RECEIVED
MAY - 2 2012
Division of Health Facilities

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 _____	04/11/2012

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 April 9, 2012 and completed on April 11, 2012 the sample included 5 residents for complete review, 13 residents for focused review, 3 closed records for review. The sample included 8 additional residents to verify specific concerns during the survey.	F 000		
F 246 SS=E	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: 1. Based on observation, resident interviews, and staff interview, the facility failed to provide reasonable accommodations of individual needs for 4 of 18 sampled residents (Resident #3, #7, #10 and #17) and 6 of 8 supplemental residents (Resident #22, #24, #26, #27, #28 and #29). The facility failed to: place call lights within reach for 4 residents (Resident #10, #26, #27, and #28); answer call lights in a timely manner (Resident #3, #22, #24 and #28); ensure the physical environment promoted independent functioning for grooming (Resident #7); and ensure adequate spacing during a transfer to a resident's bathroom (Resident #17). These occurrences may affect the quality of life and quality of care provided to all residents who reside in the facility.	F 246	Manor Care Health Services will provide services that reasonably accommodate the needs of residents in the facility's care. Identified residents during survey process were found to have call lights in reach on random audits during the week of April 22, 2012. Random audits were completed in the south dining room and resident #23 has not had to be moved during the dining experience. Resident #17's room was rearranged to allow access to the bathroom without having to move the resident. Resident #7 had a mirror placed on 4/19/12 and is able to visualize herself while grooming. Residents residing at Manor Care Health Services have the potential to be affected by the deficient practice when utilizing call lights, dining in the dining rooms or performing grooming.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Mike Kopp	administrator	5/1/12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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 _____	04/11/2012

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 246	Continued From page 1 Findings include: - During the initial tour of the facility on the morning of 04/09/12, , observation showed three residents (Resident #26, #27 and #28) either in their wheel chairs or bed with their call lights laying on the floor and out of reach. - During an interview on 04/09/12 at 10:35 a.m., Resident #24 (identified by the facility as interviewable) reported one night having to wait over an hour with her call light on before staff assisted her. - During interview on the afternoon of 04/09/12, Resident #2 (identified by the facility as interviewable) stated it takes time to get call lights answered as the facility is "short of help up here." - During an interview on 4/09/12 at 4:30 p.m., Resident #3 (identified by the facility as interviewable) reported having to frequently wait for staff to answer her call light. The resident reported that within the last month, she put on the call light and waited over one hour for staff to assist her. - Review of Resident #10's record occurred on April 09-10, 2012. The record included an interdisciplinary progress note, dated 03/25/12, which stated " . . . Able to make needs known did call 911 Saturday morning because she could not reach her call light. Bed mobility extensive assist 1-2. . . . Use of mechanical lift to transfer assist two." - A random observation on 04/10/12 at 4:35 p.m.,	F 246	Staff education presented on April 27th and 30th included review of call light response expectations and call light placement when patients are in rooms. A dining committee has been implemented. Staff education on April 27th and 30th included information on reporting concerns regarding moving residents to and from tables in the dining area and to observe for proper table location in the dining area. Staff education on April 27th and 30th also addressed accommodating individual needs for grooming. Rooms were evaluated and mirrors will be placed to ensure patients have access to mirrors. QA audits will be conducted by ADNS, Administrator or designee daily x 2 weeks during facility walk through observation to ensure call lights are in reach then twice weekly through May. Weekly audits will continue through June and then be decreased to weekly for three months and then as per QAA Committee recommendation (see exhibit 246-1). Call light audits (see exhibit 246-2) will be completed weekly by Administrator or designee. Audits of the dining area will be completed (see exhibit 246-3) by Dining Committee member or designee weekly x 4 weeks then monthly x 3 and then as per QAA Committee recommendations. Mirrors will be placed in each room by 5/16/12 and will not require ongoing QA once placed.	05/16/2012

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 _____	04/11/2012

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 246	Continued From page 2 showed a visitor approached the nurses station asking for someone to help Resident #30. The visitor commented that the resident put the call light on "quite some time ago." The visitor commented that she had been here about 20 minutes and that the resident had put the light on shortly after she had arrived. - Observation on 04/10/12 from 5:45 p.m. to 6:01 p.m. (16 minutes) showed Resident #22's call light activated. During an interview at this time, Resident #22 (identified by the facility as interviewable) stated he turned his call light on so he could talk with a nurse. At 6:01 p.m. a CNA (Certified Nursing Assistant) delivered a meal tray to the resident, shut off the call light, but failed to address why Resident #22 activated the call light. - Observation on 04/11/12 from 8:37 a.m. to 8:54 a.m. (17 minutes) showed a call light in Resident #29's room activated. A CNA (#10) stopped at the nurse's station for approximately 2 minutes (from 8:49 a.m. to 8:51 a.m.) and then proceeded to enter a resident's room that didn't have a call light on. - During an interview on 04/11/12 at 4:20 p.m., a supervisory nursing staff member (#2), stated the facility expects call lights to be answered within ten minutes. - Observation on 4/10/12 at 12:00 p.m. showed two CNA's (#7) and (#8) transferred Resident #7 into her wheelchair. The CNA (#7) placed the resident in front of the sink and handed the resident a hairbrush. The resident brushed her hair and then asked the CNA if her hair looked okay. Observation showed the resident, who uses	F 246		

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 _____	04/11/2012

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 246	Continued From page 3 a wheelchair, unable to see herself in the mirror due to the height of the mirror above the sink. - On the afternoon of 04/11/12, during a Hoyer lift transfer of Resident #17 by two CNAs (#14 and #15) from the bed to the bathroom (bed located on the window side of the room), observation showed the resident's roommate sitting next to her bed in a wheelchair. The CNA (#14) asked the resident to exit the room in order to access the bathroom with the lift for Resident #17. 2. Based on observation and staff interview, the facility failed to ensure residents could move about the dining room in 1 of 3 dining areas on the first floor (the small dining room in the South wing). Failure to ensure residents may freely enter the dining room without requiring other residents to move interfered with the dining experience for Resident #23, and has the potential to affect other residents. Failure to position the tables in the dining room in a manner that allowed unrestricted access has the potential to increase the risk for accidents. Based on review of the North Dakota Department of Health, Division of Health Facilities provider files, this facility has not sustained correction of this issue. This requirement was found to be out of compliance during the previous survey completed in 2010. Findings include: Prior to serving the noon meal on 04/10/12, in the small dining room on the South wing, observation showed Resident #23 seated in a wheelchair at the dining room table closest to the entrance of	F 246		

