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 _____	C 05/12/2011

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 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey and complaint survey started on May 9, 2011 and completed on May 12, 2011 the sample included four (4) residents for compiete review, fifteen (15) residents for focused review, and three (3) closed records for review. The sample included three (3) additional residents to verify specific concerns during the survey.	F 000		
F 156 SS=C	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)	F 156		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	6/2/11

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES

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BORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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Administrator 6/2/11

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F 156	Continued From page 1 (i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance	F156	F 156 It is the practice of this facility to inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The notifications will be made prior to or upon admission and during the resident's stay. Receipt of the information and any amendments to it will be acknowledged in writing. The facility will ensure that each resident who is entitled to Medicare benefits, in writing at the time of admission to the facility or, when the resident becomes eligible for Medicare upon returning to the facility. The Facility will provide required notices to patients who are terminating a skilled service for Medicare coverage which gives them the option for a demand bill. Residents # 4 and #21 were spoken and received documentation in reference for the denial notices when their Medicare Benefits had exhausted. Like patients were identified as those whose medicare benefits have exhausted. Those patients have been given the denial notices if appropriate.	

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F 156	Continued From page 2 directives requirements. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to provide required notices to 2 of 2 residents (Resident #4 and #21) whose Medicare coverage ended with the termination of their therapy services. Failure to provide denial notices (including the option to request a demand bill) to residents is an infringement of the residents' rights.	F 156	The Business Office Manager and the Social Worker have been educated on the regulation and the need to provide the information with any change in payer source. Random audits by the Social Worker or designee will be completed to ensure this practice is occurring. The SW or designee will provide a written summary of findings to the QAA committee weekly until directed further by the committee. Completion date: June 3rd, 2011	

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F 156	Continued From page 3 Findings include: Review of Resident #4 and #21's Medicare billing records occurred on the afternoon of 05/11/11. The records identified Resident #4's Medicare part A coverage ended on 12/24/10, and Resident #21's coverage ended on 03/25/11. Both of the situations required the facility to send a denial notice (including the option to request a demand bill) to the resident or their representative; however, review of the billing records identified the facility failed to issue these denial notices. In an interview on the afternoon of 05/11/11, a licensed staff member (#12) stated she did not send denial notices to residents after the termination of their therapy services; she sent only the provider non-coverage notices.	F 156		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, record review, resident interview, and staff interview, the facility failed to provide care in a manner and in an environment that maintained or enhanced each resident's dignity for 3 of 13 sampled residents (Resident #4, #9, and #10) observed during personal cares and during 1	F 241		

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F 241	Continued From page 4 supplemental resident (Resident #20) interview. The facility failed to enhance each resident's dignity which may negatively impact their self esteem and sense of self worth. Findings include: Review of the facility policy titled "INCONTINENCE CARE" occurred on 05/12/11. This policy, dated 12/2009, stated, ". . . PROCEDURE: . . . 2. Knock on door and request entrance. 3. Introduce self, explain procedure and provide privacy. . . ." - Review of Resident #20's medical record occurred on May 11-12, 2011. Review of the resident's current annual Minimum Data Set (MDS), dated 02/21/11, identified the resident with a Brief Interview for Mental Status score of 15, indicating intact cognition (the highest score possible). The facility also identified Resident #20 as interviewable. The MDS identified the resident as always continent of urine. During an interview with Resident #20 on 05/11/11 at 10:00 a.m., an unidentified staff member knocked on the door, opened the door and entered the room. The staff member failed to announce herself and wait for permission to enter after knocking. During a resident interview on 05/11/11 at 10:40 a.m., Resident #20 stated on the evening of April 19th, 2011, her call light was on for over an hour before staff came to assist her. The resident stated by the time staff came to provide assistance, she was incontinent of urine and soiled her undergarments and pants.	F 241	**F241** Manor Care Health Services will provide care and services in a manner that maintains dignity and respect in regard to the patient's individual needs. Patients receiving cares are at risk for staff failing to provide care in a dignified and respectful manner. In order to reduce this risk the following steps have been or will be taken. Staff members observed not knocking on a patient door and waiting for a response as well as not utilizing the privacy curtain during the survey process were educated on 5/12/11. These staff were instructed on proper techniques in entering patient rooms and reminded to provide care to patients that respected the patient's dignity. Each of the staff members verbalized understanding that their technique was inappropriate. Staff members will be in-serviced regarding dignity and respect with ADL cares. Monitoring for compliance for Dignity and Respect will be completed through observation by Director of Nursing or Designee and reported to the facility's QA Committee on a weekly basis. Compliance Date: June 10th, 2011	

