RECEIVED
JUL 26 2010
Division of Health Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355110	A. BUILDING _____ B. WING _____	07/08/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELM CREST MANOR	100 ELM AVE NEW SALEM, ND 58563

(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 07/06/10 and completed on 07/08/10, the sample included 4 residents for complete review, 9 residents for focused review, and 2 closed records for review. The sample included 2 additional residents to verify specific concerns during the survey.	F 000		
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 prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of policy and procedure, review of professional literature, and staff interview, the facility failed to provide pressure ulcer preventive measures for 2 of 9 sampled residents (Resident #3 and #8) the facility identified in need of preventive measures. Failure to provide pressure ulcer preventive measures for these residents placed the residents at risk of developing pressure ulcers. Findings include: The Agency for Health Care Policy and Research, U.S. Department of Health and Human Services, Clinical Practice Guideline, Number 3, "Pressure	F 314	1. High back wheelchair for Resident #3 was assessed by occupational therapy and nursing. ROHO cushion was ordered to be used in wheelchair and recliner. Dycem was placed in Broda chair of Resident #8. Monitoring of continual placement of dycem in Broda chair will be completed by the DON or designee daily x 5days, weekly x 4 then monthly thereafter. See example F314A. We will be unable to monitor ROHO cushion as resident #3 passed away. 2. All residents will have Braden Scale assessment completed with the MDS process. Residents triggering mild risk or higher for skin breakdown on the Braden Scale assessment will be referred to therapy for evaluation of needing pressure relief device. 3. Order was written on 7/9/10	

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Robert Owens — Administrator — 7/22/10

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that her safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days llowing 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 ays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued rogram participation.

CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-03

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355110	A. BUILDING _____ B. WING _____	07/08/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELM CREST MANOR	100 ELM AVE NEW SALEM, ND 58563

(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 314	Continued From page 1 Ulcers in Adults: Prediction and Prevention," May 1992, pages 20-27, states "Skin Care and Early Treatment . . . 6. Skin injury due to friction and shear forces should be minimized through proper positioning . . . Rationale. Shear injury occurs when the skin remains stationary and the underlying tissue shifts. This shift diminishes blood supply to the skin and soon results in ischemia and tissue damage. Most shear injuries can be eliminated by proper positioning. . . . Mechanical Loading and Support Surfaces . . . 5. . . . Shear forces are also generated when individuals sitting in a chair slide down in the chair. As a result of shear, blood vessels in the sacral area are likely to become twisted and distorted and tissue may become ischemic and necrotic. Shear forces have been suggested as contributing to the undermining seen in some sacral ulcers. . . . 9. For chair-bound individuals, the use of a pressure-reducing device such as those made of foam, gel, air, or a combination is indicated. . . . Rationale. Based on the results of animal experiments in pressure ulcer formation, the risk of developing a pressure ulcer can be diminished by reducing the mechanical loading on the tissue; this can be accomplished by using pressure-reducing devices. For the device to be effective, it must be individually prescribed . . ." Review of the facility's policy and procedure, POLICY AND PROCEDURE FOR PRESSURE ULCERS, occurred on 07/08/10. This undated policy and procedure stated "PURPOSE: To ensure that a resident who is admitted to the facility without a pressure ulcer does not develop a pressure ulcer unless clinically unavoidable. Also, a resident that has an ulcer receives care and services to promote healing and to prevent additional ulcers.	F 314	for use of ROHO cushion [illegible]igh back chair for Resident #3 [illegible]d dycem was placed in Brod[illegible]hair on 7/8/10 for resident #8. 4. CNA and Nurses in-[illegible]vice to be held 8-3-10 to review [illegible]essure ulcer information and polic[illegible] Residents with pressure sor[illegible]ssues will be reviewed at the mor[illegible]y interdisciplinary meetings. [illegible]e Agenda F314B Amendment 5. All residents having orde[illegible]or pressure relief devices will b[illegible] monitored for proper placeme[illegible]by DON or designee, daily x5, w[illegible]kly x4, then monthly thereafter.	08/6/10 8/6/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355110	A. BUILDING _____ B. WING _____	07/08/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELM CREST MANOR	100 ELM AVE NEW SALEM, ND 58563