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 _____	04/11/2012

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 246	Continued From page 4 the room. Two other residents sat at the table as well. Observation showed an unidentified resident, pushing a front wheeled walker (FWW), attempt to pass between Resident #23 and another resident seated in a wheelchair at the opposite table. An unidentified staff member asked Resident #23 if her wheelchair could be moved to enable the resident with the FWW to pass through to her dining table. The staff member positioned Resident #23 back at her table. Within five minutes another resident entered the dining room in a wheelchair. Observation showed a staff member again asked Resident #23 if she could be moved to allow the resident in the wheelchair to pass by. During a staff interview on 04/11/12 at 3:40 p.m., two administrative staff members (#2 and #9) agreed residents should not need to be moved to allow residents to access their place settings in the dining room.	F 246		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED MAY 9-12, 2011. Based on observation, record review, and resident and staff interview, the facility failed to provide effective housekeeping/maintenance services to maintain a sanitary, odor-free	F 253	Manor Care Health Services will provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Toilet risers were cleaned on 4/11/12 and 4/12/12. Bedding was changed for Resident #4 on 4/11/12. Floors in 178 and 248 bathrooms were cleaned on 4/11/12 and 4/12/12. Areas of concern noted in room 203 have been addressed. Local contractors have addressed areas of concern with plumbing and exhaust fans. We have increased the frequency of housekeeping rounds to those rooms with risers to twice per day.	

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 _____	04/11/2012

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 253	Continued From page 5 environment on 2 of 2 floors (north and south wings) Findings include: - During the initial tour of the environment on 04/09/12, observation showed the toilets/toilet risers visibly soiled with fecal material in rooms 178, 188, 260, and 265. Odors were noted in the bathroom in Room 199, in Rooms 201 and 203 and in the main hallway of the second floor. Observation showed the floor dirty in the bathroom in Rooms 178 and 248, by the bed in Room 202, and a sticky floor in Room 203. - Observation on 04/10/12 at 8:00 a.m., showed Resident #4 assisted out of bed and a piece of plastic lying on the bedsheet, and brown spots on her pillow case. The certified nurse assistant (CNA #5) did not remove the plastic or change the pillow case. At 5:20 p.m., upon request, a CNA (#6) pulled back the bedding on Resident #4's bed to reveal the piece of plastic still present and the pillow case still with visible brown spots. The CNA (#6) stated she would change the bedding. - During a toileting observation on 04/10/12 at 8:55 a.m., in room 252, the toilet riser had toilet paper wet with urine and fecal material on it. Observation at 5:10 p.m. showed the toilet paper and fecal material still present on the riser (more than eight hours later). - During all days of survey, fecal odors were present in hallway by rooms 201, 202, 203 and 204 as well as by the south entrance to the second floor dining room, which is located across	F 253	Resident rooms have potential for odors. Staff education was provided on April 27th and 30th and addressed cleaning toilet risers when soiled, handling soiled linens, and managing odors. Housekeeping rounds have been increased to twice daily for bathrooms with risers in place. Review of housekeeping policy and procedures related to resident rooms was reviewed at in-service on 4/30/12. Exhibit 253-1 QA committee members, environmental staff and nursing staff will monitor issues with toilet risers and odors QA will be daily x 2 weeks. Then BID/weekly though May. If no issues are identified will decrease to Weekly for June and then as per the QAA committee recommendations. (see exhibit 246-1). QA will start May 6th All rooms identified will be incorporated in the walk through. Exhibit 246-1.	05/01/2012 06 per Mitch Loupp. cam. 5/10/12 @ 1 p.m.

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 _____	04/11/2012

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 253	Continued From page 6 from restrooms. - On 04/09/12 at 4:55 p.m., a strong odor of urine was noted in Resident #1's bathroom. - On 4/10/12 at 8:00 a.m., an fecal odor was noted in the south hallway on 1st floor. - The environmental tour of the facility occurred on the morning of 04/11/12 with the Maintenance and Housekeeping Supervisors (Staff #3 and #4). During this tour, observation showed bathroom toilets soiled with fecal material in rooms 178, 188 and 260. Odors were present in rooms 184, 187, 188 and 199. Odors were also present in the hallway outside of room 180 and in the hallway outside of rooms 203 and 204. The floor remained sticky in Room 203. Facility staff present on the tour acknowledged the odors and soiled bathrooms/toilets. - Review of the Resident Council Meeting minutes, for the past three months, occurred on 04/10/12. The minutes from 02/23/12 meeting identified residents reported a housekeeping issue of "the toilets need to be cleaned better." During the group interview on 04/10/12 at 10:30 a.m., Resident A said that "sometimes the bathroom could be cleaner." During interview on 04/11/12 at 2 p.m., the administrator and the Director of Nursing (Staff #1 and #2) confirmed noticeable odors within the facility at times. The staff member (#1) indicated odors in Room 203 and in the hallway near that room have been an ongoing problem.	F 253		
F 323	483.25(h) FREE OF ACCIDENT	F 323	Manor Care Health Services will provide care and services that enhance personal	

