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

FORM APPROVED
OMB NO. 0938-0391

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 _____	C 11/07/2012

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 complaint investigation, conducted on 11/07/12, the sample included (3) three current residents for review and (1) one closed resident record for review.	F 000		
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	An unknown origin report was completed with a late entry of 10/22/12. An incident report will be completed on all residents with a fall, injury, verbal, sexual or physical abuse. An unknown incident report will be completed on all residents who have an injury without a known source. As part of completing the incident or unknown origin form, a family member or representative will be notified of an incident including time of notification as well as initial reporting completed by the Administrator, DON, or charge nurse and sent to the Dept. of Health if concern of abuse or neglect. See Example F225 A for revised incident form. Policy and procedure review of the revised Incident Report and the Abuse/Neglect Policy was completed	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (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 the facility's policy and procedure, and staff interview, facility staff failed to immediately report and thoroughly investigate within five working days violations involving possible physical abuse to the state survey and certification agency and failed to notify the resident's legal representative/family member for 1 of 1 sampled resident (Resident #2) with an injury of unknown origin. This failure placed all residents at risk of possible abuse/neglect and limited the legal representative/family member's ability to fully participate in the resident's care and treatment. Findings include: The facility policy titled "Abuse Policy," dated June 2012, stated, ". . . REPORTING ABUSE: 1. Any staff witnessing or possessing reliable knowledge of any act or suspected act involving mistreatment . . . including injuries of unknown source . . . must immediately notify the charge nurse, Director of Nursing . . . . A written report of incident report shall be filled out by the reporter. The Administrator . . . will notify the Department of Health . . . INVESTIGATION OF ABUSE ALLEGATIONS: 1. All allegations must be thoroughly investigated . . . 2. Investigations must be documented and all findings including the	F 225	at the nurses meeting on November 13, 2012. The Abuse and Neglect Policy was reviewed with all employees at the All Staff In-service on December 3, 2012. The changes and updates to the new Incident Report were reviewed as well as a presentation by the Director of Nursing from Marion Manor on investigation and documentation. In addition, a review of the initial Abuse Reporting Form and the location of these forms took place to ensure of proper initial reporting time of 24 hours. The revised Incident Report was implemented on November 14, 2012. See Example F225 B for meeting Agenda. Monitoring of proper completion of every Incident and Unknown Origin Reports including notification of the family/representative and Dept of Health will be completed by DON and Administrator or designee. Biweekly review of documentation of all residents will be completed by DON or designee for 3 months to ensure documentation of any incident coincides with incident reports, then 1 time per month for 6 months. The	

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F 225	Continued From page 2 initial report of allegation reported in writing to the administrator as soon as possible but no later than twenty-four (24) hours following the alleged incident. The Administrator . . . by the fifth working day will notify the State Department of Health of the investigative results. . . ." The facility policy titled "Policy on Accident/Injury Report," dated August 2011, stated, ". . . POLICY: . . . 5) All accidents/incidents are reported to the . . . family as soon as possible . . ." Review of Resident #2's medical record occurred on 11/07/12. The resident's medical diagnoses included Alzheimer's dementia, delusional disorder - jealous type, anxiety, status post cerebral vascular accident [CVA] with left hemiparesis [paralysis], chronic left frozen shoulder, and history of fractured distal radius to right wrist. The Minimum Data Set (MDS), dated 08/16/12, identified short term memory problems, moderately impaired daily decision making skills, and extensive assistance needed for mobility, transfers, and toilet use. The current care plan stated, ". . . Problem: Alteration in ADLs [Activities of Daily Living] . . . Approaches: Toilets extensive assist of one. . . . Does attempt to walk per self. Uses w/c [wheelchair] for long distances. Chair alarm . . . Padded alarm on recliner . . . Bed alarm . . . Pressure relief mattress on bed. . . . Titrate 02 [oxygen] to keep sats > [above] 90%. . . . Problem: Anxiety . . . Dementia . . . Approaches: medications as ordered . . ." The nurse's notes identified the following: * 10/13/12 at 5:40 a.m., "Res. [resident]	F 225	monitoring will be discussed and reviewed at the monthly interdisciplinary (QA) meetings. See Example F225 C for nurses notes monitoring.	12/10/12

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F 225	Continued From page 3 combative [with] cares this morning. Res. is agitated. . . . Res is confused - res. is talking about seeing snakes. . . . Observed multiple discolored areas of various sizes to wrists and hands - res. is frequently combative [with] cares and propels herself in w/c frequently. . . ." At 5:50 a.m., ". . . . Will monitor skin to wrists [and] hands daily until healed. . . ." At 7:00 p.m., "Res having [increases] in confusion, wanted to call daughter, assisted res. to call dau. [daughter], cont. [continued] confusion. gave PRN ativan. . . ." * 10/17/12 at 6:30 a.m., "Discoloration to wrists [and] hands fading. . . ." * 10/21/12 at 9:00 a.m., "Bruises to bil [bilateral] wrist-hands fading . . ." The "Doctor's Consultation" form, dated 10/22/12, stated, ". . . Symptoms and Remarks: Family requests bil. arm x-rays due to bruising [and] swelling. . . . Findings and Further Orders: Imp [Impressions] 1) bil forearm ecchymosis/trauma. Pt [patient] [with] bil forearm ecchymosis and family story can be compatable [with] physical abuse of pt. . . . 4) Please contact [physician] [with] pts events/family concerns, 5) xray of forearms . . ." The "[Clinic] Report", dated, 10/22/12, stated, ". . . The patient apparently on the 13th of October may have been treated aggressively. There is some concerns in regards that patient may have been grabbed at the wrist and forced into a position. . . . The family was made of aware of this situation on the 20th. They notice that she has a significant amount of bruising over the wrist that had an appearance of being grabbed at the wrist and forced into a position. . . . The family was made of aware of this situation on the 20th.	F 225		

