| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 355102 | A. BUILDING _____ B. WING _____ | 10/26/2011 |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| 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 |
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| F 000 | INITIAL COMMENTS<br><br>For the standard Medicare/Medicaid recertification survey started on October 24, 2011 and completed on October 26, 2011, the sample included two (2) residents for complete review, seven (7) residents for focused review, and one (1) closed record for review. | F 000 | | |
| F 323 SS=D | 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, review of policy and procedure, and staff interview, the facility failed to ensure each resident received adequate supervision and assistive devices for 3 of 4 sampled residents (Resident #1, #2, and #3) who required a gait belt for transfers. Failure to use a gait belt appropriately or as necessary has the potential to cause falls, injuries, or pain to residents.<br><br>Findings include:<br><br>Review of the facility policy titled "GAIT BELTS - USE OF" occurred on 10/26/11. This policy, dated October 2010, stated, "A gait belt is a 'large belt' that can be used in assisting a resident with a transfer or while assisting an unsteady resident | F 323 | Napoleon Care Center (NCC) will ensure that the resident environment remains free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.<br>1. Gait belts will be used properly with transfers and ambulation with residents # 1, 2, and 3.<br>2. Gait belts will be used properly with transfers and ambulation with all residents as ordered.<br>3. All residents will be evaluated by PT with an initial assessment and quarterly review for the need of a gait belt with transfers and ambulation. If a resident condition changes, nursing will direct CNA's on use of gait belts by verbal report and updating the resident's care plan.<br>4. All resident's care plans and CNA daily worksheets will reflect their need of gait belts.<br>5. Education will be provided to nursing and CNA's at their November staff meeting re: | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Richard Regner — TITLE: Administrator — (X6) DATE: 11-9-11

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

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| F 323 | Continued From page 1<br>to walk. The number of injuries to you, as well as the resident can be reduced by using a gait belt . . . Gait belts will be used: 1. with residents who PT [physical therapy] has evaluated & deemed necessary; 2. if a resident has fallen; 3. when nursing deems necessary. . . ."<br><br>- Review of Resident #2's medical record occurred on all days of survey. Diagnoses included dementia, osteoarthritis, and degenerative joint disease (DJD) of the right hip. The care plan stated, ". . . MOBILITY/TRANSFERS: Encourage to use FWW [front wheeled walker] when ambulating. Supervision and encouragement due to dementia. PT consults . . . PAIN: Resident has (L) [left] shoulder arthritis. History of (R) [right] hip DJD . . . AT RISK FOR FALLS: Due to dementia. Last fall 10/13/11. . . ."<br><br>An observation on 10/25/11 at 11:30 a.m. showed a certified nursing assistant (CNA) (#10) pulling under Resident #2's left shoulder when attempting to assist him to a standing position from his recliner. After several attempts, the CNA (#10) applied a gait belt around the resident's waist. The resident then stood up and walked to the dining room with his walker.<br><br>On 10/25/11 at 3:10 p.m. Resident #2 ambulated from his room into the dining room using his walker. Observation showed the resident took small, shuffled steps. A CNA (#2) walked beside the resident and failed to use a gait belt when walking with the resident.<br><br>During an interview on 10/25/11 at 5:15 p.m., a CNA (#2) stated at 5:00 p.m. she and another | F 323 | proper use of gait belts and when gait belts are to be used.<br>6. NCC will monitor resident # 1, 2, and 3 in addition to a random sample of residents that they are provided gait belts as ordered and are used correctly with transfers and ambulation monthly x 3 then quarterly by the QA Coordinator.<br><br>Completion Date November 30, 2011 | |

