PRINTED: 12/23/2013
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 _____	C 11/20/2013

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 unannounced complaint survey conducted on November 18-20, 2013, the sample included ten residents for focused review and two closed records. In addition, four supplemental residents were added to the sample. The complaint concerns related to access to records, privacy, cold food, safe/clean/comfortable homelike environment, maintain/improve activities of daily living, falls, and hydration were substantiated (refer to F153, F164, F241, F244, F252, F311, F323, and F327). Five unrelated deficiencies were issued at F248, F280, F282, F315, and F520.	F 000	F000 The statements made on this plan of correction are not an admission 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 set forth in the following plan of correction. The plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be corrected by the dates indicated.	
F 153 SS=D	483.10(b)(2) RIGHT TO ACCESS/PURCHASE COPIES OF RECORDS The resident or his or her legal representative has the right upon an oral or written request, to access all records pertaining to himself or herself including current clinical records within 24 hours (excluding weekends and holidays); and after receipt of his or her records for inspection, to purchase at a cost not to exceed the community standard photocopies of the records or any portions of them upon request and 2 working days advance notice to the facility. This REQUIREMENT is not met as evidenced by: Based upon record review, staff interview, and review of information provided by the complainant, the facility failed to provide requested copies of resident records for 1 of 1 record of a resident who had been discharged (Resident #11). Failure to complete a request for	F 153	**F153 Access to records** The facility strives to ensure that the resident or his or her legal representative has the right upon an oral or written request, to access all records pertaining to himself or herself including current clinical records within 24 hours (excluding weekends and holidays): and after receipt of his or her records for inspection, to purchase at a cost not to exceed the community standard photocopies of the records or any portions of them upon request and 2 working days advance notice to the facility. Resident #11 no longer resides at the facility. Arrangements have been made to supply the resident and/or family member with the appropriate requested records.	~~1-20-14~~ 01/27/14 as per Greg Stump via phone 01/16/14 DH

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE administrator | (X6) DATE 1/8/14

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

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F 153	Continued From page 1 release of resident records is a violation of Resident #11's rights. Findings include: Information provided by the complainant identified a resident's family member (B), on behalf of the resident, requested copies of physical therapy (PT) progress notes during a family care meeting on 08/22/13. In an email, dated 08/27/13, sent by family member (B) to a staff member (#13) acknowledge receipt of Resident #11's initial occupational therapy and PT evaluations. In this email, family member (B) again requested copies of Resident #11's daily progress reports (pertaining to therapy) and requested all of Resident #11's records be transferred to another healthcare provider. The family member (B) provided an address for the facility to send a consent form for Resident #11 to sign so the above records could be released. Review of Resident #11's closed medical record occurred on November 19-20, 2013. Review of Resident #11's electronic and paper medical records failed to show evidence the facility sent the above records as requested. During interview on 11/20/13 at 1:45 p.m., a medical record staff member (#16) stated once she receives a signed completed consent form, she retrieves the information, and completes a log identifying what, when, and to whom the information is sent. The medical record staff member (#16) confirmed Resident #11's record lacked evidence of a signed consent and stated the facility has not sent any information to family	F 153	Residents that reside in the facility have the potential to be affected. Staff member #13 was educated regarding supplying resident's records through personal e-mail. Staff was educated the weeks of 12-30-13 and 1-6-14 in regard to following procedure for a resident to obtain medical records. Administrator and or designee will conduct random audits weekly times 60 days to validate that medical records is completing the correct procedure when there is a request for medical records. Trends will be forwarded to the QA&A committee for further review if needed.	

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F 153	Continued From page 2 member (B) or to any other healthcare provider. During interview on 11/20/13 at 2:00 p.m., a staff member (#13) stated she recalled corresponding with Resident #11's family member (B) using her personal email account. This staff member (#13) stated she provided a family member (B) with copies of Resident #11's initial PT and OT evaluations only. This staff member (#13) stated she did not forward family member (B's) request to the facility's medical records clerk to address and process.	F 153		
F 164 SS=E	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	F 164	**F164 Privacy** The facility strives to provide privacy and confidentiality for each resident in the facility. Residents that reside in rooms I & J had no negative outcome. Resident's that reside in the facility and use a wheelchair to get to the toilet in their rooms have the potential to be affected. Residents that meet these criteria have been assessed for toileting needs and have been educated regarding calling for assistance with closing the bedroom door and/or the bathroom door. Staff was educated the weeks of 12-30-13 and 1-6-14 in regard to assist the residents with toileting and closing the doors when appropriate.	~~1-20-14~~ 01/27/14 ao per Greg Stump via phone 01/16/14 BH

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F 164	Continued From page 3 the form or storage methods, except when 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 information provided by the complainant, the facility failed to ensure personal privacy on 2 of 3 days of survey (November 18 and 19) for resident's in wheelchairs when toileting in two resident bathrooms (Rooms I and J). Failure to ensure residents can close bathroom doors while toileting is an infringement on a resident's right to privacy. Findings include: Information provided by the complainant identified a concern with privacy for residents who are wheelchair bound and need to use the bathroom. The complainant identified that residents who utilize wheelchairs are unable to close the door to the bathroom due to the small size/design of the bathroom. Observation on 11/18/13 at 6:15 p.m. showed open doors to a resident's room (I) and bathroom. Observation showed a wheelchair sitting in front of the opened bathroom door. As the surveyor walked in the corridor, observation showed an unidentified female resident stood up from the toilet, completed her own pericares, exposing her frontal periarea and legs to the surveyor. Observation on 11/19/13 at 10:30 a.m. showed the door to a resident's room (J) opened. Prior to	F 164	ADNS or designee will conduct random audits weekly times 60 days to ensure that privacy is being provided to the identified residents. Trends will be forwarded to QA&A committee with follow up as needed.	

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F 164	Continued From page 4 entering the room, the surveyor noted a resident standing up from the toilet. Observation showed the resident's exposed buttock. When requested the facility failed to submit a policy on respecting residents's right to privacy.	F 164		
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, record review, staff interview, and information provided by the complainant, the facility staff failed to provide care in a manner to enhance the dignity and respect for 3 of 11 sampled residents (Resident #1, #2, and #6) requiring assistance with Activities of Daily Living (ADLs). Failure to ensure dignity and respect during personal cares does not recognize the individuality of each resident or enhance the quality of life for each resident. Findings include: When requested the facility failed to submit a policy on resident dignity. Information provided by the complainant indicated facility staff failed to provide care in a manner that enhanced the dignity of the residents. The complainant indicated facility staff failed to adequately bathe/groom the residents.	F 241	**F 241 Dignity and Respect of Individuality** The facility strives to promote care for the resident 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. Resident # 1, #2, and #6 had no negative outcome. Resident #1's hearing aides have been replaced. Resident #2 had a bladder diary completed and his voiding pattern was obtained to create a toileting schedule. Resident #6 is assisted with dining and uses a napkin to clean face. Residents that reside in the facility and need assistance with eating and dressing have the potential to be affected. Residents that require hearing aides have the potential to be affected.	1-20-14 01/07/14 aapn Greg Stump via phone 01/16/14 BH

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F 241	Continued From page 5 - Resident #1's medical record, reviewed on all days of survey, identified diagnoses of altered mental status and muscle weakness. An annual Minimum Data Set (MDS), dated 08/28/13, identified the resident as needing assistance to complete activities of daily living (ADLs) and having moderate difficulty with hearing, (speaker has to increase volume and speak distinctly.) wears bilateral hearing aids. Observations showed the following: * On 11/18/13 at 4:56 p.m., a Certified Nursing Assistant (CNA) (#6) assisted Resident #1 to get ready for supper. Resident #1's shirt was visibly soiled with a five-to-six inch brown circular stain in the center. The CNA (#6) failed to assist Resident #1 to change her shirt before she was transported to the dining room. * On 11/19/13 at 1:40 p.m., a CNA (#5) assisted Resident #1 to the bathroom and then to bed. The CNA (#5) spoke to Resident #1 and received no responses. Observation showed Resident #1 was not wearing her bilateral hearing aids in her ears. The surveyor asked the CNA (#5) if the resident could hear the questions and the CNA (#5) stated she was sure the resident could hear her. Information provided during the survey indicated Resident #1's hearing aids had been missing for four days. During an interview the afternoon of 11/20/13, an administrative nurse (#1) confirmed staff should make sure residents are dressed in clean clothes and ensure those residents who utilize hearing aides are wearing them. - Resident #2's medical record, reviewed on all days of survey, identified diagnoses of senile	F 241	Staff was educated the weeks of 12-30-13 and 1-6-14 in regard to toileting residents, assisting the residents with dining and assuring hearing aids in place for the residents that require them. ADNS or designee will conduct weekly random audits times 60 days to validate that residents are being toileted, assisted with dining and wearing hearing aids when appropriate. Trends will be forwarded to QA&A with follow up as needed.	

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F 241	Continued From page 6 dementia with delirium and Parkinson's disorder. A significant change MDS, dated 11/05/13, identified the resident had moderate cognitive impairments, required extensive assistance of two or more persons for toilet use, was frequently incontinent of urine, and required supervision for eating. The Progress Notes, dated 09/04/13-11/16/13, showed staff: * Identified Resident #2 as being incontinent of urine on ten occasions. * Found Resident #2 with his pants lowered on six occasions. Observations showed the following: * On 11/18/13 at 10:30 a.m., Resident #2 sitting in his wheelchair in his room exposed from the waist down, with his pants and brief down around his ankles. The resident stated, "I need new pants, I wet these." * On 11/18/13 at 5:35 p.m., Resident #2 sitting in his wheelchair in the dining room. The armrest on Resident #2's wheelchair was approximately twelve inches from the edge of the table. Resident #2 attempted to feed himself, reached for the items on his plate and frequently dropped/spilled the items on his face, clothing protector, and/or napkin in his lap. The resident later scraped his clothing protector/napkin and ate the items he had dropped. During two interviewsn on the afternoon of 11/20/13, an administrative nurse (#1) stated, "He [Resident #2] must be toileting himself during the day," and confirmed staff should clean the excess food from his face, clothing protector, and napkin on his lap.	F 241		

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F 241	Continued From page 7 - Resident #6's medical record, reviewed on all days of survey, identified diagnoses of aphasia and hemiplegia. The annual MDS, dated 09/12/13, identified the resident had some difficulty making decisions in new situations and required extensive assistance of one person for eating. Observations showed the following: * On 11/18/13 at 5:35 p.m., Resident #6 sitting next to an unidentified staff member in the dining room. After waiting four-to-five minutes, Resident #6 attempted to feed herself, by scooping pureed foods off her plate with her fingers. After observing Resident #6 eating with her fingers, the staff member stated, "Wait for your feeder." * On 11/19/13 at 8:18 a.m., A CNA (#3) fed Resident #6 in the dining room. After several bites of food were offered at a rapid rate, Resident #6 sat for two-to-three minutes with egg on her bottom lip. The CNA (#3) used Resident #6's clothing protector to wipe the resident's face instead of the napkin laying next to her plate. She also watched as Resident #6 used her clothing protector to wipe/blow her nose on two occasions. * On 11/19/13 at 12:30 p.m., A CNA (#4) fed Resident #6 in the dining room. The CNA (#4) used Resident #6's clothing protector to wipe her face instead of the napkin laying next to her plate on two occasions. During an interview the afternoon of 11/20/13, an administrative nurse (#1) confirmed staff should use a napkin to clean the excess food from Resident #6's face and/or wipe her nose.	F 241		
F 244 SS=E	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION	F 244	**F 244 Listen/act on Group Grievance/recommendation**	1-20-14

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F 244	Continued From page 8 When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, review of monthly resident council meeting minutes, resident and staff interview, review of quality assurance notes, and policy and procedure review, the facility failed to act upon resident grievances; specifically concerns about the temperature of the food served in the facility. Failure to act upon the grievances of the residents resulted in residents continuing to be dissatisfied and continuing to submit grievances. Findings include: Review of the facility's "Food Temperature Maintenance During Holding" occurred on the morning of 11/20/13. This policy, dated 04/07/06, stated, ". . . Hot foods are held at 140 degrees F (Fahrenheit) or above . . . Holding hot foods above 140 degrees F but below 180 degrees and cold foods below 41 degrees F may be desirable to facilitate temperature maintenance for palatability at point of service . . ." Review of the facilities Resident Council Minutes from August-November 2013 occurred on the afternoon of 11/19/13. The Resident Council Minutes, dated 08/16/13, identified "Dietary Compliments, comments: cold food continues . . .	F 244	The facility strives to listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility No resident was identified in the cited deficiency. Residents that receive food from the kitchen have the potential to be affected. Food temperatures will be kept within the acceptable ranges. Food will be palatable of palatable consistency. Staff was educated regarding providing the residents food at palatable temperatures. Administrator or designee will conduct random audits weekly times 60 days to validate that the food is at the correct temperatures. Trends will be forwarded to the QA&A committee with follow up as needed.	

