| 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 _____ | 10/12/2016 |

| 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 |
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| F 000 | INITIAL COMMENTS<br><br>For the standard Medicare/Medicaid recertification survey, started on 10/10/16 and completed on 10/12/16, the sample included 2 residents for complete review, 8 residents for focused review, and 1 closed record for review. | F 000 | | |
| F 314 SS=D | 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES<br><br>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, review of facility policy and staff interview, the facility failed to provide care planned approaches to prevent skin breakdown and pressure ulcer development for 1 of 4 sampled residents (Resident #1) with a history of pressure ulcers. Failure to consistently implement approaches for pressure relief (i.e. use of positioning device) may result in skin breakdown and pressure ulcers.<br><br>Findings Include:<br><br>Review of the facility policy titled, "Positioning" occurred on 10/12/16. This policy, revised March 2008, stated, "Purpose: 1. To promote comfort. 2. To prevent skin breakdown. . . . 5. Used | F 314 | Napoleon Care Center will provide care planned approaches to prevent skin breakdown and pressure ulcer development for our residents at risk.<br><br>1. Resident #1 will be provided care planned approaches to prevent skin breakdown and pressure ulcers which include: blue boots to bilateral feet and gel cushion when resident is lying on his side in bed, a heel off device when he is lying on his back in bed.<br>2. Care planned approaches to prevent skin breakdown and pressure ulcer development will be provided to all residents who are at risk. | 11/16/16 |

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

Electronically Signed | 10/27/2016

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| F 314 | Continued From page 1<br>positioning devices as indicated. . . ."<br><br>Review of Resident #1's medical record occurred October 10-12, 2016. Diagnoses included healed pressure ulcers to right and left heels, peripheral vascular disease, anemia, and type 2 diabetes. A quarterly Minimum Data Set, dated 07/12/16, identified extensive assistance of two or more staff for bed mobility. The current care plan stated, ". . . Problem/Need . . . SCHEDULED CARE TASK . . . Approaches . . . Elevate heels off of bed. . . . Problem/Need, POTENTIAL SKIN BREAKDOWN: . . . L [left] heel pressure ulcer noted 9/17/12. . . . Hx [history]: Pressure Ulcer R [right] heel noted 02/27/13 (healed). . . . 3/3/16 All foot ulcers healed. . . . Approaches . . . When lying on back- Use heels off device, no blue boots/heel protectors needed. When side lying- do not use heels off device, put blue boots on & [and] place feet on top of gel pad."<br><br>A physician's order, dated 03/03/16, stated, "Keep feet protected at all times . . ." A physician encounter and procedure note, dated 04/08/16, stated ". . . Nurse reported heel worse. . . . Patient's left heel doing well. Concern about sloughing graft is not an issue. Patient has scabbed over previous ulcer and this is starting to slough off. This was gently debrided to reveal healthy tissue underneath. . . . Patient is advised to continue to offload the heels. He can start to stand, although wife states he is afraid to as he does not want to break down again. . . ." A physician order, dated 04/08/16, stated, "Offload heels, fine to shower, no need for dressing on feet."<br><br>Observation on 10/11/16 at 9:27 a.m. showed | F 314 | 3. Education will be provided to CNA's, CMA's and nurses at their November staff meeting on proper placement and positioning of resident #1 heel floatation cushion. Education will also be provided on other skin breakdown and pressure ulcer prevention techniques that are ordered and care planned for our residents at the November staff meeting. The float pm aide has forms to complete each shift that checks the residents who are ordered pressure relieving devices that they are in place. If they are not in place, they are to apply them and document on their form, which is reviewed by the charge nurse and ADON. The ADON will check weekly a random number of residents for proper prevention devices in place. The night nurse will complete a daily check around midnight for proper positioning of devices for resident #1.<br>4. Napoleon Care Center will monitor resident #1 and a random sample of residents that have pressure ulcer preventative measures care planned for proper placement daily with monthly summaries x 3, then quarterly by ADON. Reviewed at monthly QA meetings.<br>5. Completion date November 16, 2016. | |

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| F 314 | Continued From page 2<br>two certified nurse aides (CNAs) (#1 and #2) assisted Resident #1 from his wheelchair to his bed. The CNAs (#1 and #2) positioned the resident on his back and placed the top of the heels off device midway up and behind the resident's calves. This placement caused Resident #1's heels to rest on the device.<br><br>Observation on 10/11/16 at 11:20 a.m. showed two CNAs (#3 and #4) transferred Resident #1 out of bed. Resident #1's feet remained positioned on the heels off device as described on the 9:27 a.m. observation. Staff failed to properly position the heels off device for approximately two hours.<br><br>Observation on 10/11/16 at 3:10 p.m. showed Resident #1 in bed on his back, with his feet on the gel pad identified by the care plan as used with blue boots when he lies on his side. The staff failed to use the heels off device as care planned.<br><br>During an interview on 10/11/16 at 4:15 p.m., a licensed nurse (#7) stated when staff position the heels off device for Resident #1, they are to place it up to his knees so that his feet float and do not come in contact with the mattress or the device when he is on his back.<br><br>During an interview on 10/12/16 at 11:50 a.m., an administrative staff member (#8) confirmed when Resident #1 lays on his back, staff should place the heels off device behind his calves and float his feet above the mattress. | F 314 | | |
| F 328 SS=D | 483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS | F 328 | | 11/16/16 |

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| F 328 | Continued From page 3<br>The facility must ensure that residents receive proper treatment and care for the following special services:<br>Injections;<br>Parenteral and enteral fluids;<br>Colostomy, ureterostomy, or ileostomy care;<br>Tracheostomy care;<br>Tracheal suctioning;<br>Respiratory care;<br>Foot care; and<br>Prostheses.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, review of facility policy, review of professional reference, and staff interview, the facility failed to safely store oxygen cylinders in 1 of 1 oxygen storage room. Failure to store an oxygen tank securely placed residents, staff, and visitors at risk for harm.<br><br>Findings include:<br><br>Review of the policy titled "OXYGEN STORAGE" occurred on 10/12/16. This policy, revised October 2013, stated, ". . . The oxygen cylinder tanks will be secured upright either in the designated oxygen holder or chained securely to the wall. . . ."<br><br>National Fire Protection Association 55, 7.1.4.4 states, "Compressed gas containers, cylinders, and tanks in use or in storage shall be secured to prevent them from falling or being knocked over by corralling them and securing them to a cart, framework, or fixed object by use of a restraint, . . . " | F 328 | Napoleon Care Center will ensure residents receive proper treatment and care by properly storing the facilities oxygen tanks.<br><br>1. All oxygen tanks will be securely stored according to policy.<br>3. Maintenance staff will check oxygen tanks for proper storage Monday - Friday, with the charge nurse checking on weekends and holidays. Nurses, CMA's and CNA's will be educated at the November staff meeting on proper oxygen storage per NCC policy.<br>4. Napoleon Care Center will monitor oxygen storage sign off sheets with monthly summaries x 3 then quarterly by maintenance supervisor. Reviewed at monthly QA meeting.<br>5. Completion date November 16, 2016. | |

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| F 328 | Continued From page 4<br><br>Observation of the oxygen storage room occurred on 10/10/16 at 2:50 p.m. with a nurse manager (#7). Observation showed an unsecured oxygen tank. The nurse manager (#7) stated she expected the oxygen tank to be secured. | F 328 | | |