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| F 323 | Continued From page 2<br>CNA (#7) toileted Resident #2. The CNA (#2) stated they did not use a gait belt when transferring the resident.<br><br>Observation on 10/26/11 at 8:35 a.m. showed Resident #2 walking with his walker from the dining room to his bedroom. A CNA (#11) failed to use a gait belt and walked in front of the resident while assisting him back to his room.<br><br>- Review of Resident #1's medical record occurred on all days of survey. Diagnoses included edema, chronic obstructive pulmonary disease, polymyalgia rheumatica, and congestive heart failure. Resident #1's care plan identified the resident required assistance from one staff member and the use of a gait belt for transfers.<br><br>During an observation on 10/25/11 at 11:10 a.m., a nurse (#8) assisted Resident #1 to transfer from the toilet to her wheelchair. Observation showed the resident take small, shuffled steps. The nurse (#8) failed to utilize a gait belt when transferring the resident.<br><br>On 10/26/11 at 1:30 p.m. an administrative nurse (#1) stated she expected staff to use a gait belt when ambulating/transferring Resident #1 and #2.<br><br>- Review of Resident #3's medical record occurred on October 24-26, 2011. Resident #3's current care plan identified the following: HX: [history] PAIN . . . L [left] shoulder surgery 2000. . . . FALLS: At Risk for Falls: . . . Use safe and appropriate transfer techniques. . . . MOBILITY/TRANSFERS: Slow shuffling gait. . . . Goal Res. [resident] will be safe & [and] secure | F 323 | | |

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| F 323 | Continued From page 3<br>with mobility & transfers on a daily basis."<br><br>Observation, on 10/24/11 at 4:52 p.m., showed CNAs (#2 and #6) toileting Resident #3. The CNAs applied a gait belt and one of the CNAs (#6) utilized the gait belt to assist the resident to stand. The other CNA (#2) grabbed under Resident #3's left arm and pulled up to assist the resident to stand. The CNA (#2) failed to utilize the gait belt to assist Resident #3 in transferring from the wheelchair to the toilet.<br><br>During interview on 10/26/11 at 4:30 p.m., an administrative nursing staff member (#1) confirmed staff should be utilizing the gait belt and not pulling under the arm/shoulder of a resident. | F 323 | | |
| F 441 SS=D | 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS<br><br>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.<br><br>(a) Infection Control Program<br>The facility must establish an Infection Control Program under which it -<br>(1) Investigates, controls, and prevents infections in the facility;<br>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and<br>(3) Maintains a record of incidents and corrective actions related to infections.<br><br>(b) Preventing Spread of Infection<br>(1) When the Infection Control Program | F 441 | Napoleon Care Center 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.<br>1. Resident # 1 will have nursing staff complete dressing changes as per NCC protocol. Resident #1 will have staff assist her in washing her own hands after participating in her toileting before leaving the bathroom. Resident # 4 will have ADL assist from staff who follow NCC infection control protocol with glove use and hand washing | |

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| F 441 | Continued From page 4<br>determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.<br>(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.<br>(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.<br><br>(c) Linens<br>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, medical record review, policy and procedure review, family interview and staff interview, facility staff failed to follow infection control practices for 3 of 6 sampled residents (Resident #1, #4, and #5) observed receiving cares. Failure to follow glove and handwashing protocols and provide perineal care for incontinent residents may contribute to skin breakdown and to the spread of infection within the facility.<br><br>Findings include:<br><br>Review of the facility policy titled, "Procedure for Incontinent/Perineal Care," occurred 10/26/11. This undated policy stated, "Incontinent care is important because moisture and soiling of skin | F 441 | following cares. Resident # 4 will have pericare provided when staff change his wet and/or soiled incontinent products.<br>2. All residents will receive dressing changes per protocol to prevent the risk of infection. All residents who participate in their own toileting will be assisted to wash their hands prior to leaving the bathroom. All residents will receive ADL assist from staff who follow NCC protocol of glove usage and hand washing. All residents will receive pericare with incontinent product changes.<br>3. Education will be provided at the November staff meeting re: NCC infection prevention protocol including: hand washing, gloving, and dressing changes. NCC dressing change policy has been updated and will be reviewed.<br>4. NCC will monitor resident # 1, and 4 and a random sample for staff following NCC protocol for appropriate hand washing, changing gloves, and dressing changes monthly x 3 then quarterly by QA Coordinator.<br><br>Completion date 11/20/11 | |

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| F 441 | Continued From page 5 | F 441 | | |

contributes to skin breakdown. The perineal area also is a primary portal of entry for bacteria into the urinary tract, potentially causing infection. Therefore it is important that this area be kept as clean as possible. Incontinent care will be completed as follows: . . . Wash hands or use alcohol-based hand rub. Apply gloves. . . . cleanse . . perineum. . . .If gloves become grossly contaminated with feces, etc., gloves should be changed before continuing. . . Remove gloves and wash hands. Return resident to clean, comfortable position. Clean resident's unit, provide clean linen as needed and return items to the appropriate place. . . . Wash Hands. . . "

