STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355102	A. BUILDING _____ B. WING _____	09/04/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NAPOLEON CARE CENTER	311 E 4TH ST NAPOLEON, ND 58561

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey started on 09/02/14 and completed on 09/04/14, the sample included two (2) residents for complete review, seven (7) residents for focused review, and one (1) closed record for review. The sample included two (2) additional residents to verify specific concerns during the survey.	F 000	Napoleon Care Center (NCC) will ensure that all residents receive the necessary care and services in order to maintain the highest practicable, physical, mental and social well being and to be free from harm. 1. Resident no. 1 will receive the necessary care and services in order to maintain the highest practicable, physical, mental and social well being and be free of harm. 2. All NCC residents will receive the necessary care and services in order to maintain the highest practicable, physical, mental and social well being and be free from harm. All residents in the building will be assessed for the potential of them wandering. 3. Nursing, aides, and activity staff will be educated at their October staff meeting re: non-pharmacological approaches with resident no. 1 when wandering increases. Some of these approaches include looking through picture books, sorting through cards, folding wash cloths, listening to music, reading and involving her in sensory group. Also will educate on approaches and re-approaching when resident is having behaviors. The resident council	
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review, and staff interview, the facility failed to provide medically-related social services to 1 of 2 sampled residents (Resident #1) who wandered into other resident rooms and displayed physical aggression to another resident. Failure to address the wandering by developing and implementing individualized interventions placed the resident, other residents, and staff at risk for harm, and negatively impacted the psychosocial well-being of Resident #1 and other facility residents whose rooms where entered by Resident #1. Findings include: Information provided by the facility and reviewed on 09/02/14 at 12:45 p.m. identified two residents	F 250		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Richard Regner — TITLE: Administrator — (X6) DATE: 10-19-14

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

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F 250	Continued From page 1 who wandered into other resident rooms within the facility. Review of Resident Council Meeting minutes showed the following: * June 24, 2014 "Old Business . . . One member did state that she has a resident, [identified a resident] wander (sic) into her room and would like to have a stop sign banner placed on her room door. Maintenance will be informed of this and banner will be placed on door later today. Staff was also reminded to monitor [identified a resident] whereabouts and to remove her immediately if she is observed going into another resident's room. . . ." * July 15, 2014, "Old Business. . . The issue of wandering residents was also discussed amongst members with two members, [residents identified], stating that resident [two resident's identified] will enter their rooms at times. They are aware to call staff immediately and have been offered the use of stop sign banner/sign for door to deter residents. Both have declined and feel this is not helpful. Both ladies were informed that staff is working on making improvements in this area with the hope of reducing the frequency of resident's wandering into other resident rooms. . . ." * August 19, 2014, "Old Business . . . One member, [resident identified], did request magnetic strip stop sign for her room door. She continues to have a particular resident wander into her room. . . ." - During the resident Group Interview, on 09/02/14 at 1:00 p.m., 5 of 10 residents participating in the interview (Resident A, B, C, D, and E) reported Resident #1 wanders into their rooms. These residents reported staff members	F 250	meeting will include education to residents on the use of stop sign banners for their room doors and to use the call light immediately if a wandering resident enters their room. Everyone will be encouraged to close their room door when they leave their room. This information will be addressed at all future resident council meetings until resolved. A wandering assessment tool will be completed by social service staff for all new admissions, quarterly reviews and as needed. This will assist in identifying residents who are or have the potential to wander so proper care planning and staff interventions can be put into place. Activity staff will be placing resident no. 1 on a 1:1 program Monday through Friday with proper care planning and documentation on specific interventions that are used. Resident no. 1 will be placed on an Alzheimers unit waiting list at different facilities. Appropriateness of placement of wandering residents will be discussed with responsible party or family member. Responsible party of resident no. 1 is in agreement and wants resident on waiting lists located in Bowman, Jamestown and Bismarck.	

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F 250	Continued From page 2 remove Resident #1 from their rooms, however they must contact staff. The residents reported Resident #1 has wandered for some time and continues to wander in the facility. During a follow-up interview with Resident E, on the morning of 09/04/14, this resident identified it is upsetting to have Resident #1 entering her room. Resident E reports Resident #1 moves her things around and when asked denied being harmed by Resident #1. - Record review for Resident #1 occurred September 02-04, 2014. Diagnoses included Alzheimer's disease, dementia with behavior disturbance, depression, and transient cerebral ischemia. An annual Minimum Data Set [MDS], dated 08/06/14, identified the resident experienced short and long term memory problems. This MDS indicated Resident #1 displayed physical behavioral symptoms directed toward others, one to three days; other behavioral symptoms not directed toward others, one to three days; with an impact on the resident of interfering with the resident's care; with an impact on others of significantly intruded on the privacy or activity of others and significantly disrupted care or living environment; rejected care one to three days; wandered daily and while wandering significantly intruded on the privacy or activities of others. Nurses' notes identified the following behaviors: * 07/6/14, 4:16 a.m., "2145 [9:45 p.m.] call light answered from [resident identified] because [Resident #1] had gone into her [room number]. When cna [Certified Nurse Aide] tried to push [Resident #1] out of the room, [Resident #1] planted her feet down and pushed the w/c	F 250	4.NCC will monitor satisfaction regarding wandering residents by choosing a random sample of residents and asking a series of questions to monitor any concerns or complaints with wandering residents. Staff interventions will be careplanned. QA monitoring will be completed monthly x 3 then quarterly by social services. 5.Completion date Oct. 19, 2014	

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F 250	Continued From page 3 [wheelchair] back against the cna pushing the cna into the bed and the large wheel of the wheelchair rolled over the cna's right foot. . . . Resident #1 very active this evening rolling in and out of rooms. Facial expression relaxed. Smiles easily. Appeared in good spirits. At 2300 [11:00 p.m.] she was willing to go to bed. . . ." * 07/09/14, 9:25 a.m., "Psych [psychiatric] review meeting held on 7-8-14 reviewed resident's status. Resident wanders around facility throughout the day in her w/c. She does enter other resident rooms, we have placed stop signs which do not deter her. At times it is very difficult to redirect her as she will put her feet firmly on the ground and you can not move her w/c. She doesn't take any medications at this time for depression or behaviors. . . ." * 08/10/14, 12:15 a.m., ". . . Resident was feisty during HS [hour of sleep] casres [sic] and was hitting and trying to scratch at the CNA's . . ." * 08/13/14, 10:38 p.m. ". . . Does chair walk and use hand rails on wall to get around facility. Makes several rounds throughout entire facility throughout a day. Is happy and content with same. . . ." * 08/14/14, 2:58 p.m., "Late entry fort [sic] 8-14-14 Earlier in AM Resident was wandering in the hallways and did not try to exit the building Supervision provided" * 08/15/14, 1:41 a.m., "Res [resident] wonderiking [sic] up and down the halls this evening in her w/c easily redirected when told not to go into a resident room." Then at 12:25 p.m., "staff notified nurse of res wandering in hallways and in and out of other res rooms" * 08/16/14, 2:58 a.m., "Res was grabbing, hitting, scratching with hs cares redirection provided. Also res was wondering [sic] throughout the facility with her w/c last evening. Redirection	F 250		

