mild cognitive impairment, dysphagia, and diabetes. The quarterly MDS, dated 02/17/15, identified	F 312		

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F 312	Continued From page 26 severely impaired cognition, required extensive assistance for eating, and weight loss. The current care plan stated, ". . . Focus: Nutritional status as evidenced by weight loss related to oral intake, altered texture and need for assistance at meals MD [medical doctor] and family declined feeding via tube at this time. . . . Interventions . . . Encourage and assist to consume foods and/or supplements and fluids offered . . ." The current "Tasks" stated, ". . . SPECIAL NEEDS . . . Mechanical soft Finger foods THIN LIQUIDS . . . Multiple encouragements and cueing may be needed . . ." The nutrition assessment dated 02/04/14 stated, ". . . 6. Functional Problems Affecting Ability to Eat: a. Swallowing . . . m. Inability to perform ADLs without significant physical assistance . . . 7. Cognitive/Mental Status/Behavior Problems Interfering with Eating . . . e. Requires frequent/constant cueing . . . 15. Nutrition Problem: a. Inadequate oral food/beverage intake . . . e. Inadequate protein intake . . . h. Swallowing difficulty . . . l. Involuntary weight loss . . . 17. Nutrition Statement/Summary . . . [Resident #20] has a poor intake at meals. . . . She is assisted at meals by staff. . . ." Review of Resident #20's progress notes showed the following: * 03/19/15 at 3:08 p.m.: "wt. [weight] review [Resident #20] is 153# [pounds]. She has had a significant wt change. Her intakes vary but are improved from the usual. Family has chosen to not remove feeding tube. We continue to assist her with meals and offer items she likes. Goal is to maintain her wt. without using the tube. Takes water well. Does not take other fluids well.	F 312		

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F 312	Continued From page 27 Daughter is coming in at supper to feed her. She will tell her she does not want something but if she puts it to her mouth she will often times open her mouth and eat it. Staff are encouraged to make multiple attempts when feeding her. . . ." Breakfast dining observations on 03/24/15 showed the following: * 7:54 a.m.: A CNA (#21) provided encouragement from the opposite end of the table to Resident #20 who held a fork with eggs on it. The resident did not take a bite. * 8:12 a.m.: Resident #20 took a bite of eggs independently. * 8:16 a.m.: A therapy staff member (#22) assisted the resident with fluids. Staff failed to provide physical assistance for 22 minutes. Review of the meal intake documentation showed Resident #20 consumed 25% of her breakfast. Lunch dining observations on 03/24/15 showed the following: * 12:00 p.m.: Resident #20 had not touched her meal. * 12:11 p.m.: A therapy staff member (#22) assisted the resident with eating. Staff failed to provide physical assistance for 11 minutes. Review of the meal intake documentation showed Resident #20 consumed 50% of her lunch. Failure of staff to follow current "Tasks" and provide adequate assistance with meals placed Resident #18, #19, and #20 at risk for inadequate nutrition and weight loss.	F 312		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a	F 314		

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

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F 314	Continued From page 28 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 record review and staff interview, the facility failed to provide the necessary care and services to identify and/or implement interventions to prevent the worsening or development of pressure ulcers for 1 of 3 closed resident (Resident #14) records reviewed. Failure to identify and implement interventions on admission related to Resident #14's history and risk of pressure ulcers may have resulted in the development or worsening of an unstageable pressure ulcer to the heel identified approximately one month after admission. Findings include: Review of Resident #14's medical record occurred on 03/25/15. Diagnoses included a history of pressure ulcers. The quarterly Minimum Data Set (MDS), dated 12/12/14, identified severely impaired decision making, an extensive assist of two or more staff for bed mobility and transfers, and an unstageable pressure ulcer not identified on the admission MDS dated 09/22/14. Review of a hospital "DISCHARGE SUMMARY," dated 09/15/14, stated, " . . . DISCHARGE DIAGNOSES: . . . 6. Pressure ulcer, stage II over	F 314	F 314 SS=D 483.25 TREATMENT/SERVICES TO PREVENT/HEAL PRESSURE SORES Resident # 14 is no longer in the facility. Residents with pressure areas as well as ~~though~~ those who have had pressure ulcers or are at risk for pressure ulcers have the potential to be affected by this practice. ADNS or designee will provide education to nursing staff regarding skin management process and documentation of skin management. Education will include overview of existing system for skin assessment and identification of risk as well as following the Assess, Plan, Implement, and Evaluate nursing process. Audits will be completed through review of documentation for new admission and review of wound round notes three times weekly for four weeks and then weekly for 3 months. Results will be forwarded to the QAA committee for review and recommendation. Date of compliance is April 29, 2015	Phone call per consultant/ JO 4-27-15

