| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 355076 | A. BUILDING _____ B. WING _____ | 10/13/2010 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| NORTHWOOD DEACONESS HEALTH CNT | 4 N PARK ST NORTHWOOD, ND 58267 |

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| F 000 | INITIAL COMMENTS<br><br>For the standard Medicare/Medicaid recertification survey started on October 11, 2010, and completed on October 13, 2010, the sample included 3 residents for complete review, 9 residents for focused review, and 2 closed records for review. | F 000 | | |
| F 309 SS=D | 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, review of policy and procedure, record review, and staff interview, the facility failed to comprehensively assess behaviors/verbal expressions of pain and implement interventions, to alleviate the pain for 1 of 2 sampled cognitively impaired residents (Resident #9) observed experiencing pain. The failure to treat Resident #9's pain resulted in the resident not receiving optimum pain relief and possibly receiving unnecessary antianxiety medication.<br><br>Findings include:<br><br>Review of the facility's PAIN MANAGEMENT PROTOCOL occurred on 10/13/10. The protocol/policy, revised 04/10, stated:<br>"POLICY: It is the policy of NDHC [abbreviation of | F 309 | (F309) Pain Management: For Resident #9 a Duragesic patch was initiated on October 13, 2010. Resident #9 is also now receiving PROM 3 x per week for mobility and pain management.<br><br>The NDHC Assessment Coordinator will do a pain screening for Resident #9 and all other residents at NDHC that cannot self report. If the pain screening is a score of 5 or greater, the Dr. will be contacted for pain management orders and a Comprehensive Pain Assessment will be completed.<br><br>The NDHC Care Plan Team will assess for resident's pain management needs during the MDS interview. Unmanaged pain needs will be reported to the Assessment Coordinator. At that time the Assessment Coordinator will complete a Pain Screening and a Comprehensive Pain Assessment as indicated. The QA&I RN will monitor this and results will be reported at the QA&I monthly meeting. (See attached Quality Assurance Monitoring Sheet) | 11/17/10 |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| [signature] | CEO | 11/2/10 |

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.

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

PRINTED: 10/21/2010
FORM APPROVED
OMB NO. 0938-0391

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| F 309 SS=D | 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, review of policy and procedure, record review, and staff interview, the facility failed to comprehensively assess behaviors/verbal expressions of pain and implement interventions, to alleviate the pain for 1 of 2 sampled cognitively impaired residents (Resident #9) observed experiencing pain. The failure to treat Resident #9's pain resulted in the resident not receiving optimum pain relief and possibly receiving unnecessary antianxiety medication.<br><br>Findings include:<br><br>Review of the facility's PAIN MANAGEMENT PROTOCOL occurred on 10/13/10. The protocol/policy, revised 04/10, stated:<br>"POLICY: It is the policy of NDHC [abbreviation of | F 309 | October 14, 2010 per TC Administrator 11/16/10 KH 11/17/10<br><br>(F309) Pain Management: For Resident #9 a Duragesic patch was initiated on October 13, 2010. Resident #9 is also now receiving PROM 3 x per week for mobility and pain management.<br><br>The NDHC Assessment Coordinator will do a pain screening for Resident #9 and all other residents at NDHC that cannot self report. If the pain screening is a score of 5 or greater, the Dr. will be contacted for pain management orders and a Comprehensive Pain Assessment will be completed.<br><br>The NDHC Care Plan Team will assess for resident's pain management needs during the MDS interview. Unmanaged pain needs will be reported to the Assessment Coordinator. At that time the Assessment Coordinator will complete a Pain Screening and a Comprehensive Pain Assessment as indicated. The QA&I RN will monitor this and results will be reported at the QA&I monthly meeting. (See attached Quality Assurance Monitoring Sheet) | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: CEO | (X6) DATE: 11/2/10