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F 250	Continued From page 4 provided." 6:18 p.m., "res has been wandering in and out of other res rooms today" * 08/20/14, 6:23 p.m., "res was wandering in res rooms today" * 08/22/14, 7:07 p.m., "Throughout my shift resident has been busy chair walking self around facility as usual. Did take herself into a few residents [sic] rooms but was easily redirected out of them. * 08/23/14, 1:14 p.m., "Res. wandering halls this AM. Did enter a res. room at 10:23. Res. was redirected per staff out of room" * 08/25/14, 4:14 p.m., "1045 [10:45 a.m.] res grab [sic] CNA by hand and pulled her watch off her arm and threw it on the floor, happened with toileting res" * 08/26/14, 12:24 p.m., "res with increased behaviors this morning she pushed a CNA up against the wall heater in the C hallway and also was in [Resident #2 and #11's room] and kicked [Resident #11] in both shins attempts made numerous times to redirect res but she always ends up in [Resident #2 and #11's room or Resident #12's room]" * 08/27/14, 1:02 a.m., "Late entry for 8-26-14 2000 [8:00 p.m.] Has continued to wander about facility but has not tried going into other residents rooms" Then at 10:54 a.m., "1030 [10:30 a.m.] due to increased behaviors orders recd [received] to collect UA [urinalysis] today" At 4:34 p.m., "Psych review meeting held today, . . . Resident has had increased behavirors [sic] with physical abuse to aides and kicking another resident. Will check a UA to be sure no UTI [urinary tract infection] but resident has been having these behaviors and wandering in her wheelchair around our facility for quite some time, with the refusal of cares becoming worse the last few weeks. . . ." At 5:47 p.m. "res has been	F 250		

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F 250	Continued From page 5 wandering in and out of other res rooms today." At 11:45 p.m. "[Resident] wheeled in and out of residents rooms several times this evening. No complaints. In good spirits. Smiles easily." * 08/28/14, 2:25 p.m., "resident has been wandering, tried to redirect." * 08/29/14, 3:53 p.m., "Resident wonders [sic] in to other residents room and gets aggressive when she is asked to leave. Patient was started on Zyprexa today. To help with behaviors" Then at 11:35 p.m., "2000 Resident was wandering in hallways earlier in shift but sat at the area around the nurses station between 7:00PM and 8:00PM and was content and did no wandering" * 09/01/14, 1:44 a.m., "She sat at nursing station or TV room much of this evening. She did go to [Resident #2 and #11's room] and pull the strap off and wheeled herself into the room slightly. Staff took her out of the room with no resistance on her part. . ." * 09/02/14, 7:37 a.m., note entered by a dietary staff member, "On Wed. [Wednesday] Aug [August] 27th resident was on her way down the hall and was going to go into someones [sic] room asked her to go with me to the dining area for breakfast. We went down the hall to the door and after we went threw [sic] the door she wanted to go out again and I stopped her and said lets go to breakfast and she kicked out at me and called me a son-of-bitch. Went into an office to visit and did calm down somewhat." Social Service and Activity notes identified the following interventions discussed for behaviors: * 07/10/14, 11:19 a.m., Social Service note, "Call made to daughter . . . today to inform of resident's wandering behavior. Resident has been wandering throughout the facility and in resident rooms and I asked her about resident's	F 250		

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F 250	Continued From page 6 [sic] past interests so we can try to reduce this behavior. [Daughter] gave several ideas such as playing with cards, folding, old time music and looking at pictures of puppies. She did inform me that she used to enjoy holding a stuffed puppy/dolls which she would pet and talk to throughout the day. [Daughter] felt this was very comforting to her. These ideas were discussed with activity staff and will be tried with resident. Resident does have a very short attention span and so many of these activities might not be helpful. . . ." * 08/14/14, 3:32 p.m., "ACTIVITY . . . family members did provide resident with some various flash cards and photo books they wanted to be accessible for he [sic], (items placed in tv room). . . . Resident uses a W/C for mobility and is able to self propel around facility. Resident attends activity of choice, coming and going as she wishes. Resident attends sensory group as she is willing. Resident enjoys music and one on one time. . . ." * 08/14/14, 4:00 p.m., Social Service note, ". . . We did discussed [sic] resident's wandering behavior and family have brought in several diversional items that resident used to enjoy doing in the past. (doll, puzzles, cards, pictures) We discussed incident of resident hitting out at staff and [daughter] felt that this could be a result of the approach used with her. She does not like to be rushed or hurried and may become agitated when staff do not approach slowly and calmly. . . ." The current care plan, stated "Problem/Need . . . Scheduled Care Task . . . Approaches . . . FYI [for your information]: Provide diversional activities when wandering or agitated: Supplies located in tv room such as various flash cards, picture	F 250		

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F 250	Continued From page 7 books and dolls per family request. Res. also likes music. . . . Problem/Need . . . Impaired Thought Processes: Resident has dx. [diagnosis] of dementia and needs cues and direction . . . Can become resistive to cares and will wander around facility and into other res. rooms. . . . Remove resident from other resident's room as soon as possible. Turn music/tv on for resident when she is more upset or resistive to cares/wandering. (used to sing in choir) Ask family to bring pictures of family and past significant events in res. life to provide activity when she is more restless/wandering. . . . Problem/Need . . . Activities: Attends scheduled activities of choice. . . . Involvement in sensory program will benefit residents [sic] social and recreational participation level. . . . Approaches . . . provide with diversionary supplies(located in tv room) such as various flash cards, picture books and dolls per family request. . . ." During an interview on 09/04/14, at 11:52 a.m. with social work staff members (#13 and #14), the staff members confirmed Resident #1 wanders. They report they have completed interviews with residents in regards to Resident #1's wandering, asking if anyone has feelings of being endangered, the residents felt they were not in danger. When asked if Resident #1 had an altercation with any other residents they answered, "No". When asked about the location of the items from the family to engage Resident #1 when wandering, these staff members identified activities handled the intervention. During an interview with CNAs, on the afternoon of 09/04/14, these CNAs (#2, #5, and #11) all stated they were not aware of diversionary supplies placed in the TV room to use when	F 250		

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F 250	Continued From page 8 Resident #1 demonstrated behaviors. During an interview on 09/04/14 at 3:50 p.m., with an activity staff member (#15), she was able to locate the items in the TV room for staff to use to engage Resident #1 when she begins to wander into other resident's rooms. Staff failed to assess and track/trend behaviors in an attempt to determine patterns and precipitating factors; to effectively manage Resident #1's wandering; and to establish a comprehensive behavior management care plan including resident-specific behaviors with individualized interventions which were communicated to direct care staff; evaluate the effectiveness of the interventions in place; and recognize/assess the impact Resident #1's behaviors have on the well-being of other residents.	F 250	NCC will ensure that the residents receive the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. 1. Bowel assessments, dietary interventions and proper care planning will be provided to resident no. 8 to minimize her risk for constipation and being dependent on medication for bowel management. 2. Bowel assessments, dietary interventions and proper care planning will be provided to all residents to minimize their risk of constipation and being dependent on medication for bowel management. 3. All residents will be evaluated for their risk of constipation on admission, quarterly reviews and as needed. Dietary interventions	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy and procedure, and staff interview, the facility failed to provide the necessary care and services to ensure 1 of 6 sampled residents (Resident #8) with a diagnosis of constipation maintained the	F 309		