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F 244	Continued From page 9 ." During a confidential interview during the week of survey, Resident A (identified by the facility as interviewable) described the food as "warm at best." He indicated he was "one of the last ones [residents] to be served [in the dining room]." When asked for examples of foods that he considered unpalatable, he responded, "eggs and soup." - Observation of the morning meal in the second floor dining room on 11/19/13 at 7:50 a.m. showed the certified nursing assistants (CNAs) passed trays with food items to the residents present in the dining room. Observation showed most residents received egg bake with cheese and oatmeal. A test tray of the breakfast meal received at 8:23 a.m. (following service to all of the second floor residents) showed the oatmeal at 153.7 degrees F and the egg bake at 138.6 degrees F. The eggs were warm to the touch, greasy, and the cheese was tough. - Observation of the noon meal in the first floor dining room on 11/19/13 at 12:00 p.m. showed the CNAs passed trays with food items to the residents present in the dining room. A test tray of the noon meal received at 12:20 p.m. (following service to all of the first floor residents), showed the mashed potatoes at 140 degrees F, the roast beef at 129.9 degrees F, and the mixed vegetables at 97.9 degrees F. The vegetables were cold to the touch, and the meat and potatoes were warm to the touch. Review of facility quality assurance (QA) notes occurred at the conclusion of the survey. The "Patient Interview and Observation" sheets,	F 244		

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F 244	Continued From page 10 undated and unsigned, identified six residents were asked if the food tastes good and looks appealing. One of six residents responded, "No." The same six residents were asked if the food is served at the proper temperature. Four of six residents responded, "No." The facility provided no evidence interventions had been implemented to address the residents' concerns regarding food palatability. During an interview on 11/20/13 at 10:40 a.m. regarding the temperatures of the food items on the test trays, a dietary staff member (#2) agreed the palatability is a resident concern that needs correction.	F 244		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 03/07/13. Based on observation, record review, and staff interviews, the facility failed to develop and implement an individualized activity program for 3 of 10 sampled residents (Resident #5, #6, and #16) dependent on staff for activities. Failure to implement an individualized activity program to respond to the interests and current capabilities of the residents has the potential to affect their	F 248	**F248 Activities** The facility strives to provide an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental and psychosocial well-being of each resident Residents #5, #6, and #16 had no negative outcome. Residents that are dependent on staff for activities have the potential to be affected. Activity staff was educated regarding providing activities for residents that are dependent on staff. Care plans were updated to reflect current activity needs.	~~1-20-14~~ 01/27/14 ao pm Greg Shupp via phone 01/16/14 DH

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F 248	Continued From page 11 physical, cognitive, and emotional health. Findings include: Review of the facility policy titled "Activity & Recreation Service Manual" occurred on 11/20/13. This policy, dated January 2013, stated, ". . . GROUP PROGRAMS, Group programs involve a number of people in physical, mental and social interactions. By providing group programs, the center maximizes resources, encourages cohesiveness and promotes socialization . . . ONE-TO-ONE PROGRAMMING, A one-to-one program is provided for patients unable or unwilling to participate in large group settings, meeting some or all of the following criteria: * health and or disease status limits participation in group activities * isolation status; medically related or self-imposed isolation limits exposure to other patients * behavioral symptoms that limit tolerance and participation in group settings * patient chooses not to participate in group activities offered or seldom initiates own activities . . . The one-to-one program format is based upon the comprehensive assessment, interests and the physical, mental and psychosocial needs of the patient. Care plans reflect frequency and types of services provided. Visiting time frames vary according to individual patient needs . . . PROGRAM CONTENT AND GUIDELINES, It is the center's responsibility to provide programming designed to provide patients with choices of meaningful social and therapeutic activities while stimulating interest, meeting needs and connecting with the community. A comprehensive	F 248	Activity calendar has been be updated to better meet all patient's needs. Administrator or designee will conduct weekly random audits times 60 days to validate that the dependent residents are involved in activities when appropriate for the resident. Trends will be forwarded to the QA&A committee with follow up as needed.	

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F 248	Continued From page 12 program of group and individual activities enhance the physical, emotional and spiritual well-being of each patient . . ." Review of the facility document, titled "Activity and Recreation Role and Regulations," occurred on 11/20/13. The document, dated January, 2013, stated, ". . . the center involves the patient in an ongoing program of activities that are designed to appeal to his or her interests and to enhance the patient's highest practicable level of physical, mental and psychosocial well being. . . . 'activities' refer to any endeavor . . . in which a patient participates that . . . promote self-esteem, pleasure, comfort, education, creativity, success and independence. . . ." Review of the November 2013 activity calendar showed "Bingo" on alternating Saturdays as the only evening activity available. Activities during the days of survey included: * November 18 - Monday - 9:30 a.m. Turkey Brush to Canvas: 2 [second floor], 10:00 a.m. Activity Preference Committee Meeting: 1 [first floor], 10:00 a.m. Volunteer Visits: 2 [second floor], 11:00 a.m. Turkey Brush to Canvas: 1 [first floor], 1:30 p.m., Manicures: 2 [second floor], 2:00 p.m. Baking Group: 2 [second floor], 3:00 p.m. Autumn Sensory Visits:1 [first floor] * November 19 - Tuesday - 9:30 a.m. Word Game: 2 [second floor], 10:30 a.m. Catholic Mass, 10:30 a.m. One to One visits: 1&2 [first and second floor], 1:30 p.m. Life History Visits: 1&2 [first and second floor], 2:30 p.m. Devotionals with Pastor, 3:45 p.m. Book club:1 [first floor] * November 20 - Wednesday - 9:30 a.m. Helping Hands: 2 [second floor], 10:30 a.m. Swat	F 248		

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F 248	Continued From page 13 Ball Game:1 [first floor], 11:00 a.m. Life Enrichment (room to room): 1&2 [first and second floor], 2:00 p.m. Bingo: 2 [second floor], 2:30 p.m. Calming Sensory Visits:1 [first floor], 4:00 p.m. Apple Cider Refreshment Cart:1 [first floor] - Observations on November 18-20, 2013 showed staff failed to provide meaningful, individualized activities on a consistent basis. Observations at various times of the day showed between 10-20 residents seated in the TV lounge on the first floor, who were not activitly engaged in any type of activity. - Resident #5's medical record, reviewed on all days of survey, identified diagnoses of Alzheimer's disease, dementia, aphasia, and depression. The annual Minimum Data Set (MDS), dated 11/11/13, identified the resident required extensive assistance of one-to-two persons for all Activities of Daily Living (ADLs). The MDS further identified Resident #5 preferred activities such as listening to music, sitting outside, and westerns on television. The recreation/activity evaluation, dated 02/13/13, identified Resident #5 as interested in "country/western music in the lounge area 1st [floor], sit outside with wife, and sometimes westerns on tv/radio." The current care plan, revised 11/19/13, stated, ". . . Focus: [Resident #5's name] leisure and social focus at this time is 1:1 visits with activity staff, family visits, outdoor time and attending group activity and special events. . . [Resident #5's name] accepts 1:1 visits from activity staff throughout the week for increased socialization - he enjoys music, sports, news, and the outdoors.	F 248		

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F 248	Continued From page 14 . . " Interventions: Anticipate residents leisure and social needs, Assist in transport to [and] from activities of choice, as needed, Encourage participation in group activities of interest, encourage resident and wife/family to attend activities of interest together while visiting, Offer activity program directed toward specific interests/needs such as reminiscing abt. (about) sports, and read the newspaper, Provide 1:1 room visits weekly. . . ." Review of activity participation logs from October 1 - November 19, 2013 showed the following: * October 2013: independent in "television" on nine days; active participation in "1:1 visit four times, exercise/sports one day, and "visitors" on 16 days. Data recorded for the resident stated unavailable for all of his preferred activities. * November 2013: independent in "television" on one day and eyes open for "television" on five days; active participation in "visitors" on 12 days; and 1:1 visit three days. Data recorded for the resident stated unavailable for all of his preferred activities. The October/November participation logs identified Resident #5 attended four out of 38 (care-planned/preferred and offered: "cards/games, exercise/sports, music, and spiritual/religious") activity sessions offered. Staff indicated he was unavailable on 50 occasions. During an interview on the afternoon of 11/20/13, when asked for a detailed explanation of Resident #5's activity log, an administrative activity staff member (#8) made the following statements: * Auditory Stimulation: "Is marked to show a "response" when he is read to."	F 248		

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F 248	Continued From page 15 * Leisure Cart: "We take a cart with activities the residents can choose from." * Socializing: "Is marked when we say 'Hi' and stop to talk to the resident in the hall." * Visitors: "His family visits. We don't arrange those visits." When asked what "unavailable" represented as a response on the activity participation logs, the administrative activity staff member (#8) stated, "That means he was asleep. If he is sleeping, staff won't wake him up." Observations of the first floor lounge area showed the following: * 11/18/13 at 10:34 a.m., 16 residents in the television lounge. All of the residents have their heads down and eyes closed. *11/18/13 at 3:22 p.m., ten residents in the television lounge. Most of the residents have their heads down and eyes closed. *11/18/13 at 4:31 p.m., 14 residents in the television lounge. The residents have their heads down or are staring straight ahead. No structured activity occurring. *11/19/13 at 8:32 a.m., ten residents in the television lounge. The residents have their heads down or are staring straight ahead. No structured activity occurring. * 11/19/13 at 8:38 a.m., ten residents in the television lounge. The residents have their heads down or are staring straight ahead. No structured activity occurring. *11/19/13 at 8:52 a.m., 13 residents in the television lounge and six residents lined up in the east hallway. The residents have their heads down or are staring straight ahead. *11/19/13 at 10:30 a.m., seven residents in the	F 248		

