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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355041	A. BUILDING _____ B. WING _____	04/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN HOME OF THE GOOD SHEPHERD	1226 1ST AVE N NEW ROCKFORD, ND 58356

(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 04/11/11 and completed on 04/14/11, the sample included 4 residents for complete review, 9 residents for focused review, and 2 closed records for review.	F 000	E Kjelson 5.12.2011 RECEIVED MAY 13 2011 Division of Medical Facilities	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance	F 225	1. Effective immediately (4/14/11) of Concerns regarding abuse, neglect, mistreatment of residents or misappropriate of their property will be investigated with-in 5 working days, contact the Department Health by Administration. In the absence of the administrator a designated staff member will contact the Department of Health an investigation as required by law. Monitoring and thorough documentation/evaluation will be completed by the delegated member of the abuse committee the report will be given to the Administrator to place in the file or send to the Dept. of Health to review. The Administrator will complete a final report for the health department listing the date, time the health department was contacted and who the concern was reported to. A QA will be completed by the Administrator quarterly for one year and annually thereafter. Educational training will be completed on 5/09/11 for the CNA's, 5/11/2011 for the nursing staff and all other staff members on May 18th, 2011.	5/18/2011

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Eloise K. Kjelson — TITLE: Admin/CEO — (X6) DATE

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 225	Continued From page 1 with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, review of policy and procedure, and staff interview, facility staff failed to complete a thorough investigation for 1 of 1 sampled resident (Resident #9) identified with a fracture of unknown origin. Failure to investigate all alleged violations involving mistreatment, including injuries of unknown origin, report these allegations immediately to the administrator and to other officials in accordance with State law, prevent further mistreatment from occurring, and implement corrective action, does not allow the facility to determine causative factors of incidents, and places residents at risk for potential mistreatment, neglect or abuse. Findings include: Review of the facility policy titled "Abuse, Neglect, Injuries of Unknown Source and Misappropriation of Patient Resident Property. (Investigation and Reporting Process)" occurred on 04/14/11. This policy, dated 03/01/10, stated: "PURPOSE: To set forth guidelines to: . . . ensure that all alleged violations involving mistreatment, neglect, and abuse, including injuries of unknown source . . . are reported immediately to the administrator of the facility and to other officials in accordance with State law	F 225		

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F 225	Continued From page 2 through established procedures (including the State survey and certification agency). . . . INJURIES OF UNKNOWN SOURCE: An injury should be classified as an 'injury of unknown source' when both of the following conditions are met: The source of injury was not observed by any person or the source of the injury could not be explained by the resident; and The injury is suspicious because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidence of injuries over time. . . . COMPONENTS OF PROGRAM: 4. Identification: a. Events, such as suspicious bruising of patients/residents, . . . that may constitute abuse will be reported to nursing administration and investigated. . . 5. Investigation: a. The facility will immediately address any suspicious events . . . injuries of unknown source . . . b. Administration will coordinate the facility's investigation . . . c. Investigations will be done in a timely manner. d. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including the State survey and certification agency) within five working days of the alleged incident, and if the alleged violation is verified, appropriate corrective action must be taken. . . . i. Occurrences will be analyzed to determine what changes are needed, if any, to policies and	F 225		

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F 225	Continued From page 3 procedures to prevent further occurrences. . . . 7. Reporting Response: a. The Administrator, Director of Nursing, or Director of Social Services will make a telephone report to the State Health Department within the first working day an allegation is received. . . . b. Facilities must report all alleged instances . . . including injuries of unknown source . . . as required by 42 CFR & 483.13 (c)(2) and (4) referenced above. This means that all alleged instances must be reported immediately and that the results of the facility's investigation must be reported in five working days. . . ." - Review of Resident #9's record occurred on all days of survey. Resident #9's diagnoses included diabetes mellitus, right below the knee amputation on 12/16/08, Alzheimer's dementia, severe osteoporosis, and a left distal fibula fracture which occurred 10/15/10. Resident #9's quarterly Minimum Data Set (MDS), dated 09/26/10, identified the resident with short and long term memory problems, moderately impaired in daily decision making, usually able to understand, and usually able to understand others. The MDS identified the resident required extensive assistance of one person for transfers. Review of Resident #9's nurses notes for 10/15/10 included the following entries: * 4:20 a.m.: "Focus: Bruise; D) [Data] Large purple bruise noted to [left] outer ankle/foot. Admits to hurting. A) [Assessment] Will monitor." The nurse identified she notified the resident's son of the bruise. * 2:30 p.m.: "Remains very tender facial grimacing noted when touched, swollen to [left]	F 225		