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F 225	Continued From page 4 They notice that she has a significant amount of bruising over the wrist that had an appearance of being grabbed. There was some confusion as to the exact problem at the time and the family was taken [a] back in that they were not notified of the problem or the result of the problem. . . . Family members have indicated their unhappiness or their disappointment n [sic] that the nursing home did not reliably tell the family regarding the situation as well as the bruising. . . . They have discussed this concern with the director of nursing as well as a social worker and no incident report was documented on this event. The only incident report that I am assuming was done was the patient's take or punch to the CNA [certified nurse assistant]. . . . Recommendations: 1. . . . Obviously she does have areas of increased ecchymosis and bruising particularly over the rist [sic] where one can imagine that patient may have been grabbed hard or with intensity that may have made her bruise or bleed easily. . . . Obviously with patient's recounting of story as well as other physical features one cannot exclude this potential complaint. 2. Unfortunately patient is relatively asymptomatic at this point. . . . 3. I would suggest that patient come off of anticoagulation. She is certainly at high risk for thromboembolic disease by the nature of the atrial fibrillation; however, at this point with documentation of her falling family members also indicate that she is high risk for falls that Warfarin be discontinued. The use of baby aspirin can be initiated for antiplatelet affects. This may still be a problem in regards to the skin and ultimately may need to be discontinued depending on family's wishes as well as her primary attending recommendations."	F 225		

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F 225	Continued From page 5 The nurse's notes further identified the following: * 10/22/12 at 8:00 a.m., "Bruising to L) [left] wrist gone, R) [right] wrist fading. . . ." At 6:00 p.m., "Returned from clinic, xrays to bilateral arms negative . . ." * 10/23/12 at 8:00 a.m., "Bruising to bil. forearms fading. . . ." * 10/24/12 at 12:30 a.m., ". . . Bruising fading to bil. forearms. States R) wrist stiff - slightly puffy. . . ." At 2:30 p.m., ". . . Orders received from [Physician's] office to use R) wrist splint [and] xray R) wrist. . . ." * 10/25/12 at 8:45 a.m., "Left for R) wrist xray [with] CNA . . ." At 11:00 a.m., "wearing R) wrist splint." * 10/26/12 at 6:00 a.m., ". . . wearing R) wrist splint. . . ." At 8:00 a.m., ". . . Bruising to wrists fading. . . ." At 1:45 p.m., "Call received from [Physician's] office re: [regarding] R) wrist - xray neg. [negative] - [no] fracture. . . ." * 10/27/12 at 6:00 a.m., "Cont. [continues] wearing splint R) wrist . . . Bruised area bil wrist fading. . . ." * 10/29/12 at 7:00 a.m., "Bruises to bil. wrists . . . faded to light purple." * 11/01/12 at 7:00 a.m., "Bruising to bil. wrist . . . almost faded." * 11/04/12 at 8:00 a.m., "Bruises to wrists fading . . ." * 11/05/12 at 7:00 a.m., "Bruising to bil wrist . . . faded . . ." The "Report of Injury of Unknown Origin," dated 10/22/12, stated, ". . . Date Injury Found: 10/13/12 LE [late entry] 10/22/12 Describe exactly what injury was found, why it happened, if known and causes: Noted bruising to bil. wrists [and] hands of various sizes [and] colors. . . .	F 225		

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F 225	Continued From page 6 Investigation by Director of Nursing: 10/22/12 did receive call from nurse . . . re: resident's increased agitation [and] altercation with CNA . . . Nurse stated the resident had been agitated prior to the CNA entering her room - did take off neb [and] 02. Sats were low, talked about seeing snakes - did tell me that the girl took her down, twisted one arm one way [and] the other arm the other way - nurse and noc [night] CNA stated she frequently has discolored areas [and] these were not new - resident did not want CNA to assist her . . res did kick CNA in lower stomach when CNA was crouched down to talk to her - CNA did stay in room until assistance came to keep resident safe - Resident has periods of [increased] agitation - is at risk for bruising due to continuous neb txs [treatments] with steroids and coumadin . . . did tell nurse that an incident report did not need to be filled out (meaning employee incident report due to being kicked) nurse understood me as unknown origin report." During an interview on 11/07/12 at 5:00 p.m., two administrative staff members (#1 and #2) agreed facility staff should have contacted the State Department of Health 1) within twenty-four hours of hearing Resident #2's abuse allegation and/or noting bruises on her arms/wrists and 2) by the fifth working day with the results of the investigation, and should have contacted Resident #2's legal representative/family member after noting bruises on her arms/wrists.	F 225		