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F 309	Continued From page 9 highest practicable physical well-being possible regarding constipation. Failure to re-assess the resident's bowel status and include dietary interventions in the resident's bowel management program placed the resident at risk for continued constipation and dependence on medications for bowel management. Findings include: Review of the facility's policy and procedure, "Bowel Protocol," occurred on 09/04/14. This document, dated October 2010, stated "Purpose: To ensure residents are free from constipation and have regular bowel movements. Procedure: . . . 3. The nurse is to monitor resident's bowel records, if two days with no stool offer prune juice, and/or dulcolax tabs [tablets] as on standing orders. 4. Push fluids. 5. If no results and no bowel movements for three days, administer dulcolax suppository as on standing orders." The policy and procedure lacked dietary interventions or referral to the dietary department with the exception of prune juice at step 3. Review of Resident #8's medical record occurred on September 03-04, 2014. The facility admitted the resident in October 2013. Current diagnoses include dementia, constipation, and dysphagia. The resident's quarterly Minimum Data Set (MDS), dated 07/30/14, identified the resident understood others and made herself understood, required limited assistance of one person for toileting, did not walk in her room, and was occasionally incontinent of bowel. Resident #8's physician orders included the	F 309	will be implemented to reduce their risk of constipation. Care planning will reflect residents interventions. Education will be provided to the dietary manager of updated policy and to the nursing/cna staff at their October staff meeting. 4. NCC will monitor resident no. 8 in addition to a random sample of residents that they are assessed for the risk of constipation at time of admission, quarterly and as needed. Dietary interventions will be put into place and care planning will reflect interventions monthly x 3 then quarterly by the QA Coordinator. 5. Completion date Oct 19, 2014.	

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F 309	Continued From page 10 following medications, the date ordered, and the date discontinued: *Senna (laxative) 8.6 milligrams (mg), one tablet, each day; 04/04/14; 08/14/14 *Senna S (laxative and stool softener combination), one tablet, two times each day; 08/14/14; 08/25/14 *Senna S, one tablet, three times each day; 08/25/14; current order Resident #8 received one, as needed (prn), Bisacodyl (Dulcolax) suppository (stimulant laxative) on 08/14/14. The resident's ADL (Activities of Daily Living) Functional/Rehabilitation Potential Care Area Assessment (CAA), dated 02/03/14, identified the resident required limited to extensive assistance with ADLs and had some incontinence. Resident #8's current care plan, dated 10/30/13, stated "Problem . . . TOILETING: Incontinent of bowel & [and] bladder. . . . Approaches, Monitor BM's [bowel movements] daily, Assessment of bladder & bowel with admission MDS, Evaluate resident's bowel control and pattern, Medicate with laxatives/stool softeners as ordered. . . . EATING: . . . Approaches, 1 [to] 1's with CDM [Certified Dietary Manager]/RD [Registered Dietitian] . . . Diet & texture as tolerated . . ." Resident #8's care plan lacked dietary interventions regarding constipation. Resident #8's Nurse's Notes included the following: *08/10/14, 5:36 p.m. - "Noted very hard stool while in bathroom at 4:00 p.m., res. [resident] was able to evacuate stool. Will give prune juice at supper." *08/10/14, 11:24 p.m. - "6:30 p.m. glass of prune	F 309		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 11 juice given but would only take 1/2 glass . . ." *08/14/14, 10:36 a.m. - "[Health Care Provider] here to evaluate resident's constipation, orders received to give Senna S one [tablet] bid po [by mouth]." *08/24/14, 10:40 a.m. - CNA [certified nursing assistant] notified nurse of hard stool this morning, resident had senna s bid ordered on 08/14/14. Will add to [Health Care Provider] list to evaluate on her next rounds." *08/25/14, 2:27 p.m. - Res. [Resident] is continuing to have problems with constipation despite senna being increased, orders recd [received] to increase to TID." Resident #8's bowel movement records for the months of July and August 2014 showed the resident had bowel movements on 25 of 31 days in July and 27 of 31 days in August. The records showed the resident did not have bowel movements on: *July 6, 15, 18, 22, 24, and 29 *August 7, 8, 23, and 30 Facility staff administered a Bisacodyl suppository on 08/14/14 even though the records indicate Resident #8 had bowel movements on 08/09, 08/10, 08/11, 08/12, and 08/13/14. During interview, on 09/04/14 at 1:00 p.m., an administrative nurse (#1) reported she was not aware of any dietary interventions for Resident #8's constipation. The administrative nurse (#1) was uncertain why Resident #8's bowel movement record showed almost daily activity and the Nurse's Notes documented constipation. The administrative nurse (#1) was uncertain why Resident #8 received a Bisacodyl suppository on 08/14/14 since the bowel movement record shows she did have daily bowel movements on	F 309		

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F 309	Continued From page 12 the days before 08/14/14. During interview, on 09/04/14 at 1:35 p.m., a dietary management staff member (#10) reported she was not aware of Resident #8's constipation or increased use of bowel medications. The staff member (#10) reported she usually offers prune juice to a resident with constipation, then a fiber mixture of bran and prunes, and modifies the diet with the resident's input. The facility identified Resident #8's diagnoses included constipation. The facility staff received a physician's order for a laxative. The physician's order was changed to a laxative/stool softener combination and increased from one to two to three times each day. The record showed dietary involvement was limited except for occasional prune juice. Resident #8's bowel movement records show regular bowel movements and contradict nursing documentation. The facility staff administered a Bisacodyl suppository even though the record showed daily bowel movements. Facility staff failed to re-assess Resident #8's bowel status before increasing her bowel medication or attempting non-pharmacological dietary interventions.	F 309		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and	F 314	NCC will ensure that the residents who enter the facility without pressure sores do not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and	

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F 314	Continued From page 13 prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to provide necessary treatment and services to promote healing and prevent recurrence of pressure ulcers for 1 of 3 sampled residents (Resident #6) with pressure ulcers. Failure to properly position Resident #6's pressure relief device placed her at risk for recurrent development of a recently healed pressure ulcer. Failure to properly position Resident #6's lower legs placed her at risk of heel and foot skin breakdown. Findings include: Review of Resident #6's medical record occurred on September 02-04, 2014. Current diagnoses include peripheral vascular disease. The facility identified a Stage II pressure ulcer on the top of the resident's second toe on the left foot. Resident #6's significant change Minimum Data Set (MDS), dated 06/20/14, identified the resident required total assistance of two or more persons for bed mobility and one Stage II pressure ulcer. Resident #6's physician orders included: *05/29/14 - Triple Antibiotic Ointment to the left second toe *08/13/14 - Toe spacer left foot, upside down to the top of the foot; support the resident's calves and prevent heel pressure *08/21/14 - Discontinue Triple Antibiotic Ointment Resident #6's current care plan stated "Problem . .. POTENTIAL FOR SKIN BREAKDOWN: . . .	F 314	prevent new sores from developing. 1. Treatment and services will be provided to promote wound healing and prevent recurrence of pressure ulcers to resident no. 6. 2. Treatment and services will be provided to promote wound healing and prevent recurrence of pressure ulcers to all residents. 3. All residents will be assessed for their risk of developing pressure ulcers on admission, quarterly and as needed. Proper treatment and services will be provided to prevent pressure ulcers, promote healing and prevent recurring pressure ulcers. Education will be provided to nursing and CNA's on wound prevention and treatment re: resident no. 6 plan of care and general guidelines for all residents. 4. NCC will monitor resident no. 6 in addition to a random sample of residents that they have appropriate treatment and services in place to prevent pressure ulcers monthly x 3 then quarterly by the QA coordinator. 5. Completion date Oct 19, 2014.	

