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 _____	08/17/2016

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

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F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey started on 08/14/16 and completed on 08/17/16, the sample included four (4) residents for complete review, nine (9) residents for focused review, and two (2) closed resident records for review. The sample included two (2) additional residents to verify specific concerns during the survey.	F 000		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a	F 278		9/21/16

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

Electronically Signed | 09/08/2016

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F 278	Continued From page 1 material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual Version 3., and staff interview, the facility failed to ensure the Minimum Data Set (MDS) accurately reflected the residents' status for 3 of 13 sampled residents (Resident #1, #9, and #12). Failure to accurately code constipation may result in the care plan not reflecting the residents' current status and needs. Findings include: The Long-Term Care Facility RAI User's Manual, revised October 2015, page H-12, stated, "Definition: CONSTIPATION: If the resident has two or fewer bowel movements during the 7-day look-back period or if for most bowel movements their stool is hard and difficult for them to pass (no matter what the frequency of bowel movements). * Code 0, no: if the resident shows no signs of constipation during the 7-day look-back period. * Code 1, yes: if the resident shows signs of constipation during the 7-day look-back period." - Review of Resident #1's medical record occurred on all days of survey. The significant change MDS, dated 05/25/16, identified constipation. Review of the resident's bowel records identified five soft or loose bowel movements during the 7-day assessment period.	F 278	1. A review of the RAI Manual Section H regarding constipation was by completed by the DON and MDS Coordinators on August 11, 2016. The information was reviewed by the DON with the MDS Coordinators and Nurses at the Nurse Meeting held on September 6, 2016. MDS's for Residents #1-9-12 will be corrected and resubmitted. 2. All residents have the potential to be affected by this deficiency as all residents must have a completed comprehensive MDS on a routine basis. 3. Residents with comprehensive MDS Assessments will be coded accurately according to the RAI guidelines in regards to constipation. 4. DON will monitor the next comprehensive MDS assessments for Residents #1,#9 and #12 and all other residents for correct coding of section H. This monitor will be completed by the DON or Designee weekly for 1 year. The findings of this quality monitoring will be reviewed monthly at the QA Interdisciplinary Meetings.	

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F 278	Continued From page 2 - Review of Resident #12's medical record occurred on August 16-17, 2016. An annual MDS, dated 02/12/16, identified constipation. Review of the resident's bowel records identified three soft bowel movements during the 7-day assessment period. - Review of Resident #9's medical record occurred on all days of survey. The significant change MDS, dated 06/15/16, identified constipation. Review of the resident's bowel records identified three bowel movements during the 7-day assessment period. During an interview on the afternoon of 08/17/16, an administrative nurse (#1) agreed the facility mistakenly coded Resident #1, #9, and #12 for constipation on their MDSs.	F 278		
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 observation, record review and review of facility policy, the facility failed to provide the necessary care and services for 2 of 5 sampled residents (Resident #9 and #11) with orders for TED [anti embolism] hose. Failure to ensure resident's compression stockings are applied	F 309	1. Re-education to the CNA's in regards to reporting to the nurses when compression stockings are not applied as well as re-education to the nurses to assess if compression stockings are in place and why they were not applied on a	9/21/16

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F 309	Continued From page 3 daily as ordered may result in increased edema. Findings include: Review of the facility policy titled "ANTIEMBOLITIC STOCKINGS" occurred on 08/17/16. This policy, dated 2011, stated, ". . . Anti-embolitic stockings are applied appropriately to aid circulation to lower extremities and to help prevent edema. . . . Document in Clinical Notes the condition of legs and circulation when a change in condition occurs. . . . Chart if resident refuses stockings." - Review of Resident #9's medical record occurred on all days of survey. Diagnoses included atrial fibrillation (irregular heart rate), abdominal aortic aneurysm, thrombocytopenia (low blood platelets), and congestive heart failure. The physician orders stated, ". . . Circulatory Treatment: Apply TED hose (knee high) daily ON AM [morning] OFF PM [evening] (for edema) . . ." The current daily care guidelines stated, ". . . Special Instructions . . . ted hose (knee high) on am; off pm . . ." Review of the electronic treatment administration record (eTAR) identified staff signed off TED hose as applied and removed daily August 14-17, 2016. Observations throughout the survey showed Resident #9 did not have his TED hose on. - Review of Resident #11's medical record occurred on August 16-17, 2016. Diagnoses included history of venous thrombosis and	F 309	resident was completed on September 6, 2016 by the DON. Review of the Compression Stocking Policy was completed with the Nurses at the Nurse meeting on September 6, 2016. Review on the Compression Stocking Policy was reviewed with the CNA's at the CNA meeting on September 6, 2016. 2. Any resident who has an order for compression stockings could be effected. 3. CNA"s will communicate with nurses every shift whether a resident is wearing the compression stockings per order or not and why. Then Nursing will document accordingly and appropriately. 4. Monitoring of Residents #9 and #11 in regards to placement of compression stockings and chart reflection will be completed by the DON or Designee daily x 5 days, then weekly for 4 weeks and then monthly. All residents with compression stocking orders will be added to the monitor. The findings from this quality monitoring will be discussed at the monthly QA Interdisciplinary meetings.	