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F 241	Continued From page 5 During another interview with Resident #20 on 05/11/11 at 3:30 p.m., a certified nursing assistant (CNA) (#16) opened the resident's room door and walked into Resident #20's room without knocking, announcing herself, and waiting for permission to enter. - Observation of personal care occurred with Resident #10 on 05/09/11 at 4:20 p.m. A CNA (#17) assisted the resident from her wheelchair to the toilet using a mechanical sit-to-stand lift. Resident #10's roommate sat in a chair and watched as the CNA transferred her to the toilet. Observation showed a privacy curtain present in the room; however, it was not long enough to obstruct the roommate's view. After Resident #10 voided, the CNA transferred the resident with the mechanical lift from the bathroom and performed perineal cares in the resident's room. Resident #10's roommate watched the cares and could see Resident #10's buttocks. In response to the cares observed, Resident #10's roommate stated, "It's nothing I haven't seen before. Sometimes three times a day." Resident #10 stated, "You just kind of get used to it." - Observation of personal cares occurred with Resident #9 on 05/11/11 at 10:25 a.m. A nursing staff member (#14) opened the door and walked into Resident #9's room without knocking or announcing herself as two CNAs (#15 and #16) finished dressing Resident #9. - Observation of personal cares occurred with Resident #4 on 05/10/11 at 8:00 a.m. While the resident sat on the toilet with the bathroom door open, an unidentified staff member opened the	F 241		

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F 241	Continued From page 6 resident's room door without knocking or announcing herself. After realizing the resident was in the bathroom, the staff member closed the door. On 05/12/11 at 8:00 a.m., an administrative nurse (#1) stated she expected staff to knock before entering resident rooms and if no answer, knock again, then slowly peer into the room.	F 241	F253	
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: Based on observation, and resident and staff interviews, the facility failed to provide effective housekeeping to maintain a sanitary environment on 3 of 4 days (May 9, 10, and 11) of survey. Failure to maintain a sanitary environment has the potential to increase the spread of disease-causing organisms and increases the potential for unpleasant odors in resident's rooms and throughout the facility. Findings include: - During the initial tour of the environment on 05/09/11, observation of residents' bathrooms showed the toilet seats and/or high-rise devices placed on the toilet soiled with dried stool, in four double occupancy rooms and one private room. During this time, an observation also showed a soiled bedside commode in a resident's room.	F 253	Manor Care Health Services will provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Floors have been thoroughly cleaned in patient rooms and bathrooms identified in the survey. All resident bathrooms and patient rooms in the facility have been inspected to be compliant with maintaining a sanitary environment for the safety of our patients Resident room floors will be cleaned on a routine basis by housekeeping staff. Staff will clean toilets and floors as needed after they are soiled. Environmental Services and Nursing Staff will be In-serviced to ensure compliance. Housekeeping/laundry director or will spot check bathrooms on a weekly basis for four weeks and monthly thereafter, to assure that floors are clean. Administrator will spot check patient rooms monthly basis to assure cleanliness. Any problems will be reported to the Quality Assurance committee for direction and potential action. Completion date of June 10th, 2011	

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F 253	Continued From page 7 - On the morning of 05/10/11, a random observation in a resident's room on the second floor showed a trail of liquid stool from the garbage can under the sink to the hallway (approximately eight feet). The hallway and the resident's room smelled of stool. Observation identified multiple unidentified staff members walked by the resident's room and failed to clean the liquid stool off the floor. - Observation on 05/11/11 at 9:55 a.m., showed an uncovered bedpan soiled with liquid stool sitting on top of the garbage can in a resident's bathroom. The hallway and the resident's room revealed an unpleasant odor. An observation at 10:20 a.m. showed the bedpan remained in the bathroom. During the group interview, on 05/10/11 at 10:30 a.m., Resident A stated she does not believe facility staff clean the bathroom "thoroughly". During an interview on 05/12/11 at 10:15 a.m., an administrative nurse (#1) stated she expected staff, once the resident is in a safe position, to wipe off the toilet seat if it was soiled.	F 253		
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. A registered nurse must sign and certify that the	F 278		