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 _____	04/11/2012

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 SS=G	Continued From page 7 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 observation, record review, review of manufacture's recommendations, review of facility policy and procedure, and staff interview, the facility failed to ensure adequate supervision and assistance to prevent accidents for 6 of 18 sampled residents (Resident #2, #5, #10, #15, #16 and #17). Failure to evaluate the safety of Resident #5's utilization of an electric wheelchair resulted in the resident re-fracturing his right tibia and fibula. Failure to implement fall prevention strategies resulted in Resident #2 experiencing a fall requiring medical intervention due to injuries. Failure to ensure proper use of sit to stand lifts and gait belts resulted in Resident #10 and #17 experiencing pain with transfers and with Resident #15 having unsafe transfers, and failure to utilize foot pedals when transporting residents in wheelchairs placed residents (Resident #10 and #16) at risk for possible accidents and/or injury. Findings include: - Review of Resident #5's medical record occurred on April 9-11, 2012. The resident's	F 323	safety and reduce the risk for accidents and hazards. The electric wheelchair for Resident #5 was discontinued prior to survey at the time of incident. A perimeter mattress was applied during survey for Resident #2 and remains in place. No further falls at this time. Care plan was updated at the time to reflect this. Resident #2 has a reacher as per care plan and uses as she desires. It is accessible to her. Resident #10 and #17 sling was changed during survey, and education done at that time with staff. Residents utilizing electric wheelchairs or scooters are at risk for accidents. The facility does not currently have any residents using this type of device. Residents residing at Manor Care have the potential to fall and be affected by this. Residents using sit to stand lifts have the potential to be affected by sling placement and lift use. Residents currently using lifts will be evaluated during transfers for appropriate sling placement and lift device. Residents who request to utilize electric wheelchairs or scooter will be assessed for safety at admission/implementation of the device and reviewed during quarterly care planning or with significant change.	

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 _____	04/11/2012

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 8 current diagnoses included fracture of right tibia and right fibula (02/03/12), multiple sclerosis (MS), Parkinson's, and osteoporosis. The resident's first fractures to the right tibia and right fibula occurred in November of 2010 when the resident hit his bathroom doorway while in his electric wheelchair. Review of Resident #5's Annual MDS (Minimum Data Set), dated 12/05/11, (prior to the second incident of fractures) identified the resident required extensive assistance of two for bed mobility, transfers, toileting and the resident had impaired functional limitation in range of motion of the upper and lower extremities bilaterally. Resident's #5's care plan, dated 05/30/2011, stated . . ."ADL [activities of daily living] self care deficit related MS . . . Resident utilizes electric w/c [wheelchair] for locomotion, independent [with] this . . ." The current revised care plan identified Resident #5 uses a high tilt back wheelchair. A skin alteration record, dated 7/20/2011, identified the resident scraped his elbow as he was going through a doorway on his electric wheelchair. The scrape measured 0.4 centimeters (cm) by 0.4 cm and on 07/22/2011, and had a light blue bruise around the scrape which measured 3.3 cm x 2.8 cm. An Occupational therapy (OT) evaluation, completed on 01/19/12, identified Resident #5 with progressive MS, weakness, dependent with adl's (transfers, dressing, bathing) and assist with feedings. The evaluation identified the resident cannot assume or maintain functional sitting	F 323	Education related to safe transfers was provided at meetings on April 27th and 30th. Education included sit-stand and also gait belt use. Education was also provided during these meetings related to need for immediate and appropriate intervention at the time of fall. ADNS or designee will conduct QA on falls in May 2012 and then as per the QAA committee recommendations. (See Exhibit 323-4) The facility will continue the current practice of reviewing falls during daily standup meetings for accuracy/appropriateness of fall intervention. QA for lift use will be initiated following screening in May of all residents requiring use of mechanical sit-stand. QA will be done by ADNS or designee and will include Resident #10 and 17 for 3 months and an additional 6 random transfers. (see exhibit 323-5 and 323-6). Ongoing monitoring will be completed as per QAA Committee recommendations. See addendum re: foot pedals monitoring & implementation mid 5/11/12	5/16/2012

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

PRINTED: 04/19/2012
FORM APPROVED
OMB NO. 0938-0391

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 _____	04/11/2012

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 9 balance. Evaluation of ADL's included: "Eating and Feeding -moderate assistance; grooming, bathing, dressing, toilet hygiene, transfers, and bed mobility as dependent assistance. Summary and Assessment- . . . difficulty operating his power w/c. Pt [patient] has very limited ROM [range of motion] in B [bilateral] UE's [upper extremities] limiting ability to complete own ADLs . . . . Weekly Status on 02/02/12 stated, . . . Pt has been struggling [with] driving electric w/c . . . Will screen for safety [with] w/c. Pt today requested that I drive for him. adjusted speed to lowest setting. will see if pt has easier time [with] driving." Resident #5's nurse's notes identified the following: * 01/08/12, 1 p.m.- ". . . Having more difficulty feeding self, operating electric w/c [wheelchair], picking up items [with] his hands etc. . . ." * 01/11/12, 2325, ". . . Has trouble operating electric w/c. does run into objects et [and] walls @ [at] x's [times]" * 02/03/2012, " . . . Late entry for February 3rd, 2012 at 11 am; [resident] in lounge backed into other resident with his electric w/c. Reminded [resident] to be careful with the electric w/c "I know". This morning [resident] coming out of his room with electric w/c & [and] ran into treatment cart. Pushed treatment cart approx [approximately] 3 feet down hallway before stopping. Weakness noted to right hand due to dx [diagnosis] of MS. Screen given to PT [physical therapy] to evaluate for w/c safety." Resident #5's Clinical-Assessment-Report notes identified the following: * 01/08/12, 1:00 p.m. - ". . . 2. . . . is more quiet	F 323	Addendum for F-323 Resident # 17 refuses to use foot pedals. This was discussed with her and her daughter at time of the survey. We will continue to encourage her to use her foot pedals. Care plan updated for resident #17. Footrest for resident # 10 Broda were also obtained and placed. Staff were educated at all staff inservices on April 27th and 30th to use foot pedals on any resident that is not able to consistently hold their feet up during transfers, and to remove once they got to the location they were going. QA will consist of residents being watched during transportation to DR, resident #10 and #17 will be included in observations and random audit of 5 other residents. QA will begin May 14th and will be weekly through May. If no issues identified will go to monthly and per QA committee recommendation	5/14/12

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 _____	04/11/2012

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 9	F 323		

balance. Evaluation of ADL's included: "Eating and Feeding -moderate assistance; grooming, bathing, dressing, toilet hygiene, transfers, and bed mobility as dependent assistance. Summary and Assessment- . . . difficulty operating his power w/c. Pt [patient] has very limited ROM [range of motion] in B [bilateral] UE's [upper extremities] limiting ability to complete own ADLs . . . . Weekly Status on 02/02/12 stated, . . . Pt has been struggling [with] driving electric w/c . . . Will screen for safety [with] w/c. Pt today requested that I drive for him. adjusted speed to lowest setting. will see if pt has easier time [with] driving."