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F 248	Continued From page 16 television lounge. Six residents have eyes closed and no structured activity occurring. *11/20/13 at 9:10 a.m., 13 residents in the television lounge and six residents lined up in a row in the hallway. The residents have their heads down or are staring straight ahead. No structured activity occurring. - Resident #6's medical record, reviewed on all days of survey, identified diagnoses of aphasia, hemiplegia, and depression. The annual MDS, dated 09/12/13, identified the resident had some difficulty making decisions in new situations and required extensive assistance of one-to-two persons for all Activities of Daily Living (ADLs). The MDS further identified Resident #6 preferred activities such as listening to music, reading and attending outings and religious activities. The recreation/activity evaluation, dated 09/16/13, identified Resident #6 as interested in "animals/pets, cards/games, children, current events/news, movies, spiritual hymns and country music, outdoor activities, parties/socials, reading, Lutheran church, talking/conversing, travel/outings, and baseball games on tv/radio." The current care plan stated, ". . . Focus: [Resident #6] enjoys activities such as bingo, crafts, church, baking group, having her nails done and attending music programs. . . . [Resident #6] does need assistance and cues to participate in group activities. She benefits from 1:1 visits for socialization weekly with staff. . . . Interventions: Assist in planning and/or encourage to plan own leisure time activities, Assist to transport to [and] from activities of choice, Encourage participation in group activities of interest, Give verbal reminders of activities	F 248		

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F 248	Continued From page 17 before activity begins, Offer 1:1 visits weekly [revised 11/19/13], Offer brief visits to ensure are receiving sufficient social and recreational contacts, prn. . . . Focus: . . . depression . . . Interventions: . . . Encourage to take active social role within facility." Review of activity participation logs for October 1 - November 19, 2013 showed the following: * October 2013: independent in "reading" on 15 days and "television" on 27 days; active participation in "arts/crafts, beauty shop, bingo, leisure cart, music/singing, and special event" on one day, and "visitors" on four days. * November 2013: independent in "reading" on 12 days and "television" on 13 days; active participation in "cooking, movie, and visitors" on one day. The October-November participation logs identified Resident #6 attended four out of the possible 38 (care-planned/preferred: "arts/crafts, bingo, cooking, music/singing, and spiritual/religious") activity sessions offered. Staff indicated she was unavailable on 34 occasions. Observations showed the following: * 11/18/13 at 3:08 p.m. and 4:50 p.m., Resident #6 sitting in her wheelchair in the lounge with her head lowered. * 11/19/13 at 9:28 a.m. and 10:45 a.m., Resident #6 lying in bed, with eyes closed. * 11/19/13 at 1:55 p.m. and 11/20/13 at 10:10 a.m., Resident #6 sitting in her wheelchair in her room with her head lowered. Her television on in the background. * 11/19/13 at 3:00 p.m., Resident #6 sitting in her wheelchair in the activity room during "Devotions."	F 248		

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F 248	Continued From page 18 During an interview on 11/20/13 at 10:00 a.m., when asked for an explanation of Resident #6's activity log, an administrative activity staff member (#8) made the following statements: * Beauty Shop: "Is marked when they get their hair done." * Leisure Cart: "We take a cart with activities to the residents. They can pick whatever they want from the cart." * Off-site: "Her family takes her out." * Reading: "She's independent." * Socializing: "Is marked when we stop to talk to the residents." * Television: "She's independent." * Visitors: "Her family visits. We don't arrange those visits." When asked what "unavailable" represented as a resident response on the activity participation logs, the administrative activity staff member (#8) stated, "That means she was asleep. If she is sleeping, staff won't wake her." She also reported recently updating Resident #6's care plan to include "1:1 visits due to her recent change [of status]." Observations during survey showed, other than attending devotions on one occasion, staff failed to provide meaningful and individualized activities specific to Resident #6's physical and cognitive abilities. Whether she was placed in her room or in the second floor lounge, Resident #6 sat in silence or laid in her bed/sat in her wheelchair with her head lowered and eyes closed. - Resident #16's medical record, reviewed on November 19-20, 2013, identified diagnoses of acute respiratory failure, pneumonia, anemia, dementia, and hemiplegia with left sided weakness. A significant change MDS, dated	F 248		

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F 248	Continued From page 19 10/14/13, identified the resident displayed severe cognitive impairment, had some difficulty making decisions in new situations and required extensive assistance of one-to-two persons for all ADLs. The MDS further identified Resident #6 preferred activities such as listening to music, spending time outdoors, and participating in religious activities. The recreation/activity evaluation, dated 10/15/13, identified Resident #16's current interests include: farm animals, pets, children, current events/news, exercise/physical activities, old time country music, outdoor activities, reading the newspaper, Lutheran church, talking/conversing, and sports and news on TV/radio. The current care plan stated, ". . . Focus: [Resident #16] enjoys independent leisure activities including watching TV (news and sports), keeping up with the news and reading his newspaper. [Resident #16] is able to make daily leisure choices with invites and cues from staff. [Resident #16] prefers to not attend group activities unless large special event in which he needs invites from staff . . . [Resident #16] accepts 1:1 visits from activity staff weekly for increased socialization throughout his day and assistance with leisure pursuits, as needed . . . Interventions: Assist to transport to [and] from activities of choice, Encourage participation in group activities of interest, Give verbal reminders of activities before activity begins, Offer 1:1 visits weekly [revised on 11/06/13], Offer leisure materials as needed or requested, provide monthly activity calendar, respect residents choice to make daily leisure choices. Review of activity participation logs from October	F 248		

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F 248	Continued From page 20 1 - November 18, 2013 showed the following: * October 2013: independent in "television" on 21 days; active participation in "socializing" on 23 days; "visitors" on seven days; and an "off-site outing" and "special event" each on one day. * November 2013: independent in "television" on nine days; active participation in "socializing" on 13 days; and "visitors" on five days. The October-November 2013 participation logs identified Resident #6 refused spiritual/religious activites on one occassion and was unavailable to attend on 16 occasions and refused music/singing activities on two occassions and was unavailable on four occasions. The facility failed to ensure Resident #5, #6 and #16, who were dependent on staff, were provided a meaningful activity program responsive to their strengths and deficits.	F 248		
F 252 SS=E	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observation, information from the complainant, and review of facility quality assurance (QA) notes, the facility failed to ensure the resident's environment remained free of offensive odors during 3 of 3 days (November 18 - 20, 2013) of survey. Failure to prevent odors,	F 252	**F252 Clean and Comfortable** The facility strives to provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. Rooms 185,168, 186 & 192 have been cleaned and assessed for odors. Residents that reside in the facility have the potential to be affected. Housekeeping and licensed staff was educated regarding cleaning rooms and observing for odors in rooms.	~~1-20-14~~ 01/27/14 ao per Greg Stump via phone 01/16/14 BH

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F 252	Continued From page 21 placed residents and staff in an uncomfortable and unpleasant environment. Findings include: Information provided by the complainant indicated facility staff failed to provide an environment free of odors for the residents. The complainant stated the facility "smelled of feces and urine." Upon entering the facility on 11/18/13 at 10:30 a.m., members of the survey team noted a strong stale musty odor/smell on the first floor while walking down the hallway to the family dining/conference room. During the initial tour on 11/18/13 at 10:36 a.m., the south hallway contained a stale musty odor, the east hallway near room A had urine odors. Four hours later, the odors were still present. On 11/19/13 at 8:13 a.m., the odor of urine is present in the hallway near the first floor dining room and near room E. At 8:40 a.m., the east hallway smelled of urine. At 10:00 a.m., the odor of urine is present near room A. At 10:04 a.m., the strong odor of urine is present near room D and the hallway near room C. At 1:03 p.m., the odor of urine is present in the north hallway. Observations on 11/20/13 at 7:40 a.m., showed the north hallway and the conference room with a strong musty smell and the odor of urine near room E. Review of facility QA notes occurred at the conclusion of the survey. The "Patient Interview and Observation" sheets, undated and unsigned, identified rooms C, F, G, and H, each person	F 252	Administrator or designee will conduct random weekly audits times 60 days to validate that the environment is comfortable. Trends will be forwarded to the QA&A committee with follow up as needed.	

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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 _____	C 11/20/2013

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 252	Continued From page 22 interviewed said, "No" when asked if the room is free of odors. Hand written comments stated, "Very strong urine odor in bathroom [sic] room C [room number stated] floor is sticky. Dried urine under bed in room F [room number stated] floor is sticky [sic]."	F 252		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 03/07/13. Based on observation, record review, and resident and staff interviews, the facility failed to	F 280	**F 280 Right to participate in care plan** The facility strives to develop a comprehensive care plan within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with the responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. Resident #2, #3, and #6 had no negative outcome. Resident #2 care plan has been revised to match the cares and equipment that this resident requires. Resident #6 care plan has been revised to match the cares and equipment that this resident requires.	~~1-20-14~~ 01/29/14 as per Greg Stump via phone 01/16/14 BH

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F 280	Continued From page 23 review and revise the resident's plan of care for 3 of 10 sampled residents (Resident #2, #3, and #6). Failure to review and revise the plan of care limited the facility's ability to communicate care needs and ensure continuity of care for each resident. Findings include: - Resident #2's medical record, reviewed on all days of survey, identified diagnoses of senile dementia with delirium, Parkinson's disorder, history of urinary tract infection (UTI), and history of falls. A significant change Minimum Data Set (MDS), dated 11/05/13, identified the resident had moderate cognitive impairments, required extensive assistance of two or more persons for transfers and toilet use, supervision for eating, and was frequently incontinent of urine. The current care plan identified, "Focus Urinary incontinence . . . Interventions Place urinal/bedpan within resident's reach, Provide incontinent care as needed. . . . Focus . . . history of falls . . . Interventions . . . Patient at times will self transfer without assistance, Reinforce need to call for assistance . . . Sara [stand] lift for all transfers, Toilet with rounds at night, Visual reminders to ask for help placed in room and in bathroom. . . . Focus Nutritional status . . . Interventions Report any increased difficulty swallowing. . . ." The assignment sheet utilized by direct care staff, printed 11/20/13, identified, "ADLs [Activities of Daily Living] . . . transfer with assist of [two] and gait belt . . . Safety . . . Sara lift for all transfers, Toilet with rounds at night . . . Bowel/Bladder . . . Provide incontinent care as needed. . . .	F 280	Resident #3 care plan has been revised to match the cares and equipment that this resident requires. Residents residing in the facility have the potential to be affected. Care plans will be updated with MDS schedule. Licensed staff was educated on creating and updated care plans to reflect current resident status. ADNS or designee will conduct random weekly audits times 60 days to ensure that care plans are created and updated following the MDS schedule and with change in condition. Trends will be forwarded to the QAA committee with follow up as needed.	