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F 278	Continued From page 8 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: Based on observation, record review, review of professional reference, resident interview, and staff interview, the facility failed to complete Minimum Data Set (MDS) assessments which accurately reflect the residents' current status for 4 of 5 sampled residents (Resident #4, #8, #11, and #15) identified as having toileting plans. Failure to accurately assess and code the MDS may affect the level of care provided to residents. Findings include: - The Centers for Medicare and Medicaid Services (CMS) has outlined the standards of practice regarding toileting programs in the	F 278	F 278 It is the intent of the facility to assure that assessments accurately reflect the resident's status. Residents # 4, #8, #11 & #15 were reviewed and care plans and assessments revised to accurately reflect toileting needs. Like resident have been identified as those identified on the MDS as being on a scheduled toileting plan. These resident assessments have been reviewed with corrections completed as needed. MDS staff has been in-serviced on the requirement for completion of accurate assessments and on the qualifying factors to code a scheduled toileting plan. MDS staff is responsible to assure assessments accurately reflect the resident's status. ADNS or designee will randomly audit completed MDS' for accurate coding of: scheduled toileting plans. The ADNS will provide a written summary of findings to the QAA Committee weekly until further directed by the committee. Completion Date: June 3rd, 2011	

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F 278	Continued From page 9 Long-Term Care Facility Resident Assessment Instrument User's Manual, Version 3.0, dated 07/10, page H-6, which states "Toileting (or trial toileting) programs refer to a specific approach that is organized, planned, documented, monitored, and evaluated, and is consistent with the nursing home's policies and procedures and current standards of practice . . ." - Review of Resident #4's medical record occurred on all days of survey. Resident #4's quarterly MDSs, dated 02/02/11 and 05/02/11, identified frequent incontinence and the use of a toileting plan. Resident #4's current care plan, revised 04/03/11, stated, ". . . Urinary/Bowel incontinence related to loss of bladder muscle tone . . . Interventions . . . Toilet every 2-3 hours, as needed and during night rounds. . . ." The care plan also identified an initiation date of 11/05/10 for Resident #4's current toileting schedule. Resident #4's medical record lacked an assessment related to her urinary continence or any tracking/analysis of her bladder habits. During an interview on 05/10/11 at 3:05 p.m., a certified nursing assistant (CNA) (#8) stated, "She [Resident #4] lets us know when she needs to go." During an interview on 05/11/11 at 3:45 p.m., a CNA (#9) stated Resident #4 asks staff to help her to the bathroom, and they do not usually have to ask her if she needs to go. - Review of Resident #8's medical record occurred on May 9-12, 2011. The facility admitted the resident in 07/09. Current diagnoses included	F 278		

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F 278	Continued From page 10 aphasia - post cerebral vascular accident (CVA), bladder hypertonicity, and history of urinary tract infections. The resident's annual MDS, dated 07/28/10 and her quarterly, dated 04/22/11, identified the resident had frequent bladder incontinence, dependent on staff for toileting, and on a scheduled toileting program. The resident's Resident Assessment Protocol (RAP), dated 07/23/10, stated regarding urinary incontinence, ". . . Is on toileting q [every] 2 hours during day with toileting q 3-4 hours at noc. [night]. Wears pads during day and briefs at noc. Staff assist with personal cares." Resident #8's Incontinence Monitoring, dated 08/17/09, stated, "Residt [resident] completed the three day incontinence monitoring. She had numerous incontin [incontinent] episodes per-day. She does use her call light. She is very hard to understand. She will be placed on scheduled toileting." Resident #8's current care plan, dated 08/10/09, stated, "Focus: Urinary incontinence related to impaired mobility, physical limitations, medications, hx (history) of overactive bladder. Interventions: . . . *Remind and assist as needed with toileting at routine times such as upon arising in AM, before/after meals, activities, therapy and at bedtime." Review of Resident #8's "Resident Information Sheet", dated 05/10/11, provided daily to the CNAs, identified Resident #8 as being "incontinent and on a toileting plan, (Toilet ac/pc [before and after] meals, HS [hour of sleep], PRN	F 278		