Resident #5's nurse's notes identified the following:
* 01/08/12, 1 p.m.- ". . . Having more difficulty feeding self, operating electric w/c [wheelchair], picking up items [with] his hands etc. . . ."
* 01/11/12, 2325, ". . . Has trouble operating electric w/c. does run into objects et [and] walls @ [at] x's [times]"
* 02/03/2012, " . . . Late entry for February 3rd, 2012 at 11 am; [resident] in lounge backed into other resident with his electric w/c. Reminded [resident] to be careful with the electric w/c "I know". This morning [resident] coming out of his room with electric w/c & [and] ran into treatment cart. Pushed treatment cart approx [approximately] 3 feet down hallway before stopping. Weakness noted to right hand due to dx [diagnosis] of MS. Screen given to PT [physical therapy] to evaluate for w/c safety."

Resident #5's Clinical-Assessment-Report notes identified the following:
* 01/08/12, 1:00 p.m. - ". . . 2.. . . is more quiet

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 _____	04/11/2012

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 10 and more depressed due to progression of MS and increased inability to do adl's per self, Is having more difficulty with swallowing with a straw, feeding self (recently spilled cocoa on himself). Has more difficulty picking up things with his hands, has more problems steering his electric w/c, . . ." * 02/03/12, 6:25 p.m. - ". . . 2. . . . CNA [Certified Nursing Assistant] requested nurse to look at res. [resident] leg. Noted redness and swelling to RLE [right lower extremity] above ankle where res previous healed fx [fracture]. Noted RLE not stable with movement and res c/o [complained of] discomfort with movement . . . 6. Res [resident] has been bumping/running into objects with electric w/c more frequently. . . . Did have fx to tib/fib [tibia/fibula] of RLE over 1 year ago. . . . 23. increased difficulty controlling elect [electric] w/c . . . Likely has fx of RLE, needs to be sent to ER [emergency room] for xray of RLE and eval/tx [evaluation/treatment]. A Physical Therapy (PT) evaluation, completed on 02/15/12 (after Resident #5's fractures) stated, " . . . History of MS and Parkinsonism with severe debility. Has been dependent for all ADL's does have an electric w/c which he has been using but has progressively become less safe with its use. Recently sustained a R [right] tib-fib fx due to running into an object. . . ." A confidential interview (#A) on 04/11/12 at 3:45 p.m. identified Resident #5 damaged walls and doors of the facility with his electric wheelchair prior to the injury. During an interview on 04/10/12 at 4:00 p.m., a nursing staff member (#11) stated she thought	F 323		

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 _____	04/11/2012

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 11 they had done an evaluation in the past on the resident's ability to use the electric wheelchair, but could provide no recent evaluation. Failure to reassess Resident #5's ability to safely utilize his electric wheel chair and implement additional interventions which would address his increased risk of injury due to his physical decline resulted in the resident re-fracturing his right tibia and fibula. - Review of the facility's fall prevention policy occurred on 04/11/12. The policy, dated 2011 (unspecified month), stated: ". . . Some risk factors or conditions that may predispose a patient to fall may include . . . arthritis, history of falls . . . peripheral neuropathies . . . unsteady gait, muscle weakness . . . medications, physical environment . . . Medication side effects may pre-dispose a patient for falls . . . may include, but are not limited to: . . . anti-depressants . . . benzodiazepines [includes diazepam/Valium], anxiolytics [anxiety medication], psychotropics [antidepressants/antianxiety/antipsychotic drugs] . . . If . . . the patient is found to be at risk for fall or has a history of falls . . . an initial plan of care is developed and individualized interventions are initiated . . ." Review of Resident #2's medical record occurred on all days of survey. Resident #2's diagnoses included depression, poly neuropathy (nerve damage initially starting in both feet and may progress to involve the feet, calves, and fingers/hands), diabetes, difficulty in walking (dated 11/17/11), osteoarthritis, anxiety disorder, and rheumatoid arthritis.	F 323		

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 _____	04/11/2012

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 12 Resident #2's medications included Cymbalta (antidepressant) daily since 09/18/09, Diazepam (Valium) two times a day since 11/13/09, Seroquel (antipsychotic) (since 09/03/09), and Sertraline (Zoloft) (antidepressant) two times a day since 05/09/08. Review of the most recent MDS, dated 01/23/12 and an annual, dated 07/23/11, identified Resident #2 with no cognitive impairment and extensive assistance of two or more persons for bed mobility and one person for transfers. The falls Care Area Assessment (CAA), dated 07/23/11, stated, ". . . had a fall 6/21/11 in her room reaching for phone, and rolled out of bed, landing face first on the floor. She was treated for hematoma to foreahead [sic], laceration to bridge of nose and a skin tear to left forearm . . . has a hx [history] of falls and is careplanned for falls. She is alert and can make needs known. Takes seroquel, diazepam, sertraline and cymbalta . . ." Care Plan Considerations" included to minimize risks "She is careplanned as at risk for falls due to generalized weakness, self transfer attempts at times . . . Staff assist with all adls as needed. . . ." Resident #2's current care plan included the following focus (problems): * "At risk for falls due to generalized weakness, self transfer attempts at times" with interventions of "Have commonly used articles within easy reach . . . Reinforce need to call for assistance . . . Resident refuses Dycem to wheelchair . . . . Phone to be within reach . . . Provide assist to with [sic] ADLs as needed; Current medication review; Resident educated on fall risk and call lite. Encouraged to ask for assistance; Allow resident adequate time to assist with turning,	F 323		

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 _____	04/11/2012

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 13	F 323		

transferring, etc." Nurse's notes between 12/14/11 and 03/16/12 identified Resident #2 required extensive assist of one for bed mobility, and for transfers, which conflicts with the MDS, dated 01/23/2012, which identified the resident required extensive assist of two or more persons with bed mobility.