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F 225	Continued From page 4 leg lift used to transfer A: sent for xray of (L) leg due to [increased] pain [increased] swolling [sic]. D: DON [Director of Nurses] notified. * 5:00 p.m.: "Administrator notified. R: [response] Cam boot applied per OT [occupational therapy] & [physician's name]. R: orders observed. A: Family notified." Review of the physician progress note, dated 10/15/10, stated, ". . . 92-year-old who is here with left foot pain. Staff noted that he was black and blue and swollen in the lateral aspect of his foot. They have no idea what happened with it. They claim that he has not fallen at all at the Lutheran Home. The patient really doesn't communicate very well. When I ask him if it hurts he just kind of laughs at me but when I push on the lateral malleolus he gets pretty angry and states 'yep that is where it hurts.' He doesn't know if he has fallen. He really doesn't have any complaints or concerns for me. He doesn't really know why he is here today. . . . A: LEFT FIBULAR FRACTURE. . . . We are going to put the patient in a CAM walker [restrictive boot worn for severe ankle sprains, soft tissue injuries, and/or fractures of the lower leg], keep him non-weight bearing . . ." On the afternoon of 04/12/11, a request for the investigation of the injury of unknown origin occurred. Two administrative staff members (#3 and #8) provided the "Injury of Unknown Origin" report form and an "EMPLOYEE RESIDENT INVESTIGATION REPORT" narrative. The injury of unknown origin form identified the same information as reported in the nurses notes at 4:20 a.m. on 10/15/10 as well as the resident's condition during the night of, not "Resistive with cares," no "Fragile skin," no "Recent fall,", no	F 225		

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F 225	Continued From page 5 "Use of mechanical lifts," and not "Suspicious in nature." The backside of the form identified one interview occurred on the afternoon of October 15, 2010 at 2:00 p.m. with a CNA who worked the previous evening. The interview identified the resident had no bruise noted that evening, denied the resident had a fall that evening, reported the resident transferred with an stand (EZ) lift, and had no difficulty with the stand lift that evening. The form did not identify if the CNA followed the plan of care for the transfer (i.e., one or two assist). The Investigation Report identified an Xray taken of the resident's foot, and the identification of a fracture. The investigation report lacked the following: * interviews with other staff working the evening of 04/14/10. * interviews with staff working the night shift of 04/15/10. * a review of Resident #9's record for other possible contributing factors. * an environmental analysis of Resident #9's room, including evaluating whether facility staff had utilized side rails on the resident's bed on the night the injury occurred. Observation on survey identified the presence of four quarter side rails attached to the resident's bed. * whether the staff member transferring the resident on the evening of 10/14/10 followed the resident's care plan. * whether staff on the night shift of 10/15/10 performed any transfers or repositioning during the night. * an evaluation of the transfer method staff utilized for the resident with a below the knee amputation of the right leg, without a prosthesis. * an analysis of all contributing factors that may	F 225		

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F 225	Continued From page 6 have caused the fracture, including the resident's diagnosis. With the completion of a thorough investigation, the facility could assure no mistreatment, abuse or neglect occurred, and the facility could put measures in place to prevent future reoccurrences. The investigation report also identified the facility failed to notify the State agency of the injury of unknown origin. An interview occurred on the morning of 04/13/11 with an administrative staff member (#8). The staff member agreed a more thorough investigation of the fracture should have occurred and stated the State agency was not notified of the injury of unknown origin at any time, and agreed this should have occurred.	F 225		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, record review, and staff interview, the facility failed to provide an ongoing, meaningful activity program to meet the physical, mental, and psychosocial needs of 2 of 4 sampled residents (Resident #1 and #11) residing in the facility's special care dementia unit. Failure to provide meaningful activities designed to reflect each resident's interests and individual status has the	F 248		

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F 248	Continued From page 7 potential to negatively impact a resident's overall well-being. Lack of meaningful activities may have contributed to Resident #1 and Resident #11's wandering and mood/behavior symptoms, resulting in increased restlessness, agitation, and isolation. Findings include: Review of the facility policy titled "Activities for Impaired Cognitive Residents" occurred on 04/14/11. This policy, dated 01/13/10, stated, "Purpose: Is to provide activities for the cognitively impaired meeting the requirements of the federal, state and facility policy . . . A) On going program of activities that is designed to appeal to his/her interests and to enhance the resident's highest level of physical, mental and psychosocial well-being. B) One-One programming for each resident to [sic] their needs C) Validation working with memory items of their individual past. D) Involve in small group activities that keeps the residents' interest for short periods." - Review of Resident #1's medical record occurred on all days of survey. Diagnoses included dementia, agitation, anxiety, and psychotic disorder. Psychotropic medications for Resident #1 included Seroquel 100 milligrams twice daily. Resident #1's current re-admission Minimum Data Set (MDS), dated 03/28/11, identified moderately impaired daily decision making skills and long-term and short-term memory problems. The MDS showed the resident with a variety of mood and behavior symptoms, including physical behavioral symptoms directed toward others, other behavioral symptoms not	F 248	1. Corrective action took place for activity staff regarding residents # 1 and # 11 by memo on May 11. It will be further reviewed at the monthly activity staff meeting in May. 2. All residents have the potential of not having their activity needs met. Activity preferences will be reviewed for all residents. Special care will be taken in educating staff regarding re-approaching resident if disinterested or agitated at the time an activity is offered. 3. Other staff in addition to activity staff will be retrained as to what activities residents have been interested in. Returned personal interest forms will be reviewed with staff in special care unit during Angel Wing unit meeting May 11. Education to all staff will be done by memo on May 11, 2011 and further reviewed at the all staff in-service in May. Other staff will be educated on further documentation on activities, specifically a numbering system now being used by activity staff. Continued on next page.	5/11/2011