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F 278	Continued From page 11 [as needed])." During a conversation on 05/10/11 at 9:00 a.m., Resident #8 stated "she had been to the bathroom once today." A CNA (#2) stated, "Resident #8 takes herself to the bathroom then puts on her call light for assistance to get off. We do peri cares and apply a dry pad for her." Observation on 05/10/11 at 5:00 p.m., identified a CNA (#4) asked Resident #8 if she had had a bowel movement. Resident #8 replied "she had a bowel movement and voided in the toilet, but did not remember when." The CNA #4 did not offer to take the resident to the bathroom or check to see if she was dry. - Review of Resident #11's medical record occurred on all days of the survey. The quarterly MDS, dated 03/07/11 and the significant change MDS, dated 04/20/11, identified Resident #11 had frequent incontinence, and on a toileting plan. The MDS dated 04/20/11 also indicated a trial of a toileting plan with no improvement. Review of Resident #11's Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA), dated 04/27/11, stated, ". . . occ [occasionally] incontinent of bladder. Staff assist to toilet per set routine. Does alert staff of need to toilet prn . . ." Resident #11's current care plan lacked any focus area, goals and/or interventions related to bladder incontinence and/or a toileting plan. - Review of Resident #15's medical record occurred on 05/11/11. Diagnoses included	F 278		

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F 278	Continued From page 12 Alzheimer's, dementia with depression, muscle weakness, and atherosclerosis. Resident #15's quarterly MDS, dated 04/19/11, identified the resident as severely impaired in cognition, frequent bladder incontinence, required extensive assistance of one person for transfers, toileting, personal hygiene, and on a scheduled toileting program. Review of Resident #15's current care plan stated, "Focus: Urinary incontinence (likely combination functional, overflow, and stress incontinence) . . . *Remind and assist with toileting and repositioning at routine times, such as upon arising in AM, before/after meals and naps, on scheduled rounds at night, at hs, and prn." Resident #15's Urinary Incontinence and Indwelling Catheter CAA, dated 10/19/10, stated, " . . . Resident is aware of the urge to void and requests assist, but frequently has leaking during transfer. . . ." Review of Resident #15's "Resident Information Sheet," dated 05/10/11, identified Resident #15 is incontinent and on a toileting schedule as follows, "toilet ac/pc meals, hs, prn." Observation on 05/11/11 at 3:05 p.m., showed Resident #15 being transferred from her bed to the wheelchair,and assisted to the bathroom at her request. A CNA (#7) assisted the resident onto the toilet. Her brief was wet and the resident voided again as she transferred onto the toilet. During an interview, on 05/12/11 at 10:00 a.m., a CNA (#2) stated, "[Resident #15] usually calls for assistance when she has to use the bathroom."	F 278		

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F 278	Continued From page 13 During an interview, on 05/12/11 at 05/12/11 at 9:05 a.m. a supervisory nursing staff member (#3) agreed the resident's MDS and current care plan are inconsistent with the care provided.	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 record review, facility policy review, professional reference review, and staff interview, the facility failed to provide care and services according to professional standards of quality for 2 of 16 sampled residents (Resident #10 and #14) receiving "as needed" (PRN) medications. Failure to evaluate and document the reason for and/or response to PRN medications may result in residents receiving unnecessary medications, experiencing adverse reactions, and may limit the staff's ability to determine effectiveness of the medications. Findings include: Kozier & Erb's "Fundamentals of Nursing, Concepts, Process and Practice," 8th Edition, dated 2008, page 850, stated, ". . . Ten 'Rights' of Medication Administration . . . Right Evaluation . . . Conduct appropriate follow-up (e.g., was the desired effect achieved or not? Did the client experience any side effects or adverse reactions?). . . ." Review of the facility policy titled "Medication	F 281	**F281**. Manor Care Health Services will provide services that meet the professional standards of quality. Facility assessed resident #10 and #14 they had no adverse side effects from utilizing PRN Medication. Residents requiring the use of PRN Medications are at risk for adverse side effects. Nurse Management will educate Nursing Staff on the proper documenting procedure when utilizing PRN Medication during Nurse Meeting June 7th. Nurse Management Staff or designated staff will audit the use of PRN Medications to ensure compliance of the correct procedure in documenting the use PRN Medications. This audit will be submitted to the Quality Assurance Committee on a monthly basis and will continue per QA recommendations. Completion date of June 10th, 2011	