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 309 | Continued From page 1<br>facility organization] to assess all patients/residents for pain and provide treatment/intervention to achieve optimal comfort and control of pain.<br>PROCEDURE:<br>1. Complete screening on admission (within 24 hours), readmission, quarterly, or significant change. Pain Assessment Tool is available.<br>2. If the pain screening score is 5 or greater, the physician will be notified and a comprehensive pain assessment must be done.<br>3. After completion of the Comprehensive Pain Assessment, the physician will be notified by the nurse of any concern regarding the level of comfort being provided to the patient/resident or other concerns regarding the pain management plan.<br>4. PRN [as needed]/Pain Medication Assessment should be completed with each prn medication. . . ."<br>5. Resident's level of comfort will be monitored by CNA [certified nursing assistant] staff on a daily basis. CNA's (sic) will ask residents if they are comfortable or if having pain. CNA's will observe residents for signs of pain. Resident's report of pain, or staff observations of pain, will be reported to unit nurse. Pain will be assessed by licensed nurse and documented in chart note or in medication administration tabs of EMR [electronic medical record]. Ineffective therapy will be reported to the physician.<br>6. Educate patient/resident/family as cognitive level permits regarding pain management rights. Ask patient/resident to participate in setting pain control goals and developing treatment plan."<br><br>The facility Pain Assessment Tool included indicators for "patients/residents who have difficulty communicating. Look for actions that | F 309 | NDHC Nursing staff will be educated on Pain Management Protocol (see attached) by NDHC Assessment Coordinator and Nurse Administrators.<br><br>An RN from Altru Hospice will inservice NDHC Nursing staff on pain management on November 11, 2010. | |

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| F 309 | Continued From page 2<br>may show pain . . .<br>Voice: Moaning, crying, groaning, calling out, screaming . . .<br>Body movements . . . rigid posture . . . guarding part of the body . . .<br>Daily Activities: More rest periods, less social activity . . . Mood: More irritability, confusion; more withdrawn or agitated."<br><br>The facility Comprehensive Pain Assessment Form, titled for "Not Able to Self-Report" also included "Indicators of Pain - based on observation for 3-5 minutes." These indicators included: ". . . Unusual Fidgeting: . . . Guarding of a body part . . . Tugging or rubbing . . . Unusual Negative Vocalization . . . Noise or speech with negative quality . . . Varying pitch noise with a definite unpleasant sound . . . Faster rate in conversation or drawn out as in a moan or groan . . . Repetitive words with a mournful tone . . . Grunting or groaning . . ."<br><br>Observation on the afternoon of 10/11/10 identified Resident #9 seated in her wheelchair at a dining room table expressing a desire to lay down and with complaints of pain. These observations included:<br>* 5:24 p.m., Resident #9 calling out, "Hey lady come here," as a staff nurse (#12) walked by. The staff nurse (#12) walked over to Resident #9 and asked what she needed. Resident #9 stated, "Take me to my bed," and stated her head hurt and she hurt all over. The staff nurse (#12) told Resident #9 he would check with the other nurse when she last received pain medication. The staff nurse (#12) stated Resident #9 often hollers out at suppertime wanting to go to bed, but they try to get Resident #9 to stay up long enough to eat first. | F 309 | | |

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| F 309 | Continued From page 3<br>* 5:40 p.m., Resident #9 hollered out "help me" and stated her hand hurt. A staff nurse (#15) entered the dining area, and the surveyor asked the nurse to assist Resident #9. The staff nurse (#15) asked the medication nurse (in the corridor just outside of the dining room), if the resident received her pain medication, to which the medication nurse confirmed she had. The resident continued to ask to go to her room. Two of the resident's table mates responded to the resident by saying they could not do anything. Resident #9 continued to ask to go to bed and stated, "I promise I won't ask you again. Will you take me out." A CNA (#16) sat down in a chair next to Resident #9 and assisted Resident #9 to drink a glass of juice. The resident, with her eyes closed, asked again to lay down, and the CNA (#16) stated "you need to eat first" to which the resident promptly responded "can I lay down a little bit?" and "Can I lay down? I hurt so." The CNA (#16) walked away from Resident #9 and assisted another CNA in the dining area to pass the supper trays. The staff nurse (#15) exited the dining room shortly after. Resident #9 continued to plead to go back to bed. The resident's table mate to her right side stated, in a frustrating voice, "you can't eat when you lay down." Resident #9 responded with "would you just lay me down and put me to bed?" Resident #9's table mate then stated, "There is no bed here." Resident #9 stated again, "I hurt so" and continued to plead to lay down, repeating several times she "hurt so." The two CNAs continued to serve 23 residents their supper trays, while one dietary staff member poured drinks, and one dished up the individual plates. At 5:52 p.m., the CNA (#16) began delivering/serving supper to all of Resident #9's table mates (four residents at the table) and Resident #9 again pleaded to lay down | F 309 | | |