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F 314	Continued From page 29 . . . buttock followed by the wound care nurse during hospitalization . . . Continue with wound care as we have been doing here in the hospital until resolution of . . . pressure ulcer and to be followed by wound therapist at [nursing home]. . . ." Review of Resident #14's "Physician's Admission Orders," dated 09/15/14 identified, "Aloe Vista creme to coccyx to prevent breakdown." Review of the facility's "Patient Admission/Readmission Screen" for Resident #14 identified, ". . . Skin . . . Braden Scale for Predicting Pressure Sore Risk Score: 12 . . . High Risk for Skin Breakdown . . . ." The care plan identified: * On admission - "Focus * Circumferential Bruising too [sic] Bilateral lower extremities Date Initiated: 09/15/14 . . . Interventions * Administer treatment per physician orders . . . Report evidence of infection such as purulent drainage, swelling, localized heat, increased pain, et. [and] Notify physician prn [as needed]. . . ." * "Focus * Right heel unstageable pressure ulcer Date Initiated: 10/06/14 . . . Interventions * Administer treatment per physician orders . . . Foam tegaderm to be applied to right heel every 72 hours and PRN Date Initiated: 10/06/2014 . . . * Prevalon boot to be applied bilateral all the time except during cares Date Initiated: 10/14/2014 . . . * Report evidence of infection such as purulent drainage, swelling, localized heat, increased pain, etc. Notify physician prn Date Initiated: 10/14/2014. . . ." Review of Resident #14's progress notes identified:	F 314		

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F 314	Continued From page 30 * 09/16/15 at 7:45 p.m. - ". . . Healed pink skin from old sores noted to bilateral buttocks. . . ." * 09/22/14 at 11:24 a.m. - ". . . Care conference held today . . . Open pressure sores are closed and continue to heal. . . ." * 09/25/14 at 12:56 p.m. - ". . . Resident's skin is currently intact. . . ." * 10/05/14 at 2:22 p.m. - ". . . bruise on resident's right heal [sic]. 3/3 [3 by 3 centimeter (cm)] circle blue non-bleachable [sic] skin discoloration is noted on the right heal [sic], skin warm and intact, no drainage noted at this time, the heal [sic] elevated at [sic] while in bed." * 10/06/14 at 12:36 p.m. - ". . . bruised area on her R [right] heel. Has history of skin breakdown . . . Recommend offering supplement (Nutrition treat) if eats less than 50%. . . ." * 10/06/15 at 4:38 p.m. Late Entry - ". . . Wound Rounds . . . Unstageable pressure ulcer noted to right heel on admission measurements are as follows 3.3 x 3.0 cm . . . Braden done on 10/06/2014 score is 11.0. Nutritional Assessment done on 09/21/2014 . . . Current intake is 50-75% intake. 50% meets her needs . . . Care plan is in place to promote healing and prevent additional ulceration and infection . . . Pressure reducing surface to bed and chair in place upon admission. Current treatment foam tegaderm dressing to be applied to right heel every 72 hours and as needs, bilateral provolone [sic] boots applied. . . ." (Staff failed to document the presence of this unstageable pressure ulcer on admission). * 10/06/15 at 7:14 p.m. - ". . . Note that resident has a 3.3cm x 3.0cm circular fluid filled blister that is a dark greenish/black color to right heel. . . ." * 12/31/14 at 1:54 p.m. - ". . . Unstageable pressure ulcer noted to right heel on admission . . . Eschar to heel measures 2cm X 1.7cm. . . ."	F 314		

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F 314	Continued From page 31 * 01/08/15 at 8:35 a.m. - ". . . Unstageable pressure ulcer noted to right heel on admission . . . Eschar to heel measure 2cm X 1.4cm. . . ." During an interview on 03/25/15 at 3:00 p.m. an administrative staff member (#4) failed to provide documentation that nursing staff identified and assessed a right heel pressure ulcer on admission, implemented a care plan specific to the resident's history of and current pressure ulcer, and documented treatment and regular assessment of the resident's skin issues. Failure of the facility to accurately identify, assess, and implement interventions regarding pressure ulcers during Resident #14's admission, may have contributed to the development of an avoidable, facility acquired pressure ulcer or the worsening of an existing non-facility acquired pressure ulcer to the right heel.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on record review and family and staff	F 315		