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F 280	Continued From page 24 Food/Fluids No straws. . . . Special Needs . . . Toilet upon awakening, before all meals and @ H.S. [Hour of Sleep]. . . ." The Progress Notes, dated 09/04/13-11/16/13, showed staff: * Identified Resident #2 as being incontinent of urine on ten occasions. * Transferred Resident #2 with the assistance of one person on four occasion. * Transferred Resident #2 utilizing a Sara [stand] lift and the assistance of two persons on three occasion. * Educated Resident #2's family regarding his "more frequent toileting schedule." * Found Resident #2 with his pants lowered on six occasions. * Found Resident #2 sitting on the floor in his bathroom, after he attempted to self-transfer from the toilet to his wheelchair on one occasion. * Found Resident #2 laying on the floor in his bedroom, incontinent of urine on one occasion. Observations showed the following: * On 11/18/13 at 10:30 a.m., Resident #2 sitting in his wheelchair in his room exposed from the waist down, with his pants and brief down around his ankles. The resident stated, "I need new pants, I wet these." Two unidentified certified nurse assistants (CNAs) entered Resident #2's room, and using a stand lift provided pericares/changed the resident's clothing. * On 11/18/13 at 5:35 p.m., Resident #2 sitting in his wheelchair in the dining room. Resident #2's diet card [located next to his plate] read, "Adaptive Equipment: Sip Lids, No Straw." Staff placed a straw in his open milk carton as they provided tray set-up. The armrest on Resident #2's wheelchair was approximately twelve inches	F 280		

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F 280	Continued From page 25 from the edge of the table. Resident #2 attempted to feed himself, reached for the items on his plate and often dropped/spilled the items on his face, clothing protector, and/or napkin in his lap. The resident later scraped his clothing protector/napkin and ate the items he had dropped. The current care plan and assignment sheet utilized by direct care staff failed to identify the number of personnel, the level of assistance, and the type of equipment required to safely transfer Resident #2, failed to outline Resident #2's individualized toileting schedule, and failed to identify any dysphagia interventions (positioning and/or equipment) recommended for Resident #2. - Resident #6's medical record, reviewed on all days of survey, identified diagnoses of aphasia, hemiplegia, and contracture of the hand. An annual MDS, dated 09/12/13, identified the resident had some difficulty making decisions in new situations and required extensive assistance of one-to-two persons for all Activities of Daily Living (ADLs). The current care plan stated, ". . . Focus: ADL Self care deficit . . . Interventions: . . . Needs edema glove to R [right] handHas [sic] resting hand splint on R arm during day, off at HS [hour of sleep]. . . ." The assignment sheet utilized by direct care staff, printed 11/20/13, identified, ". . . Special Needs . . . Pureed diet. Edema glove to the right hand and right hand splint - on in a.m. and off at HS. . . ." Observations on 11/19/13 at 9:15 a.m. showed	F 280		

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F 280	Continued From page 26 two CNAs (#4 and #9) assisting Resident #6 with her TED hose (compression stockings.) When asked if Resident #6's wore an edema glove and/or hand splint, one CNA (#4) reported the glove was "in her drawer," and the other CNA (#9) stated, "I haven't seen that [splint] in a year." During an interview on 11/20/13 at 10:25 a.m., when asked if staff should be applying Resident #6's edema glove and/or splint, a managerial nurse (#10), after reviewing the resident's medical record, stated, "It's confusing." She later reported that both items had been discontinued in July of 2013. The current care plan had not been revised to accurately reflect Resident #6's non-use of her edema glove and/or right arm splint. - Resident #3's medical record, reviewed on all days of survey, identified diagnoses osteoarthrosis, joint and shoulder pain, type II diabetes, depressive disorder, hypertension, and obesity. The quarterly MDS, dated 10/12/13, identified Resident #3 had intact cognitive skills for decision making and required extensive assistance of two or more persons for transfers and toilet use. On 11/18/13 at 3:25 p.m., Resident #3 stated she is able to take herself into the bathroom during the day and uses a bedpan at night. The current care plan identified, "Focus ADL [activities of daily living] self care deficit as evidence by the need for physical assist related to weakness . . . Interventions Transfer with sit to stand lift [a type of mechanical lift], [Resident name] is noted to self transfer without calling for	F 280		

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F 280	Continued From page 27 assist . . . ." On 11/19/13 at 2:45 p.m., a certified nurse aide (CNA) (#15) stated Resident #3 self transfers to/from the toilet during the day and does utilize a bed pan at night. This CNA (#15) stated staff members do not use a sit to stand lift to assist the resident with transfers. On 11/20/13 at 10:55 a.m., a registered nurse (RN) (#10) stated "due to resident and staff safety" therapy recommended the use of a mechanical lift for transfers with Resident #3, but the resident refuses to allow its use. Facility staff failed to review and revise Resident #3 plan of care to identify the resident's refusal to use a mechanical lift with transfers as recommended.	F 280		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to provide care according to the individual care plan for 1 of 10 sampled residents (Resident #1). Failure to implement the care plan as written has the potential to affect the resident's safety and physical well-being.	F 282	**F 282 Services by qualified persons/per care plan** The facility strives to have qualified persons deliver care in accordance with each resident's written plan of care. Resident #1 had no negative outcomes. Residents residing in the facility have the potential to be affected. Care plans will be updated with MDS schedule. Licensed staff was educated on following the plan of care for the residents. ADNS or designee will conduct random audits weekly times 60 days to ensure that	~~1-28-14~~ 01/27/14 ao per Greg Stump via phone 01/16/14 BH

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F 282	Continued From page 28 Findings include: - Observation of personal cares occurred on 11/18/13 at 4:56 p.m. A certified nurse aide (CNA) (#12), utilizing a gait belt, assisted Resident #1 to pivot transfer from her bed to her wheelchair. Resident #1 wore non-skid slipper socks on her feet and no stockinettes. - Observation of personal cares occurred on 11/19/13 at 1:40 p.m. A CNA (#5), utilizing a gait belt, assisted Resident #1 to pivot transfer from her wheelchair to the toilet, back to her wheelchair, and then to bed. Resident #1 wore non-skid slipper socks on her feet and no stockinettes. - Observation of Resident #1's feet and ankles occurred on 11/20/13 at 9:30 a.m. The resident wore non-skid slipper socks on her heel and no stockinettes. The CNA commented Resident #1's legs are swollen. Review of Resident #1's medical record occurred November 18-20, 2013. Resident #1's current care plan, updated 07/29/13, identified the problem of "ADL (activities of daily living) self care deficit as evidenced by weakness related to physical limitations. Interventions: Assist of two and gait belt for transferring. . . Stretch net stockinettes toes to knee on during [the] day." During an interview on 11/20/13 at 9:35 a.m., a CNA (#5) stated the Kardex for Resident #1 identified the resident wears stockinettes daily, on in the morning and off at bedtime. During an interview on 11/20/13 at 1:35 p.m., an administrative nurse (#1) verified Resident #1's	F 282	appropriate interventions are in place and being followed. Trends will be forwarded to the QA&A committee with follow up as needed.	

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F 282	Continued From page 29 care plan was current. She stated Resident #1 required two staff and a gait belt for transfers, and she is to wear stockinettes daily. Failure to provide the correct number of staff for transfers and failure to apply Resident #1's stockinettes as ordered does not follow her plan of care and may lead to injury from a fall and/or pain from increased edema in her legs.	F 282		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview, and information provided by the complainant, the facility failed to provide residents with the appropriate treatment/restorative therapy (RT) services to maintain their highest practicable level of physical, mental, and psychosocial well-being for 1 of 1 record of a resident discharged from the facility (Resident #10) for whom restorative therapy services were recommended. Failure to provide restorative therapy services and utilize his leg brace as recommended for Resident #10 did not provide him the opportunity to maintain his range of motion, balance, strength, endurance, and mobility, and may have contributed to his falls with injury. Findings include:	F 311	**F 311 Treatment/services to improve/maintain ADL's** The facility strives to provide the necessary services to assist residents who are unable to carry out activities of daily living the assistance that they need. Resident #10 has been discharged from the facility Residents that have braces and walking programs have the potential to be affected. Licensed staff was educated regarding the process for following plan of care for a resident on Restorative programs. ADNS or designee will conduct random audits weekly times 60 days to validate that a resident on Restorative is having their plan of care followed as written. Trends will be forwarded to the QA&A committee with follow up as needed.	~~1-20-14~~ 01/29/14 as per Greg Stump via phone 01/16/14 AH

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F 311	Continued From page 30 Information provided by the complainant indicated facility staff failed to implement interventions/assistive devices and provide restorative therapy services following discharge from rehabilitative therapy. - Resident #10's medical record, reviewed on all days of survey, identified diagnoses of transient ischemic attacks (TIAs), Parkinson's disease, osteoarthrosis, osteoporosis, vertigo, difficulty walking, history of falls with contusions/fractures of the facial/nasal bones, clavicle, sternum, lumbar vertebra, pubis, and acetabulum (hip). The quarterly MDS, dated 08/04/13, identified the resident had moderate cognitive impairments, required extensive assistance of one person for dressing, transfers, walked in room/corridor, locomotion on/off unit, stabilized with staff assistance when moving from a seated to standing position, walking, turning around, moving on/off toilet and from surface to surface, and experienced falls since being admitted to the facility. The MDS further showed Occupational/Physical therapy (OT/PT) and Restorative Nursing services were not being provided at the time of the assessment. The current care plan identified, "Focus ADL [Activities of Daily Living] Self care deficit as evidenced by weakness, limited ROM [range of motion]related to recent fall with fractures . . . Interventions . . . Transfer with 1 assist with gait belt, Uses walker and assist of 1 for ambulation. . . . Focus At risk for falls due to unsteady gait, history of falls . . . Interventions . . . Provide assist to transfer and ambulate as needed . . ." The care plan failed to address Resident #10's right leg brace.	F 311		

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F 311	Continued From page 31 The assignment sheet utilized by direct care staff, printed 11/20/13, identified, ". . . Usually independent with ambulkation [sic] with cad. [sic] walker . . . FALL RISK . . . Gait belt for transfer with 1 staff assist . . . Mobility Device: Uses w/c to move about . . ." A progress note, dated 03/25/13 at 9:49 a.m., identified, "Noted to have recent increase in falls. . . . requesting . . . PT to evaluate and treat for strengthening," and at 8:33 p.m., ". . . his right leg brace . . . hurts him to wear it . . ." The rehabilitation progress note, dated 03/29/13, identified, ". . . skilled PT appropriate due to high frequency of falls," and the note dated 06/21/13 further identified, "D/C [Discontinue] skilled PT . . . Pt [patient] able to amb [ambulate] to/from meals with 4ww [4 wheeled walker] (SBA-CGA) [standby assist-contact guard assist] up to 200 feet, in addition, he needs CGA-SBA for transfers. w/c for longer distance. . . ." During an interview on 11/20/13 at 2:00 p.m., a physical therapist (#13) stated, "Pt able to amb to/from meals up to 200 feet" is equivalent to a walk-to-dine [RT] program for the resident. There is no reason he [Resident #10] couldn't have been walking." The progress notes identified the following: * On 07/24/13 at 2:29 p.m., "Staff responded to patient yelling and found him on the floor in his room lying on his right side . . . Patient had been in bed and was going to take himself to the bathroom using the w/c . . ." * 07/27/13 at 4:50 p.m., ". . . needs much assistance e [sic] by staff to go to bath room and	F 311		