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| F 309 | Continued From page 4<br>and complain she "hurt so." At 5:55 p.m., the CNA (#16) sat down next to Resident #9 to provide feeding assistance. Resident #9 continued to complain of hurting and said "lady will you help me? I'm hurting so much." Observation showed Resident #9's face flushed, and staff nurse (#15) entered the dining room area at this time. The CNA (#16) proceeded to feed Resident #9 her supper.<br><br>Record review on the morning of 10/13/10 showed Resident #9 received a scheduled dose of Tylenol 650 milligrams (mg) at 4:51 p.m. on 10/11/10.<br><br>On 10/12/10 at 5:05 p.m., a CNA (#17) walked into Resident #9's room and the resident stated, "Will you help me?" The CNA (#17) asked Resident #9 if she would like to go to the bathroom and the resident responded saying she did not have to go, but she would. After assisting Resident #9 with a drink of water, the resident told the CNA (#17) she hurts along the side, while rubbing her outer upper thighs. The CNA (#17) asked the resident if she should tell the nurse and the resident responded with "do what you have to." The CNA (#17) transferred the resident from her wheelchair to the toilet with a stand lift. Once the resident sat down on the toilet she requested the CNA "put me to bed. I'm hurting." The CNA (#17) told the resident she was going to eat and the resident responded with "whatever you want me to do." Upon standing the resident, the CNA proceeded to perform perineal cares, and the resident asked "put me to bed. I hurt. Will you help me lady?" The CNA (#17) noted the resident had not completed toileting and positioned the resident back onto the toilet. Resident #9 then informed the CNA (#17) she was hurting so "on | F 309 | | |

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| F 309 | Continued From page 5<br>the sides" and said "Don't hurt me so much. I hurt all the time." Upon completion of toileting, Resident #9 complained of discomfort while the CNA gently provided perineal cares. Once the CNA (#17) positioned the resident down in her wheelchair, Resident #9 no longer complained of pain.<br><br>Review of Resident #9's medical record occurred on October 12-13, 2010. The record identified Resident #9 as 96 years old. Medical diagnoses included dementia, macular degeneration, depression, degenerative joint disease and osteoarthrosis. Resident #9's current medication regimen included an order for Tylenol 650 mg three times a day, ordered initially on 10/02/08; Tylenol 650 mg every four hours as needed for pain, initially ordered 12/03/04; Lorcet (Hydrocodone 5 mg with Tylenol 500 mg) one to two tablets every four hours as needed for moderate to severe pain, initially ordered on 11/03/09; and Lorazepam Intensol (used for the short-term relief of the symptoms of anxiety) 0.25 mg to 2 mg every 3-4 hours as needed, initially ordered on 10/02/08.<br>Review of Resident #9's current care plan identified the problems of:<br>* ". . . will ask repetitive questions. Becomes restless and seeks reassurance. She will yell out 'Lady' or '[daughter's first name]'. She is easily redirected and reassured." with approaches of ". . . She usually just wants to talk for a bit then she is content. . . . Assess for pain and report to nursing . . . "<br>* "Potential for pain related to degenerative joint disease. See pain assessment tool" with approaches including "Assist with repositioning every two to three hours and prn. Offer her warm blankets to ease pain as appropriate. Administer | F 309 | | |

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| F 309 | Continued From page 6 | F 309 | | |

pain medication as ordered. Complete the pain assessment score as per protocol and inform the MD [medical doctor] if current pain management is not effective."