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F 309	Continued From page 4 embolism (blood clots). The physician orders stated, ". . . CIRCULATORY TREATMENT: Apply TED hose (knee high) both lower extremity(s) when up ON AM OFF PM (for edema) . . ." The current care plan stated, ". . . Problem . . . Self Care Deficit . . . Approach . . . ted hose on AM and off HS [night]. . . ." Review of the eTAR identified staff signed off TED hose as applied on August 17, 2016. Observation on 08/17/16 at 9:55 a.m. showed Resident #11 did not have her ted hose on.	F 309		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a	F 441		9/21/16

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F 441	Continued From page 5 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: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 08/06/15 PERINEAL CARES/HAND HYGIENE 1. Based on observation, record review, and review of facility policy, the facility failed to provide services in a manner that prevents the spread of infectious organisms for 2 of 8 sampled residents (Resident #4 and #9) observed during perineal cares. Failure to follow proper procedure when providing perineal care, and perform hand hygiene after cares has the potential to cause or spread infection within the facility. Findings include: Review of the facility policy titled "TOILETING HYGEINE [sic]" occurred on 08/17/16. This undated policy, April 2014, stated, ". . . PROCEDURE . . . 3. Using a peri wipe or wash	F 441	1. The policy and procedure for proper hand hygiene was reviewed and revised by the DON and placed for nurse and CNA review on August 26, 2016. This information was again reviewed with the nurses and CNA's at department meetings on September 6, 2016. Policy for Perineal Care was reviewed and revised by the DON and placed for nurse and CNA review on August 26, 2016. The information was again reviewed with the nurses and CNA's at department meetings on September 6, 2016. Re-education for medication pass regarding infection control and Review of the Policy and Procedure for Medication Administration was completed by the DON with the nurses at the Nurse meeting on September 6, 2016. 2. All residents have the potential to be affected by this deficiency.	

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F 441	Continued From page 6 cloth - wipe front to back (towards rectum) assuring not to use the soiled area of the wipe/cloth more than one time. . . ." Review of the facility policy titled "PROPER HANDWASHING" occurred on 08/17/16. This policy, not dated, stated, ". . . POLICY: Hands must be washed: *Before and after resident care and treatments. *If gloves are worn, wash hands after removing gloves. . . ." - Review of Resident #4's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease and dementia. The quarterly Minimum Data Set (MDS), dated 07/09/16, identified occasionally incontinent of urine and frequent bowel incontinence and extensive assistance from two or more people for toilet use. Observation on 08/16/16 at 9:44 a.m. showed two certified nursing assistants (CNAs) (#3 and #4) assisted Resident #4 to the bathroom. Observation showed the resident was incontinent of bowel movement (BM). The CNA (#3) performed perineal care, wiping the resident from the front perineal area to the back. The CNA (#3) used the same area of the cloth to again wipe the resident from the front to the back and then used the same cloth and wiped the front perineal area. The CNA (#3) removed her gloves, transferred Resident #4 to her wheelchair, removed the mechanical lift sling, attached the chair alarm to Resident #4's shirt, applied the footboard to the wheelchair, gave the resident her call light, turned on the television, and washed her hands. The CNA (#3) failed to perform hand hygiene after providing perineal cares and prior to	F 441	3. CNA's will perform proper hand hygiene following personal cares and proper perineal cares. Nurses will use proper infection control methods when administering medications. 4. Hand Hygiene and Perineal Care Monitoring will be completed by the DON or Designee for Residents #4 and #9 on a weekly basis for 4 weeks and then monthly. A random selection of residents will also be added to these monitors. Monitor for medication pass will be completed by the DON or Designee on a daily basis for 5 days, weekly for 4 weeks and then monthly. All three of the monitors will be reviewed at the monthly QA Interdisciplinary Meeting.	

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F 441	Continued From page 7 completing other tasks. - Review of Resident #9's medical record occurred on all days of survey. The significant change MDS, dated 06/15/16, identified frequently incontinent of urine and occasional bowel incontinence and extensive assistance from two or more staff for toilet use. Observation on 08/15/16 at 1:50 p.m. showed two CNAs (#7 and #8) assisted Resident #9 with perineal cares. Observation showed the resident was incontinent of urine. The CNA (#8) donned a pair of gloves, performed perineal care, applied a clean brief, disposed of the soiled brief, and repositioned the resident without removing her gloves. The CNA (#8) failed to remove her gloves after providing perineal cares and prior to completing other tasks. MEDICATION ADMINISTRATION 2. Based on observation and review of professional reference, the facility failed to follow infection control practices for 2 of 2 supplemental residents observed receiving medications. Failure to follow infection control practices during medication administration has the potential to spread infection to residents. Findings include: Saxton and Clark, "Geriatric Medication Handbook," 7th edition, Med-Pass, Inc., OH, 2005, page 146, stated, ". . . Tablets and capsules should not be poured in the nurse's hand or touched during the medicine pass. The	F 441		

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F 441	Continued From page 8 nurse should wear gloves when cutting tablets in half or touching them for any other reason. . . ." - Observation on 08/15/16 at 11:40 a.m. showed a nurse (#2) obtained two of Resident #16's medication cards (one month supply on one card). When the nurse punched one of the tablets from the card, the tablet fell into the drawer of the medication cart, and with her bare hands, the nurse (#2) obtained the tablet from the drawer and placed it in Resident #16's medication cup. - Observation on 08/15/16 at 11:43 a.m. showed a nurse (#2) obtained five of Resident #17's medication cards. When the nurse punched one of the tablets out of the card, the tablet fell into the drawer of the medication cart and, with her bare hands, the nurse (#2) obtained the tablet from the drawer and placed it in Resident #17's medication cup. Failure to protect the residents' medications from possible contamination by bare-hand contact placed the residents at increased risk of developing an infection.	F 441		