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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355031	A. BUILDING _____ B. WING _____	R 05/13/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS An on-site revisit was conducted May 12-13, 2015 to determine compliance with the deficiencies identified during the March 23-25, 2015 survey. The revisit sample included 12 residents for focused review of the areas of non-compliance. The sample also included two (2) additional residents to verify specific concerns during the survey. The tag numbers enclosed in { } denotes citations that remained not met as determined by the on-site revisit.	{F 000}	Minot Plan of Correction for Survey Revisit May 12-13 The statements on this plan of correction are not admittances to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the center has taken or will take action as set forth in the following plan of correction. The plan of correction constitutes the center's assertion of compliance. All alleged deficiencies cited have been or will be corrected by dates indicated.	
{F 164} SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when	{F 164}	F 164 MARs for residents #11 and #14 were covered upon the nurse's return to the medication cart. Residents who receive medications have the potential to be affected by this practice. Education will be provided by ADNS or designee to licensed nurses regarding the need to keep MARs covered when not in use. Educational sessions were held June 9th, 10th, and 11th. Licensed nurses who did not attend a session will be educated prior to June 17th.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: administrator — (X6) DATE: 6/11/15

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355031	A. BUILDING _____ B. WING _____	R 05/13/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 164}	Continued From page 1 release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation and review of facility policy, the facility failed to ensure confidentiality of resident's clinical information for 2 random residents (#11 and #14) during random observations on 2 of 2 days of survey (May 12-13, 2015). Failure to ensure confidentiality of resident's clinical information is an infringement on the resident's rights. Findings include: Review of the facility policy titled "Clinical Record System - Overview" occurred on 05/13/15. This policy, undated, stated, ". . . The center maintains information contained in the clinical record as confidential, regardless of the form or storage method . . . Individuals charting in the clinical records are expected to adhere to ethical principles and professional standards . . ." - Observation on 05/12/15 at 5:05 p.m. identified a medication cart located in the hallway west of the 1st floor nursing station. The medication administration record (MAR) for Resident #11, which included confidential information, sat open on top of the medication cart, visible to any visitors, residents, and staff near the medication cart. - Observation on 05/13/15 at 8:40 a.m. identified a medication cart located in the east hallway near the dining room on the 1st floor. The MAR for	{F 164}	Audits will be completed by Administrator, department managers, or a nursing team member five times weekly for four weeks then three times weekly for three months with results submitted to QAPI committee for analysis and recommendation. Date of compliance is 06-17-15	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355031	A. BUILDING _____ B. WING _____	R 05/13/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 164}	Continued From page 2 Resident #14, which included confidential information, sat open on top of the medication cart, visible to any visitors, residents, and staff near the medication cart.	{F 164}	F 312 Resident #1 received a drink as requested. Staff caring for her offered the drink from a glass when Resident #1 was unable to use the straw offered with her drink. Resident #1 was reassessed and may use straws if desired. Care plan and task list were updated for this resident. Residents with restrictions on the use of straws were identified and plan of care reviewed by the interdisciplinary team. Nursing assessments, speech therapy screenings/assessment or MD review was completed when indicated. Care plans/task lists were audited and modified as needed based on reassessment findings. The ADNS or designee will provide education licensed nurses and nursing assistants regarding following the task list and ensuring assistance is provided as outlined in the plan of care. Educational sessions were provided on June 9th, 10th, and 11th. Licensed nurses and nursing assistants who did not attend a session will receive education prior to June 17th.	