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F 315	Continued From page 32 interview, the facility failed to follow physician's orders for the completion of a lab test and ensure timely notification to the physician of the results for 1 of 13 sampled residents (Resident #2) with lab results reviewed. Failure to obtain a repeat urinalysis (UA) resulted in delayed treatment and may have contributed to unnecessary discomfort. Findings include: Review of Resident #2's medical record occurred on all days of survey. Diagnoses included dementia. During an interview on 03/23/15 at 3:47 p.m., a family member (#2) stated Resident #2 had a urinary tract infection (UTI) in December 2014 and facility staff failed to complete a follow-up UA as ordered until she asked about the results. The family member stated when facility staff completed the follow-up UA, the results showed the UTI still present and a course of antibiotics reordered. Review of the December 2014 progress notes showed the following: * 12/17/14 at 2:50 p.m.: "Received a new order from [name of physician] for Cipro [antibiotic] 250 mg [milligrams] PO [by mouth] BID [twice a day] for 7 days for a UTI then repeat UA. . . ." * 12/23/14 at 1:25 p.m.: ". . . Resident remains on Cipro 250mg one tablet po BID for urinary tract infection (12/17-12/23). . . ." Review of the December 2014 Medication Administration Record (MAR) showed Resident #2's last dose of antibiotics administered on the morning of 12/24/14. Review of the lab reports identified a urinalysis	F 315	F 315 SS=D 483.25 NO CATHETER, PREVENT UTI, RESTORE BLADDER Resident #2 was treated and no longer has a UTI. Residents who require follow up UAs after treatment of a UTI have the potential to be affected by this practice. Alert charting process and lab tracking process will be followed by nurses for residents with UTIs. ADNS or designee will provide education to licensed nurses regarding the management of UTI and on lab tracking process for follow up labs as ordered. Audits of follow up documentation for residents with UTIs and compliance with follow up UAs will be completed weekly for four weeks then monthly for 3 months with results forwarded to QAA committee for review and recommendations. Date of compliance is April 29, 2015.	

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F 315	Continued From page 33 completed on 12/29/14 at 1:00 p.m. (5 days after Resident #2 completed his antibiotics). A final urine culture report, dated 12/31/14, identified Resident #2's urine positive for infection. Review of the January 2015 progress notes showed Resident #2 started on antibiotics on 01/02/15 (two days after the facility received the final urine culture report). During an interview on 03/25/15 at 11:00 a.m., an administrative nurse (#4) stated she would expect a follow up UA done within 48 hours following the completion of antibiotic therapy. The failure to complete a follow-up UA in a timely manner resulted in delayed treatment of the UTI. Failure to ensure prompt notification after receiving the final results of the urine culture on 12/31/14 further delayed treatment of Resident #2's UTI.	F 315		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, observation, staff interview, and review of facility policy and procedure, the facility failed to ensure staff	F 323		

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F 323	Continued From page 34 provided the necessary interventions and supervision to prevent falls and/or injury for 6 of 13 sampled residents (Residents #1, #5, #6, #7, #8, and #9) observed during cares. Failure of staff to use a gait belt for Resident #1, properly place a gait belt for Resident #9, use two staff to transfer Resident #5 and #6, placed the residents at risk for falls and/or injury. Failure of staff to place pillows to prevent Resident #7 from falling out of bed, and use two staff during cares with Resident #8, placed both residents at risk for injury. Findings include: Review of the facility policy and procedure titled "Gait Belt" occurred on 03/25/15. This policy and procedure stated, "PURPOSE: To safely and effectively transfer or ambulate a patient . . . 6. Place gait belt around waist . . . 7. Secure belt by threading end through buckle . . . 8. Adjust belt to snug fit . . . 11. Grip belt at patient's sides by placing hands upward under belt . . ." - Review of Resident #6's medical record occurred on all days of survey. Diagnoses included fracture of trimalleolar (ankle). Progress notes, dated 03/17/15, stated, "Resident is staying overnight at [hospital name] following her right ankle surgery . . ." Resident #6's current significant change in status assessment (SCSA) Minimum Data Set (MDS), dated 02/03/15, identified the resident required extensive assistance of two or more staff members for transfers. Resident #6's current care plan included the following:	F 323	F 323 SS=E 483.25 FREE OF ACCIDENT /HAZARDS SUPERVISION/DEVICES Education was provided to staff members caring for Resident #5 regarding the use of mechanical lift with two, #6 for transfers with assist of 2, for resident #1 ~~and~~ and #9 regarding proper application of gait belts, and for resident #8 regarding the need for two staff to be present for cares. The care plan was updated for Resident # 7 modifying falls prevention interventions and removing pillows to edge of bed as an intervention to prevent falls. Phone call per Consultant 4-27-15 Residents who transfer with the assistance of a gait belt, require assist of two with cares or transfers, or who have resident specific safety interventions in place have the potential to be affected by this practice. ADNS or designee will provide education on the application of gait belts, following interventions for the use of 2 staff for resident and staff safety, use of resident specific safety interventions and following safe transfer practices to nursing staff members who assist with transferring residents.	