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F 311	Continued From page 32 transfer . . ." * 09/25/13 at 10:49 p.m., ". . . Res. [Resident] has a cut to bridge of nose . . . 6 cm [centimeters] by 1 cm ped [sic] purple area down length of nose. . . . . reddened areas under both eyes. . . . deep pudple [sic] bruise to right ear approximately 4 cm by 1 cm. . . ." Facility staff failed to document Resident #10's 09/25/13 fall in the progress notes. The incident report, dated 09/25/13, identified, "resident was transferring from wheelchair to bed . . ." * 10/16/13 at 6:40 p.m., ". . . pt. was found on the floor of his room next to his wheelchair. . . . Pt had a large gash in his forehead that was bleeding continuously. L [left] hand was swollen and purple. Had a [sic] gashes on L side of nose and bridge of nose. L knee purple and swollen. . . . Order for pt to go to to [sic] the ER [Emergency Room] for evaluation. . . ." * 10/17/13 at 2:16 a.m., ". . . ER nurse reported [Resident #10] broke his nose from the fall. . . ." * 10/22/13 at 1:15 p.m., "Resident was yelling 'On the floor. On the floor.' Patient was found lying on the floor in front of wheelchair in hallway. Patient's sutures from fall on 10/16/13 had opened up on patient's forehead. . . . Paged [Physician] and received order to send to ER for sutures to forehead. . . ." The unsigned physician's discharge summary (written by the facility following Resident #10's transfer to the ER on 10/22/13) identified, "Resident admit to [Facility] after hospitalization for falling . . . Resident completed PT . . . program for strength, endurance, balance, pain tx and safety awareness. Resident reached his highest level goals that was able to obtain. Resident had numerous falls and started declining in health. . . ."	F 311		

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	355031	A. BUILDING _____ B. WING _____	C 11/20/2013

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 311	Continued From page 33 During an interview on 11/20/13 at 9:40 a.m., when asked who was responsible for providing RT services following discharge from PT, an administrative rehabilitation staff member (#14) stated, "We don't have an RT program. We communicate with nursing during the Eagle Room [Interdisciplinary Staff] meeting. Nursing adds it to the task list for the CNAs to follow." The facility failed to provide documentation showing nursing/CNA staff provided RT services to Resident #10. During interview on 11/20/13 at 11:00 a.m., an administrative nurse (#1) stated, "There is no place [on the computer] to document RT tasks." During an interview on 11/20/13 at 2:00 p.m., when asked who was responsible for providing RT services following discharge from PT, a physical therapist (#13) stated, "The RT program was cut. We expect the nursing staff to implement the program, with the CNAs. It should be added to [the resident's] task list." When asked if Resident #10 required assistance with his right leg brace, the physical therapist (#13) stated, "He had to wear a brace for stability. He had it for years, even before he came to our facility. If it's important to the patient, it should be on his careplan. I think it rubbed him the wrong way if it wasn't put on right. If I re-laced it, he had no complaints." The facility failed to: * Develop an effective process for communicating Restorative Therapy needs within the facility. * Provide Restorative Therapy services to Resident #10 (as recommended by Physical	F 311		

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F 311	Continued From page 34 Therapy) which placed him at risk of losing range of motion, balance, strength, endurance, and mobility, and may have contributed to his falls with injury. * Assist Resident #10 with his right leg brace which may have prevented him from maintaining his ability to ambulate and placed him at risk for discomfort/injury.	F 311		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of the facility's policy and procedure, and staff interview, the facility failed to provide services to restore as much normal bladder function as possible for 1 of 1 sampled resident (Resident #2) requiring extensive assistance for toileting. Failure to assess and provide interventions addressing the resident's individualized toileting needs resulted in increased episodes of avoidable incontinence, and the utilization of an antipsychotic medication. Findings include:	F 315	**F315 No Catheter prevent UTI, restore bladder** The facility strives to ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Resident #2 has had a bladder assessment and appropriate interventions have been put in place. Residents who are frequently incontinent and who take antipsychotics have the potential to be affected. Licensed staff was educated regarding completing Bladder diary, incontinence assessment and developing a toileting plan when appropriate for the resident.	~~1-20-14~~ 01/09/14 as per Greg Stump via phone 01/16/14 STH

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F 315	Continued From page 35 Review of a facility document, titled "Urinary Incontinence Practice Guide Flowchart," occurred on 11/20/13. The document, dated 2012, stated, "Assessment . . . Initiate Bladder Diary . . . Complete Urinary Incontinence Evaluation . . . Plan Develop . . . Care Plan, Toileting Program as appropriate . . ." Resident #2's medical record, reviewed on all days of survey, identified diagnoses of senile dementia with delirium, Parkinson's disorder, and history of urinary tract infection (UTI). The significant change Minimum Data Set (MDS), dated 11/05/13, identified the resident had moderate cognitive impairments, required extensive assistance of two or more persons for transfers and toilet use, and was frequently incontinent of urine. The current care plan identified, "Focus Inappropriate sexual behaviors . . . Interventions . . . explore effects of behavior on others . . . Set limits for acceptable behaviors . . . Focus Cognitive loss . . . as evidenced by . . . poor safety awareness . . . Focus Urinary incontinence . . . Interventions Place urinal/bedpan within resident's reach, Provide incontinent care as needed. . . . Focus . . . history of falls . . . Interventions . . . Patient at times will self transfer without assistance, Reinforce need to call for assistance . . . Sara [stand] lift for all transfers, Toilet with rounds at night, Visual reminders to ask for help placed in room and in bathroom. . . ." The assignment sheet utilized by direct care staff, printed 11/20/13, identified, "ADLs [Activities of Daily Living] . . . transfer with assist of [two] and gait belt . . . Safety . . . Sara lift for all transfers,	F 315	ADNS or designee will conduct random audits weekly times 60 days to ensure that appropriate interventions are in place and being followed. Trends will be forwarded to the QA&A committee with follow up as needed.	

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F 315	Continued From page 36 Toilet with rounds at night . . . Bowel/Bladder . . . Provide incontinent care as needed. . . . Special Needs . . . Toilet upon awakening, before all meals and @ H.S. [Hour of Sleep]. . . ." The Progress Notes identified the following: * 09/04/13 at 7:30 a.m., "Patient was sitting in hallway with pants down to thighs. Did have brief on. When CNA [Certified Nursing Assistant] attempted to take to room to pull up pants, patient became combative." * 09/04/13 at 11:52 p.m. [sic], "Patient again was sitting in room with pants down to thighs, brief was on. CNA asked patient if he needed help pulling up his pants to get ready for lunch. Patient stood up and CNA attempted to help pull up pants. Patient slapped CNA's hands away and stated 'get the hell away from me.' CNA stepped back and assisted other resident in room into the bathroom. [Resident #2] then attempted to open bathroom door. CNA informed patient that he would have to wait." * 09/04/13 at 1:45 p.m., "cna to nursing station stating resident is sitting on floor in bathroom in room, found resident sitting on floor bathroom call light on states he transfered [sic] self from toilet back to w/c [wheelchair] and lost his balance . . ." The CNA computerized charting identified staff failed to toilet Resident #2 from 6:03 a.m - 9:59 p.m. * 09/08/13 at 4:44 p.m., ". . . Residnet [sic] is noted ot [sic] be incontinent of bladder. . . ." * 09/09/13 at 2:35 a.m., ". . . Incontinent of bladder. . . ." * 09/19/13 at 4:30 p.m., "Observed resident coming out of his room with sweatpants and pullup pulled down while sitting in his wheelchair. I instructed him to return to his room and pull up his pants. He asked what difference does it	F 315		

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F 315	Continued From page 37 make? I told him that if he wanted to have his pants down, that he needed to stay in his room with door closed. He then proceeded to wheel toward his bed. I left the room and closed the door. When he came back out of his room, he had his pants pulled up." The CNA computerized charting identified staff failed to toilet Resident #2 from 6:21 a.m - 9:59 p.m. * 09/23/13 at 1:37 a.m., "Staff found pt. [patient] laying on floor by foot of his bed, laying slightly on his right side facing the door. . . . laceration noted to left forehead area just above left eye brow area. . . . Incont. [Incontinent] of urine noted. . . ." * 09/24/13 at 6:32 p.m., ". . . Went to Sarah [sic] lift for transfers. . . ." * 10/14/13 at 5:19 p.m., "[Resident #2] had been reported going in to [sic] other patients rooms with his pants down around his knees. [Registered Nurse] and I [Administrative Personnel] addressed this behavior with [Resident #2]. He was informed that the wondering [sic] in to [sic] others rooms and being in that state of undress in public area was not acceptable. He indicated that he understood this and would not wonder [sic] into others rooms and he would be appropriately dressed when in public areas." The CNA computerized charting identified staff failed to toilet Resident #2 from 6:07 a.m - 9:58 p.m. * 10/15/13 at 2:00 a.m., ". . . No attempts to go into other patient's rooms [and] come out with himself exposed so far. . . ." * 10/18/13 at 5:17 p.m., "Resident observed to be in hallway at this time with pants to mid thigh. Resident asked repeatedly to go back into room and await assistance with pants and resident refused. . . ."	F 315		

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F 315	Continued From page 38 The CNA computerized charting identified staff failed to toilet Resident #2 from 6:09 a.m - 9:33 p.m. * 10/21/13 at 1:38 a.m., "Patient noted to be out of room with pants down x [times] 1 so far this shift. Patient was assisted back to room to be covered up." The CNA computerized charting identified staff failed to toilet Resident #2 from 6:00 a.m - 9:59 p.m. * 10/22/13 at 2:49 p.m., "Spoke with [Physician] in regards to [Resident #2's] inappropriate sexual behavior. . . . [Physician] increased Risperdal . . ." * 10/22/13 at 4:58 p.m., "Order to transfer . . . for psych evaluation . . ." * 10/30/13 at 3:42 p.m., "Resident returned from [Hospital]. . . . bladder . . . incontinencies [sic]. . . " * 11/05/13 at 3:27 p.m., "Spoke to [Physician's] office and informed her of [Resident #2's] change in condition regarding increased assistance with transfers . . ." * 11/06/13 at 3:49 a.m., ". . . transfers with the assist of 1 and at times an assist of 2 with Sara lift no behaviors noted incontinent of bladder . . ." * 11/06/13 at 12:33 p.m., "Order rec'd [received] from [Physician] to decrease risperdone . . ." * 11/09/13 at 10:22 a.m., ". . . CNA reported at breakfast time that resident had pants pulled partially down. Resident removed from dining room and redressed. . . ." The CNA computerized charting identified staff failed to toilet Resident #2 from 6:31 a.m - 9:59 p.m. * 11/10/13 at 3:21 a.m., ". . . transfers with the assist of 1 and at times an assist of 2 with Sara lift no behaviors noted this evening incontinent of bladder . . ." * 11/11/13 at 3:17 p.m., ". . . incontinent of . . .	F 315		

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F 315	Continued From page 39 bladder. Transfers with assist of one . . ." * 11/12/13 at 12:24 a.m., "This resident is limited to extensive asist [sic] for bed mobility and transfers, has to be reminded to call for assistance for these transfers . . . is incontinent of . . . bladder . . ." * 11/13/13 at 9:51 a.m., ". . . incontinent of . . . bladder. . . ." * 11/14/13 at 3:39 a.m., ". . . Assist of one with transfers and toileting. . . . Incont of bladder at night." * 11/14/13 at 3:12 p.m., "Patient Care Conference Held . . . Nursing informed [Family Member] that patient continues to come out of his room with his pants pulled down. He stated he often toilets himself and cannot pull his pants up himself. Nursing educated [Family Member] that patient is not supposed to toilet himself and he is on a more frequent toileting schedule now to help. . . ." * 11/16/13 at 12:44 a.m., "This resident . . . is incontinent of . . . [bladder], is extensive assist for . . . transfers, has to be frequently reminded to use staff assistance and many times does not comply with safety. . . ." Facility staff found Resident #2 with his pants lowered on six separate occasions, each occuring during the day shift between 10:22 a.m. and 5:19 p.m. During the initial tour on 11/18/13 at 10:30 a.m., observation showed Resident #2 sitting in his wheelchair exposed from the waist down, with his pants and brief down around his ankles. The resident stated, "I need new pants, I wet these." Resident #2 was cued to use his call light to request assistance, which he was unable to locate. [The call light was hanging behind the headboard of the bed.] The surveyor then exited the resident's room and requested staff	F 315		