Review of nurse's notes identified the following falls:
* 06/12/11 at 2:15 p.m., ". . . res [resident] yelling in her room. Res found lying next to her bed face down on the floor. States her phone was ringing et she was attempting to reach it when she rolled out of bed. 7 cm x [by] 7 cm hematoma noted to forehead. 1.3 cm x 1.5 cm laceration to bridge of nose [with] bruising et swelling present. Also noted 3 cm x 2.4 cm skin tear to [left] forearm. . . . Stated only has discomfort to nose. Skin tears cleaned et steristrips applied. Assisted to bed by [two] nurses." Further review of the record identified nursing staff sent the resident to the emergency room (the same day), received a computerized axial tomography (CAT) of the head, and sutures to the nose. The notes stated, upon return, ". . . Bed in low position. Res. educated that bed must remain in low position for her safety." An occupational therapy (OT) evaluation completed on 06/14/11 stated, "Received screen regarding resident fall out of bed. . . . Pt. bed to be in low position [with] side table/telephone within reach. No skilled OT services needed at this time."
* 08/24/11 at 5:30 a.m. identified staff found the resident sitting on the edge of the bed as she "heard her mother call her in the hallway."
* 12/14/11 at 9:00 p.m., "Resident was reaching for object while in w/c et fell landing on the floor

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 _____	04/11/2012

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 14 on her [right] side head touching wall. States didn't hit my head. . . . 2.1 x 0.9 cm skin abrasion to [right] knee . . . Able to move all extremities [without] difficulty. . . ." * 03/16/12 at 5:13 a.m., "Resident thought at 3:25 AM that her son was calling her and so she attempted to get out of bed with out assistance and was found on her back laying ion [sic] the floor her room mate put the call light on . . . Assist 3 and gait belt to get resident back onto her feet . . . No visiable [sic] injury marks and resident denied injury or pain. . . ." The nurse's notes identified a medication review occurred on 03/19/12 and addressed the use of Cymbalta with "Noted side effect of nightmares and vivid dreams. When reading follow up documentation from her fall, noted that she was asleep and believed she heard her son hollering for help . . ." * 03/26/12 at 8:31 p.m., "Resident found on the floor at the foot of her bed at 3:45 pm. States she was going to look for her other pair of glasses on the other side of the bed (by walking) and 'went down.' . . . Reminded res to utilize call light for assist. Res has long hx of falls and continues to believe she can walk . . ." Following this fall, a request for a PT evaluation and treatment for strengthening occurred; the evaluation stated the plan would be "to train nursing to amb. [ambulate] to improve strengthening . . ." * 04/08/12 at 11:56 p.m., "4/8/12 @ [at] 11 PM staff [one staff member] was in the process of changing her brief and had her on her right side and was about a foot from the edge of the bed but resident reached to her bed side stand and got two make up pencils and caused her self to fall out of the bed hitting the waste basket and causing a laceration to above her nose to for head [sic] 2.04 x .01 and below left eye 3 x .5 cm	F 323		

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 _____	04/11/2012

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 15 laceration and bruise to the area. below it 1 x 6 cm bruise to cheek bone, left knee 2 x 3.5 cm abrasion and right knee 1.75 x 1.5 cm no bleed. Right elbow .5 x 2.25 cm purple and blue bruise. . . ." A fall assessment for both the 03/26/12 and 04/08/12 falls identified the resident as having "Impulsivity or poor safety awareness" and "Visual impairment." The assessment failed to include the environmental factors in place at the time of the fall. The additional comments, dated 03/26/12, stated, "States shew [sic] was going to look on the other side of her bed for her other glasses when she fell. Does have a long hx of fall, lacks safety awareness. Believes she is more capeable [sic] than she truly is with mobility." The additional comments, dated 04/08/12, stated, "Instructed not to be reaching for items as staff is changing briefs. Has history of lack of safety awareness even when instructed and educated about it. Feels she is able to do things when in fact she lacks limitation of thigs [things] at times." During interview on the afternoon of 04/11/12, two administrative staff members (#2 and #9) stated Resident #2 had a reacher available in her room sitting on the window sill. The falls verify the reacher was not available during the falls and/or the resident failed to utilize the reacher on each occasion. Observations on April 9-10, 2012 showed no measures to prevent or reduce an injury to Resident #2 in the event of a fall, including: a fall mat, low bed, perimeter mattress, or accessibility of a reacher. Record review lacked evidence of an evaluation of the resident's current	F 323		

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 _____	04/11/2012

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 16 medications, room, other environmental risk factors and accessibility of the reacher. The care plan lacked interventions including a fall mat, low bed and a reacher. The record stated Resident #2 lacked safety awareness, yet staff continued to instruct her to call for assistance. Failure to reassess and implement preventive fall measures resulted in Resident #2 experiencing a fall/injury and placed the resident at risk for further falls/injury. - Review of the manufacturer's instructions, undated, for the use of the "STAND UP AND TRANSPORT SLINGS" for the Arjo stand lift and Chorus stand lift, stated, ". . . Before lifting the patient, make sure the bottom edge of the standing sling is positioned on the lower back of the patient . . . Position the standing sling around the patient's torso just below the shoulder blades and under the arms . . . NOTE: Make sure the bottom edge of the sling is on the lower back . . . Secure the standing sling to the patient by buckling the belt. . . . WARNING: The belt MUST be snug, but comfortable on the patient, otherwise the patient can slide out of the sling during transfer, possibly causing injury. . . . Adjust the belt for a snug, but comfortable fit. . . . Attach the standing sling to the stand up lift. . . ." Review of a facility policy on "Mechanical Lifts" (full body lifts) occurred on 04/11/12. The policy, dated 03/10, stated, "PURPOSE: to move immobile or obese patients for whom manual transfer poses potential for staff or patient injury. . . . Position sling with the head section of the sling under the patient's neck, base of the spine covered and leg sections fit under thigh to the	F 323		