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F 281	Continued From page 14 Management Guidelines: Documentation" occurred on 05/12/11. This policy, dated 08/11/06, stated, ". . . Guideline: . . . Document PRN medication administration on the MAR [medication administration record] along with the reason for the medication immediately following administration. Document effectiveness of the intervention on the back of the MAR . . . Review each MAR after each medication administration is completed and prior to the end of the shift to ensure documentation is complete and supports services provided including . . . documentation of initials on MAR for PRN medication administration with reason for administration and effectiveness of medication noted on back of MAR . . ." - Review of Resident #10's medical record occurred on all days of survey. Diagnoses included bipolar disorder, anxiety, and depression. Current medications included Ambien (a hypnotic) 5 milligrams (mg) every evening PRN. Review of Resident #10's use of PRN Ambien from January-April 2011 revealed facility staff failed to evaluate and document the resident's response to/effectiveness of the medication on the following occasions: *January 2011: Ambien given 21 of 31 days, no follow-up documented on six occasions *February 2011: Ambien given 25 of 28 days, no follow-up documented on 10 occasions *March 2011: Ambien given 22 of 31 days, no follow-up documented on two occasions *April 2011: Ambien given 27 of 30 days, no follow-up documented on seven occasions *Of the 105 occasions Resident #10 received	F 281		

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F 281	Continued From page 15 PRN Ambien, staff failed to perform appropriate follow-up 25 times. - Review of Resident #14's medical record occurred May 11-12, 2011. Medical diagnosis included osteoarthrosis, spinal stenosis, lumbosacral neuritis, and lumbar/lumbosacral disk degeneration. An admission Minimum Data Set (MDS), dated 03/03/11, identified the resident is on a scheduled pain medication; received a PRN pain medication; and during the pain assessment interview Resident #14 identified she had occasional pain with a numeric rating scale of three, with 10 being the worst pain. Resident #14's current care plan identified a problem of potential for pain with an intervention of, "Give PRN [as needed] meds [medications] for breakthrough as per MD [medical doctor] orders and note the effectiveness." Review of Resident #14's use of PRN pain medications from January to May 2011 revealed facility staff failed to document the the resident's response to/effectiveness of the medication on the following occasions: * January 2011: pain medication administered 20 times, no follow-up documented on six occasions. * February 2011: pain medication administered 20 times, no follow-up documented on four occasions. * March 2011: pain medication administered 41 times, no follow-up documented 10 occasions. * April 2011: pain medication administered 15 times, no follow-up documented seven occasions. * May (1-12) 2011: pain medication administered	F 281		

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F 281	Continued From page 16 17 times, no follow-up documented four occasions. * Of the 123 occasions Resident #14 received a PRN pain medication, staff failed to perform appropriate follow-up 31 times. During an interview on the morning of 05/12/11, a supervisory nursing staff member (#1) stated she expected staff to check on the resident and chart the effectiveness of PRN medications within an hour of administration.	F 281		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, record review, facility policy review, and staff interview, the facility failed to provide services necessary to maintain good oral hygiene for 1 of 1 sampled resident (Resident #9) with a "nothing by mouth" (NPO) status. Failure to provide oral care for a resident who is unable to maintain oral hygiene independently may result in a loss of comfort and dignity, as well as increase the risk for respiratory tract infections and inflammation of oral mucous membranes. Findings include: Review of the facility policy titled "Oral Hygiene	F 312	F 312 Reviewed Oral Care for residents #9. This review revealed no negative outcome for the patient. Residents requiring assistance with oral cares are at risk for receiving an insufficient amount of assistance with this task. Staff members were in-serviced on proper Oral Hygiene Random audits will be completed by Director of Nursing and designee on a weekly basis for a month and continued per QA recommendation. Date of completion will be June 10, 2011.	

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F 312	Continued From page 17	F 312		

and Denture Care" occurred on 05/12/11. This policy, dated January 2011, stated, ". . . Purpose: To remove plaque and food debris from teeth and mouth, decrease mouth odor, massage gums and clean tongue, and to promote moist lips and mouth. . . . Offer more frequently to patients receiving oxygen, semi-comatose, or with nasal gastric tubes. Special attention should be given to the roof of the mouth and tongue where mucous may accumulate. Mouth swabs can be used to clean the roof of the mouth and tongue . . ."