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F 314	Continued From page 14 Seen by Podiatrist 05/29/14. 08/21/14 L [left] 2nd toe healed. . . . Approaches . . . 08/13/14 Provide dorsal toe spacer to L foot (upside down). . . . Support under calves to prevent heel pressure in bed. . . ." Observation on September 02-04, 2014 showed a toe spacer package with a marked diagram indicating desired placement of the toe spacer posted on the wall in Resident #6's room. Observation identified the following: *09/03/14, 8:25 a.m. - Two certified nursing assistants (CNAs) (#3) and (#11) provided Resident #6 with toileting and positioning in bed. The left foot had a white sock covering the toe spacer on the dorsal surface of the foot and was twisted over the toes. At the completion of this episode of care, the CNAs (#3) and (#11) positioned a pillow under the resident's heels instead of under her calves. The CNAs did not remove the sock and check the position of the toe spacer. *09/03/14, 1:45 - Resident supine in bed, sleeping, and pillow under heels. *09/03/14, 2:10 p.m. - Two CNAs (#6) and (#12) provided cares to Resident #6 in bed and repositioned the left toe spacer. The CNAs (#6) and (#12) removed the resident's sock, revealing the toe spacer on the bottom of the foot, repositioned the toe spacer to the bottom of the foot, and put the resident's sock back on. During interview, on the morning on 09/04/14, an administrative nurse (#1) confirmed the facility staff should relieve pressure from Resident #6's heels and ensure the toe spacer is properly positioned to relieve pressure from the dorsal surface of the left toe.	F 314		

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F 314	Continued From page 15 Failure to position the pillow under Resident #6's calves and relieve pressure from the resident's heels placed the resident at risk of skin breakdown. Failure to place the toe spacer over the top of the resident's foot resulted in friction over the recently healed Stage II pressure ulcer and placed the resident at risk of recurrent pressure ulcers.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and review of facility policy, the facility failed to provide proper perineal care for 2 of 6 sampled residents (Resident #1 and #2) who required assistance with toilet use. Failure to provide appropriate perineal care with toilet use placed the residents at risk for urinary tract infections and skin breakdown. Findings include: Review of the facility policy/procedure titled	F 315	NCC will ensure that the residents who are incontinent of bladder receive appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. 1.Proper perineal care will be provided for residents no. 1 and 2. 2.Proper perineal care will be provided for all residents at NCC. 3. Education will be provided to the nursing and CNA staff on perineal care at their October staff meetings. 4.NCC will monitor a random sample of CNA's that proper perineal care is provided to residents who are dependent with their pericare monthly x 3 then quarterly by the QA Coordinator. 5.Completion date Oct 19, 2014.	

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F 315	Continued From page 16 "Perineal Care" occurred on 09/04/14. This policy, dated March 2009, stated, "Purpose: 1. To cleanse the perineum. 2. To prevent infections. 3. To prevent body odors. Procedure . . . 5. Wash or assist the resident in washing the urethral area first and the rectal last....Always front to back, one stroke only, then fold the cloth and use clean surface for next stroke. Pat dry. . . ." - Record review for Resident #1 occurred September 02-04, 2014. An annual Minimum Data Set (MDS), dated 08/06/14, identified the resident required extensive assistance of two staff members for toilet use and personal hygiene, and frequently incontinent of urine. The medical record showed Resident #1 began a course of Cipro, an antibiotic, for a urinary tract infection on 09/02/14. The current care plan for Resident #1 stated Problem Onset 08/27/2014 UTI: Resident exhibits signs/symptoms of UTI . . . Approaches . . . Use proper procedure when assisting with pericare. . . ." Observation of care provided to Resident #1 occurred on 09/03/14 at 10:33 a.m. Two CNAs (#2 and #5) transferred Resident #1 from her wheelchair to the toilet and lowered the resident's pants and brief, cued the resident to sit down, removed the wet urine soaked brief, and secured a clean brief around the resident's thighs. After the resident voided, the CNAs (#2 and #5) assisted the resident to stand, and a CNA (#2) cleansed Resident #1 from front to back one time using a disposable wipe, cleansed half way down the resident's inner/back thighs and then cleansed from front to back again without folding the disposable wipe to a clean area. The CNAs (#2 and #5) removed their gloves, pulled up the resident's brief and pants, and transferred the	F 315		

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F 315	Continued From page 17 resident back to her wheelchair. The CNA (#2) failed to use a clean area of the disposable wipe or to obtain a fresh wipe before cleansing from front to back after cleansing the resident's thighs. - Record review for Resident #2 occurred September 02-04, 2014. An annual MDS, dated 06/27/14, identified the resident required extensive assistance of two staff members for toilet use, independent with set up help for personal hygiene, and frequently incontinent of urine. Observation of care provided to Resident #2 occurred on 09/03/14 at 10:20 a.m. Two CNAs (#2 and #5) assisted Resident #2 from her bed to the bathroom with a stand lift. The CNAs (#2 and #5) lowered the resident's pajama bottom and brief, and observation showed Resident #2's brief to be dry. Resident #2 informed the CNAs (#2 and #5) she was done. One CNA (#2) cleansed Resident #2 as she stood utilizing the lift, from front to back one time using a disposable wipe, cleansed half way down the resident's inner/back thighs and then cleansed from front to back again without folding the disposable wipe to a clean area. The CNA (#2) failed to use a clean area of the disposable wipe or to obtain a fresh wipe before cleansing from front to back after cleansing the resident's thighs. Failure to provide appropriate perineal care following urine incontinence placed Resident #1 and #2 at risk of recurrent UTI's, and/or skin irritation/breakdown.	F 315		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323	NCC will ensure that the resident environment remains free of accident hazards as is possible; and each resident receives adequate supervision and assistant devices to prevent accidents.	