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 _____	04/11/2012

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 17 inside of the leg . . . Verify the patient is positioned in the center of the sling . . ." Review of the facility policy titled "Gait Belt "occurred on 04/11/12. This policy, dated 12/2009, stated, " . . . 7. Secure Belt . . . 8. Adjust belt to snug fit . . .11. Grip belt at patient's sides by placing hands upward under belt, palms facing away from patient . . ." - Review of Resident #10's medical record occurred on April 9-10, 2012. Current diagnoses include obesity and osteoporoses. The record identified the resident has a history of a shoulder fracture with severe degenerative changes in the right shoulder, including osteoporosis. Observations of care identified the following: * 04/09/12 at 4:30 p.m., two CNAs (#18 and #19) transferred Resident #10 from a wheelchair to the bathroom utilizing an Arjo stand lift. Observation showed the harness unable to overlap due to the resident's abdominal and/or chest girth. Upon first raising the resident, the harness (sling) slid under the resident's arms, raising her arms above shoulder level. With this movement, Resident #10 stated, "ouch." Observation showed the resident standing slightly above a 90 degree level during the transfer and unable to fully bear weight during the transfer. * 04/10/12 at 8:10 a.m., two CNAs (#20 and #21) transferred Resident #10 from the bed to the bathroom. Observation showed the harness unable to overlap upon placement. Observation showed Resident #10 stood slightly above a 90 degree level and unable to fully bear weight during transfer. The harness slid under the	F 323		

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 _____	04/11/2012

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 18 resident's arms (axilla). The CNAs failed to ensure the belt tightened around the resident's abdomen upon standing. When the resident was done on the toilet, the CNA (#20) raised the resident to a standing position and provided pericares, the resident maintained the same position. While the CNA (#20) performed the pericare and applied a cream to her groin area, Resident #10 asked to "please" be sat down in her chair. Observation showed Resident #10's feet/legs not secured at the base of the lift. * 04/10/12 at 8:40 a.m., two CNAs (#7 and #22) attempted to transfer Resident #10 with a Hoyer lift (full body lift). The CNAs positioned the sling behind the resident's head causing her head to flex forward with the initiation of the transfer. Resident #10 cried out "ouch, ouch, I don't like to use this one." A CNA (#22) left the room to "check on it." Resident #10 stated the Hoyer lift transfer was "so uncomfortable, it pinches me so bad." A CNA (#22) returned with a physical therapist (PT) (#23) who questioned if Resident #10 could use the "other machine" to see how it worked. Upon utilizing the stand lift, the PT (#23) asked if the resident could stand up taller. The resident did not. The PT (#23) asked the resident if it hurt under her arms. The resident stated "it hurts better" and stated the other lift (Hoyer) hurts all over. Resident #10 stood slightly above a 90 degree level. The PT (#23) suggested a seat strap and stated the CNAs should be sure the resident's feet remained on the platform. Observation showed the Resident #10's feet/legs not secured on the platform at the base of the lift. * 04/10/12 at 10:10 a.m., observation showed two CNAs (#10 and #22) transfer Resident #10 with a stand lift, failing to secure the harness around the trunk of the resident's body while in a standing	F 323		

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 _____	04/11/2012

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 19 position. The harness slid upright directly under the resident's axilla (under arms). Observation showed no seat strap utilized. Resident #10's nurse's notes identified the following: * 02/16/12 at 8:18 p.m., "Bruise to upper interior right arm resolved. continues to have many other bruises up dated on skin sheet today." * 03/01/12 at 10:57 p.m., "Had some areas of bruises resolved this evening. Area to back of left hand resolved, and back of left elbow and upper chest of redness to left chest." A "SKIN ALTERATION RECORD," dated 03/01/12 through 03/15/12 identified the bruise as "Bruise bil [bilateral] legs from mechanical lift." The bruises measured on 03/01/12 as 6 centimeters (cm) length by 7 cm width to the inner aspect of the left leg; and 1.2 cm by 4 cm to the right leg, purple in color. - Review of Resident #17's record occurred on 04/11/12. Current diagnoses included morbid obesity, and history of lymphatic malignancy. The record identified the resident on Coumadin (a blood thinner) on a daily basis. On 04/11/12 at 1:30 p.m., two CNAs (#14 and #15) transferred Resident #17 with a Chorus stand lift from the wheelchair to the toilet and from the toilet to the bed. Upon lifting the resident, with each transfer, the CNAs failed to secure the strap across the resident's abdomen/chest and the harness pulled up into the resident's axilla, pulling her shoulders outward. With the second transfer, Resident #17 told the CNAs not to raise the lift "too high."	F 323		

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 _____	04/11/2012

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 20 During an interview on 04/11/12 at 3:40 p.m. two supervisory staff members (#2 and #9) stated the sling/harness should not slide into the resident's axillary region with transfers. The supervisory staff member (#9) stated they would check on sling size guidelines. Failure to ensure proper use of sit to stand lifts resulted in Resident #10 and #17 experiencing pain with transfers. - Review of Resident #15's medical record occurred on 04/11/12. Diagnoses included Alzheimer's dementia and history of a hip fracture on 01/11/12. The current MDS, dated 02/17/12, identified Resident #15 required extensive assistance with transfers and toilet use. The current care plan, revised on 03/15/12, stated, "ADL Self care deficit as evidenced by weakness, confusion related to disease process L [left] hip fracture, Alzheimer's dementia . . . Interventions . . . Transfer with 1 assist with gait belt . . ." Observation on 04/10/12 at 5:00 p.m., showed Resident #15 in a recliner in the lounge area. The CNA (#8) lifted under the residents left arm while transferring to the wheelchair. The CNA (#8) failed to utilize a gait belt. Observation on 04/11/12 at 8:40 a.m. showed Resident #15 in his wheelchair. The CNA (#13) applied a gait belt around the resident's waist. The CNA (#13) lifted under the resident's right arm and with her left hand she held on to the back of the resident's pants. The CNA (#13)	F 323		

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 _____	04/11/2012

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 21	F 323		

transferred the resident to the recliner. The CNA (#13) failed to utilize the gait belt during the transfer.