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F 323	Continued From page 35 * Focus - "Requires assistance/potential to restore function for TRANSFERRING from one position to another as evidenced by physical limitations secondary to lower extremity injury." Intervention/Tasks - ". . . TRANSFERS: 2 person with moderate level of assist with gait belt. TOE TOUCH WEIGHT BEARING TO RIGHT . . ." * Focus - "At risk for falls due to history of falls; history of self-transfers." Resident #6's "Tasks" (a certified nursing assistant care guide) stated, ". . . Gait belt transfer. Assist of 2 with moderate assist . . ." * On 03/24/15 at 10:25 a.m., observation showed two certified nursing assistants (CNA) (#9 and #13) present in Resident #6's room. One CNA (#9), using a gait belt, assisted Resident #6 with transferring from the wheelchair to her bed. The CNAs failed to use two staff members to ensure Resident #6's safety when being transferred. * On 03/24/15 at 11:45 a.m., observation showed a CNA (#24) assisted Resident #6 with transferring from the bed to her wheelchair, using a gait belt. The CNA failed to use two staff members to ensure Resident #6's safety when being transferred. During an interview on the morning of 03/25/15, an administrative nurse (#4) stated her expectation would be for two staff members to assist in transferring Resident #6. - Review of Resident #1's medical record occurred on all days of survey. The current care plan stated, ". . . Focus: ADL [activities of daily living] Self care deficit as evidenced by weakness/shortness of breath with exertion related to pneumonia/respiratory failure . . .	F 323	Audits of compliance with transfer status, use of two staff when indicated, placement of resident specific safety interventions and safe use of gait belt will be audited through visual observation. Audits will be completed three times weekly for four weeks then weekly for 3 months with results forwarded to QAA committee for review and recommendations. Date of compliance is April 29, 2015.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES	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 323	Continued From page 36 Interventions/Tasks . . . Transfer with 1P [person] and gait belt . . ." Observation on 03/24/15 at 8:58 a.m. showed a CNA (#7) assisted Resident #1 to the toilet. When pivoting the resident from her wheelchair to the toilet, the CNA (#7) failed to apply the gait belt and lifted under the resident's left arm. The CNA (#7) failed to apply a gait belt when she transferred Resident #1 back to her wheelchair. - Observation on 03/24/15 at 8:20 a.m., showed a CNA (#9) transferred Resident #9 from the toilet to his wheelchair. The CNA (#9) failed to apply the gait belt snuggly allowing for a gap between the resident's chest and the gait belt with standing. When the CNA (#9) transferred Resident #9 to a recliner in the lounge she again failed to apply the gait belt snuggly allowing the belt to slide up Resident #9's back. Observation on 03/24/15 at 12:15 p.m., showed a CNA (#9) transferred Resident #9 from his wheelchair to the toilet. The CNA (#9) failed to apply the gait belt snuggle allowing for a gap between the resident's chest and the gait belt with standing. - Review of Resident #5's medical record occurred on March 23-25, 2015. The resident's diagnoses included muscle atrophy, paralysis agitans, and arthritis. The current quarterly MDS, dated 03/06/15, identified extensive assistance of two persons with transfers. Resident #5's care plan identified " . . . ADL Self care deficit as evidenced by weakness related to physical limitations. . . . Transfer with sit to stand mechanical lift and 2P [two persons]. . . ."	F 323		

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F 323	Continued From page 37 Resident #5's "Tasks" indicated " . . . Transfer with sit to stand mechanical lift and 2P . . ." Observation on 03/24/15 at 4:30 p.m., showed one CNA (#7) transferred Resident #5 in a sit to stand mechanical lift from the bathroom to his wheelchair. - Review of Resident #7's medical record occurred on all days of survey. Diagnoses included osteoporosis, arthritis, and a history of falls. The annual MDS, dated 01/25/15, identified severely impaired cognition and a fall in the last three months. The current care plan identified, "Focus * At risk for falls due to history of falls r/t [related to] immobility, decreased vision . . . Interventions/Tasks . . . * Position 2 pillows on window side of bed while in bed in position of comfort. Date Initiated: 01/16/2015. . . ." The current "Tasks" stated, " . . . * SPECIAL NEED: Position body pillow on window side of the bed while in bed in position of comfort. . . ." Resident #7's progress note, dated 01/15/15, stated, "Resident had unwitnessed fall at 2350 [11:50 p.m.]. Resident was half in bed and half out of bed . . . head out and on the floor between the bed and the window. . . Neuro checks where [sic] started per facility and were WNL [within normal limits]. . . ." Observations on 03/23/15 at 10:10 a.m. and 03/24/15 at 11:35 a.m. and 1:50 p.m. showed Resident #7 in bed without a pillow positioned on the window side of the bed and the bed pulled away from the window/wall. Failure of staff to follow physician orders to place	F 323		