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F 248	Continued From page 8 directed toward others, rejection of care, and daily wandering. The MDS also identified the resident required extensive assistance of one staff member for locomotion on and off the unit, rarely/never able to understand others, and sometimes able to make himself understood. Review of Resident #1's current care plan identified "Resident has limited attendance in activity program." The care plan identified the goal of "I sometimes like to watch TV and visit. I like to reminisce about my Alaskan fishing trip and push myself around in w/c [wheelchair]." The care plan listed the following approaches: coffee time in AM and PM, provide reading material as resident wishes, small group activities (on unit, if willing), introduce to other residents, barber shop, TV in room, honor resident's wishes and choices, activity calendar in room, observe for further interests, and visits prn (as needed). Observations of Resident #1 occurred throughout the survey and revealed the following: * 04/12/11 at 8:15 a.m.- Sitting in wheelchair at the dining room table (nothing on table) looking around the room. * 04/12/11 at 8:30 a.m. - Devotions being read aloud to all residents in dining room. Resident sitting in wheelchair looking around and self-propelling. * 04/12/11 at 8:40 a.m. - Sleeping in wheelchair. * 04/12/11 at 9:25 a.m. - Self-propelling in wheelchair in the hallway. * 04/12/11 at 9:50 a.m. - Sitting in wheelchair, dozing on and off. * 04/12/11 at 10:40 a.m. - Self-propelling in w/c, repeatedly pressing on bar to open door to go outside, wandered into another resident's room. A staff member took the resident back to the main	F 248	4. The corrective action was completed on May 11. 5. The corrective action will be monitored by the activity director. The activity director will submit a report of monthly results to the QA committee. The activity director will monitor the information on a sample group of residents weekly for 4 weeks, then monthly for 3x, then quarterly 3x.	5-11-2011

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activity/dining area and visited with the resident, approximately two minutes. Resident said "no" in a calm manner when asked if he wanted to roll a ball with the other residents. Staff made no further attempts to re-approach the resident and failed to engage the resident in a different activity he might enjoy.
* 04/12/11 at 11:25 a.m. - Self-propelling in hallway. Knocking on closed doors. Wandered into another resident's room. A staff member took the resident back to the activity/dining area and visited with the resident for approximately one minute. No activity provided.
* 04/12/11 at 12:05 p.m. - Sitting in w/c in the hallway.
* 04/12/11 at 2:20 p.m. - Sitting in w/c in the hallway.
* 04/12/11 at 3:10 p.m. - Sitting in w/c having a snack.
* 04/12/11 at 4:00 p.m. - Sitting at table (nothing on table), occasionally self-propels around room.
* 04/12/11 at 4:40 p.m. - Self-propelling/wandering in hallway. Knocking on doors. Taken back to activity/dining area by staff. No activity provided.
* 04/13/11 at 8:20 a.m. - Sitting up to table (nothing on table), no stimulation. Resident stated, "Well, I better get going." Started to self-propel around room.
* 04/13/11 at 9:25 a.m. - Sitting in w/c by tables. No interaction or stimulation. Resident looking around room. A staff member sat at a table nearby and was reading the paper to herself. The staff member failed to read the paper aloud so Resident #1 and other residents could listen.
* 04/13/11 at 9:45 a.m. - Declined to lay down. Sat in w/c in dining room area and given a dietary supplement.
* 04/13/11 at 10:25 a.m. - Sitting up to the table in

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F 248	Continued From page 10 w/c. A board with various locks sitting on the table in front of resident. Resident was not engaged. Resident #1 was looking around the room and not attempting to manipulate any of the locks on the board. * 04/13/11 at 1:45 p.m. - Laying in bed. * 04/13/11 at 3:05 p.m. - Self-propelling/wandering in hallway. Re-directed and taken back to activity/dining area. No activity provided. * 04/13/11 at 3:40 p.m. - Repeatedly pushing on the bar to open the door to go outside. Continued to self-propel and wander in hallway. The above observations showed the facility failed to provide ongoing individualized and engaging activities to Resident #1 and failed to consistently implement the activity approaches identified in the resident's care plan. During an interview on 04/12/11 at 4:15 p.m., when asked what activities staff are to do with Resident #1, an activity staff member (#12) stated, "You know he wanders in the hallway and self propels a lot." The staff member (#12) stated the resident has a short attention span, but she encourages staff to engage the resident by reading the paper to him, bringing him to devotionals, and visiting with him one to one. The staff member (#12) stated she considers a one to one activity to be anywhere from 5 to 15 minutes, depending on the resident and if they are receptive to visiting that day. On 04/13/11 at 9:35 a.m., a certified nursing assistant (CNA) (#13) stated Resident #1 likes games, cards, and pictures and indicated his participation level varies day to day.	F 248		