{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 and record review, the facility failed to ensure staff provided adequate assistance with fluids for 1 of 4 sampled residents (Resident #1) care planned "no straws" for fluid intake. Failure to provide adequate assistance for fluid intake placed this resident at risk for choking/aspiration. Findings include: - Review of Resident #1's medical record occurred on all days of survey. Diagnoses included dysphagia. The current care plan stated, "FOCUS: Nutritional status . . . Interventions: . . . NO STRAWS . . . " Observation on 05/12/15 at 3:30 p.m. showed two certified nursing assistants (CNAs) (#7 and #9) completed personal cares and positioned Resident #1 in her wheelchair. The resident stated, "I'm thirsty," and the CNA (#7) obtained the cup of water and straw from the nightstand	{F 312}		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355031	A. BUILDING _____ B. WING _____	R 05/13/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 312}	Continued From page 3 and offered it to the resident. Resident #1 failed to draw water up through the straw and the CNA (#7) stated, "Maybe we should get her a glass". The CNA (#7) obtained a glass of water and observation showed Resident #1 drank from the glass.	{F 312}	Audits will be completed five times weekly for four weeks and then three times weekly for three months by Administrator, SLP, therapy team member, dietary team member, or nursing team member . Results of audits will be forwarded to the QAPI committee for review and recommendations. Date of compliance is 06-17-15	
{F 314} SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to provide the necessary treatment and services to promote the healing of a facility acquired pressure ulcer for 1 of 2 (Resident #1) sampled residents with a facility acquired pressure ulcer. Failure to implement established treatment interventions has the potential to delay the healing of Resident #1's pressure ulcer. Findings include: Review of Resident #1's medical record occurred on all days of survey. Diagnoses included a right heel pressure ulcer. The current care plan stated, "Focus: R [right] heel unstageable area related to:	{F 314}	F 314 Prevalon boots were provided for Resident #1, wound assessment was completed, physician updated and decision was made to continue with current treatment. Education was provided to assigned nurse regarding preventive measures and dressing changes. Residents with pressure related skin breakdown and those at high risk for skin breakdown have the potential to be affected by this practice. These residents have been reviewed by the interdisciplinary team and care plans have been modified to reflect current needs when indicated. Availability of products for preventive measures has been validated.	

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 _____	R 05/13/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 314}	Continued From page 4 impaired mobility . . . Interventions: . . . *Float heels as able *Prevalon boots [boots to protect the heels] bilaterally at all times except during cares *Use pillows and/or positioning devices as needed." A "Skin Alteration Record," dated 05/04/15, identified a 6 by 4 centimeters (cm) fluid filled blister to Resident #1's right heel. A progress note, dated 05/04/15, identified a light purple and brown blanchable area on her right heel and measured 6 by 4 cm. A physician's order, dated 05/04/15, included bilateral Prevalon boots and a Tegaderm foam dressing to her right heel. The most current "Pressure Ulcer Assessment," dated 05/12/15, identified the pressure ulcer measured 4 by 3 cm. Observations included the following: *05/13/15 at 8:00 a.m. - Resident #1 seated in the dining room in a wheelchair and tennis shoes on bilaterally. *05/13/15 at 9:23 a.m. - Resident #1 positioned on her back in bed with her heels resting directly on the mattress. The nurse (#1) removed the resident's right TED hose and observation showed no dressing on the pressure ulcer. The nurse stated she did not know when the dressing had been removed. The nurse (#1) applied a new dressing, located the Prevalon boots in the closet, and applied one to Resident #1's right foot. The nurse (#1) failed to apply a Prevalon boot to the resident's left foot and failed to elevate her heels before she left the room. *05/13/15 at 1:10 p.m. - Resident #1 positioned on her back in bed with a Prevalon boot on her right foot only. The facility staff failed to follow Resident #1's care	{F 314}	ADNS or designee will provide education to licensed nurses and nursing assistants regarding skin and wound management. Education will address preventive measures as well as compliance with wound care orders. Education was provided on June 9th, 10th, and 11th. Licensed nurses or nursing assistants who did not attend a session will be educated prior to June 17th. Audits will be completed five times weekly for four weeks then three times weekly for three months by Administrator, ADNS, department manager, licensed nurse, or nursing team member. Results of audits will be forwarded to the QAPI committee for review and recommendations. Date of Compliance: 06-17-15	