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F 323	Continued From page 18 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. TRANSFERS/AMBULATION - GAIT BELTS Based on observation, record review, and policy/procedure review, the facility failed to provide adequate supervision and assistive devices necessary to prevent accidents for 3 of 5 sampled residents (Resident #1, #4, and #5) observed during transfers and ambulation. Failure to use gait belts, or use them properly during transfers and ambulation placed residents at risk of accidents and injury. Findings include: Review of the facility policy "Gait Belts," occurred on 09/04/14. This policy, dated March 2009, stated, "Purpose: 1. To prevent injury to the resident or staff while ambulating the resident. 2. To provide an additional sense of security for the resident. Procedure: . . . 2. Securely apply the gait belt around the resident's waist. 3. Walk along the side of the resident while holding the belt securely in the back. . . ." - Review of Resident #4's medical record occurred on September 02-04, 2014. Resident #4's current care plan stated, "Problem/Need . . . Mobility/Transfers . . . Approaches . . . Provide 1	F 323	A.Gaitbelts 1.Gaitbelts will be used properly with transfers and ambulation on resident numbers 1, 4, and 5. 2.Gaitbelts will be used properly with transfers and ambulation with all residents as ordered. 3.All resident s will be evaluated by PT with an initial assessment and quarterly review for the need of a gaitbelt with transfers and ambulation. If a resident condition changes, nursing will direct CNA's on the use of gaitbelts by verbal report and updating the residents careplan. All residents careplans and FYI section on the computer will reflect their need of gait belts. Education will be provided to nursing and CNA's at their Oct. staff meeting re: propoer use of gaitbelts and when gaitbelts are to be used. 4.NCC will monitor resident no. 1, 4, and 5 in addition to a random sample of residents that they are provided gait belts as ordered and are used correctly by with transfers and ambulation with a random sample of CNA's monthly x 3 then quarterly by the ADON/Therapy Coordniator. 5.Completion date Oct 19, 2014.	

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F 323	Continued From page 19 assist with ambulation with FWW & [and] GB [gait belt]. . . . 1 assist with bed mobility and transfers. . . . Problem/Need . . . At Risk for Falls . . . Approaches . . . Use safe and appropriate transfer techniques. . . . " Observation on 09/02/14 at 8:25 a.m. showed a certified nursing assistant (CNA #2) applied a gait belt loosely around Resident #4's waist. The CNA (#2) assisted Resident #4 to transfer from the wheelchair to her recliner by holding one hand under the resident's shoulder and the other onto the loose gait belt. Observation on 09/02/14 at 10:05 a.m. showed a CNA (#5) assisted Resident #4 to walk with the FWW from the bathroom to her recliner. Observation showed a gait belt on the resident, but the CNA failed to hold onto the gait belt. Observation on 09/02/14 at 11:05 showed a CNA (#5) assisted Resident #4 to walk with the FWW from the bathroom to her recliner. Observation showed a gait belt on the resident, but the CNA failed to hold onto the gait belt. Observation on 09/02/14 at 2:25 p.m. showed a CNA (#6) assisted Resident #4 to stand up from the toilet and ambulate to her recliner with a FWW. The CNA failed to utilize a gait belt. - Review of Resident #5's medical record occurred on September 02-04, 2014. Resident #5's current care plan stated, "Problem/Need . . . Several areas of skin breakdown to bilat. [bilateral] feet . . . L heel skin graft . . . Approaches . . . Res [resident] is to wear PRAFO braces at all times. . . . "Problem/Need . . . Impaired Mobility . . . Approaches . . . Wt [weight]	F 323	B.Fall Prevention 1. Fall prevention measures will be in place for residents no. 3 and 6. 2. Fall prevention measures will be in place for all residents who are at risk for falls. 3. All residents on admission and as needed will be evaluated for fall risk. Bed and chair alarms will be used to prevent falls as needed. All falls will be completely investigated, noting if alarms are in place or not, if they are functioning and if not what interventions were done about it. Fall prevention interventions will be properly care planned. Education will be provided to nursing and CNAs at their Oct. staff meeting. 4. NCC will monitor resident numbers 3 and 6 and a random sample of residents that fall precautions are in place and all falls are properly investigated monthly x 3 then quarterly by the QA coordinator. 5. Completion date Oct. 19, 2014.	

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F 323	Continued From page 20 bearing for transferring only with 1-2 assist. May use standing mechanical lift for transfers to recliner. . . . Problem/Need . . . At Risk for Falls . . . Approaches . . . use safe and appropriate transfer techniques. . . ." Review of Resident #5's progress notes, dated 08/09/14, stated, ". . . informed spouse that resident is very very scared of falling therefore transfer with the resident can be difficult. When resident gets scared will . . . transfer himself quickly and then plop self into the chair. . . . Resident asked why we can't use 'the machine to put me in the chair, that way I won't fall.' Telephone order received that an EZ stand [mechanical stand lift] may be used to transfer resident into his recliner." - Observation on 09/02/14 at 9:30 a.m. showed a CNA (#2) assisted Resident #5 to a standing position by lifting under the resident's arm, and then pivot transferred him to his wheelchair. The CNA (#2) failed to apply a gait belt prior to the transfer. - Observation on 09/02/14 at 9:45 a.m. showed a CNA (#9) assisted Resident #5 to transfer from his wheelchair to the bathchair. On the first transfer attempt, Resident #5 had a PRAFO brace (devise worn on the calf and foot similar to a boot] on one foot/leg (left) and the right PRAFO off. The resident had a difficult time standing up, so the CNA placed the other PRAFO brace on the right leg. The CNA (#9) commented the floor in the tub room can at times be slippery. The CNA (#9) failed to apply a gait belt prior to the transfer. - Record review for Resident #1 occurred September 02-04, 2014. An annual MDS, dated	F 323	C.Hazardous Chemicals 1. Hazardous chemicals will be secure to prevent resident's risk of injury. 2/3. Sea Clens wound cleaner will be kept in a secured cabinet to prevent resident injury. All chemicals will be kept in secured cabinets or areas. 4.NCC will monitor the storage of seaclens and all chemicals that it is stored properly in a secure area monthly x 3 then quarterly by the Maintenance Supervisor. 5. Completion date Oct. 19, 2014.	

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F 323	Continued From page 21 08/06/14, identified the resident required extensive assistance of two staff members for transfers and toilet use. The current care plan, stated "Problem/need . . . Mobility/Transfers: . . . Approaches Transfers with standing mechanical lift & [and] 1 assist or pivot transfer with 2 assist with GB [gait belt]. . . ." During an observation on 09/02/14 at 4:18 p.m., two CNAs (#6 and #7) transferred Resident #1 from her wheelchair to the toilet using a gait belt. The CNA (#6) held onto the gait belt and placed her forearm under the resident's arm, the other CNA (#7) held the gait belt and Resident #1's hand. The gait belt slid up the resident's back, to her shoulders as she stood. When Resident #1 finished on the toilet, the CNAs (#6 and #7) pivot transferred her to her wheelchair. One CNA (#7) held the gait belt, the other CNA (#6) placed her forearm under the resident's arm and failed to use the gait belt. During an observation on 09/03/14 at 10:33 a.m., two CNAs (#2 and #5) pivot transferred Resident #1 from her wheelchair to the toilet by placing their forearms under the resident's arms and pulled up on her pants. When the resident sat on the toilet, the CNA (#2) placed a gait belt around the resident's chest. The CNAs (#2 and #5) assisted the resident to stand and the gait belt pulled up under Resident #1's arms. Both CNAs (#2 and #5) then pivot transferred Resident #1 to her wheelchair, one holding the gait belt and the resident's hand, the other held under the resident's arm. Failure of the CNAs to use gait belts and/or to use them properly during transfers placed Resident#1 and the staff members at risk of an	F 323		