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F 315	Continued From page 40 assistance for Resident #2. Two unidentified CNAs entered Resident #2's room, and using a stand lift provided pericares/changed the resident's clothing. Facility staff failed to notify the surveyor of any further attempts to toilet Resident #2 throughout the survey. The CNA computerized charting identified staff failed to toilet Resident #2 during the day shift. [Documentation showed staff did attempt to toilet the resident an average of four-to-five times each night.] During an interview on 11/20/13 at 11:00 a.m., an administrative nurse (#1) acknowledged she was unable to locate Resident #2's "Patient Admission/Readmission Screen, Bladder Diary, or Urinary Incontinence Evaluation." When reviewing the CNA computerized charting she stated, "The staff are doing a good job at night. They are toileting him three or four times a night. He must be toileting himself during the day. He transfers himself without asking for help." The facility failed to: * Assess Resident #2 upon admission [Admission/Readmission Screen] * Assess Resident #2 once the facility identified he was incontinent of bladder [Bladder Diary and/or Urinary Incontinence Evaluation] * Develop a toileting care plan based on the results of the assessment. The lack of toileting interventions resulted in Resident #2's being place in undignified situations; sitting in soiled clothing and/or exposing himself in public. * Recognize Resident #2's cognitive deficits/poor safety awareness limited his ability to use his call light functionally to request toileting assistance and placed him at risk for further falls	F 315		

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F 315	Continued From page 41 * Provide toileting cares during the day thereby reducing the number of incontinent episodes, and * Recognize Resident #2's behaviors as possibly correlated to toileting needs versus inappropriate sexual behaviors.	F 315		
F 323 SS=G	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: 1. Based on record review, review of facility policy, staff interview, and information provided by the complainant, the facility failed to provide the necessary assistance to prevent falls with injury for 1 of 1 sampled resident (Resident #4) and 1 of 1 record of a resident discharged from the facility (Resident #10) who experienced falls with injury which resulted in hospitalization. Failure of the facility to reassess Resident #10 and implement fall safety interventions for Residents #4 and #10 resulted in unwitnessed falls resulting in injury requiring emergency care. Findings include: Information provided by the complainant indicated facility staff failed to provide care in a manner that ensured the safety of residents. The complainant indicated facility staff failed to initiate fall	F 323	**F323 Free of accident Hazards/supervision/devices** The facility strives to provide an environment that remains as free of accidents and hazards as is possible. And provide each resident adequate supervision and assistance devices to prevent accidents Resident #4 has been reassessed for falls and appropriate interventions put in place. Resident #10 no longer resides in the facility. Resident #2 had no negative outcome. Residents who are frequently incontinent and who take antipsychotics; or residents on a walking program, residents with braces and have the potential to be affected. Those resident who could be affected have had their care plan reviewed and updated Licensed staff was educated regarding following the process for assessing and implementing interventions when a	~~1-20-14~~ 01/27/14 ao per Greg Stump via phone 01/16/14 SH

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F 323	Continued From page 42 prevention interventions in a timely manner. Review of a facility document, titled "Fall Practice Guide Flowchart," occurred on 11/20/13. The document, dated 2011, stated, "Assess: . . . Complete MDS (Minimum Data Set) . . . Plan: Develop Initial . . . Care Plan . . . Task List . . . Implement: Ongoing Fall Prevention Strategies . . . Evaluate: Change in Condition or Fall Occurrence . . . Eagle Room Review (Interdisciplinary Staff Meeting) . . . Complete Fall Evaluation . . . Revise Initial . . . Care Plan . . . Task List . . ." Resident #10's medical record, reviewed on all days of survey, identified diagnoses of transient ischemic accidents (TIAs), Parkinson's disease, osteoarthrosis, osteoporosis, vertigo, difficulty walking, history of falls with contusions/fractures of the facial/nasal bones, clavicle, sternum, lumbar vertebra, pubis, and acetabulum (hip). The [Hospital] Transfer Record, dated 11/07/12 (upon admission to the nursing home), identified, ". . . Diagnoses: fall, acetabulum fx [fracture], facial/lumbar/sternal fxs . . . Mental Status: occasionally confused . . . Ambulation Status: assist, walker . . . Nurse's Report: . . . Follows most commands, Doesn't always answer . . . [increased] confusion at x's [times] . . ." The quarterly MDS, dated 08/04/13, identified the resident as moderately cognitively impaired, required extensive assistance of one person for dressing, transfers, walking in room/corridor, locomotion on/off unit, and toilet use, required staff assistance to stabilize when moving from a seated to standing position, walking, turning around, moving on/off toilet and from surface to	F 323	resident sustains a fall. Care plans will be updated to reflect current plan of care. Staff was educated regarding cueing residents to lift feet during transfer or applying foot pedals to wheel chairs of those residents that cannot raise their feet on cueing. ADNS or designee will conduct random audits weekly times 60 days to ensure that appropriate interventions are in place for residents with falls and that residents are being cued or feet pedals are applied to wheelchairs as needed. Trends will be forwarded to the QA&A committee with follow up as needed.	

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F 323	Continued From page 43 surface, was frequently incontinent of bowel and bladder, and experienced falls since admit to the facility. The MDS further showed Occupational/Physical therapy (OT/PT) and Restorative Nursing services (RT) were not being provided at the time of the assessment. The current care plan identified, "Focus ADL [Activities of Daily Living] Self care deficit as evidenced by weakness, limited ROM related to recent fall with fractures . . . Interventions . . . Transfer with 1 assist with gait belt, Uses walker and assist of 1 for ambulation. . . . Focus At risk for falls due to unsteady gait, history of falls . . . Interventions . . . Provide assist to transfer and ambulate as needed [Initiated 11/07/12], Staff education regarding wheelchair/resident safety and awareness. [Initiated 11/28/12] . . . Encourage resident to wear nonskid slippers when shoes are removed [Initiated 03/18/13] . . . perimeter mattress [Initiated 04/11/13] . . . Self locking brakes on wheelchair [Initiated 05/03/13] . . . Shoes placed on floor beside bed for easier patient access [Initiated 07/25/13] . . . Resident not to be left unattended in wheelchair in room. To be laid down after meals [Initiated 10/17/13] . . ." The assignment sheet/task sheet utilized by direct care staff, printed 11/20/13, identified, ". . . Usually independent with ambulkation [sic] with cad. [sic] walker . . . FALL RISK perimeter mattress . . . Gait belt for transfer with 1 staff assist . . . Mobility Device: Uses w/c to move about, Non-slip slippers when shoes are removed . . ." Resident #10's progress notes identified the following:	F 323		

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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 _____	C 11/20/2013

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 44 * 03/14/13 at 12:28 p.m., "Floor nurse reports that she was alerted by CNA [Certified Nursing Assistant] that resident lying on floor. Entered room to find resident lying on R [right] side with head resting on nightstand. States he landed on his R side. Stated discomfort to R shoulder and R wrist. Noted dark reddened area to R wrist measuring 3.4 x 4.4 cm [centimeters]. Skin intact. No redness noted to R shoulder. Physical assessment completed. ROM [Range of Motion] intact to bilateral lower and upper extredmitied [sic]. Able to move R wrist and hand. Assisted up with 2 staff and gaitbelt. Resident rates pain at 1/10 . . . Neurochecks initiated per unwitnessed fall. Neuros intact. . . ." * 03/14/13 at 8:40 p.m. and 03/15/13 at 5:51 p.m., ". . . resident still continue [sic] to get out of bed and wheelchair without asking for assistance. . . ." The fall event form, dated 03/14/13 at 12:37 p.m., stated, "States was trying to get up per self. Call light not on. Declined need to void. Staff to ensure up for meals 15 minutes prior to meal time." The facility failed to add this intervention to Resident #10's care plan. The progress notes identified the following: * 03/16/13 at 10:10 p.m., identified, "pt [Patient] was noted on floor beside bed laying on back, no shoes or socks on, wc [wheelchair] bedside [sic] bed, call light noted attach [sic] to pillow. pt states that he was getting out of w/c when he got dizziness [sic] and fell. noted a skin tear to LFA [left forearm], 3 cm x 2.5 cm in size. no other injuries noted. . . . pt c/o [complained of] of pain to neck and back, neuro checks normal. . . ." The facility initiated the following fall intervention on 03/18/13: "Encourage resident to wear nonskid slippers when shoes are removed."	F 323		

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F 323	Continued From page 45 * 03/24/13 at 4:39 p.m., "Resident . . . Has been instructed to use call light so staff can assist to bath room is forgetful lacks safety awareness and lacks understanding of his limitations." * 03/25/13 at 9:49 a.m., "Noted to have recent increase in falls. . . . requesting . . . PT [Physical Therapy] to evaluate and treat for strengthening. . . ." * 03/26/13 at 3:46 p.m., "PT attempted evaluation today to address multiple falls. Pt refused at this time, will attempt tomorrow." * 03/27/13 at 2:16 a.m., "pt transfer [sic] self to commode twice during shift. pt did not use call light for assistance. pt instruct [sic] to call for assistance with transfer and toileting to prevent falling." The rehabilitation progress note, dated 03/29/13, identified, "PT eval [evaluation] [with] Tx [Therapy] order completed on this date. . . . skilled PT appropriate due to high frequency of falls. . . ." The progress notes identified the following: * 03/31/13 at 2:21 a.m., "[Resident #10] was found laying on the floor next to his bed. Stated, 'I rolled out of bed.' A skin tear to left elbow 1.0 cm x 1.0 cm reddened area to the lower left back approx [approximately] 10.0 x 12.0 cm, with skin abrasion in the middle, approx 6.0 cm x 5.0 cm A purple bruise to left forearm approx 14.0 cm x 7.0 cm. [Resident #10] denies hitting his head . . . Neuro checks started . . ." * 03/31/13 at 9:06 a.m., ". . . A small abrasion noted to right mid back, and and [sic] abrasion to left elbow. . . ." The fall event form, dated 03/31/13, stated, "Fall mat in place while in bed." The facility failed to	F 323		

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F 323	Continued From page 46 add this intervention to Resident #10's care plan. The progress notes identified the following: * 04/03/13 at 12:39 p.m., ". . . pt continues to transfer self from w/c to bed, w/c to commode. pt instructed to call for assistance with transfers to prevent falling." The facility initiated the following fall intervention on 04/11/13 (11 days after he fell from his bed): "Perimeter mattress." * 05/15/13 at 3:19 p.m., ". . . He also has a history of falls. Physical therapy reports that they are currently working [sic] strengthening and walking with resident. . . ." * 06/07/13 at 2:51 a.m., ". . . [Resident #10] was caught transferring self from the bed to w/c or from toilet to w/c. . . . Staff educated [Resident #10] to wait for help and that he could fall during his transfer. [Resident #10] had no response to staff." A rehabilitation progress note, dated 06/21/13, stated, "D/C [Discontinue] skilled PT . . . Pt able to amb [ambulate] to/from meals with 4ww [4 wheeled walker] (SBA-CGA) [standby assist-contact guard assist] up to 200 feet, in addition, he needs CGA-SBA for transfers. w/c for longer distance. . . ." A progress notes dated 07/24/13 at 2:29 p.m. stated, "Staff responded to patient yelling and found him on the floor in his room lying on his right side in front of the couch. Patient had been in bed and was going to take himself to the bathroom using the w/c and chair rolled away from him. Denies injury . . . Neurochecks started . . ." The incident report, dated 07/24/13, stated,	F 323		