Failure to ensure proper use of a gait belt resulted in unsafe transfers for Resident #15.

- Record review for Resident #16 occurred on 04/11/12. The resident's most recent MDS, dated 03/02/12, identified the resident as cognitively intact with a Brief Interview for Mental Status (BIMS) score of 14 and extensive assistance needed for locomotion on and off the unit.

Observation on 04/10/12 at 9:10 a.m. showed Resident #16 slouched in her wheelchair, propelled in the hallway by a CNA (#16). The wheelchair lacked foot pedals and Resident #16's left foot caught on the carpet and she lunged forward in her chair. The CNA immediately stopped and with a nurse's (#17) assistance, repositioned the resident upright in the wheelchair. The CNA then continued to transport the resident down the hall without foot pedals.

- Observation of an unidentified direct care staff propelling Resident #10 in her Broda wheelchair occurred on 04/09/12 at 3:25 p.m. and 4:40 p.m. and on 04/11/12 at 8:46 a.m. On all occasions, Resident #10's feet skimmed the carpet surface on the floor. A Broda chair is designed to encourage self-mobility.
During interview on 04/11/12 at 3:40 p.m. with two administrative staff members (#2 and #9), they agreed residents should have pedals on their wheelchairs for safe transport.

Failure to utilize foot pedals during wheelchair

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 _____	04/11/2012

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 22 transport may result in injury to the resident.	F 323		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure the physician acted upon the consultant pharmacist's recommendation for 1 of 5 sampled resident (Resident #10) identified receiving a hypnotic (used to promote sleep) medication. Failure to act upon the drug irregularities identified by the consultant pharmacist may result in the prolonged and unnecessary use of a hypnotic medication, and may result in adverse consequences. Findings include: Review of Resident #12's record occurred on April 9-10, 2012. Resident #12's medical diagnoses included congestive heart failure and sleep apnea. Resident #12's medication regimen included Zolpidem (Ambien) five milligrams (mg), initiated on 11/21/10, with orders to "Watch for side effect."	F 428	Manor Care Health Services will ensure that the drug regimen for residents are reviewed at least monthly. Resident # 10 Ambien was addressed during survey process. The MD wrote a note to Survey team addressing his desire to not change dose as he had attempted in the past and was unsuccessful. We will continue to monitor her medications and request GDR in compliance with regulations. ManorCare Health Services now has a permanent Pharm D consultant that has been employed at facility since Jan 2012 and therefore consistency with GDR recommendation is anticipated, as she does her monthly review. DON will monitor Pharmacy recommendations and ensure that adequate rational is obtained prior to filing the recommendations. The consultant pharmacist will supply MD's that are admitting to ManorCare with education regarding regulations and need for specific and individualized rational regarding all refusals to proceed with GDR. Nurse managers will also	

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 _____	04/11/2012

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 428	Continued From page 23 A pharmacy form titled "Sedative/hypnotic Medications Justification/Gradual Dose Reduction Attempt Form," dated 06/15/11, recognized the use of the Zolpidem, started November 2010, and no reduction attempted. The physician responded by marking the form as "NO, a dose reduction is not indicated at this time because: (Clinical rationale must be documented on this form or in patient's clinical record)." The physician responded also with "Thanks." A verbal order, dated 07/28/11, stated, "Ambien 5 mg: Chronic Insomnia, No dose reduction: Doing well on current tx [treatment]." The pharmacist sent another recommendation to the physician on 02/27/12 stating, "Consider reducing zolpidem to 2.5 mg [milligrams] HS [bedtime] and monitoring patient's response (i.e. sleep log). If a dose reduction is not appropriate at this time, please provide clinical rationale for continuing current dose." The physician responded on 03/06/12 with "No change. Thanks." The pharmacist's "Monthly Drug Regimen Reviews" included the following reviews of the Zolpidem: * 05/11/11: "GDR [gradual dose reduction] should be considered for Zolpidem." * 06/11/11: "Still no dose reduction on Zolpidem." * 07/11/11: "Asked DON [director of nurses] to get documentation from Dr [doctor] as to why he didn't do GDR." * 10/28/11: "Still no F/U [follow-up] on Ambien . . ." * 11/22/11: ". . . Need F/U on Ambien" * 02/27/12: "TDR [trial dose reduction] Zolpidem."	F 428	receive further education thus ensuring recommendations are followed up thoroughly and completely. Pharmacy recommendations will be signed by the DCD upon follow-up, and also by the ADNS to ensure double check are in place (see Exhibit 428-2). The ADNS or designee will perform QA on GDR's and MD response to Pharmacy review (see Exhibit 428-1). This will be done monthly on 10 residents x 3 months, and thereafter 5 residents per month and then as per the QAA committee recommendations.	5/16/2012

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 _____	04/11/2012

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 428	Continued From page 24 The physician failed to provide a clinical rationale for the continued use of the Ambien even though the pharmacist repeatedly addressed this issue. During interview on 04/11/12 at 3:40 p.m. with a supervisory staff member (#2), the staff member agreed the physician needs to respond to pharmacy reports.	F 428		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their	F 441	Manor Care Health Services will provide care and services that prevent the development of disease or infection. Resident #2 and #4 have no negative consequence as related to improper hand hygiene. Employee/CNA #10 was educated 4/12/2012 when deficient practice was brought to DON attention. (see Exhibit 441-1) Residents that reside at ManorCare Health Services have the potential to be impacted by poor hand hygiene practices. A mandatory in-service for nursing staff was held on April 27th at 1pm and 2:30, with repeat in-services held on April 30th at 1:30 and 5pm. Hand hygiene education will be provided at that time to staff (see Exhibit 441-2 and 441-3)	