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F 323	Continued From page 38 a body pillow beside the resident on the window side of bed, increased Resident #7's risk for further falls and injury. - Review of Resident #8's medical record occurred on all days of survey. Diagnosis included left hip fracture, rib fracture, dementia with behaviors, pain, arthritis, osteoporosis, and macular degeneration. The admission MDS, dated 01/27/15, identified extensive assist of two or more for bed mobility, transfers, and toilet use, frequently incontinent of bowel and bladder, short and long-term memory problems, and severely impaired decision making skills. The current care plan stated, "Focus * ADL Self care deficit as evidenced by weakness related to recent HX [history] Left hip, rib fracture and alzheimer's [sic] disease. Date Initiated: 01/21/15 . . . Interventions/Tasks . . . Extensive assist with daily hygiene, grooming, dressing, oral care and eating as needed . . . Transfer with 2 staff assist with gait belt . . . Focus * Verbal/physical agitation related to: Cognitive impairment and adjustment to environment. Date Initiated: 01/21/2015. . . . Interventions/Tasks . . . If strategies are not working, leave (if safe to do so) and re-approach later . . . Use consistent routines and caregivers for ADL's . . . Focus *At risk for alteration in skin integrity related to: impaired mobility, incontinence, impaired cognition, fragile skin of aging. Date Initiated: 01/21/2015. . . . Focus * Skin tear to right and left forearm Date initiated: 02/12/2015. . . ." The current "Tasks" stated, "ADL Assist - Usually 2 person with EXTENSIVE level of assist. . . ." A physician's exam, dated 02/25/15, stated, "Extensive ecchymosis [bruising] of her upper	F 323		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 323	Continued From page 39 extremities bilaterally . . . not oriented to person, place, or time. . . ." Review of Resident #8's progress notes, dated 02/15/15 through 03/25/15, identified: * 02/03/15 - ". . . very confused . . . assist of two and a gait belt for transfers and toileting . . . incontinent of bowel and bladder. . . ." * 02/12/15 - ". . . skin tear to right forearm during the morning care . . . 3cm [centimeters] by 2cm. . . ." * 02/17/15 - ". . . skin tear to right outer forearm . . . 5cm x 2.5 cm. . . ." * 02/18/15 - ". . . combative this shift with ADL's." * 02/21/15 - ". . . Resistive to personal cares, therefore, requires assist of two. . . ." * 02/22/15 and 02/24/15 - ". . . assist of two with ADLs. . . ." * 02/25/15 - ". . . sustained a skin tear, measuring 2.5 CM alongside current existing bruise at this time. . . ." * 02/26/15 - ". . . total assist for bed mobility. . . ." * 03/01/15 - ". . . agitated with cares and will hit and scratch. . . ." * 03/06/15 - ". . . combative and started hitting . . . upset and yelling. . . ." * 03/18/15 - ". . . extremely combative . . . is hitting and biting staff. . . ." * 03/23/15 - ". . . has a 0.05cm skin tear to left arm, reopened old skin tear. . . . combative this morning. . . ." * 03/24/15 - ". . . quite combative this evening. . . ." *03/25/15 - ". . . quite combative and resistant with HS [bedtime] cares. . . ." Observations on 03/23/15 at 4:00 p.m. and 03/24 15 at 12:10 p.m., showed cares completed with an assist of two CNAs while Resident #8	F 323		

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F 323	Continued From page 40 displayed combative behaviors. Further observation showed slight bruising to both Resident #8's hands and arms, and a piece of tape covered a skin tear on the left arm. Another observation on 03/24/15 at 9:55 a.m. showed one CNA (#16) provided incontinence cares for Resident #8, including changing of the brief while the resident continually hit and yelled at the CNA. The CNA stated that usually two staff completed cares due to the resident's physical behavior of hitting, pinching, and scratching. Part way through cares, the CNA activated the call light to get assistance due to the resident's continued combativeness, but continued to roll the resident back and forth in bed to complete peri-cares while stating, "Please don't pinch. Be nice. Let go of my arms please." Another CNA came to the room to answer the call light (approximately ten minutes later), but the CNA (#16) indicated no assistance was needed by this time. During an interview on 03/25/15 at 1:00 p.m. an administrative staff member (#3) confirmed Resident #14 required an assist of two staff to complete cares. Failure to complete cares with the assistance of two staff, may have placed Resident #8 at risk of increased behaviors, skin tears, bruising, and possible left hip injury/pain.	F 323		
F 327 SS=D	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health.	F 327		