(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 314	Continued From page 1 Ulcers in Adults: Prediction and Prevention," May 1992, pages 20-27, states "Skin Care and Early Treatment . . . 6. Skin injury due to friction and shear forces should be minimized through proper positioning . . . Rationale. Shear injury occurs when the skin remains stationary and the underlying tissue shifts. This shift diminishes blood supply to the skin and soon results in ischemia and tissue damage. Most shear injuries can be eliminated by proper positioning. . . . Mechanical Loading and Support Surfaces . . . 5. . . . Shear forces are also generated when individuals sitting in a chair slide down in the chair. As a result of shear, blood vessels in the sacral area are likely to become twisted and distorted and tissue may become ischemic and necrotic. Shear forces have been suggested as contributing to the undermining seen in some sacral ulcers. . . . 9. For chair-bound individuals, the use of a pressure-reducing device such as those made of foam, gel, air, or a combination is indicated. . . . Rationale. Based on the results of animal experiments in pressure ulcer formation, the risk of developing a pressure ulcer can be diminished by reducing the mechanical loading on the tissue; this can be accomplished by using pressure-reducing devices. For the device to be effective, it must be individually prescribed . . ." Review of the facility's policy and procedure, POLICY AND PROCEDURE FOR PRESSURE ULCERS, occurred on 07/08/10. This undated policy and procedure stated "PURPOSE: To ensure that a resident who is admitted to the facility without a pressure ulcer does not develop a pressure ulcer unless clinically unavoidable. Also, a resident that has an ulcer receives care and services to promote healing and to prevent additional ulcers.	F 314	for use of ROHO cushion in high back chair for Resident #3 and dycem was placed in Broda chair on 7/8/10 for resident #8. 4. CNA and Nurses in-service to be held 8-3-10 to review pressure ulcer information and policy. Residents with pressure sore issues will be reviewed at the monthly interdisciplinary meetings. See Agenda F314B	08/6/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355110	A. BUILDING _____ B. WING _____	07/08/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELM CREST MANOR	100 ELM AVE NEW SALEM, ND 58563

(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 314	Continued From page 2 PREVENTION . . . PRESSURE REDISTRIBUTION: . . . 6. When a resident is up in a chair: a. Consider postural alignment, weight distribution, sitting balance and stability and pressure redistribution. . . . c. Use pressure-reducing cushion on the seat of the chair. d. Check for bottoming out and sliding. e. Position resident to avoid sliding . . ." - Resident #3's medical record, reviewed on July 06-08, 2010, identified the facility admitted the resident on 05/17/10 following an episode of bleeding in his brain. Current diagnoses included a history of sacral and coccyx pressure ulcers. The resident's current Minimum Data Set (MDS), dated 06/13/10, identified short and long term memory problems, moderately impaired daily decision making, required total assistance of two or more persons for bed mobility and transfers, one Stage I and one Stage II pressure ulcer, and use of a pressure relieving device in a chair. The resident's admission MDS, dated 05/23/10, also identified the use of a pressure relieving device in a chair. Resident #3's physician orders, dated 06/04/10, included "ROHO cushion in recliner chair at all times." (A ROHO cushion is brand of seat cushion using air cells capable of being adjusted to the individual.) Resident #3's current care plan, dated 06/01/10, stated "Problem, . . . Mild Risk for Skin Breakdown . . . Goals . . . Free from . . . Skin Breakdown . . . Staff to anticipate resident's needs . . . Approaches . . . [modified] 06/04/10, 27. ROHO cushion in recliner @ [at] all times. . .	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355110	A. BUILDING _____ B. WING _____	07/08/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELM CREST MANOR	100 ELM AVE NEW SALEM, ND 58563