Review of Resident #9's medical record occurred on May 10-12, 2011. Diagnoses included cerebrovascular accident (CVA), right-sided hemiparesis, and NPO status. Resident #9 received continuous oxygen via nasal cannula, feedings via gastrostomy tube, and was unable to communicate.

Resident #9's care plan, revised 04/27/2011, stated, ". . . Focus . . . ADL [activities of daily living] Self care deficit as evidenced by inability to turn, eat, communicate, and perform any personal cares secondary to a CVA . . . Interventions . . . Provide assistance with all ADL's including repositioning, oral cares, cath [catheter] cares, skin care . . . Focus . . . inflamed oral mucous membranes with sore present related to: npo status . . . Interventions . . . Administer treatment per physician orders . . ."

Resident #9's current medications included Nystatin liquid applied to the mouth daily for 10 days, initiated on 05/04/11.

Observation on 05/10/11 at 11:45 a.m. showed a nurse (#12) entered Resident #9's room and

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F 312	Continued From page 18 applied the Nystatin liquid in his mouth. The nurse stated, "He has sores in his mouth." Observation on 05/10/11 at 4:03 p.m. showed two certified nursing assistants (CNAs) (#9 and #17) changed Resident #9's incontinence brief and assisted him to reposition. The CNAs failed to perform oral cares for Resident #9. Observation showed a large amount of dried mucous on and between the resident's lips. The dried mucous held Resident #9's lips together over the right side of his mouth. Resident #9's lips were dry and cracked. Observation showed no oral swabs available for use in the resident's room. Observations at 4:46 p.m., 5:20 p.m., and 5:53 p.m. showed the resident lying in bed with his lips and mouth as described above. In an interview on the morning of 05/12/11, an administrative nursing staff member (#1) confirmed the CNAs should have performed oral cares and stated she expected oral cares to be done every two hours or more often if needed for an NPO resident.	F 312		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a	F 329		

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F 329	Continued From page 19 resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review and review of professional reference, the facility failed to ensure 1 of 1 sampled resident (Resident #4) with a scheduled hypnotic received a gradual dose reduction (GDR). Failure to attempt a GDR (unless contraindicated) may result in residents receiving unnecessary medications and experiencing adverse drug reactions related to these medications. Findings include: The Centers for Medicare and Medicaid Services (CMS) has outlined the standards of practice regarding the tapering of a medication dose/Gradual Dose Reduction (GDR) which states the purpose of tapering a medication is to find an optimal dose or to determine whether continued use of the medication is benefiting the resident. Tapering may be indicated when the resident's clinical condition has improved or	F 329	**F329** Manor Care Health Services will ensure that residents in the facility are free of any unnecessary drugs. Resident #4 use of hypnotic was reviewed by the pharmacist with recommendations forwarded and discussed with the residents primary physician. Residents using hypnotic medications have the potential to be affected and have been reviewed for GDR's by the pharmacist. Any recommendations have been discussed with the primary physician with any resultant orders processed. Licensed staff re-educated on the GDR requirements for hypnotic use. Pharmicist re-educated on providing recommendations for required GDR for hypnotics. A summary of any concerns or trends will be gathered by and Director of Nursing or designee and reported to the QI committee monthly for review and possible action. Completion Date: June 10th, 2011	

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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

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F 329	Continued From page 20 stabilized or the underlying causes of the original target symptoms have resolved. Often, however, the only way to know whether a medication is needed indefinitely and whether the dose remains appropriate is to try reducing the dose and to monitor the resident closely for improvement, stabilization, or decline. For as long as a resident remains on a sedative/hypnotic that is used routinely and beyond the manufacturer's recommendations for duration of use, the facility should attempt to taper the medication quarterly unless clinically contraindicated. Lippincott, Williams, and Wilkins, "Nursing 2011 Drug Handbook," 31st edition, page 788, stated, "Ambien . . . Alert: . . . Use drug only for short-term management of insomnia, usually 7 to 10 days. . . ." Review of Resident #4's medical record occurred on all days of survey. Diagnoses included anxiety and depressive disorder. Medications included Ambien (a hypnotic) 5 milligrams (mg) every evening, initiated on 11/21/10. Resident #4's Minimum Data Sets (MDSs), dated 05/02/11, 02/02/11, and 11/11/10, identified the resident with moderately impaired cognition. The physician's progress notes since the initiation of the Ambien failed to identify Resident #4's use of Ambien, clinical rationale for continued use, or contraindications for attempting a quarterly GDR.	F 329		
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.	F 428		