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F 327	Continued From page 41 This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy and procedure review, and staff interview, the facility failed to provide fluids during cares for 3 of 5 sampled residents (Resident #2, #5, and #9) dependent on staff to provide fluids. Failure to offer fluids placed these residents at risk of dehydration and constipation. Findings include: Review of the facility's "Phase 3: Implement" policy on hydration occurred on the afternoon of 03/25/15. The policy, not dated, indicated, ". . . Prompting patients to consume fluids and hydrate themselves is the single most effective approach in maintaining fluid balance. Patients regardless of cognitive status, often respond to prompts to drink fluids. Depending on the individualized care plan, some patients may require more frequent and scheduled prompting. Prompting fluid intake can be paired with other scheduled interactions such as: 'water in-water out' - prompting to drink fluids is paired with toileting activities, 'sip 'n go' - any staff person entering a patient room while the patient is awake, offers fluids or prompts to drink, 'TAPS' - 'turn and position, sip' where fluids are offered with each position change. . . ." - Review of Resident #5's medical record occurred on March 23-25, 2015. The resident's diagnoses included Alzheimer's disease and dysphagia. The current care plan identified ". . . Risk for Constipation . . . Encourage and assist as needed to consume fluids offered at and between meals. . . ." Observations of care identified facility staff failed	F 327	F 327 SS =D 483. 25 SUFFICIENT FLUID TO MAINTAIN HYDRATION Staff members caring for residents #9, #5, and #2 were educated on the need to offer fluids when providing care as well as at mealtimes. Residents requiring physical assistance with the intake of fluids have the potential to be affected by this practice ADNS or designee will provide education to nursing staff members on methods to promote adequate hydration while providing routine care. Measures that will be implemented include following hydration practice guidelines for offering fluids with cares. A hydration cart will be utilized during activities as well. Audits of assistance with fluid intake during routine care will be completed three times weekly for four weeks then weekly for 3 months. Results of audits will be forwarded to QAA committee for review and recommendations. Date of compliance is April 29, 2015	

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F 327	Continued From page 42 to offer/assist Resident #5 with fluids during the following interactions: *03/24/15 at 9:30 a.m. - Two CNAs (#9 and #13) transferred the resident from his wheelchair to his bed and assisted with personal cares. *03/24/15 at 12:00 p.m. - Two CNAs (#13 and #19) assisted the resident with personal cares in bed and transferred resident to his wheelchair. *03/24/15 at 4:30 p.m. - One CNA (#7) transferred the resident from his bed to the bathroom, assisted with personal cares, and transferred the resident to his wheelchair. - Review of Resident #9's medical record occurred on March 23-25, 2015. The resident's diagnoses included dementia and dysphagia. The current care plan identified ". . . Constipation . . . Encourage and assist as needed to consume all fluids offered at and between meals. . . ." Observations of care identified facility staff failed to offer/assist Resident #9 with fluids during the following interactions: *03/23/15 at 4:35 p.m. - One CNA (#8) transferred the resident from a recliner to his wheelchair, transferred the resident from his wheelchair to the bathroom, assisted with personal cares, transferred the resident to his wheelchair, encouraged the resident to move into the hallway. *03/24/14 at 8:20 a.m. - One CNA (#19) assisted the resident with personal cares, transferred to his wheelchair, assisted the resident to move to the lounge, and transferred the resident from his wheelchair to a recliner. *03/24/15 at 12:15 p.m. - One CNA (#19) transferred the resident from his wheelchair to the bathroom, assisted with personal cares, transferred the resident to his wheelchair, and	F 327		

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F 327	Continued From page 43 assisted the resident to the dining room. - Review of Resident #2's medical record occurred on all days of survey and diagnoses included dementia. The quarterly Minimum Data Set (MDS), dated 03/11/15, identified short and long-term memory problems and extensive assistance for eating. The current care plan stated, ". . . Focus: Nutritional status . . . Need for assistance with all food and fluids . . ." Review of a progress note dated 09/10/14 at 8:38 a.m. stated, ". . . Totally dependent on staff for all food and fluids. . . ." Observation on 03/23/15 at 4:35 p.m. showed two CNAs (#8 and #14) transferred Resident #2 from his wheelchair into bed, changed the resident's incontinent product, transferred the resident back into his wheelchair, and transported him to the lounge. The staff (#8 and #14) failed to offer Resident #2 fluids during cares. Observation on 03/24/15 at 9:47 a.m. showed two CNAs (#9 and #13) transferred Resident #2 from his wheelchair into bed and changed the resident's incontinent product. The staff members (#9 and #13) failed to offer the resident fluids during cares. During an interview on 03/25/15 at 11:23 a.m., an administrative staff member (#15) confirmed staff should offer fluids with cares.	F 327		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS	F 328		