(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 314	Continued From page 3 ." Resident #3's medical record included documentation facility staff identified skin breakdown on the resident's buttocks on 05/29/10 and healed on 06/14/10. Wound Documentation, dated 05/29/10, identified the right buttock area "1 cm [centimeter] superficial," the left buttock area "2 cm x [by] 1 cm red area," and "Wound Bed: Pink/beefy red tissue." The documentation did not identify depth or stage of the breakdown. Observation, on 07/08/10 at 8:43 a.m., identified light redness on Resident #3's buttocks in the areas of the previous skin breakdown. Observations of Resident #3 and his room were as follows: *07/06/10, 1:30 p.m. - A ROHO cushion on an arm chair in the resident's room. Facility staff reported Resident #3 out of the facility for a physician appointment. *07/06/10, 3:40 p.m. - Resident #3 returned to the facility, seated in a high back reclining, multi-position wheelchair without a seat cushion. Facility staff transferred him to bed. *07/07/10, 9:25 a.m. - Certified Nursing Assistants (CNA) (#3) and (#4) transferred the resident from bed to a high back reclining, multi-position wheelchair without a seat cushion. The wheelchair foot rest was positioned below the resident's feet and he did not have any support for his feet or legs. In this position, Resident #3 slouched in the chair and slid forward on the seat, with potential for shear forces on his buttocks and coccyx. Observation showed a ROHO cushion on an arm chair in the resident's room. *07/07/10, 10:20 a.m. - Resident #3's spouse arrived to visit and reported the high back	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355110	A. BUILDING _____ B. WING _____	07/08/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELM CREST MANOR	100 ELM AVE NEW SALEM, ND 58563

(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 314	Continued From page 4 reclining, multi-position wheelchair foot rests "broke yesterday" while at the physician's appointment and could not be adjusted into a higher, supportive position. The resident's spouse requested the CNA (#3) to contact facility staff to repair the wheelchair. CNA (#3) contacted an occupational therapy staff member. *07/07/10, 11:00 a.m. - A licensed physical therapy staff member (#7) entered the resident's room to provide exercise. This staff member commented the resident was "sliding forward." *07/07/10, 11:30 a.m. - Resident #3 seated in the high back reclining, multi-position wheelchair with the foot rests adjusted to support the lower extremities and reduce the potential shear force. A ROHO cushion remained on an arm chair in the resident's room. CNA (#3) and (#4) transferred the resident from the chair to bed. *07/07/10, 3:05 p.m. - Resident #3 seated in the high back reclining, multi-position wheelchair with the foot rests supporting the lower extremities and without a seat cushion in the chair. A ROHO cushion remained on an arm chair in the resident's room. *07/08/10, 12:30 p.m. - Resident #3 seated in the high back reclining, multi-position wheelchair with the foot rests supporting the lower extremities and without a seat cushion in the chair. A ROHO cushion remained on an arm chair in the resident's room. Facility staff transferred Resident #3 from the bed to the chair and failed to identify the lack of lower extremity support in the chair, resulting in potential shear forces to the resident's buttocks and coccyx. The resident's spouse identified the lack of lower extremity support and "sliding" and requested facility staff address this concern. Facility staff failed to ensure the use of the	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355110	A. BUILDING _____ B. WING _____	07/08/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELM CREST MANOR	100 ELM AVE NEW SALEM, ND 58563

(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 314	Continued From page 5 available ROHO cushion when Resident #3 was in the wheelchair for three days of observation. Resident #3's history of skin breakdown, the potential of shearing forces, and the lack of a cushion in the chair placed him at risk of recurrence of pressure ulcers. - Resident #8's medical record, reviewed on July 06-08, 2010, identified the facility admitted the resident on 01/13/03. Current diagnoses included dementia and Alzheimer's disease. The resident's current MDS, dated 05/23/10, identified short and long term memory problems, severely impaired daily decision making, total assistance of two or more persons for bed mobility and transfers, and no current or history of pressure ulcers. Resident #8's physician orders included, dated 08/26/09, "Dycem sheet on top of cushion in Broda chair to prevent sliding." (Dycem is a brand of non-skid material. A Broda chair is a brand of multi-position wheelchair.) Resident #8's current care plan, dated 11/25/09, stated "Problem . . . Moderate Risk for Skin Breakdown . . . Approaches . . . 22. Dycem Sheet on top of cushion in pressure reduction chair to prevent sliding. . . ." Resident #8's medical record included occupational therapy documentation as follows: *08/24/09, "Consult initiated regarding shifting forward in Broda chair. . . . Piece of Dycem placed in chair to prevent shifting or pelvic tilt in chair. . . ." *08/26/09, ". . . Resident [with] decreased shifting in chair. Dycem effective to reduce movement/shifting in chair. . . ."	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355110	A. BUILDING _____ B. WING _____	07/08/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELM CREST MANOR	100 ELM AVE NEW SALEM, ND 58563