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F 323	Continued From page 47 "Resident was attempting to take himself to the bathroom, stated that his shoes were in his chair so he was going to put his shoes on the couch, when he went to do so, he stated that he fell, he denies hitting his head, denies pain et [sic] states that he was not injured. The w/cf [sic] was at his side as he was pushing the wheelchair." The progress notes identified the following: The facility initiated the following fall intervention on 07/25/13: "Shoes placed on floor beside bed for easier patient access (even though Resident #10 required extensive assistance for both dressing and transfers)." * 07/27/13 at 4:50 p.m., ". . . needs much assistance e [sic] by staff to go to bath room and transfer but this is the norm for resident." * 08/04/13 at 2:48 p.m., ". . . is frequently reminded to use assistance for transfers . . ." * 09/25/13 at 10:49 p.m., ". . . Neuro checks WNL [within normal limits] Res. [Resident] has a cut to bridge of nose with dressing intact. No drainage noted. Res. has 6 cm by 1 cm ped [sic] purple area down length of nose. Res. has reddened areas under both eyes. Res. has deep pudple [sic] bruise to right ear approximately 4 cm by 1 cm. . . ." Facility staff failed to document Resident #10's 09/25/13 fall in the progress notes. The incident report, dated 09/25/13, stated, "resident was transferring from wheelchair to bed, and apparently mis-judged distance and hit head/glasses on headboard." A physician order, dated 09/25/13 (and written following the Resident #10's second fall from his wheelchair), stated, "Cold compress to L forehead - prn [as needed], paper tape to skin tear to nose, monitor daily, follow fall protocol (per	F 323		

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F 323	Continued From page 48 facility)." The progress notes identified the following: * 09/26/13 at 2:44 a.m., "Resident had facial discomfort . . . Right ear has dark bruise to area and below eyes with bruise to nose area and paper tape to nose abrasion from bumping face. . . . Would not open right [sic] due to fall. Refused to open right eye for staff. . . ." * 09/26/13 at 11:29 a.m., ". . . all neuro's intact . . . does have skin tear to bridge of nose, papertape intact, bruise noted today to right ear also." The facility failed to complete a fall evaluation, revise the interdisciplinary care plan, or update the task list as per physician's order/fall protocol. * 10/16/13 at 6:40 p.m., "At 6:40 p.m., pt. was found on the floor of his room next to his wheelchair. Pt was assessed. . . . Pt had a large gash in his forehead that was bleeding continuously. L [left] hand was swollen and purple. Had a [sic] gashes on L side of nose and bridge of nose. L knee purple and swollen. . . . [On-call Physician] was notified at 7 p.m. Order for pt to go to to [sic] the ER [Emergency Room] for evaluation. Pt left facility at 7:20 p.m. via ambulance." * 10/16/13 at 11:21 p.m., "Resident arrived back in the facility via ambulance/stretcher." * 10/17/13 at 2:16 a.m., ". . . [Physician] ordered to take out the sutures after 10 days . . . Change dressing daily, apply Bacitracin ointment, and non-adherent dressing until resolved. . . . [Resident #10] requested pain med [medication] . . . at 11:30 p.m. and again at 1:30 a.m. C/O pain to right wrist, fingers, and headache. [Resident #10] has bruising to both eyes, bridge of nose, knuckles to both hands and right wrist. Sutures to forehead above nose . . . Swelling noted to fingers, and knuckles bilateral. Swelling noted to	F 323		

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F 323	Continued From page 49 right eye. ER nurse reported [Resident #10] broke his nose from the fall. . . ." * 10/17/13 at 10:20 p.m., "Resident is on neuro checks for recent fall. . . ." The facility initiated the following fall intervention on 10/17/13 (after Resident #10 experienced his third fall from the wheelchair): "Resident not to be left unattended in wheelchair in room. To be laid down after meals." * 10/18/13 at 5:52 a.m. and 2:02 p.m., "Continues on neuro checks per policy. Eyes purple and swollen bilaterally. C/o headache . . . Stitches intact to laceration mid forehead . . . Swelling and bruising to hands bilaterally. Transferred self into bed x 1 today. Reminded that he needed to wait for staff to assist with transfers." * 10/18/13 at 8:47 p.m. and 10/19/13 at 1:48 p.m., ". . . Sutures to for head [sic] in tact [sic] and covered . . . Has bruises to face and eyes purple wine color and to back of hands. . . . Remains on Neuro checks." * 10/19/13 at 2:52 p.m., ". . . reminded to use call light for assistancea [sic] . . . neurochecks within normal limits . . ." * 10/21/13 at 1:28 p.m., "Resident is complaining of not feeling well today, cannot specify what it actually is. . . ." * 10/22/13 at 1:15 p.m., "Resident was yelling 'On the floor. On the floor.' Patient was found lying on the floor in front of wheelchair in hallway. Patient's sutures from fall on 10/16/13 had opened up on patient's forehead. Pressure was applied to area to stop the bleeding. Neurochecks started. . . . Paged [Physician] and received order to send to ER for sutures to forehead. . . . Notified ambulance of need for transfer to ER." * 10/22/13 at 1:33 p.m., "Ambulance here to transfer patient to ER." * 10/22/13 at 9:05 p.m., ". . . [Family] stated	F 323		

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F 323	Continued From page 50 Resident is being admitted into hospital for possible CVA [cerebrovascular accident/stroke] . . . ." The physician's discharge summary, dated 10/22/13, identified, "Resident admit to [Facility] after hospitalization for falling . . . Resident completed PT [and] OT program for strength, endurance, balance, pain tx and safety awareness. Resident reached his highest level goals that was able to obtain. Resident had numerous falls and started declining in health. . . ." During interviews on 11/20/13 at 11:00 a.m. and 1:30 p.m., an administrative nurse (#1) reported the facility is alarm/restraint free. She described Resident #10 as "impatient" and "not wanting to ask for help." When asked why the facility failed to request a Physical Therapy reassessment for Resident #10, she stated, "PT was offered in the past. He refused sometimes. That's probably why they didn't do it [refer to Physical Therapy]." During an interview on 11/20/13 at 2:00 p.m., when asked who was responsible for assessing a resident's safety, a physical therapist (#13) stated, "Physical Therapy, if it has to do with weakness. We determine if therapy is appropriate, and make safety recommendations." When asked when she would consider it appropriate/expect facility staff to refer a resident to her department, she stated, "It depends on the resident, and what the investigation showed . . . the circumstances of the fall." When the question was rephrased specific to Resident #10, she stated, "With repetitive falls. Maybe after the second fall from the same surface."	F 323		

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F 323	Continued From page 51 When asked for examples of the safety recommendations she referred to above, the physical therapist (#13) reported the facility is restraint free. She indicated some interventions (dicem, seatbelts, pummel cushions, even certain types of chairs) would be considered a restraint, and even if determined to be in the resident's best interest (following an assessment), would not be allowed in the facility. When asked what the therapists do if presented with a cognitively impaired resident who has a history of falls, she stated, "It makes it difficult. We could recommend 1:1 care. If we can't care for the resident, maybe they should be referred to another location [facility] who can meet their needs." The facility failed to: * Follow the physician's order, dated 09/25/13, to "follow fall protocol [Fall Practice Guide Flowchart]." * Refer to Physical Therapy/reassess Resident #10's strength, endurance, balance, and safety awareness as per the facility's fall protocol. * Recognize Resident #10's cognitive deficits/poor safety awareness limited his ability to use his call light functionally to request assistance and placed him at risk for further falls. * Update the fall care plan/task list (based on the results of the reassessment) as per the facility's fall protocol, and ensure both documents reflect the same information. * Consider all possible safety interventions (dicem, seatbelt, pummel cushion, a different type of wheelchair, transfer to another facility, etc), if it were determined to be in Resident #10's best interest, following his repeated falls and based upon the results of his reassessment. * Monitor the effectiveness and modify Resident #10's fall interventions when necessary.	F 323		

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F 323	Continued From page 52 - Resident #4's medical record, reviewed on all days of survey, indicated diagnoses of muscle weakness, osteoarthritis NOS (not otherwise specified), and difficulty in walking. The quarterly MDS, dated 10/25/13, identified the resident as having severe cognitive impairments, required physical assistance of one person for transfers and toilet use, unsteady, required staff assistance for transitions and walking, and frequently incontinent of bowel and bladder. Resident #4's care plan, dated 04/25/13, stated, "Problem: ADL's [Activities of Daily Living]: Self care deficit as evidenced by weakness related to physical limitations. . . Interventions: . . . Ambulation: On walk to dine program. Ambulate with assist of one and a gait belt. Often transfers self in room. . . ." Review of Resident #4's progress notes idicated the following: * 07/27/13 at 10:51 p.m., "Resident about to transfer self and to go to bath room and lost grasp of w/c as it was facing toward the head of the bed and he slipped and was found on the floor laying on his left side. Possibly struck a metal part on the side of the w/c and caused considerable skin tear to his left arm. To upper shoulder area 1.24x1 cm, open area not able to approximate the skin with surrounding this sight [sic] a 6x6 redness slight bruise like appearance. To above elbow area left arm 8x4 cm skin tear that was able to approximate the skin and use steri strips with bruising to the area. Above wrist area 4x2.5 cm skin tear approximated and steri strips applied. To inner left arm area bruising and skin tear 13.4x2 cm which as well [sic] it was approximated and steri strips applied. Stocklnette	F 323		

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F 323	Continued From page 53 was placed on arm to secure area and to prevent steri strips from coming off for protection. . . Resident was instructed to use call light and staff would be in to help him with toileting. . ." * 10/08/13 at 6:15 p.m., "Pt (patient) was found on the floor of his bathroom, still holding onto his chair. Pt. was assessed. . . Denies pain or discomfort. Pupils unequal (L (left) larger than R (right), reactive to light and accommodation. . ." * 11/01/13 at 9:13 p.m., "Resident was found sitting on the floor with his back to the side of the bed. Resident stated he had called out for help and no one came so he self transfers [sic]. When examined by staff only notice [sic] left hand/wrist swollen tender to touch no discoloration. Could move fingers and thumb and wrist with pain only to palpation. No discoloration noted. W/c was away from door. Resident assistance [sic] three to mechanical lift to transfer to bed. . . Trinity ER (emergency room) was called . . . Ambulance was called . . . They placed resident on straight board and cervical collar due to it being a no witnessed fall. . . Resident was alert to name and what occurred but not to date time and place. . ." * 11/01/13 at 11:23 p.m., "ER called and stated resident has a fracture to his hand and that they splinted it and ace wrapped hand and arm. . ." The "Incident Report - Patient Involved" report, dated 11/01/13 at 8:00 p.m., stated, ". . . Description of Incident: Resident found sitting on the floor with his back to the bed had self transferred himself from the bath room. Examined by staff and has left wrist pain and swollen to area able to move fingers, thumb, and wrist. . ." During an interview on 11/20/13 at 1:35 p.m., an administrative nurse (#1) identified the facility	F 323		