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F 248	Continued From page 11 An activity staff member (#11), on 04/13/11 at 10:00 a.m., stated she has daily one to one visits with Resident #1. She stated the time varies from 2 to 15 minutes, depending on his mood. The staff member (#11) stated if Resident #1 becomes agitated, she will ask him to work on a tool board, but stated he prefers to be left alone when he is agitated. - Review of Resident #11's medical record occurred on 04/13/11. Diagnoses included Alzheimer's dementia with severe behavioral disturbance, anxiety, agitation, and impulse control disorder. Psychotropic medications for Resident #11 included Risperdal 0.5 milligram twice daily. Resident #11's current quarterly MDS, dated 03/20/11, identified severely impaired daily decision making skills and long-term and short-term memory problems. The MDS showed the resident with a variety of mood and behavior symptoms, including physical behavioral symptoms directed toward others, other behavioral symptoms not directed toward others, rejection of care, and wandering. The MDS also identified the resident sometimes understands others, and sometimes makes herself understood. Review of Resident #11's current care plan identified "Resident has limited attendance in activity program." The care plan identified the goal of "Resident will be encouraged to sit and rest during the day for 1-1 [one to one] activities and listen to reading." The care plan listed the following approaches: inform/invite and encourage to attend activities, assist as needed; coffee time in AM and PM, provide reading material and crafts as resident wishes and house therapy if willing; small group activities if willing;	F 248		

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	355041	A. BUILDING _____ B. WING _____	04/14/2011

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F 248	Continued From page 12 introduce to other residents; beauty shop; TV in room; watches TV in sitting room; honor resident's wishes and choices; activity calendar in room; observe for further interests; and visits prn. Observations of Resident #11 occurred throughout the survey and revealed the resident spent her time doing the following: * Sitting in a chair by the dining room. No engaging activities attempted with resident. * Laying in her bed in silence. * Sitting in a chair by the dining room being fed by a staff member for meals. During an interview on 04/13/11 at 10:00 a.m., when asked what activities staff are to do with Resident #11, an activity staff member (#11) stated the resident doesn't really talk, but staff will visit with her, sit by her, and look at her photo book. On 04/13/11 at 4:00 p.m., an activity staff member (#12) stated residents should be provided with engaging and stimulating activities. The facility failed to develop an ongoing, meaningful, and individualized activity program designed to meet the current physical, mental, and psychosocial needs for Resident #1 and #11. The facility failed to consistently provide stimulating and engaging activities to these residents and failed to adapt their activity program to their changing needs. Failure to implement an individualized activity program did not allow staff to consistently implement and monitor the effectiveness of planned diversional activities to respond to Resident #1 and #11's behaviors. A well-developed and individualized activity program could potentially decrease the residents'	F 248		

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F 248	Continued From page 13 wandering, restlessness, and aggressive behaviors; decrease the need for psychotropic medications; and improve the residents' quality of life.	F 248		
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, resident interview, and staff interview, the facility failed to assess the benefits of pain medications and provide additional pain relieving interventions, for 1 of 1 sampled interviewable resident (Resident #6) with complaints of pain. Failure to provide additional pain relieving interventions or consider additional pain medications resulted in Resident #6 experiencing unrelieved pain. Findings include: Review of the facility policy and procedure, Pain, occurred on April 13-14, 2011. This policy, revised 09/10, stated "Purpose: To ensure that pain relief defined by a mutually determined goal by resident and/or family and staff is provided for each individual resident according to their individual needs. Policy Statement: It is the expectation of all staff	F 309		

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F 309	Continued From page 14 that pain can and will be relieved according to the goal determined by the resident and/or family. . . . Every resident will have a pain screening done at admission, quarterly, with onset of new pain, with a change in intensity of pain, or with a significant change in condition. Residents can expect the staff to believe their reports of pain and that the staff will respond appropriately and on a timely basis. . . . A pain management team is responsible to ensure the goals of pain management are met. The pain management team will meet prn [as needed] to review residents with pain issues. . . ." Resident #6's medical record included a hospital admission note, dated 12/24/10, which stated "ADDENDUM: . . . The major problem exists here with regards to her hips. Her right hip does not exist; it is basically fused. The left hip is almost as bad. It contains a central 2-centimeter in diameter through and through lesion which looks like an active area of bone destruction vesicular in nature, extending at least through the length [sic] of the bone has occurred. My guess would be that this is painful. . . . This lady is currently taking Percocet 1/2 tablet [sic] of the 5/325 mg [milligrams] [5 mg oxycodone hydrochloride/325 mg acetaminophen (narcotic pain reliever)] per day. She is 85 years of age. She is running out of her medicine early which means that she is taking more than 4 doses a day; each dose for her 1 1/2 taken four times daily. . . . trying to to keep her functional which means to keep her pain free; pain of which she has plenty of. . . . treating her pain is the most important factor to be considered here rather than deciding on how much pain medicine to use. The latter point [treating her pain] is an extraordinarily important but one has to work with	F 309	1. Corrective action took place for resident # 6 on 4/14/11 with the need for reduction in medications due to lethargy and decline in ADLS. Further changes made with resident # 6's pain medication regime and further evaluation of pain control will continue. 2. All residents have the potential for the need for pain management. 3. Education on proper pain management was reviewed with the Resident Care Coordinators on 4/14/11 and with the RN/LPNs on 5/11/11/ (see attachment C) 4. Corrective action completed on 5/11/11. 5. A QA was developed to monitor adequate pain management. The DON will assign nursing staff to perform a QA on 1 resident with the need for pain management weekly x 4. 1 resident monthly x 3, and then 1 resident quarterly x 3 and then evaluation for further review. (see attachment D)	5/11/11