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F 323	Continued From page 22 accident and/or injury. 2. FALL PREVENTION MEASURES Based on observation, record review, and staff interview, the facility failed to ensure fall prevention measures were in place for 1 of 2 sampled residents (Resident #3) with an alarmed seat belt and failed to ensure investigation and implementation of corrective action regarding falls for 2 of 4 sampled residents (Resident #3 and #6) with a history of falls. Failure to ensure alarmed seat belts and chair alarms were in place limited the facility's ability to intervene during the resident's attempts to self transfer and reduce the risk of injury. Failure to investigate and implement corrective action following Resident #3's and #6's falls placed all residents at risk of injury. Findings include: - Review of Resident #3's medical record occurred on September 02-04, 2014. The facility admitted the resident in August 2011. Current diagnoses include dementia with behaviors and anxiety. The annual Minimum Data Set (MDS), dated 08/02/14, identified severe cognitive impairment, fluctuating inattention and disorganized thinking, wandering one to three days of the seven day assessment period, the resident required extensive assistance of two or more persons for transfers, walking did not occur, and falls occurred. Resident #3's Fall Risk Assessment, dated 08/06/14, identified the resident as a "High Risk" for falls. The medical record identified the facility initiated fall interventions as follows: *07/17/13 - bed alarm	F 323		

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F 323	Continued From page 23 *10/22/13 - chair alarm *07/10/14 - alarmed seat belt Resident #3's Falls Care Area Assessment (CAA), dated 08/07/14, identified the resident self propelled his wheelchair in the facility with his lower extremities and leaned forward or slid out of his wheelchair, experiencing multiple falls. The facility implemented fall prevention devices including: a silent chair alarm, bed alarm, self locking brakes, fall mat, low bed, and an alarmed seat belt. Resident #3's Restraint Reduction Notes, dated 08/13/14, stated "Restraint Reduction Committee met today and discussed resident's status. No changes made. Continues with alarmed pelvic belt to help with positioning in w/c [wheelchair]. Can open belt on command at times but does spontaneously open belt frequently. . . . Has strong history of self transfers and falls thus has bed and chair alarms in place . . ." Resident #3's current care plan, stated "Problem . . . FALLS: At Risk for Falls . . . Approaches . . . Silent bed alarm. Provide chair alarm. . . . Place alarmed seat belt to w/c. . . ." Resident #3's Nurse's Notes identified the resident experienced the following falls and "near miss" and failed to identify fall interventions in place: *11/30/13, 12:36 p.m. - "Resident was placed in recliner in TV [lounge] by nurses station as was anxious and propelling self around facility. Resident scooted self to front/foot of recliner and by time staff got to resident has [sic] gently slide [sic] self of [sic] end onto floor onto butt. Resident laughing. Did not hit head. Skin assessment for	F 323		

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redness/scraping in case back slid against foot rest. Nothing noted. . . ."
*04/24/14, 10:09 a.m. - "NEAR MISS: Resident found in recliner and was in w/c. Resident did not have chair alarm in w/c. None of the staff admit to having helped resident transfer from w/c into recliner so resident is assumed to have self-transferred."
*06/05/14, 1:05 p.m. - "CNA [Certified Nursing Assistant] passing resident's room when he yells to her to get some help in here. Resident found sitting on the floor mat that is beside his bed at [sic] closer to the foot end of the bed with his spine resting on bedframe and knees to chest. Appears as if resident scooted off the edge of the bed. Bed is in lowest position. It is not possible for resident to have hit head. Resident denies pain. ROM [Range of Motion] is intact. . . ."
*06/28/14, 6:45 p.m. - "He had wheeled himself into room [number]. When he was taken out of the room he slid off his wheelchair in the hallway, going down on his left side and then sitting on the floor. Very slight superficial abrasion left knee approx. [approximately] 1.0 cm [centimeter] in diameter."

On the morning on 09/04/14, an administrative nurse (#1) provided the incident reports for the above falls and "near miss." The incident reports provided the following information in addition to the Nurse's Notes:
*11/30/13, 12:36 p.m. - "Additional Follow-ups - 12/06/13, No injuries s/p [status post] fall. Safety reminders given to staff."
*04/24/14, 10:09 a.m. - No additional information.
*06/05/14, 1:05 p.m. - "Additional Follow-ups - 06/12/14, Res. [Resident] without injury. Safety precautions in place. Res. started on Risperdal [anti-psychotic medication] 06/10/14 for

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F 323	Continued From page 25 agitation/behaviors." *06/28/14, 6:45 p.m. - "Additional Follow-ups - 07/16/14, 07/07/14 No ill effects from falls. Neurochecks negative. Safety reminders given to staff. Investigations for the incidents previously identified were limited to the information identified. - Observation on 09/03/14 at 2:30 p.m., identified Resident #3 propelling his wheelchair in the halls with his feet and the alarmed seat belt released and tucked along his legs in the wheelchair. Observation showed the resident continued to self propel the wheelchair unattended in the halls. On 09/03/14 at 3:55 p.m. (one hour and 25 minutes after the initial observation), Resident #3's unfastened seat belt was brought to the attention of an administrative nurse (#1). The administrative nurse (#1) found Resident #3 sitting on part of the seat belt and fastened the buckle. During interview, on the morning of 09/04/14, an administrative nurse (#1) reported the facility staff toileted Resident #3 before 2:30 p.m. on 09/03/14 and failed to fasten the seat belt. The administrative nurse (#1) agreed the facility staff should have fastened the seat belt. Incident reports showed Resident #3 had a history of falls without fall interventions, such as chair alarms, in place. The facility's fall investigations, corrective action documentation, and quality assurance monitoring fail to identify corrective action implemented for these issues. Observation identified facility staff failed to implement Resident #3's fall prevention	F 323		

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F 323	Continued From page 26 measures. - Review of Resident #6's medical record occurred on September 02-04, 2014. The facility admitted the resident in September 2010. Current diagnoses include dementia. The annual MDS, dated 09/18/13, identified the resident required limited assistance of one person for transfers and walked in the room and corridor. Resident #6's Nurse's Notes identified the resident experienced the following fall: *12/10/13, 7:31 a.m. - "Bath aide was transferring res. from bed to bathchair. Res. did not have slippers on & floor is slippery & res. slid on floor and CNA lowered res. to ground. Res. did not hit head. No injuries obtained." On the morning on 09/04/14, an administrative nurse (#1) provided the incident report for the above fall. The incident report provided the following information in addition to the the Nurse's Notes: *12/10/13, 7:31 a.m. - "Additional Follow-ups - 01/06/14, No injuries s/p fall. Safety reminders to staff regarding use of nonskid slippers for transfers when shoes are not worn." Resident #6's Fall Risk Assessment, dated 09/18/13, identified the resident demonstrated balance problems while standing and walking and was a High fall risk. Resident #6's care plan, dated 09/26/13, stated "Problem . . . TRANSFERS: Hx [History]: tremors . . . Approaches . . . For transfers . . . May use 1 assist with pivot transfers and use of gait belt. Ambulation with use of GB [gait belt] and FWW [front wheeled walker] with 1 assist as res.	F 323		