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

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 _____	R 05/13/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 314}	Continued From page 5 plan related to the pressure ulcer treatment plan and may have delayed the healing process.	{F 314}	F 323	
{F 323} SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and review of facility policy, the facility failed to ensure staff provided the necessary interventions and supervision to prevent falls and/or injury for 5 of 9 sampled residents (Residents #5, #7, #9, #12, and #13) observed during cares. Failure to properly use a gait belt for Residents #5, #7, #9, and #13 and use two staff to transfer Resident #12, placed the residents at risk for falls and/or injury. Findings include: Review of the facility policy and procedure titled "Gait Belt" occurred on 05/13/15. This policy, dated December 2009, stated, "Purpose: To safely and effectively transfer or ambulate a patient . . . 6. Place a gait belt around waist. Do not place . . . his chest . . . 7. Secure belt by threading end through buckle . . . 8. Adjust belt to snug fit . . . 11. Grip belt at patient's sides by placing hands upward under belt, palms facing	{F 323}	Skin evaluations to check for latent injuries associated with transfers including examination of axillae were completed for residents #5, 7, 9, and 13. No injuries were noted upon examination. IDT review of transfer status for resident #5, #9, and #13 was completed and the transfer status for these residents remains unchanged. Transfer status for resident #7 was updated to include mechanical lift. IDT review of transfer status for #12 was completed and care plan was updated to reflect current needs. Residents requiring assistance with transfers have the potential to be affected by this practice. The IDT reviewed transfer status for residents and completed updates to care plans and task lists when indicated. The ADNS or designee will provide education to licensed nurses and nursing assistants regarding the use of the gait belt and following the plan of care for transfers. Education will include visual training on application of a gait belt and on appropriate technique for completing transfers with gait belts. Education was	

PRINTED: 05/27/2015
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355031	A. BUILDING _____ B. WING _____	R 05/13/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 323}	Continued From page 6 away from patient . . ." - Resident #13's care plan on 05/13/15, stated, ". . . At risk for falls due to unsteady gait, history of falls . . . Provide assist to transfer and ambulate as needed . . ." Observation during the initial tour on 5/12/15 at 11:05 a.m., showed a certified nurse assistant (CNA) (#4) utilized a gait belt to transfer Resident #13 to the bed. The CNA (#4) lifted under the resident's left axilla with one hand and transferred her onto the bed. The resident then yelled "bathroom". The CNA (#4) lifted under the resident's left axilla and transferred her to the bathroom via a wheelchair. - Review of Resident #7's care plan identified ". . . ADL Self care deficit as evidenced by weakness related to recent HX [history] Left hip, rib fracture . . . Transfer with 2 staff assist with gait belt . . ." Observation on 05/12/15 at 3:05 p.m., showed two CNAs (#5 and #6) transfer Resident #7 from the wheelchair to her bed using a gait belt. The CNAs (#5 and #6) lifted under the resident's axilla with one hand and used the gait belt with the other hand. The resident did not bear weight. Observation on 5/12/15 at 5:00 p.m., showed two CNAs (#5 and #7) transferred Resident #7 from the bed to her wheelchair using a gait belt. The CNAs held onto the gait belt with one hand and held onto the resident's pants with the other hand. The CNAs used the resident's pants to lift the resident and transfer the resident to the wheelchair. Observation on 5/13/15 at 9:40 a.m., showed two	{F 323}	provided on June 9th, 10th, and 11th. Licensed nurses or nursing assistants who did not attend a session will receive education prior to June 17th. Audits for compliance will be completed 5 times weekly for 4 weeks and then 3 times weekly for three months. Audits will be completed by ADNS, nurse manager, licensed nurse, or nursing team member. Direct observations of transfers with gait belts will be completed as part of these audits. Results of audits will be forwarded to the QAPI committee for review and recommendations. Date of compliance is June 22, 2015.