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F 328	Continued From page 44 The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to safely secure an oxygen tank for 1 of 3 sampled residents (Resident #1) dependent on oxygen. Failure to secure the oxygen tank placed the facility's residents, visitors, and staff at risk of injury. Findings include: Observation on 03/24/15 at 10:26 a.m. showed a nurse (#10) placed an oxygen tank free-standing in Resident #1's room. The unsecured oxygen tank tipped over on the floor. During an interview on 03/25/15 at 11:47 a.m., an administrative staff member (#3) stated staff are expected to use a cart when transporting oxygen tanks.	F 328	F 328 SS=D 483.25 TREATMENT/CARE FOR SPECIAL NEEDS The nurse caring for resident #1 was re-educated immediately upon Administrative Director of Nursing Services hearing of the oxygen being transported inappropriately. Residents who require the use of portable oxygen tanks have the potential to be affected by this practice. ADNS or designee will provide education to nursing staff regarding proper transportation of oxygen tanks. ADNS or designee will ensure that rolling carts for transportation of tanks are readily available for staff use. Audits will be completed weekly for four weeks then monthly for 3 months. Results of audits will be forwarded to QAA Committee for review and recommendation.	
F 431 SS=D	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	F 431	Date of compliance is April 29, 2015.	

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F 431	Continued From page 45 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. 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 and review of facility policy, the facility failed to store all medications in a secure manner on 1 of 2 nursing units (2nd floor). Failure to store all medications securely may result in unauthorized access to	F 431	F 431 SS=D 483.60 DRUG RECORDS, LABEL. STORE DRUGS AND BIOLOGICALS The licensed nurse involved in caring for resident #26 was educated regarding the need to secure the medication cart when nurse leaves medication cart unattended. Residents who may gain access to an unlocked, unattended medication cart have the potential to be affected by this practice. ADNS or designee will provided education to licensed nurses regarding locking the med cart every time they walk away from it and it is not in their direct line of site. Security of medication carts will be audited three times weekly for four weeks and then weekly for 3 months. Results of audits will be forwarded to the QAA committee for review and recommendations. Date of compliance is April 29, 2015.	

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F 431	Continued From page 46 medications. Findings include: Review of the facility policy titled "Storage of Medications" occurred on 03/25/15. This policy, dated September 2011, stated, ". . . Medication rooms, carts, and medication supplies are locked or attended by persons with authorized access. . . ." - Observation on 03/24/15 at 11:55 a.m. showed a nurse (#10) administering medications to Resident #26 in her room while the medication cart remained unlocked in the corridor outside the room and near a dining room. Residents and staff walked by the unlocked medication cart to enter the dining room for the noon meal. - Observation on 03/24/15 at 12:10 p.m. showed a nurse (#23) administering medications to residents in the dining room while her medication cart remained in the corridor outside the dining room. On one occasion, the nurse (#23) failed to lock the medication cart. Observation identified residents and staff near the unlocked and unattended medication cart. - A random observation on 03/24/15 at 12:40 p.m. identified an unlocked and unattended medication cart in the corridor outside of the dining room. Observation showed staff and residents walking passed the cart to exit the dining room.	F 431		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a	F 441		

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F 441	Continued From page 47 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. (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: Based on observation, staff interview, and policy review, the facility failed to follow standard	F 441	F 441 SS=E 483.65 INFECTION CONTROL, PREVENTION SPREAD, LINENS Staff caring for residents #5, #10, #11, and #13 were educated on proper hand hygiene when providing care. Residents who require assistance with personal care have the potential to be affected by this practice. ADNS or designee will provide education regarding glove use, hand hygiene, and peri care to nursing staff. Infection control measures will be implemented and reviewed by ADNS or designee. Direct care audits through observation will be completed three times weekly for four weeks then weekly for 3 months. Results of audits will be forwarded to QAA Committee for review and recommendations. Date of compliance is April 29, 2015	