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F 309	Continued From page 15 it to accomplish the primary point which is to treat her pain which is definitely severe." Review of Resident #6's medical record occurred on April 11-14, 2011. The facility admitted Resident #6 in January 2011 after hospitalization for pain control and a fall. The resident's diagnoses included cellulitis, peripheral vascular disease, osteoarthritis, and degenerative joint disease. The resident's admission Minimum Data Set (MDS), dated 01/11/11, and quarterly MDS, dated 04/01/11, identified the resident was cognitively intact, received scheduled and PRN pain medications, experienced almost constant pain that did not limit her sleep or day-to-day activities. The MDS, dated 01/11/11, identified Resident #6 required extensive assistance of one person and a walker to ambulate in her room and the hallway, identified her pain intensity on a scale of 0-10 (no pain to worst pain) as "5;" and, the MDS, dated 04/01/11, identified limited assistance of one person for ambulation and pain intensity of "9." Resident #6's Activities of Daily Living (ADL) Care Area Assessment (CAA), dated 01/17/11, stated ". . . She was having a lot of knee pain, decreasing her mobility. . . . We hope to get her pain under better control . . ." The resident's Pain CAA, dated 01/17/11, identified Resident #6's increased pain may increase her behaviors, and stated ". . . pain . . . causing a decline in function which is demonstrated by this resident's: poor mobility and c/o [complaints of] of knee pain. . . . will always have some arthritic pain in her knees but we hope to get it under better control and allow her more mobility and comfort. She was recently started on a Fentanyl patch for better pain control. Her pain ranges from a 5-10 and she	F 309		

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F 309	Continued From page 16 gets several Norco [narcotic pain reliever] pills prn qd [every day]. . . ." Resident #6's current care plan, dated 01/17/11, identified monitoring of pain and medications as directed by the resident's physician. Resident #6's physician orders for pain medications included: *01/04/11, admission - Fentanyl (opioid analgesic), transdermal patch, 12 micrograms per hour (mcg/hr), every 72 hours (q72hr). - Gabapentin (anticonvulsant for nerve pain), 100 mg two times each day (bid). - Flurbiprofen (nonsteroidal anti-inflammatory drug), 100 mg, bid, PRN. - Norco 5/325 (5 mg hydrocodone/325 mg acetaminophen), 1 1/2 tablets, four times each day (qid), PRN. *02/09/11 - Increased Fentanyl patch to 25 mcg/hr, q72hr. *03/01/11 - Discontinued Flurbiprofen. *03/14/11 - Tylenol (Acetaminophen) Extra Strength 750 mg, q4hr, PRN. *03/21/11 - Increased Fentanyl patch to 75 mcg/hr, q72hr. *03/25/11, return from hospital - Morphine IR (Immediate Release) 15 mg, bid. *03/29/11 - Changed Morphine IR 15 mg, from scheduled bid to PRN bid. Review of Patient #6's PRN Medication Administration Records (MARs) for February, March, and through April 12, 2011 identified the following frequency of PRN pain medications for back, knee or leg pain: *Flurbiprofen - February, two times. *Norco - February, 81 times; March, 91 times;	F 309		

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F 309	Continued From page 17 April, 38 times; as frequently as every 3 hours 20 minutes (03/20/11). *Tylenol Extra Strength - 11 times. *Morphine IR - none. (Facility staff did administer this medication on 04/13/11 after this issue was discussed with the facility staff.) Comments for the PRN pain medications, including Flurbiprofen and Tylenol, showed Resident #6 obtained pain relief with all of the PRN medications. During interview, on 04/12/11 at 10:50 a.m., with Resident #6, identified by the facility as interviewable, she reported the increased dose of Fentanyl on 03/21/11 did not provide much pain relief and she must still request additional pain medication three or four times each day. She reported some frustration with the facility staff delaying providing the PRN medications or questioning the need and questioned if the facility staff were "worried about being addicted" and her age of "85." During interview, on 04/13/11 at 8:15 a.m., a supervisory nursing staff member (#14) reported assessments of the resident's pain are done with the MDS and on the MARs when medications are administered. This staff member reported Resident #6 recently changed physicians after the resident's previous physician questioned the resident's need for pain medications. This staff member (#14) confirmed Resident #6 received the PRN pain medications three to four times each day, in addition to the scheduled pain medications. It is unknown why the facility staff did not provide the PRN Morphine IR until 04/13/11. The physician identified Resident #6's pain issue,	F 309		