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F 428	Continued From page 21 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 facility policy review, the facility's consultant pharmacist failed to identify medication regimen irregularities for 1 of 1 sampled residents (Resident #4) receiving a scheduled hypnotic. Failure to recognize and report medication irregularities may result in residents receiving unnecessary medications and experiencing adverse consequences related to these medications. Findings include: Review of the facility policy titled "Consultation Recommendations: Medical Professional" occurred on 05/12/11. This policy, dated 08/11/06, stated, ". . . Purpose: To provide a process whereby medical consultant recommendations are identified and communicated to the physician and initiated following approval . . . Examples of consultants providing recommendations . . . Pharmacist . . ." Review of Resident #4's medical record occurred on all days of survey. Diagnoses included anxiety and depressive disorder. Medications included Ambien (a hypnotic) 5 milligrams (mg) every evening, initiated on 11/21/10. Resident #4's	F 428	**F428** It is the intent of Manor Care Health Services to complete drug regimen review at least once per month by a licensed pharmacist. Resident #4 had a drug regimen review completed May 18, 2011 and records were updated. Residents using hypnotic were identified and records reviewed for compliance with drug regimen reviews. Discussion was held with the pharmacist regarding drug regimen review. The pharmacist is responsible for completing drug regimen reviews and the ADNS is responsible for monitoring compliance. Monitoring will be completed twice weekly with summary reported to QAA committee weekly until further directed by the committee. Completion Date: June 3rd, 2011	

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F 428	Continued From page 22 Minimum Data Sets (MDSs), dated 05/02/11, 02/02/11, and 11/11/10, identified the resident with moderately impaired cognition. The facility's consultant pharmacist reviewed Resident #4's medications monthly; however, the pharmacist failed to recommend a quarterly dose reduction attempt related to the use of Ambien since initiated on 11/21/10.	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	F 441 Corrective action was taken by the administrative nurse when she was informed by the surveyor that staff had not taken care of bed pan and stool on the floors as well as properly washing hands after peri-cares. The administrative nurse removed the bed pan from the room. She also educated the CNA directly involved in the incident and posted written information to remind staff members to empty pans and clean items that are soiled in a timely matter. Residents #1, #2 and #5 was assessed and no negative outcomes have been identified. Residents are at risk for exposure to micro-organisms when infection control guidelines are not followed. Staff Members educated on Infections control practices and guidelines. Random audits/observations of staff for adherence to infection control guidelines will be completed by Director of Nursing or designee three times weekly for four weeks. Additional monitoring will be completed as per QAA Committee recommendations. Date of completion is June 10, 2011.	

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F 441	Continued From page 23 hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 04/22/10. Based on observation, review of facility policy and procedure, and staff interview, the facility failed to follow acceptable infection control standards for 3 of 11 sampled residents (Resident #1, #2, and #5) observed receiving personal cares and on 1 of 3 days (May 10, 2011) of meal service. Failure to perform hand hygiene after completing pericares and failure to properly handle ready-to-eat foods has the potential to spread infections throughout the facility. Findings include: Review of the facility policy titled "INCONTINENCE CARE" occurred on 05/12/11. This policy, dated 12/2009, stated, "PURPOSE: To outline a procedure for cleansing the perineum and buttocks after an incontinence episode or with daily care . . . PROCEDURE: . . . 4. Perform hand hygiene. 5. Apply latex free non-sterile gloves . . . 8. If feces present, remove with toilet paper or disposable wipe by wiping	F 441		