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 _____	04/11/2012

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 441	Continued From page 25 hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON MAY 12, 2011 and APRIL 22, 2010. Based on observation, review of facility policy and procedure, and staff interview, the facility failed to follow acceptable infection control standards for 2 of 9 sampled residents (Resident #2 and #4) observed receiving personal cares. Failure to perform hand hygiene after completing perineal cares does not ensure a safe and sanitary environment to prevent the transmission of disease and infection. Findings include: Review of a facility policy and procedure titled "Hand Hygiene" occurred on 04/11/12. This policy, dated December 2009, stated, ". . . When to wash hands: when hands are visibly dirty or contaminated or are visibly soiled with blood or other body fluids . . . When to wash hands or use an alcohol-based hand rub: Before applying and after removing gloves . . . After contact with body fluids or excretions. . . . Moving from a	F 441	QA will be performed by the ADNS or designee on 5 random staff per week X 2months. If compliance is 100% at that time will reduce to 10 staff members per month for one quarter and then as per the QAA committee recommendations. (see Exhibit 441-4) CNA # 10 will have a minimum of 4 audits over the next two months. QA will begin May 2012	5/01/2012

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 _____	04/11/2012

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 441	Continued From page 26 contaminated body site to a clean body site . . . After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient . . ." - During an observation on 04/10/12 at 10:00 a.m., a certified nurse assistant (CNA) (#10) provided toileting and personal cares assistance for Resident #2 in the resident's bathroom that is shared by a roommate. The CNA washed his/her hands, donned gloves, and entered the resident's bathroom to find no waste bag in the wastebasket and a soiled brief in the bottom of the wastebasket. The CNA (#10) obtained a new waste bag, removed the soiled brief from the wastebasket, placed it into the waste bag, and placed the bag into the wastebasket. The CNA (#10) wearing the same gloves, then placed a gait belt around Resident #2, transferred the resident out of the wheelchair, pulled the resident's pants down, removed a soiled incontinent brief, sat the resident on the toilet, exited the bathroom, removed the gloves, and washed his/her hands. After donning a new pair of gloves, the CNA (#10) entered the bathroom, obtained toilet tissue, and wiped urine off the floor. With these same gloves, the CNA (#10) touched the door handle to exit the bathroom, opened the door of the room (to access a new pair of pants obtained by another staff member), removed Resident #2's soiled pants, put on the clean pants, assisted the resident to stand by grasping the gait belt, and performed pericares. After assisting the resident to sit in the wheelchair, the CNA (#10), still wearing the same gloves, removed the gait belt, pulled the resident's shirt down, grabbed the handles of the wheelchair, and moved Resident #2 back to her	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 _____	04/11/2012

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 441	Continued From page 27 bedside. The CNA then removed the gloves and washed his/her hands. - Observation on 04/09/12 at 3:30 p.m., showed a CNA (#12) provided pericares, removed gloves and without performing hand hygiene; moved Resident #4's wheelchair closer to her bed, lowered the resident's bed, placed a sweater in the back of the wheelchair, placed a gait belt to assist the resident to transfer, obtained a comb from the bedside table and handed it to another CNA who provided grooming, adjusted Resident #4's shirt and pant legs, and positioned the foot pedals on the resident's wheelchair. The CNA (#12) then washed his/her hands prior to exiting the room. - Observation of Resident #4 on 04/10/12 at 2:25 p.m., showed a CNA (#6) changed her gloves after providing pericares with incontinent stool. The CNA failed to perform hand hygiene between glove changes and proceeded to place a pillow under the resident's legs, placed a blanket over the resident, lowered the bed, and then removed her gloves and performed hand washing. During interview on the afternoon of 04/11/12, two administrative staff members (#2 and #9) indicated staff failed to perform proper hand hygiene when informed of the above observations.	F 441		
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of	F 520	Manor Care Health Services does and will continue to have regularly scheduled meetings of the QAA committee as outlined in the federal requirements. Specific issues with repeat deficiencies are addressed in those specific POC's	

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 _____	04/11/2012

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 520	Continued From page 28 nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on review of North Dakota Department of Health (ND DoH), Division of Health Facilities provider files and record review, the facility failed to maintain a Quality Assurance (QA) committee which identified and addressed quality issues; and failed to develop and implement appropriate plans of action to correct deficient practice and ensure compliance with federal requirements. Failure to effectively utilize QA contributed to repeated failure to maintain compliance in the following areas: ensuring residents could freely enter the dining room without disturbing other residents (2010) (Refer to F246), maintaining a sanitary and comfortable interior (Refer to F253),	F 520	Facility residents have potential to be affected. ManorCare Health Services has had a significant turnover in nursing management and administrator since last survey. The QA committee is now back on schedule with regular monthly meetings, following the facility and corporate QA calendar for QA audits and has the required members for the QA committee. Regular QA committee meetings will continue to be held on regular schedule. Facility QA audits will be done per facility QA plan and per POC from this survey to address quality concerns. Facility will assess QA plan and function on a quarterly basis starting 5/15/12. Facility administrator, Nurse Managers or designees will do QA Exhibit 520-1 Monthly for 6 months to review effectiveness of QA program then as needed per the QAA committee recommendations. QA related to F-tags from this survey will be reviewed monthly until issues are resolved.	5/15/2012

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 _____	04/11/2012

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 520	Continued From page 29 and adequate hand hygiene to prevent the spread of infections (Refer to F441). Failure to sustain compliance with identified issues could impact the quality of life for all residents of the facility. Findings include: Refer to the following tags: F 246 - Failure to ensure residents could move freely about the dining room without disturbing other residents (2010) F 253 - Failure to provide services to maintain sanitary bathrooms and an environment kept free from odors (2011) F 441- Failure to maintain proper hand hygiene techniques after providing personal cares (2010 and 2011) The facility's QA Committee failed to adequately address quality concerns and ensure sustained compliance with the federal requirements regarding dining room access, maintenance of a sanitary environment and prevention of the spread of infection.	F 520		