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F 309	Continued From page 18 use of pain medications, and difficulty with pain control prior to admission. The facility staff continued to administer PRN pain medications, including the narcotic Norco, three to four times each day in addition to increased amounts of the scheduled opioid, Fentanyl. The facility failed to assess Resident #6's pain control program except to increase the Fentanyl. Despite this increase Resident #6 continued to request the PRN pain medication three to four times each day. Failure to fully assess Resident #6's pain, pain control program, and pain medications resulted in Resident #6 continuing to experience pain, limited mobility, and potential for behaviors, as identified by the facility.	F 309		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy/procedure, record review, and staff interview, the facility failed to provide supervision and assistive devices necessary to prevent accidents for 2 of 2 sampled residents (Resident #2 and #3) residing on the special care dementia unit and observed during transfers. Failure to use gait belts appropriately has the potential for residents to experience falls, injuries, and/or pain.	F 323	1. Corrective action took place for resident # 2 and # 3 in regards to following the care plan for proper transfer technique and education on proper use of transfer belt on 4/14/11. Further education was given on 4/18/11 at an all staff in-service on 5/9/11 at a CNA meeting. 2. All residents requiring assistance with transfers have the potential to be affected by improper transfers. 3. Staff was educated at an all staff in-service on 4/18/11 and the CNA meeting on 5/9/11; and LPH/RN will be educated at nurses meeting on 5/11/11 on proper use of transfer belt and following care plan for transfer method. Continued on next page	5/11/11

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F 323	Continued From page 19 Findings include: Review of the facility policy titled "Transfers with use of Transfer Belts/Mechanical Lifts" occurred on 04/14/11. This policy, dated 01/04/08, stated, "If a resident needs hands on assistance of trained staff for balance or lifting and maintaining standard position, transfer belt/gait belt must be used, unless otherwise care planned. The resident must be able to bear some weight once in standing positioning; 1 or 2 person assist may be used as care plan indicates . . . The use of assistive devices for transfer will be care planned for each individual requiring assistance with transfers . . ." Review of the facility policy titled "Applying a Transfer Belt" occurred on 04/14/11. This policy, revised 01/04/08, stated, "Use of Transfer Belt: Transfer belts are to be used when any contact is required for balance or weight bearing assistance . . . 5. Assist the resident to a sitting position. 6. Place the belt over the resident's clothing and around the waist. 7. Tighten the transfer belt until it is snug. Leave enough room to insert at least 2 fingers into the belt. The fingers should fit comfortably under the belt . . . 9. Assist to standing. Recheck belt for proper snugness. Tighten belt if needed. Be sure that transfer belt does not ride up under shoulders or breasts for comfort measures. 10. Positioning of transfer belt/gait belt may vary due to medical condition/resident preference as care plan indicates." - Review of Resident #3's medical record occurred on all days of survey. Diagnoses	F 323	4. Corrective action will be completed on 5/11/11. 5. A QA is in place to monitor proper use of transfer belt and safety during transfers. Two residents and 2 CNAs per week times 4; 1 CNA and resident monthly times 3; and evaluation for further review by staff development coordinator or her designee.	

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F 323	Continued From page 20 included dementia, pain, behaviors, and osteoarthritis. The resident's medical record identified the resident fell at home prior to admit and fractured her pelvis. The resident's most recent fall at the facility occurred on 03/26/11. Review of Resident #3's admission Minimum Data Set (MDS), dated 01/18/11, identified the Brief Interview for Mental Status (BIMS) summary score of five, indicating severely impaired cognition. The admission MDS showed the resident required extensive assistance of two or more staff members for transfers and toilet use and revealed Resident #3 has a history of falls. Resident #3's current ADL (activities of daily living) care plan identified the resident transferred with assistance of one staff member and a gait belt. The most recent transfer assessment, dated 01/11/11, recommended staff transfer Resident #3 with a gait belt and two staff members or with a mechanical lift (EZ stand) if needed. Observations of Resident #3 during transfers revealed the following: * 04/12/11 at 8:30 a.m. - A certified nursing assistant (CNA) (#4) assisted Resident #3 with toileting. The staff member (#4) failed to utilize a gait belt when transferring the resident. Resident #3 was unsteady and took small, shuffling steps as she pivoted to the toilet while holding the grab bar on the wall in the bathroom. * 04/12/11 at 3:50 p.m. - Two CNAs (#5 and #6) assisted the resident with toileting. Resident #3 utilized the grab bar on the wall next to the toilet and took small shuffling steps to transfer between her wheelchair and the toilet. The staff members failed to utilize a gait belt during the transfer.	F 323		