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F 441	Continued From page 24 from front of perineum toward rectum. Discard soiled materials and gloves. 9. Perform hand hygiene. 10. Apply latex free non-sterile gloves . . . 12. Cleanse peri-area and buttocks with cleansing agent wiping from front of perineum toward rectum . . . 15. Remove linen/underpad and discard. 16. Remove and discard gloves. 17. Perform hand hygiene . . . 19. Reposition for comfort with call light in reach and provide additional care needs requested by patient. . . ." Review of the facility policy titled "HAND HYGIENE" occurred on 05/12/11. This policy, dated 12/2009, stated, ". . . When to wash hands or use an alcohol-based hand rub: * Before applying and after removing gloves * After having direct contact with patient's intact skin (e.g., when taking pulse or blood pressure and turning a patient) if hands are not visibly contaminated * After contact with body fluids or excretions. Mucous membranes, non-intact skin and wound dressings if hands are not visibly soiled * Moving from a contaminated body site to a clean body site during patient care * After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient * Before inserting invasive devices. . . ." Review of the facility policy titled "Food Services" occurred on the afternoon of 05/11/11. This policy, dated 06/02/06, stated, " . . . Food Preparation, Holding and Service Practices . . . Use utensils or gloves to avoid touching food directly."	F 441		

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F 441	Continued From page 25 - Observation on 05/10/11 at 4:10 p.m. showed two certified nursing assistants (CNAs) (#8 and #9) changed Resident #5's brief, incontinent of urine and stool, while the resident laid in bed. After completing pericares, the CNA (#9) removed her gloves, placed a clean brief on the resident, adjusted Resident #5's clothing, transferred the resident to her wheelchair with a mechanical lift, combed her hair, put the resident's glasses on, and pushed the resident to the TV area. The CNA (#9) then went back to the resident's room, bagged the garbage, took it to the soiled utility room, and then used hand sanitizer at the nurse's station. The CNA (#9) failed to perform hand hygiene immediately after completing pericares. The staff member (#8) also assisting Resident #5 with the brief change and transfer, failed to perform hand hygiene at any time during the observation and went to answer another resident's call light immediately after exiting Resident #5's room. - An observation on 05/10/11 at 12:10 p.m., showed Resident #2 sitting on the toilet. A CNA (#13), while not wearing gloves, removed the resident's wet incontinent liner and placed it in the garbage. The CNA (#13), without performing hand hygiene, then went into the resident's room, opened the closet and removed a clean incontinent product, shut off the television, arranged items on the resident's bedside table, and returned to the bathroom to apply the clean product. During this process the CNA (#13) failed to perform any hand hygiene. During an interview on 05/12/11 at 8:00 a.m., an administrative nurse (#1) stated she expected staff to perform hand hygiene immediately after	F 441		

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F 441	Continued From page 26 completing pericares, once the resident is in a safe position. The staff member (#1) stated even if staff touch a resident's brief or their bedding, she expected them to perform hand hygiene. - Observation on 05/10/11 at 5:13 p.m. identified a CNA (#4) assisted Resident #1 to the bathroom. The CNA donned gloves, emptied Resident #1's leg bag of urine, removed her gloves, and left the room without performing hand hygiene. The CNA (#4) later returned to assist the resident with perineal cares after he had a bowel movement. The CNA removed her gloves and again failed to complete hand hygiene. The resident was not offered hand hygiene before going to the dining room. During an interview on 05/12/11 at 9:05 a.m., an administrative nurse (#1) agreed the CNA (#4) did not follow proper hand hygiene protocol. The nurse agreed the CNA should have washed her hands after providing cares and before leaving the room. Failure to perform proper hand hygiene after perineal cares may cause a transfer of microorganisms, which could result in an infection. - Observation of the evening meal service on 05/10/11 showed the following instances of bare hand contact by facility staff members with ready to eat food while serving residents their meal. * Observation of a CNA (#6) occurred in the large dining room on first floor at 5:38 p.m. The CNA (#6) prepared a slice of bread using her bare hands to remove the bread from a plastic bag,	F 441		

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F 441	Continued From page 27 hold it in place while applying margarine, put the two halves together into a sandwich, and place the buttered bread into the resident's hand. * Observation of a management staff member (#5) occurred in the small dining room on first floor at 5:48 p.m. assisting two residents. The management staff member (#5) prepared slices of bread using his bare hands to remove the bread from the plastic bag, and to hold the bread in place while applying margarine. During an interview on 05/12/11, at 1:50 p.m., an administrative nurse (#3) identified staff are trained to avoid bare hand contact with ready to eat foods.	F 441		
F9999	FINAL OBSERVATIONS Based on observation, records review, and staff interview, the complaint investigated in conjunction with the standard Medicare/Medicaid survey was not substantiated.	F9999		