(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 314	Continued From page 6 Observation identified Resident #8 in the Broda chair with a seat cushion without the Dycem in place throughout the afternoon and for the evening meal on 07/06/10; throughout the morning, for the noon meal, and in the afternoon on 07/07/10; and, in the morning and for the noon meal on 07/08/10. Observation failed to show the Dycem in place at any time. During interview, on 07/08/10 at 2:00 p.m., a nursing management staff member (#6) reported the facility staff began using the high back reclining, multi-position wheelchair for Resident #3 approximately one week ago and previously Resident #3 had been seated in the arm chair with the ROHO cushion. This staff member agreed facility staff should have provided a cushion for Resident #3 when he was seated in the multi-position wheelchair. The staff member (#6) also agreed facility staff should have used the Dycem to reduce the potential for shearing for Resident #8. Failure to provide a seat cushion for Resident #3, as prescribed and available in the resident's room, placed Resident #3 at risk of recurrent skin breakdown. Failure to provide a postioning device (Dycem) for Resident #8 increased the potential for shearing forces and the residents' skin breakdown.	F 314		
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.	F 323	1. All nurses will be in-serviced on proper medication storage on medication cart and locking of medication cart when it is not within sight 2. Policy and Procedure review will be completed at the Nurse's	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355110	A. BUILDING _____ B. WING _____	07/08/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELM CREST MANOR	100 ELM AVE NEW SALEM, ND 58563

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 7 This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 08/13/09. Based on observation, record review, review of product warning labels, facility policy review, and staff interview, the facility failed to maintain an environment free of hazardous chemicals and failed to properly store medications on 2 of 3 days of survey (July 6-7, 2010). These practices placed residents with memory loss and/or wandering behaviors at risk for exposure to hazardous chemicals and/or medications. Findings include: - Observations of the environment on 07/06/10 at 5:00 p.m. and on 07/07/10 at 9:00 a.m. and 12:10 p.m., identified the following: * The unlocked utility room (Cedar/Spruce Units) contained one can of Lysol Disinfectant Spray in the unlocked cupboard to the right of the sink. The product label stated, "Lysol Disinfectant Spray . . . causes moderate eye irritation . . ." * The unlocked spa (Willow Unit) housed two shower rooms. The first unlocked shower room contained a spray bottle of DMQ Damp Mop Neutral Disinfectant Cleanser on the floor and large plastic container of Lysol IC Quaternary Disinfectant Cleanser on the lower left shelf of the unlocked cupboard. The product labels stated, "DMQ Damp Mop Neutral Disinfectant Cleanser . . . corrosive . . . causes irreversible eye damage . . . harmful if swallowed . . ." and "Lysol IC Quaternary Disinfectant Cleanser . . . corrosive . .	F 323	meeting scheduled for 8-3-10 see agenda F323A. 3. Monitoring of proper storage of medication on the medication cart and locking of the medication cart will be completed by DON or designee on a daily basis x 5, weekly x 4 then monthly thereafter – see example F323 B. All chemicals that were not behind locked doors have been put in those areas that are now secure. Policy for chemical storage has been made, see example F323(C). At the July 20th In-service all employees were educated on the following in F323 C example: 1) Areas that are needed to be protected for proper storage of Chemicals A) Maintenance B) Laundry C) Dietary D) Nursing storage E) Housekeeping 2) Need to protect residents from all types of chemicals. In the case of wandering residents.	08/6/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355110	A. BUILDING _____ B. WING _____	07/08/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELM CREST MANOR	100 ELM AVE NEW SALEM, ND 58563