Review of the facility policy titled, "Dressing Application - Clean," occurred 10/26/11. This policy, dated as revised 10/10, stated, "Purpose: 1. To prevent infection in an open area. 2. To prevent contaminated drainage from toughing [sic] clothes or linen. Procedure: . . . 2. Wash you hands . . . 3. Put on gloves. 4. Remove the soiled dressing. Be sure to place it separately from the clean area. Place in a waterproof bag. 5. Change your gloves. 6. Cleanse wound with the solution ordered. Always clean the area from the center out. 7. Apply the dressing. 8. Remove your gloves. 9. Wash your hands. . . ."

Review of the facility policy titled, "Procedure for Handwashing," occurred on 10/26/11. This undated policy stated, " . . . When to Wash Hands (at a minimum) . . . Before eating and drinking. Before and after using the toilet. After sneezing, coughing, or blowing your nose. . ."

- During a family interview, at 2:35 p.m. on 10/24/11, a family member of Resident #4 stated

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| F 441 | Continued From page 6<br>staff members will sometimes remove her husband's wet, incontinent brief and place a new brief on without "cleaning" him first.<br><br>- Review of Resident #5's medical record occurred on October 24-26, 2011. The Minimum Data Set (MDS), dated 07/27/11, identified Resident #5 as always incontinent of urine. Observation, on 10/24/11 at 4:10 p.m., showed certified nurse aides (CNAs) (#2 and #3) toilet Resident #5. The CNAs removed the brief, wet with urine, and replaced it with a clean/dry brief without providing any perineal cleansing.<br><br>Observation, on 10/25/11 at 10:00 a.m., showed CNAs (#4 and #5) providing morning cares for Resident #5. The CNA (#4) donned gloves and then said, "I am going to sneeze." The CNA obtained a tissue and blew her nose while wearing the gloves. Without removing or changing her gloves after blowing her nose, the CNA (#4) continued dressing Resident #5 and transferred him to the toilet with the standing lift.<br><br>- Observation on 10/25/11 at 11:10 a.m. showed Resident #1 sitting on the toilet in her bathroom. A nurse (#8) entered the bathroom to change the resident's dressing on her left buttock. The nurse (#8) washed her hands, donned gloves, removed the soiled dressing (scant serous drainage visible), sprayed the ulcer with a saline-based cleanser, dried the ulcer using a gauze pad, applied a new dressing, and then removed her gloves and washed her hands. The nurse (#8) failed to change her gloves and perform hand hygiene after removing the soiled dressing and prior to cleansing the wound and applying a clean dressing. After completing the dressing change, | F 441 | | |

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| F 441 | Continued From page 7<br>the nurse (#8) assisted Resident #1 to transfer from the toilet to her wheelchair. Resident #1 completed pericares independently after voiding in the toilet. The nurse (#8) failed to assist/encourage Resident #1 to perform hand hygiene after completing pericares. Resident #1 then went to the dining room for the noon meal where she ate a peanut butter sandwich with her bare hands.<br><br>During an interview on 10/26/11 at 1:30 p.m., an administrative nurse (#1) stated she expected staff to change gloves and perform hand hygiene after removing a soiled dressing and prior to cleansing the wound and applying a new dressing. The staff member (#1) stated she expected staff to encourage Resident #1 to wash her hands after completing pericares independently.<br><br>On 10/26/11 at 3:30 p.m., an administrative nurse (#9) stated the facility's policy on dressing changes should include performing hand hygiene when changing gloves after removing a soiled dressing and prior to cleansing a wound and applying a new dressing.<br><br>- Observation on 10/25/11 at 2:20 p.m. showed one CNA (#7) position Resident #4 on his side in bed while the other CNA (#2) provided perineal care after the resident had a large, soft, incontinent bowel movement. After the CNA (#2) provided perineal cares, she removed her gloves, applied a new brief, pulled up the resident's pants, and transferred the resident to his wheelchair using a mechanical lift. Without performing hand hygiene, the CNA (#2) combed Resident #4's hair and gave him several | F 441 | | |

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| F 441 | Continued From page 8<br>spoonfuls of thickened water to drink. The CNA (#2) failed to perform hand hygiene immediately after transferring the resident to his wheelchair or before offering him fluids. | F 441 | | |