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F 441	Continued From page 48 infection control practices for 4 of 13 sampled residents (Resident #5, #10, #11, and #13) observed receiving assistance with personal cares. Failure to perform hand hygiene after completing perineal care has the potential to spread infection within the facility. Findings Include: Review of the facility policy titled "Hand Hygiene" occurred on 03/25/15. This policy, dated 2013, stated, "Hand hygiene is the single most important measure for reducing the risk of spread of infection. . . . The following is a list of some situations that require hand hygiene . . . Before and after assisting a patient with toileting (perform handwashing with soap and water) . . . After removing gloves . . . After contact with a patient's . . . body fluids or excretions . . ." - On the afternoon of 03/23/15, observation showed two CNAs (#14 and #17) provided personal cares for Resident #10 after an episode of urinary incontinence. While Resident #10 laid in bed, the CNA (#17) applied gloves, used a perineal wipe to cleanse the resident's perineal area, tossed the soiled disposable wipes across the bed and onto the floor, missing the garbage container. Using the same gloved hands, the CNA opened a lotion bottle, put lotion on the resident's perineal area; and touched the package of disposable wipes, the mechanical lift sling pad, the resident's pillows, the bedside drawer handle, and the closet drawer handle. The CNA (#17) then removed her gloves, failed to perform hand hygiene, donned clean gloves, and performed other tasks such as assisting the resident to transfer from the bed to his wheelchair, and adjusting the resident's clothing.	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355031	A. BUILDING _____ B. WING _____	03/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 441	Continued From page 49 The CNA (#17) failed to remove her soiled gloves prior to touching clean objects and failed to perform hand hygiene immediately after removing the soiled gloves. - On 03/24/15 at 2:30 p.m., observation showed two CNAs (#18 and #20) provided personal cares for Resident #10 after an episode of urinary incontinence. While Resident #10 laid in bed, the CNA (#18) applied gloves and wiped the resident's perineal area. The CNA (#18) then removed her gloves, failed to perform hand hygiene, donned clean gloves, and performed other tasks such as applying the mechanical lift sling pad, and transferring the resident from the bed to his wheelchair. The CNA (#18) failed to perform hand hygiene immediately after removing the soiled gloves. - On 03/24/15 at 3:16 p.m., observation showed a CNA (#9) provided personal cares for Resident #11 after an episode of urinary incontinence. While Resident #11 laid in bed, the CNA (#9) applied gloves and wiped the resident's perineal area. The CNA (#9) then removed her gloves, failed to perform hand hygiene, donned clean gloves, and performed other tasks such as pulling Resident #11's pants up, applying a gait belt, putting on the resident's slippers, transferring the resident from the bed to her wheelchair, and adjusting the resident's clothing. The CNA (#9) failed to perform hand hygiene immediately after removing the soiled gloves. - Observation on 03/24/15 at 4:30 p.m., showed the CNA (#7) applied gloves and assisted Resident #5 in the bathroom with personal cares after a bowel movement. Without removing her soiled gloves, the CNA (#7) opened the door to	F 441		

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F 441	Continued From page 50 the bathroom and transported the resident in a sit to stand mechanical lift to his wheelchair. The CNA (#7) then removed her gloves, adjusted the resident's shirt, and applied the foot pedals to the resident's wheelchair before performing hand hygiene. The CNA (#7) failed to perform hand hygiene after providing perineal care prior to doing other tasks. - Observation on 03/25/15 at 8:53 a.m., showed a CNA (#18) assisted Resident #13 to stand up from the toilet, provided perineal cares, removed her gloves, and assisted Resident #13 into the wheelchair. The CNA (#18) removed the resident's glasses, changed the resident's soiled shirt and placed the glasses back on the resident. The CNA (#18) assisted Resident #13 to wash his hands and then the CNA (#18) performed hand hygiene. The CNA (#18) failed to perform hand hygiene after providing perineal care prior to doing other tasks. During an interview on 03/25/15 at 11:15 a.m., an administrative nurse (#2) stated once the resident is in a safe position, she expected staff to perform hand hygiene immediately after completing perineal care and removing their gloves.	F 441		
F 502 SS=B	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the	F 502		

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F 502	Continued From page 51 facility failed to ensure the laboratory collection tubes (vacutainers) available for use by facility staff in 1 of 2 medication rooms (first floor) had not expired. Use of expired vacutainers when obtaining blood samples from residents may result in inaccurate lab test results. Findings include: Observation in the facility's medication room occurred on 03/25/15 at 2:10 p.m. and revealed the following: * 1 green topped vacutainer expired in November 2014 * 3 yellow topped vacutainers expired in January 2015 * 10 blue topped vacutainers expired in February 2015 During interview at this time, a nurse (#12) stated an administrative nurse obtains blood samples via the tubes.	F 502	F 502 SS=B 483.75 ADMINISTRATION No residents were identified as affected by this practice. Residents with orders for labs that require the use of vacutainers have the potential to be affected by outdated lab supplies. ADNS or designee will educate nurses and supply clerk regarding checking outdates on lab tubes. Routine checking for expiration dates on supplies will be completed a minimum of once each month. Audits of lab supplies will be completed weekly for four weeks then monthly for 3 months. Results of audits will be forwarded to QAA committee for review and recommendations. Date of compliance is April 29, 2015.	