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F 323	Continued From page 21 * 04/13/11 at 10:20 a.m. - A CNA (#7) assisted Resident #3 with toileting. The staff member (#7) asked the resident if she wanted to use the gait belt and the resident responded in a calm manner, "I don't think we need that." The staff member failed to change her approach and did not re-attempt to use the gait belt. The resident used the grab bar to pivot from her wheelchair to the toilet and used a walker to transfer from the toilet back to her wheelchair. Resident #3 was unsteady and took small, shuffling steps as she transferred. During the transfer, the resident stated, "my left leg is no good today." - Review of Resident #2's medical record occurred on all days of survey. Diagnoses included degenerative joint and disc disease, alzheimer's dementia with behaviors, chronic pain, and arthritis. The resident's medical record identified the resident fell at the facility and fractured her left hip on 02/22/11. The resident's most recent fall at the facility occurred on 03/20/11. Resident #2's current significant change MDS, dated 03/10/11, identified the BIMS summary score of four, indicating severely impaired cognition. The MDS showed the resident required extensive assistance of two or more staff members for transfers and revealed Resident #2 has a history of falls. Resident #2's current ADL care plan identified the resident transferred with assistance of one to two staff members. The most recent transfer assessment, dated 03/04/11, recommended transferring Resident #2 with a gait belt and two staff members or the use of a mechanical lift (EZ stand) as needed.	F 323		

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F 323	Continued From page 22 During an observation on 04/12/11 at 2:45 p.m., two CNAs (#5 and #6) transferred Resident #2 from her bed to her wheelchair using a gait belt. During the transfer, the gait belt remained loose and rose to the resident's axilla (arm pits). The staff members failed to reposition and tighten the gait belt. Resident #2 was unsteady and unable to bear full weight and assist with the transfer. During an interview on 04/13/11 at 4:30 p.m., a nursing staff member (#3) stated she expected staff members to use gait belts appropriately when transferring residents who required assistance.	F 323		
F 441 SS=B	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.	F 441		

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F 441	Continued From page 23 (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 (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, review of facility policy and procedure, and staff interview, the facility failed to ensure contracted workers practiced good hand hygiene after handling soiled linen and handled, processed, and transported soiled linen in a safe manner, during 2 of 2 days (April 12 -13, 2011) of observation of 3 of 4 resident care units (Prairie Building A, and Building B) Failure to ensure these workers did not carry the soiled linen against their clothing and between the resident care units, placed all facility residents at risk of contamination from any source of infection in the soiled linen. Findings include Review of the facility policy and procedure, "Proper Linen Handling," occurred on April 14, 2011. This policy, dated 10/05/08, stated "Purpose: Proper handling of linen is required for infection prevention	F 441	1. Corrective action took place on 4/14/11 /11 with speaking to contracted worker's supervisor in regards to proper linen handling, hand hygiene with handling soiled linens. They were instructed to supervising their workers for proper infection prevention practices. 2. All residents have the potential to be affected by infection prevention practices. 3. Education on proper handling of linens and hand hygiene was proved on 4/14/11 to contracted worker's supervisors. Further education to contracted workers and their supervisors will be provided by 5/19/11. 4. Corrective action will be completed on 5/19/11 5. A QA has been developed to insure contracted workers practice proper hand hygiene and handling of linens. One contracted worker per week x 4 and then designee.	5/19/11

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	355041	A. BUILDING _____ B. WING _____	04/14/2011

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F 441	Continued From page 24 Procedure: 1. Wash hands before touching clean linen. . . . 3. Carry linens away from your body; avoid contact between your clothing and the linen. . . . 11. After handling soiled linens, wash hands." - On 04/12/11 at 8:40 a.m., observation showed an unidentified contract worker (A) carried soiled bed linen against her body from one hallway of Building, A, to the adjacent hallway of Building B, searching for a soiled utility room. An unidentified contract worker supervisor (B) gestured from the end of the hall towards the worker and the worker entered the soiled utility room with the soiled linen. The worker (A) left the soiled utility room of Building B and returned to Building A for other tasks. It is unknown if worker (A) performed hand hygiene. - On 04/12/11 at 8:45 a.m., observation showed an unidentified contract worker (C) carried soiled bed linen against her body from Building A to the soiled utility room of Building B. The contract worker (C) left the soiled bed linen in the soiled utility room and returned to Building A. It is unknown if worker (C) performed hand hygiene. - Observation on the morning of 04/12/11, on the Prairie Unit, showed an unidentified contract worker (D) holding soiled linen against her body. This worker (D) then went down the hall leading to the soiled utility room. Observation showed this worker (D) exited the soiled utility room, walked to the linen storage closet, and obtained clean linen. - Observation on 04/13/11 at 8:55 a.m. showed an unidentified contract worker (E) carried soiled bed linen against her body to the soiled utility room in Building B.	F 441		

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F 441	Continued From page 25 During an interview, on 04/13/11 at 10:30 a.m., a maintenance management staff member (#1) and a nursing supervisory staff member (#2) reported the contract workers are from a local workshop organization and are supervised by the supervisor (B). These staff members reported the contract workers provide bed making services Monday through Friday and are not assigned to resident rooms in any type of infectious isolation. Staff member (#2) reported the facility has provided education for proper handling of soiled linen and hand washing to the organization and contract workers but did not have documentation of this education. Staff members (#1) and (#2) agreed the workers should not carry soiled linen against their bodies and should perform hand hygiene after handling soiled linen and before handling clean linen. Soiled bed linen in contact with the workers' bodies may contaminate the worker's clothing. Moving about the the facility may spread any contaminants to all resident care units, placing all facility residents, staff, and visitors at risk. Failure to ensure workers transported soiled linen appropriately and not against their bodies, failure to limit the movement of soiled bed linen from one unit to another without being bagged or secured, and failure to ensure infection control information was provided to the contract workers placed residents residing on these units at risk of contamination by any infectious organism in the bed linens.	F 441		
F 454 SS=C	483.70 LIFE SAFETY FROM FIRE The facility must be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel and the public.	F 454		