Review of Resident #9's pain screening tool forms, dated 08/18/10 and 06/02/10, identified the nursing staff gave the resident a total pain score of 5, and lacked evidence of physician notification. The total pain score included points given for a mental status of confusion (1 point); somewhat able to communicate (1 point); intermittent/occasional pain less than daily (1 point); and more than one condition/diagnosis which included degenerative joint disease, osteoporosis, and cyst on her mid back. Both forms identified the resident had no pain and/or denied pain with the assessment. The comprehensive pain assessment completed on 08/18/10 identified the resident has no pain indicators noted; and the 06/02/10 pain assessment identified indicators of pain included "Restless impatient motion, negative vocalization when having discomfort to mid back. Does not have any indicators of pain now."A pain assessment completed 02/25/10 identified indicators of pain as "Unusual Negative Verbalization: Noise or speech with negative quality."

Review of Resident #9's chart notes (interdisciplinary notes) on the morning of 10/13/10 lacked an entry of Resident #9's complaints of pain on 10/11/10 during the evening meal, and on 10/12/10 during transfers and toileting, just before supper. Chart notes identified the following:
* 10/10/10 at 6:44 p.m.: "Requesting to lay down instead of go to supper. Yelling 'lady, lady' in

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| F 309 | Continued From page 7<br>room before supper but wouldn't need anything with asked [sic]."<br>* 10/09/10 at 2:30 a.m.: "resident calling out 'I hurt so' and holding lower abdomen. I did medicate resident for discomfort with APAP 650 mg po [orally] at this time. Has had no further episodes of calling out in pain or of showing signs of discomfort."<br>* 10/07/10 at 9:05 p.m.: "Son was here visiting this afternoon and told writer that resident seems to be in pain. Scheduled Tylenol was given and resident went to supper shortly after. Resident was then yelling out with cares at HS [bedtime] and stated 'I'm gonna go and not come back'." The record lacked evidence nursing staff administered Resident #9 any pain medication other than the scheduled Tylenol.<br>* 10/02/10 at 2:00 p.m.: "Calling out for [daughter's name] a lot today. Resident spoke with [daughter's name] per telephone. Resident also made statement 'don't hurt me' several times today when CNA's doing any cares." The record lacked evidence nursing staff administered Resident #9 any pain medication other than the scheduled Tylenol.<br>* 09/29/10 at 11:30 p.m.: "resident calling out '[daughter's name]' and 'I hurt so'. Medicated with Acetaminophen 650 mg po. 2445 [00:45], continues calling out '[daughter's name]' and 'Help me'. stating it's time for church. resident found with legs off the bed on mat attempting to crawl out of bed. Medicated with Ativan [anti-anxiety medication] . . . for agitation. . . ." Review of the prn Medication Administration Record (MAR) showed the nurse administered Tylenol at 11:30 p.m.<br>* 09/18/10 at 3:40 p.m.: "Resident . . . did take medication with much encouragement. . . . Did take medication at noon with no problems. | F 309 | | |

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| F 309 | Continued From page 8<br>Daughter [first name] asking about her Tylenol and wondering if it's not working anymore."<br>* 09/17/10 at 11:01 p.m.: "Daughter concerned about res. [resident] calling out, making statements that she was being hurt. Given scheduled tyl. [Tylenol], then dau. [daughter] attempted to assist res. with coffee and banana bread. Heard res. cry out, 'Do you enjoy hurting me?' when assistance was offered. . . ."<br>* 09/03/10: "Quarterly MDS [Minimum Data Set] completed 9/2/2010 . . . continues with a diagnosis of dementia and depression. . . . continues to trigger for moods and now has declined in behaviors. She asks repetitive questions and has repetitive verbalizations. She often hollers out for 'lady' or for her daughter . . . She usually redirects but for only short periods of time. She has an order for prn Ativan which is used when she becomes rather agitated and cannot be redirected. She has sad facial expressions and does complain of pain in her back. She does not move very much except from bed to chair or to wheel chair. She is more than likely stiff and does have osteoporosis which could cause some pain in her bones and muscles. She has declined in behaviors as she has been more resistive with cares. She will tell staff 'no' and try to push their hands away when they are trying to do cares. She is usually fine once she is up it is just the activity and movement that is probably causing some pain and stiffness. . . ."<br>* 08/29/10 at 4:56 a.m.: "On last rounds CNA reported that resident yelled out, 'Don't hurt me!' and swung her arm to hit the CNA in the head. . . ."<br>* 08/27/10 at 11:30 a.m.: "Call received from daughter . . . States that she had just been on the telephone with her mother. Says that her mother | F 309 | | |