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355031	A. BUILDING _____ B. WING _____	R 05/13/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 323}	Continued From page 7 CNAs (#8 and an unidentified CNA) transferred Resident #7 from the wheelchair onto the toilet. The CNAs each lifted under the resident's axilla with one hand and grabbed the gait belt at the back with the other hand to lift the resident to standing position. The gait belt slid up around the resident's chest and under her axilla. - Review of Resident #9's medical record occurred on 05/13/15. Diagnoses included muscle weakness, difficulty in walking, history of fall, and lower leg neuropathy. The care plan identified ". . . ADL Self care deficit related to . . . physical limitations . . . Transfer with 1 assist with gait belt . . ." Observation on 05/12/15 at 4:07 p.m., showed a CNA (#3) transferred Resident #9 from the bed to her wheelchair. The CNA (#3) lifted under the resident's axilla with left hand and grabbed the back of the gait belt with the right hand to assist the resident to stand and pivot into the wheelchair. - Review of Resident #5's care plan identified ". . . ADL Self care deficit . . . generalized weakness related to recent pneumonia . . . Transfer with 1 assist with gait belt . . . When ambulating standing by assist with gaitbelt . . . At risk for falls due to new environment and location. Hx [history] of weak knees . . . Stand by assist of 1 with a gait belt for ambulation . . ." Observation on 05/13/15 at 9:45 a.m., showed a CNA (#2) transferred Resident #5 from his wheelchair to the bed. The CNA (#2) failed to secure the gait belt in place around the resident's waist, and as the resident stood the gait belt fell unfastened to one side of the resident. The CNA	{F 323}		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355031	A. BUILDING _____ B. WING _____	R 05/13/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 323}	Continued From page 8 (#2) lifted under Resident #5's left axilla and transferred him to the bed. - Review of Resident #12's care plan identified ". . . Requires assistance/ potential to restore function for TRANSFERRING from one position to another as evidenced by physical limitations secondary to lower extremity injury . . . TRANSFERS: 2 person with moderate level of assist with gait belt. TOE TOUCH WEIGHT BEARING TO RIGHT . . ." Observation on 05/12/15 at 3:34 p.m., showed a CNA (#9) transferred the resident from the wheelchair to the bathroom using a gait belt. Resident #12 pulled herself up and self pivoted to the toilet bearing weight on both legs. The CNA stood by the resident as she self pivoted and transferred to the toilet. The staff failed to provide a two person assist with a gait belt for the transfer.	{F 323}		
{F 431} SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when	{F 431}	F 431 No residents were identified as having been affected by this practice. Residents who reside in the facility have the potential to be affected by the practice. The ADNS or designee will provide education to licensed nurses regarding securing medication carts to ensure patient safety. Education was provided June 9th, 10th, and 11th. Licensed nurses who did not attend a session will receive education prior to June 17th. Audits of medication security will be completed five times weekly for four weeks and then three times weekly for three months with results forwarded to the QAPI committee for review and recommendation. Audits will be completed by Administrator, ADNS, nurse manager, department manager, or nursing team member. Date of compliance is 06-17-15	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355031	A. BUILDING _____ B. WING _____	R 05/13/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 431}	Continued From page 9 applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and review of facility policy, the facility failed to store all medications in a secure manner on 1 of 2 nursing units (1st floor). Failure to store all medications securely may result in unauthorized access to medications. Finding include: Review of the facility policy titled "Storage and Expiration Dating of Drugs, Biologicals, Syringes and Needles" occurred on 05/13/15. This policy, revised on 05/01/13, stated, ". . . The Nursing Center should ensure that all drugs and biologicals, including treatment items, are securely stored in a locked cabinet/cart or locked medication room, inaccessible by residents and	{F 431}		

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 _____	R 05/13/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 431}	Continued From page 10 visitors . . ." -Observation on 05/12/15 at 5:05 p.m. showed an unlocked and unattended medication cart located in the hallway west of the 1st floor nursing station. An unidentified resident was seated in her wheelchair next to the unlocked medication cart. -Observation on 05/13/15 at 8:40 a.m. identified an unlocked and unattended medication cart in the east corridor outside of the first floor dining room. An unidentified resident was seated in her wheelchair next to the unlocked medication cart. Residents and staff walked by the unlocked medication cart to exit the dining room.	{F 431}		