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F 323	Continued From page 54 interventions following each of the above-mentioned falls. After the 07/27 fall, the interventions included minimizing environmental clutter and reminding the resident to use his call light. Following the 10/08 fall, staff added the intervention of self-locking brakes to the resident's wheelchair. Following the 11/01 fall, staff added the intervention for the resident to receive occupational therapy when he is healed enough. The administrative nurse (#1) stated the facility is restraint free so alarms or positioning devices are not considered as an intervention for fall prevention. The facility failed to provide a copy of the restraint free policy upon requested. The facility failed to ensure Resident #4 received the care and services necessary to attain the highest degree of safety possible when he began falling during self-transfers. THIS IS A REPEAT DEFICIENCY FROM THE SURVEYS COMPLETED ON 04/11/12 and 03/07/13. 2. Based on observation, record review, and staff interview, the facility failed to provide assistive devices necessary to prevent accidents for 1 of 9 sampled residents (Resident #2), 4 of 4 supplemental residents (Resident # 12, #13, #14, and #15), and 2 unknown residents observed without wheelchair foot pedals in place. Failure to apply foot pedals to wheelchairs during staff-assisted transport may result in falls and/or injuries to the residents. Findings include: When requested the facility failed to submit a policy on transferring residents.	F 323		

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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 323	Continued From page 55 - Resident #12's medical record, reviewed on 11/20/13, identified diagnoses of muscle weakness. The admission Minimum Data Set (MDS), dated 11/15/13, identified the resident required extensive assistance for locomotion on/off the unit. Observation during the initial tour on 11/18/13, showed an unidentified Certified Nurse Assistant (CNA) transported Resident #12 down the hallway to the dining room in a wheelchair without footpedals. During transport, Resident #2's feet brushed the floor. The CNA failed to cue the resident to lift her feet and failed to place footpedals on her wheelchair. - Observation on 11/18/13 at 6:10 p.m. showed an unidentified CNA transported an unknown resident from the dining room down the north hallway in a wheelchair without foot pedals. During transport, the resident's feet brushed the tiled floor. The CNA failed to cue the resident to lift her feet and failed to place footpedals on her wheelchair. - Resident #13's medical record, reviewed on 11/20/13, identified diagnoses of dementia, abnormal gait, and history of falls. The quarterly MDS, dated 10/30/13, identified the resident as moderately cognitively impaired and required extensive assistance for locomotion on/off the unit. Observation on 11/19/13 at 9:32 a.m., showed a CNA (#9) transported Resident #13 down the hallway towards her room in a wheelchair without footpedals. During transport, Resident #13's feet brushed the floor. The CNA failed to cue the	F 323		

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F 323	Continued From page 56 resident to lift her feet and failed to place footpedals on her wheelchair. - Resident #14's medical record, reviewed on 11/20/13, identified diagnoses of history of fractures. The quarterly MDS, dated 09/23/13, identified the resident as moderately cognitively impaired and required extensive assistance for locomotion on/off the unit. Observation on 11/19/13 at 9:34 a.m., showed a CNA (#9) transported Resident #14 down the hallway towards her room in a wheelchair without footpedals. During transport, Resident #14's feet brushed the floor. The CNA failed to cue the resident to lift her feet and failed to place footpedals on her wheelchair. - Resident #15's medical record, reviewed on 11/20/13, identified diagnoses of dementia and difficulty in walking. Observation on 11/19/13 at 11:00 a.m., showed a CNA (#9) transported Resident #15, whose left leg was in a brace, down the hallway towards his room in a wheelchair without footpedals. During transport, Resident #15's feet brushed the floor. The CNA failed to cue the resident to lift his feet and failed to place footpedals on his wheelchair. - Resident #2's medical record, reviewed on all days of survey, identified diagnoses of senile dementia with delirium, Parkinson's disorder, and history of falls. The significant change MDS, dated 11/05/13, identified the resident as moderately cognitively impaired and required extensive assistance for locomotion on/off the unit.	F 323		

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F 323	Continued From page 57 Observation on 11/19/13 at 2:00 p.m., showed an unidentified CNA transported Resident #2 in a wheelchair without footpedals. During transport, Resident #2's feet brushed the floor. The CNA failed to cue the resident to lift his feet and failed to place footpedals on his wheelchair. - Observation on 11/20/13 at 11:26 a.m. showed an unidentified CNA transported an unknown resident without foot pedals. During transport, the resident's feet brushed the carpeted floor. The CNA failed to cue the resident to lift her feet and failed to place footpedals on her wheelchair. During an interview on 11/20/13 at 10:25 a.m., when asked if/when staff should place footpedals on the residents' wheelchairs, two managerial nurses (#10 and #11) stated, "If they [the residents] can't lift their legs, we'd expect them to have pedals. If the resident has a cast or splint [brace], we'd expect their feet to be on pedals. If they aren't on, they [the CNAs] have to go get them and put the pedals on then. If the resident can lift their legs, they should cue the resident to put them up." During an interview on 11/20/13 at 1:30 p.m., an administrative nurse (#1) confirmed staff should place foot pedals on the resident's wheelchair or cue the residents to lift their feet during transport.	F 323		
F 327 SS=D	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health.	F 327	**F327Sufficient fluid to Maintain Hydration** The facility strives to provide each resident with sufficient fluid intake to maintain proper hydration and health.	~~1-20-14~~ 01/29/14 as per Greg Stump via phone 01/16/14 BL

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F 327	Continued From page 58 This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of professional literature, staff interview, and information provided by the complainant, facility staff failed to offer fluids to 2 of 8 sampled residents (Resident #5 and #6) dependent on staff for fluid intake. Failure to offer fluids during cares increased the residents' risk of dehydration and urinary tract infections. Findings include: Information provided by the complainant indicated facility staff pass fresh water during the day, but fail to offer dependent residents a drink before exiting their rooms. - Resident #6's medical record, reviewed on all days of survey, identified diagnoses of aphasia, hemiplegia, and contracture of the hand. The annual Minimum Data Set (MDS), dated 09/12/13, identified the resident had some difficulty making decisions in new situations and required extensive assistance of one to two or more persons for all Activities of Daily Living (ADLs). A nutrition assessment, dated 09/13/13, identified Resident #6 required nectar thickened liquids, significant physical assistance to complete ADLs, frequent/constant cueing, and 2000 milliliters (ml) of fluids daily. Her meal intake averaged 26-50%. The current care plan stated, ". . . Focus: Requires assistance for EATING as evidenced by need for . . . thickened liquids related to: difficulty swallowing . . . Interventions: . . . Provide nectar thickened fluids as ordered."	F 327	Resident #5 & #6 had no negative outcome. Dietary has reassessed fluid needs and updated care plan. Residents that need extensive to total assistance to receive fluids have the potential to be affected. Nursing staff was educated regarding offering fluids to residents that require extensive to total assist with consuming fluids. ADNS or designee will conduct weekly random audits times 60 days to validate that they are receiving adequate fluids to maintain hydration. Trends will be forwarded to QA&A with follow up as needed.	

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F 327	Continued From page 59 The assignment sheet utilized by direct care staff for Resident #6, printed 11/20/13, identified, ". . . Food/Fluids . . . Nectar-like thickened liquids (FYI) . . ." Observations showed the following: * 11/19/13 at 9:15 a.m., two Certified Nurse Assistants (CNAs) (#4 and #9) assisted Resident #6 with toileting cares. The CNAs failed to offer Resident #6 water prior to exiting the room. A glass of covered/untouched nectar thickened liquid on the bedside table. * 11/19/13 at 9:28 a.m. and 10:45 a.m., Resident #6 laid in bed with her eyes closed. A glass of covered/untouched nectar thickened liquid on the bedside table. * 11/19/13 at 1:55 p.m. and 3:00 p.m., and 11/20/13 at 10:00 a.m., Resident #6 laid in her bed or sat in her wheelchair in her room with her eyes closed. Two glasses of covered/untouched nectar thickened liquids on the bedside table. During an interview on 11/20/13 at 10:25 a.m., when asked if/when staff should offer fluids, two managerial nurses (#10 and #11) stated, "Thick liquids are passed with the snack cart. Snacks are passed three times a day. Staff should offer after cares and between meals." Observations during survey showed staff failed to provide Resident #6 with thickened liquids following cares and/or between meals. One-to-two glasses of covered/untouched nectar thickened liquids remained on her bedside table. - Resident #5's medical record, reviewed on all days of survey, identified diagnoses of Alzheimer's disease, dementia, aphasia, and	F 327		

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F 327	Continued From page 60 Parkinson's disease. The annual MDS, dated 11/11/13, identified the resident as requiring extensive assistance of one or more persons for all Activities of Daily Living (ADLs). A nutrition assessment, dated 02/11/13, identified Resident #5 as dependent upon staff for all food and fluid and required 2100 (ml) of fluids daily. His meal intake averaged 50-70%. The current care plan stated, ". . . Focus: Needs assistance at meals. . . Interventions: . . . Assist to consume all foods, fluids and/or supplements provided." The assignment sheet utilized by direct care staff for Resident #5, printed 11/20/13, identified, ". . . Food/Fluids . . . Doc (document) fluids offered . . ." Observations showed the following: * 11/18/13 at 4:50 p.m., two CNAs (#5 and #12) assisted Resident #5 with toileting cares. The CNAs failed to offer Resident #5 water prior to exiting the room. A covered water pitcher sat on the bedside table. * 11/19/13 at 1:56 p.m., two CNAs (#5 and #6) assisted Resident #5 with toileting cares. The CNAs failed to offer Resident #5 water prior to exiting the room. A covered water pitcher sat on the bedside table. Observations during the survey showed staff failed to provide Resident #5 with liquids following cares and/or between meals.	F 327		
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS	F 520	**F520 QAA Committee-Members/meet Quarterly/plans**	1-20-14

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F 520	Continued From page 61 A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 04/11/12 and 03/07/13. Based on review of North Dakota Department of Health (ND DoH), Division of Health Facilities provider files, record review, and staff interview, the facility failed to maintain a Quality Assurance (QA) committee which identified and addressed quality issues; and failed to develop and implement appropriate plans of action to correct	F 520	Manor Care will maintain a quality assessment and assurance committee that identifies quality care concerns and implements modifications and corrections of facility systems in a timely manner. QA Committee has met to review quality of care concerns and implemented corrections (see Plan of Correction for153, F164, F241, F244, F248, F252, F280, F282, F311, F315, F323 & F327) Administrator or designee will direct QA meetings monthly to validate progress of the plan of correction. Findings from the audits will be reported to the QAPI committee weekly for review and recommendation. QA committee will meet weekly for 60 days to review findings and determine any trends.	01/29/14 as per Emg Stamp via phone 01/16/14 BH

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F 520	Continued From page 62 deficient practice and ensure compliance with federal requirements. Findings include: Review of the state agency files indicated the facility failed to maintain compliance at F248, F280, and F323 as indicated by deficiencies cited during the last standard survey on 03/07/13. Refer to F248, F280, and F323 for specific findings. During an interview on 11/20/13 in the afternoon, an administrative staff member (#7) stated they monitor areas identified as needing improvement based on the survey completed 03/07/13. Failure of the facility to effectively utilize QA resulted in continued noncompliance in the following: *F248 providing activities for dependent residents *F280 revising resident care plans *F323 accidents and supervision related to falls	F 520		