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| F 309 | Continued From page 9 | F 309 | | |

was . . . yelling out in pain . . . CNA states that when [daughter] called the room they had just gotten [Resident #9] up. [Resident #9] was yelling out. Saying that she wanted to get back into bed. This is usual for [Resident #9] no matter what time she is gotten up. . . ."
* 08/27/10 at 3:19 p.m.: ". . . CNA reports that resident was uncooperative with AM [morning] cares. . . . No further complaints once she was up in her wheelchair. . . ."
* 08/21/10 at 8:00 p.m.: "Has been calling out 'lady' since assisted to bed at 19:20 [7:20 p.m.], writer has tried redirect as well as CNAs- states needs to get up and go home, have been repositioning her back into bed after her attempts to get out by swinging legs off low bed onto mat, CNAs report they have put her back X [times] 4 at least. Used body pillow to her right side- 'I don't live here, I have to go home.' Given Ativan intensol . . . to help with agitation and anxiety."
* 08/15/10 at 10:06 p.m.: "Yelling 'Lady, lady' in dining room at supper. Unable to redirect for very long until supper was served."
* 08/01/10 at 10:17 p.m.: "Resident spoke with daughter on phone @ [at] 1645 [4:45 p.m.], CNA then informed writer that daughter would like [Resident #9] to have something for the pain in her legs, scheduled Tylenol 650 mg given @ that time. . . ."
* 06/02/10, Social Service Note: ". . . continues with a diagnosis of dementia and depression. . . . continues to trigger for mood due to repetitive questions and verbalizations. . . . She will also yell out for [daughter] several times each day or just call out for 'lady'. She also has sad facial expressions and her daughter tells us she is complaining of pain. She does not relay this information to staff however. When asked if she has pain she doesn't understand what we are

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| F 309 | Continued From page 10<br>asking. . . ."<br>* 06/01/10 at 5:30 p.m.: ". . . resident talking non stop and yelling out. Face flushed. Unable to redirect her. Had just been toileted. Resident denies pain. . . . Removed from dining room as residents yelling disrupted other resident's. (sic)"<br><br>Additional record review identified the following:<br>* Nursing staff administers Resident #9's scheduled Tylenol at 8:00 a.m., 11:00 a.m. and 5:00 p.m. daily. This provided pain medication for Resident #9 three hours between the first two doses and six hours between the next two doses; and nothing from 5 p.m. to 8 a.m. daily.<br>* Nursing staff administered a prn dose of Tylenol on eight occasions between September 15 and October 9, 2010. The administration of these doses occurred between the hours of 11:28 p.m. and 5:00 a.m. only. Nursing staff never administered Resident #9 any doses of Hydrocodone with Tylenol in this time period.<br>* Resident #9 last received Lorcet for pain on three occasions in July 2010: on July 13 at 12:54 a.m.; July 19 at 4:36 a.m.; and July 21 at 6:16 a.m.<br>* The above chart notes, the observations and staff interview on October 11-12, identified Resident #9 experienced pain in the afternoon hours or around the supper hour on seven occasions between September 17 and October 12.<br>* Resident #9 received no restorative therapy services for her recognized stiffness, including range of motion exercises.<br>* Resident #9 received hospice services for debility prior to September 2009, although these services have been discontinued.<br>* Physician orders showed an order for Roxanol discontinued on 11/03/09 when an order for | F 309 | | |

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| F 309 | Continued From page 11<br>Lorcet occurred.<br><br>An interview occurred on 10/13/10 at 9:20 a.m. with a nursing staff member (#14). The staff member stated the following:<br>* Resident #9's scheduled Tylenol administration coincides with her meal time as it doesn't work to schedule her pain medications at night as the resident doesn't take medications well during the night.<br>* When completing pain assessments on Resident #9, when asking Resident #9 if she has pain, Resident #9 would ask if "she should."<br>* Resident #9's daughter does not want the resident too "somnolent" yet also doesn't want her in pain.<br>* Resident #9 received Roxanol (oral Morphine Sulfate solution) when she received hospice services.<br>* Did not know if a longer acting pain medication had been tried for Resident #9.<br>* The nurse identifying Resident #9 in pain on Monday afternoon (October 11, 2010) could have administered the resident a stronger pain medication.<br>* There would be a maximum of four grams of Tylenol Resident #9 could receive per day. Administering three scheduled doses of Tylenol per day would deliver two grams of Tylenol per day, and would allow nursing staff to administer another three doses of prn Tylenol per day, or four doses of Lorcet, before this maximum would be obtained.<br>* The nurse did not say if Resident #9's physician was opposed to alternative pain management measures/medications.<br><br>An interview occurred with two administrative nursing staff members (#13 and #18) at 10:05 | F 309 | | |