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F 454	Continued From page 26 This REQUIREMENT is not met as evidenced by Based on observation, review of professional reference, review of facility policy and procedure, and staff interview, the facility failed to comply with Life Safety Code requirement NFPA 99 for Health Care Facilities to protect the health and safety of residents, personnel, and the public, regarding oxygen storage in 1 of 1 oxygen storage area (Building B) This failure could result in an oxygen tank falling and becoming a projectile, placing residents, staff, and visitors in the area at risk of injury Findings include Life Safety Code requirements state "Nonflammable medical gas systems and equipment used for the administration of inhalation therapy and for resuscitative purposes comply with National Fire Protection Association (NFPA) 99, 13-5 1. 7-1 2, NFPA 70 " Standard for Storage, Use, and Handling of Compressed Gases and Cryogenic Fluids in Portable and Stationary Containers Cylinders, and Tanks, NFPA 55 7 1 4 4 states "Securing Compressed Gas Containers, Cylinders and Tanks 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, unless otherwise permitted by 7 1 4 4 1 and 7.1 4 4 2 7 " Review of the facility policy and procedure Oxygen Storage and Safety, occurred on	F 454	1. First corrective action is to train the staff to how to store the oxygen tanks when taking out the full tanks and how to store the empty ones to make sure they are in a secured area. 2. When a resident needs an oxygen tank each one will be put in the tank holder on the wheel chair and to make sure it is secured properly and that the empty tank is put in the storage holding corral frame so they do not tip or fall out and chains them down properly. 3. The facility will look at how much oxygen tanks we need and that they are all secured. If we need more oxygen tanks then we will need to look into getting more secured system like more tank holders. 4. The correction of the deficiency was stated right away as soon as we were told about it. 4/14/11 5. The facility will check on the storage area where the oxygen is stored to make sure they are properly placed in the holders. The facility will check the oxygen storage area monthly for six months then quarterly. The monitoring will be done by maintenance department and also nursing department.	4/14/11 Δ to 4/15/11 per phone call c Ella Rutzke 5/9/11 (Despain)

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F 454	Continued From page 27 04/13/11. This policy, dated 12/01/10, stated "Procedure: 1. Oxygen cylinders must be stored in racks with chains, sturdy portable carts, and/or approved stands. . . . 7. Oxygen cylinders may not be left free standing. They must be securely fastened at all times. . . ." During the environmental tour, on 04/13/11 at 9:30 a.m., observation identified the following: *Building B, oxygen storage room - a mobile oxygen storage rack with "E" size tanks stored horizontally on several levels with individual dividers. On top of this rack, without dividers, chains, or other restraint, were five "E" tanks. Without dividers or restraints the "E" tanks could fall off the rack. Empty spaces were available in the divided spaces of the rack. A maintenance management staff member (#1), present for the environmental tour, confirmed the five "E" size oxygen tanks were not properly secured and were a potential hazard.	F 454		
F 494 SS=B	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	F 494		

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F 494	Continued From page 28 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. This REQUIREMENT is not met as evidenced by. Based on review of the state nurse aide registry files, facility record review, and staff interview, the facility failed to ensure a certified nursing assistant (CNA) (#10) working with residents in the facility was certified The CNA (#10) provided 260 hours of nursing related services without verifying competency through certification This has the potential to affect resident care Findings include A CNA (#10) contacted the state nurse aide registry on 10/06/10 to renew her certification. The state nurse aide registry file review identified the CNA's (#10) certification expired 07/08/10 On 10/07/10, nurse aide registry personnel contacted the facility regarding the CNA's expired certification. A facility administrative nursing staff member (#3) indicated information would be provided regarding the dates and hours worked by the CNA (#10) since 08/12/10, the CNA's date of hire The staff member provided information by fax	F 494	1. Corrective action took place for CNA # 10 on 10/6/10. 2. All employees who require licensing and/or certification will be required to present proof of license or certification prior to starting work. 3. Education was provided to managers involved with employees requiring licensure and/or certification on 10/7/10. Human resources have developed a check list which includes licensure/certification. (see attachment A) 4. Corrective action completed on 10/7/10. 5. A QA was developed to monitor all new employees personnel file for proper licensing/certification. Human resources will perform a QA on all new hires and on 4 ransom employees quarterly x 4. (see attachment B)	4/14/2011 A to 04/15/11 per phone call t Ella Hutzpe 5/19/11 CDesperV

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F 494	Continued From page 29 transmission on 10/07/10 which identified CNA (#10) had worked with residents in the facility without certification for a total of 260 hours between 08/16/10 and 10/06/10.	F 494		