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F 323	Continued From page 27 [resident] tolerates. . . ." The care plan failed to include the intervention to use nonskid slippers for transfers when shoes are not worn. During interview, on the morning of 09/04/14, an administrative nurse (#1) reported the facility changed to a hard surface flooring prior to Resident #6's fall. Facility staff were not used to this flooring and attempted to transfer the resident on the new flooring. The administrative nurse (#1) reported all staff were instructed to not transfer or ambulate residents without foot wear. No documentation of the instruction was available. The incident reports for Resident #3's and Resident #6's falls failed to include investigations to determine the cause so appropriate interventions could be implemented to prevent further falls. During interview, on 09/04/14 at 1:30 p.m., an administrative nurse (#1) reported each resident fall is reviewed at the time and any corrective action is communicated to staff by shift report and communication book. The facility quality assurance committee reviews each resident fall for tracking and trending. Review of the quality assurance monitoring documentation showed total numbers of falls reviewed and facility trends documented. The documentation lacked information regarding specific residents or incidents. The administrative nurse (#1) reported corrective action documentation by shift report and communication book was not available. 3. UNSECURED CHEMICALS Based on observation, review of product information, and staff interview, the facility failed to ensure the resident environment remained free	F 323		

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F 323	Continued From page 28 of accident hazards in 1 of 1 examination room. Failure to secure hazardous chemicals in a resident care area placed residents at risk of injury. Findings include: Review of the internet site www.coloplast.ca occurred on 09/04/14. The internet site included Material Safety Data Sheet (MSDS) information which identified Sea Clens Wound Cleanser may cause eye and skin irritation. During the facility environmental tour on 09/04/14 at 9:15 a.m., observation in the facility examination room identified an unlocked floor level cabinet containing approximately 10 six ounce containers of Sea Clens Wound Cleanser labeled "Keep Out Of Reach Of Children." A maintenance department management department staff member (#8) confirmed the cabinet should be secured. The examination room is located across the hall from a resident television lounge on the main hall between resident care units A and B, the dining room, and the facility's front entrance. Observation throughout the survey showed the examination room door open, ambulatory residents unsupervised in the lounge, and residents ambulating independently past the examination room.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any	F 329	Each resident will be free from unnecessary drugs.	

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F 329	Continued From page 29 drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review, and staff interview, the facility failed to ensure a medication regimen free from unnecessary medications for 1 of 3 sampled residents (Resident #1) receiving an as needed (PRN) antipsychotic medication. The facility failed to adequately assess the resident and attempt non-pharmacological interventions prior to administering the antipsychotic medication which placed Resident #1 at risk of receiving an unnecessary medication and experiencing adverse consequences related to its use. Findings include:	F 329	1. Unnecessary psychotropics will not be used for resident no. 1. 2. Unnecessary psychotropics will not be used with any NCC residents. 3. Residents with prn medication orders will be properly assessed and provided non-pharmacological interventions prior to medication administration. Documentation will include the behaviors and non –pharmacological interventions. If medication is still necessary it will be given as ordered and documentation will be noted on its effectiveness. Psychotropic medication use is reviewed with our mental health consultant and GDR's will be attempted as consultant orders. Education will be provided to nurses and CNA's at their monthly staff meeting on non-pharmacological approaches to redirect behaviors and the necessary charting for nursing staff with medication administration. 4. NCC will monitor resident no. 1 in addition to a random sample of residents with prn pscyhotropics that they are free from unnecessary psychotropics and if	

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F 329	Continued From page 30 Record review for Resident #1 occurred September 02-04, 2014. Diagnoses included Alzheimer's disease, dementia with behavior disturbance, depression, and transient cerebral ischemia. An annual Minimum Data Set [MDS], dated 08/06/14, identified the resident experienced short and long term memory problems. This MDS indicated Resident #1 displayed physical behavioral symptoms directed toward others, one to three days; other behavioral symptoms not directed toward others, one to three days; with an impact on the resident of interfering with the resident's care; with an impact on others of significantly intruded on the privacy or activity of others and significantly disrupted care or living environment; rejected care one to three days; wandered daily and while wandering significantly intruded on the privacy or activities of others. The current care plan, stated "Problem/Need . . . Problem Onset: 08/27/2014 Psych Meds [Antipsychotic Medications]: Maintained on psychotropic medications for s/s [signs/symptoms] behaviors & [and] anxiety . . . Approaches . . . If behavioral symptoms represent a change or worsening condition, provide a medical workup to rule out underlying medical or physical causes of the behaviors as appropriate. . . . Attempt non-pharmacologic, person-centered interventions prior to Antipsychotic medications as able for treatment of behavioral symptoms. See activity section for interventions to offer. Music was always a passion for res. [resident] also . . . Problem Onset: 08/13/2013 Activities: Attends scheduled activities of choice. . . . Involvement in sensory program will benefit residents [sic] social and	F 329	prn psychotropics are used there is non-phamacological approaches attempted and documented prior to medication administration. Complete documentation will be present when medications are given and the effectiveness of the medication. Monitoring will be monthly x3 and then quarterly by the QA coordinator. 5. Completion date Oct. 19, 2014.	

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F 329	Continued From page 31 recreational participation level. . . . Approaches . . . provide with diversionary supplies(located in tv room) such as various flash cards, picture books and dolls per family request. . . ." Review of Resident #1's medication administration record (MAR) from 08/29/14 through 09/03/14 showed nursing staff administered the prn Zyprexa five of six days. The reasons stated for administration included "[up] wandering & unable to redirect" and "[up] wandering & difficult to redirect." Nursing notes identified the following (also refer to F250): * 08/27/14, 10:54 a.m., "1030 [10:30 a.m.] due to increased behaviors orders recd [received] to collect UA [urinalysis] today" Then at 3:47 p.m. "Phone call placed to daughter [named] discussing resident's behaviors and that [medical practitioner] would like resident to take Risperdal [an antipsychotic] 0.25 mg in the am [morning] and every 4 hours prn po [orally]. [Daughter's name] is in agreement. Will monitor effectiveness." At 3:52 p.m. "Phone order received from [medical practitioner] for Risperdal 0.25mg every am and every 4 hours prn po for her behaviors of resisting cares, kicking another resident, scratching and pinching staff. Resident is difficult to redirect when wandering into other resident rooms." At 4:34 p.m., "Psych [psychiatric] review meeting held today, . . . Resident has had increased behavirors [sic] with physical abuse to aides and kicking another resident. Will check a UA to be sure no UTI [urinary tract infection] but resident has been having these behaviors and wandering in her wheelchair around our facility for quite some time, with the refusal of cares becoming worse the last	F 329		