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

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FORM APPROVED
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| F 309 | Continued From page 12<br>a.m. on 10/13/10. The nursing staff members stated Resident #9's pain should be managed better. The staff members stated on the afternoon of 10/11/10, the nurse should have administered Resident #9 a stronger pain medication. The staff members also stated a pain assessment questioning a cognitively impaired resident on her pain is not useful, as other methods need to be utilized as well.<br><br>Observation and record review showed Resident #9 demonstrated difficulty expressing the location of her pain to facility staff, although assessments identified the resident with stiffness and possible pain in her bones and muscles related to osteoporosis; with behaviors including yelling, resistance to cares, and sad facial expressions; and complaints of "hurting" during the afternoon hours and during the night. The facility failed to adequately assess this pain on a daily basis, and on quarterly assessments, to determine if Resident #9 had optimal pain relief. The facility failed to appropriately respond to complaints of pain, and failed to utilize a stronger alternative already ordered for pain relief. Nursing staff failed to acknowledge/recognize Resident #9's distressed behavior in relation to verbalized pain on the afternoon of 10/11/10, and failed to acknowledge/document Resident #9's pain on the afternoon of 10/12/10 as expressed during personal cares. Resident #9's current scheduled administration of Tylenol (pain medication) includes a six hours gap before the 5:00 p.m. dose when the resident displayed pain symptoms, and a 15 hour period of no pain medication scheduled with documentation of pain during this time period. | F 309 | Revised care plan to include use of transfer belt on Resident #6<br><br>Will review all other care plans of possible effected residents to include transfer belts.<br>per TC Administrator 11/16/10 KH | |
| F 323 SS=D | 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES | F 323 | | |

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| F 323 | Continued From page 13<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, policy and procedure review, and staff interview, the facility failed to use an assistive device (gait/transfer belt) for 1 of 1 sampled resident (Resident #6) observed ambulating with the assist of two staff members. Failure to use gait or transfer belts places residents at risk for injury.<br><br>Findings include:<br><br>Review of the facility's policy titled, "Safe Operating Procedures for Chief Hazards, "occurred on the afternoon of 10/13/10. The policy stated, ". . . 9. Assisting Patients/Residents While Ambulating . . . d. Use a transfer belt. . . ."<br><br>Review of the facility's policy titled, "Gait Belt," stated, "Purpose: 1. To prevent injury to the resident or staff while ambulating the resident. . . Procedure: 3. Walk along the side of the resident while holding the belt securely in the back with an underhand grasp. 4. If the resident stumbles or loses balance, lean the resident erect or towards you to stabilize him or her."<br><br>Review of Resident #6's medical record occurred on October 11-13, 2010. The resident's | F 323 | (F323) Transfers: For Resident #6 and all other residents in Long Term Care at NDHC, staff has been educated to use gait/transfer belts on all transfers. Inservice regarding appropriate gait/ transfer belt use will be done by PT/OT by November 17, 2010.<br><br>The QA&I RN will collect data on gait/ transfer belt usage and report results at the QA&I monthly meeting. (See attached Quality Assurance Monitoring Sheet). Also see Job Safety Training (attached, page 3).<br><br>Any unsafe practices observed during QA&I monitoring will be corrected and staff educated at the time of observation. | 11/17/10 |

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| F 323 | Continued From page 14 | F 323 | | |

diagnoses included severe Alzheimer's disease and dementia with behavioral disturbances. The most recent Minimum Data Set (MDS), dated 07/26/10, identified short and long term memory problems, severely impaired decision-making skills, and rarely to never understood or understands others.