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 8 . causes irreversible eye damage and skin burns . . . harmful if swallowed . . ." The second unlocked shower room contained a spray bottle of DMQ Damp Mop Neutral Disinfectant Cleanser on the lower left shelf of the unlocked cupboard. Resident #11's medical record, reviewed July 6-8, 2010, identified diagnoses included Alzheimer's dementia. The admission Minimum Data Set (MDS), completed 05/05/10, identified problems with short and long term memory, moderately impaired daily decision making skills, and wandering behaviors. Resident #11's Nurse's Note, dated 05/19/10 at 14:00 [2:00 p.m.], stated, "CNA's reported res [Resident] found in spa rm[room] . . ." During interview on 07/07/10 at 12:10 p.m., the management maintenance staff member (#10) agreed the facility failed to properly store hazardous chemicals. Failure to secure hazardous chemicals inside locked rooms and/or cupboards places wandering residents at risk of coming into direct contact with the chemicals and causing potentially serious harm or side effects. - Review of the facility policy titled "ADMINISTRATION OF MEDICATION" occurred on 07/08/10. The policy, dated 7/05 (July 2005), stated, "Standard: All medications are administered safely and appropriately to aid residents to overcome illness, relieve and prevent symptoms, and help in diagnosis. . . . Procedures: . . . 2. Bring medication cart to an area adjacent to resident room. . . . 23. Never leave medication cart open and unattended. . . ."	F 323	3) The facility will have each department do chemical checks starting with July 23rd and weekly by each department until 9/23/10 and monthly there after. See example for all departments. 4) Monitoring will be done by all departments under the direction of the administrator who will have all sheets turned in at each monthly interdisciplinary meeting.	08/6/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355110	A. BUILDING _____ B. WING _____	07/08/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELM CREST MANOR	100 ELM AVE NEW SALEM, ND 58563

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 9 On 07/06/10 at 8:35 a.m., a random observation showed an unlocked and unattended medication cart located in the hallway outside the dining room and front desk/office area. Observation showed eight bottles of medications, two cards of medications, and two vials of insulin boxes on top of the cart. Observation showed an absence of licensed nursing staff in the area. Review of Resident #11's medical record revealed a Nurse's Note, dated 06/12/10 at 8:30 a.m., stated, "Needs redirection to stay out of residents rooms and not to pick up items from medication cart." During an interview on 07/08/10 at 3:40 a.m., an administrative nurse (#6) agreed the medication cart should be locked when not attended. Failure to store medications inside the medication cart and failure to lock the medication cart when not attended places the residents at risk of taking medications which do not belong to them, and if ingested causing potentially serious harm or side effects.	F 323		
F 356 SS=B	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law).	F 356	1. Posting of the Nursing staff will be completed at the beginning of each shift by assigned wing nurse 2. Policy and procedure review will take place at the Nurses and CNA meeting scheduled for 8/3/2010. See agenda F356A. 3. The monitoring of the posting	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355110	A. BUILDING _____ B. WING _____	07/08/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELM CREST MANOR	100 ELM AVE NEW SALEM, ND 58563

(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 356	Continued From page 10 - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to post the total number and the actual hours worked, by licensed and unlicensed staff directly responsible for resident care, for each shift on 3 of 3 days of survey (July 6-8, 2010). Findings include: Observation on all days of survey (July 6-8, 2010) identified staffing data written on a marker-board located on the wall directly across from the nurses station. The facility posted the number and the actual hours worked by licensed and unlicensed staff directly responsible for resident care for the 07/06/10 a.m. and 07/07/10 p.m. shifts. Facility staff did not update the board with	F 356	will be completed by DON or designee daily x 5 then weekly x 4 then monthly thereafter. See example F356B	08/6/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355110	A. BUILDING _____ B. WING _____	07/08/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELM CREST MANOR	100 ELM AVE NEW SALEM, ND 58563

(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 356	Continued From page 11 the staffing data for every shift. Observation on 07/08/10 at 10:40 a.m., further identified a facility maintenance staff member removed the marker-board from the wall and placed it on the floor behind the nurses station. The maintenance department prepared the area for repainting. During interview on 07/08/10 at 12:50 p.m., the administrative nursing staff member (#6) stated the data should have been updated "every shift" and agreed the facility failed to maintain the required posting of staff.	F 356		