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F 329	Continued From page 32 few weeks. . . ." * 08/29/14, 9:49 a.m., "Phone call placed to [medical practitioner] re [regarding]: resident behaviors and that we were going to try Risperdal but with investigation had noted the last time that was tried resident had a seizure. Order rec [received] d/c [discontinue] risperdal and use zyprexa 2.5mg bid prn and [medical practitioner] will evaluate next week when she is here for her consult visit." (The MAR showed nursing staff did not administer the risperdal.) * 08/30/14, 6:15 p.m., "res was given the zyprexa this morning and she has slept all morning and all afternoon, she was easy to arouse to be taken out for meals, no wandering today" * 09/01/14, 4:41 p.m., "1430 [2:30 p.m.] Res medicated with zyprexa for wandering and intruding behavior of other res." 4:15 p.m. res is more calm and with less roaming" * 09/02/14, 11:10 a.m., "urine culture recd back and is positive orders recd via phone for cipro 500mg BID x 5 days [twice a day for five days]." During an interview on 09/04/14 at 2:40 p.m., an administrative nursing staff member (#1) stated nursing staff administering an as needed antipsychotic medication should attempt non-pharmacological interventions before administration. She confirmed staff failed to identify the non-pharmacological interventions attempted before each administration of the antipsychotic medication. Nursing staff failed to identify attempted non-pharmacologic, person-centered interventions to alter Resident #1's behavior prior to the administration of a prn antipsychotic medication for treatment of behavioral symptoms	F 329		

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F 329	Continued From page 33 as stated in the care plan. Failure to consistently identify/document the actual behavior exhibited, and show the ineffectiveness of care planned and other interventions may have resulted in the initiation of an unnecessary antipsychotic medication for Resident #1.	F 329		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.	F 441	NCC will maintain an infection control program to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. 1. Resident no. 3, 4, 5, and 8 will have care provided by staff following proper infection control guidelines related to hand hygiene, glove usage, and skin ulcer care after perineal care to prevent the spread of infection. 2. All residents will have cares provided by staff following proper infection control guidelines to prevent the spread of infection. 3. Education will be provided to the nurses and aides at their October staff meeting on the policies of proper perineal care, glove usage, hand washing and ulcer care. 4. NCC will monitor resident no. 3, 4, 5, and 8 and a random sample for staff following NCC protocol for appropriate perineal care, glove usage, hand washing and ulcer care monthly x 3 then quarterly by the QA Coordinator. 5. Completion date Oct. 19, 2014.	

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F 441	Continued From page 34 (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation and review of facility policy, the facility failed to follow standard infection control practices for 4 of 6 sampled residents (Resident #3, #4, #5, and #8) observed during perineal care. Failure to follow infection control practices related to hand hygiene, glove usage, and skin ulcer care after perineal care has the potential to cause or spread infection within the facility. Findings include: Review of facility policy "Perineal Care," occurred on the afternoon of 09/04/14. This policy, dated March 2009, stated, "Purpose: 1. To cleanse the perineum. 2. To prevent infections. . . . Procedure: . . . 4. Put on your gloves. 5. wash or assist the resident in washing the urethral area first and the rectal last. . . . 7. Remove your gloves. 8. Wash your hands. . . ." - Observation on 09/02/14 at 9:30 a.m. showed a CNA (#2) toileted Resident #5 in the bathroom. The CNA (#2) provided perineal and rectal care after Resident #5 had a bowel movement. The CNA assisted the resident to his wheelchair and positioned his legs on the foot rests. The CNA removed her gloves, wheeled Resident #5 into his room, moved his bedside table, and	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355102	A. BUILDING _____ B. WING _____	09/04/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NAPOLEON CARE CENTER	311 E 4TH ST NAPOLEON, ND 58561

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 35 positioned his call light, water mug and other items on the bedside table. The CNA then went back to the bathroom and washed her hands before leaving the room. The CNA failed to wash her hands after completing perineal care and prior to completing other tasks. - Observation on 09/02/14 at 10:05 a.m. showed a certified nursing assistant (CNA #5) toileted Resident #4. The CNA (#5) provided perineal and rectal care after Resident #4 had a bowel movement. Using the same gloves worn for the perineal/rectal care, the CNA (#5) dispensed Calmoseptine cream into her gloved hand and applied the cream to an open stage 2 pressure area on Resident #4's sacrum. The CNA failed to remove her gloves and wash her hands prior to applying cream to Resident #4's open pressure ulcer. - Observation on 09/03/14 at 1:30 p.m., showed CNAs (#2 and #3) provided toileting for Resident #3. The CNAs assisted the resident to stand in the stand lift, removed his brief, used wipes to cleanse the frontal perineal area, then another wipe to cleanse the rectal area. One CNA (#2) wore gloves, wiped stool from the resident's rectal area until clean, assisted the other CNA (#3) to apply a clean brief, and pull up the resident's pants. The CNA (#3) removed her gloves. The CNAs (#2 and #3) assisted Resident #3 to sit in his wheelchair, removed the lift sling, and applied his seat belt. The CNA (#2) failed to wash her hands after completing perineal care and prior to completing other tasks. - Observation on 09/04/14 at 8:55 a.m., showed a CNA (#4) assisted Resident #8 to the bathroom for toileting. The CNA (#4) reported she used	F 441		

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	355102	A. BUILDING _____ B. WING _____	09/04/2014

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F 441	Continued From page 36 gloves and wipes to provide perineal cares for the resident after the resident voided on the toilet. Observation identified the CNA (#4) assisted Resident #8 from the bathroom to her wheelchair and then to her bed. The CNA (#4) adjusted the head of the bed, provided a blanket and call light for the resident, and opened the room window shades. Then, the CNA (#4) washed her hands. The CNA (#4) failed to perform hand hygiene after completing perineal care and prior to completing other tasks.	F 441		
F 494 SS=D	483.75(e)(2)-(3) NURSE AIDE WORK > 4 MO - TRAINING/COMPETENCY A facility must not use any individual working in the facility as a nurse aide for more than 4 months, on a full-time basis, unless that individual is competent to provide nursing and nursing related services; and that individual has completed a training and competency evaluation program, or a competency evaluation program approved by the State as meeting the requirements of §§483.151-483.154 of this part; or that individual has been deemed or determined competent as provided in §483.150(a) and (b). A facility must not use on a temporary, per diem, leased, or any basis other than a permanent employee any individual who does not meet the requirements in paragraphs (e)(2)(i) and (ii) of this section. Nurse aides do not include those individuals who furnish services to residents only as paid feeding assistants as defined in §488.301 of this chapter.	F 494	NCC will assure all licensed CNA's will have current licensure and are competent to provide nursing related services. 1. Individual A has renewed her license and has had a competency evaluation on her CNA duties. 2. All licenses CNA's will have current licensure and have competency evaluations annually. 3. ADON has organized a list of all CNA's with their license expiration dates and posted it in their report room in addition to her office. 4. NCC will monitor a random sample of CNA's for current licensure monthly x 3 then quarterly by the ADON. 5. Completion date Oct. 19, 2014.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355102	A. BUILDING _____ B. WING _____	09/04/2014

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F 494	Continued From page 37 This REQUIREMENT is not met as evidenced by: Based on information from the nurse aide registry, the facility failed to ensure 1 of 1 direct care staff (Individual A) who provided resident care maintained a current certification. Failure to ensure certification of caregivers placed residents at risk of receiving care from unqualified staff. Findings include: Information from the North Dakota nurse aide registry identified Individual A's nurse aide certification expired on 03/09/2014. This information showed Individual A worked 12 days, March, 12, 13, 17, 19, 20, 22, 23, 24, 26, 27, 31, 2014 and April 1, 2014, with an expired certification.	F 494		