Observation of Certified Nursing Assistants (CNAs) ambulating Resident #6 occurred on 10/12/10 at 8:15 a.m. and 10:30 a.m. with CNAs (#6 and #7) and at 4:00 p.m. with CNAs (#8 and #9). Observation showed the CNAs ambulated the resident while each aide held one of the resident's elbows and walked the resident around the perimeter of the Special Care Unit's main living area. During these observations, the CNAs did not use a gait or transfer belt. Observations of Resident #6 showed him intermittently crossing his feet, a toe to heel gait, and slight leaning of his body to the right and backwards.

Resident #6's most recent fall risk assessment, dated 04/27/10, identified a score of eleven, with a score more than ten indicating a high risk for falls.

Resident #6's current care plan, identified the resident with the problems " . . . at risk for and have a history of falls . . . do not look where I am going or look down at my pathway . . ." and the problem ". . . gait unsteady and lose balance at times . . . , dated 10/03/10." The goals for the resident included "Minimal to no injury from any fall thru next review with the revised approach on 10/03/10, ". . . Provide me with assist of two if I need any with ambulation and transfers. . . ."

The observation of Resident #6 ambulating with

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| F 323 | Continued From page 15<br>the assist of two CNAs on 10/12/10 at 4:00 p.m. occurred with an administrative nursing staff (#10). The staff member confirmed the observation of the toe to heel gait and slight leaning. The staff member recognized the need for two staff members to assist Resident #6 because facility staff was "afraid of [the resident] falling."The staff member confirmed the CNAs assisting the resident to ambulate were providing assistance with weight bearing. The staff member agreed facility staff should use a gait or transfer belt when assisting Resident #6 to ambulate.<br><br>Interview of a risk management staff member (#11) on 10/12/10 at 4:30 p.m., revealed this staff member agreed facility staff should use a gait or transfer belt with two CNAs assisting a resident to ambulate.<br><br>Interview of a CNA (#7) on 10/13/10 at 8:05 a.m., identified no change in the residents ambulating since initiating assistance of two. The CNA stated the resident "walks really good but by the second time around [the perimeter of the unit's main living area] he's getting tired and his legs give a little more." This staff member agreed facility staff should use a gait or transfer belt when assisting Resident #6 to ambulate. | F 323 | | |
| F 364 SS=D | 483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP<br><br>Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.<br><br>This REQUIREMENT is not met as evidenced | F 364 | (F364) Food Temperature: For Resident #1 and all other residents of NDHC the following procedure is now in place. Dietary staff is filling a container with crushed ice to within one inch of the top. They are then placing pint containers of milk into the ice so that the milk carton is submersed nearly to the top. A | 10/19/10 |

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| F 364 | Continued From page 16<br>by:<br>Based on observation, record review, policy and procedure review, resident interview, and staff interview, the facility failed to provide food at temperatures to enhance the palatability of foods. A concern about the food temperature of milk was voiced by 1 of 4 residents (Resident #1) during individual interviews. Failure to ensure residents receive food that is palatable and served at the proper temperature places residents at risk of nutritional decline.<br><br>Findings include:<br><br>Review of the facility's policy titled, "Dietary Services," occurred on the morning of 10/13/10. The policy, approved September 2010, stated, "Cold tables: a. Must be able to keep cold foods below 41 [degrees] F. . . ."<br><br>Review of the facility's policy titled, "Food Temperature Checks," occurred on the afternoon of 10/13/10. The policy, revised August 2007, stated, ". . . Procedure: 1. All hot and cold foods are checked and recorded for the correct temperature in the main kitchen and smaller dining areas prior to meal services and at the end of service. . . ."<br><br>During interview on the afternoon of 10/11/10, Resident #1 identified a problem with receiving warm milk on several occasions during meal time.<br><br>Observation of meal service in the Dakota dining room on 10/12/10 at noon, showed dietary staff pouring milk into glasses from an assortment of open half gallon and one quart cartons, held in a tub of ice. Observation showed the bottom one | F 364 | temperature is then taken and recorded prior to service and again at the end of service. We are now recording the milk temperature at all meals. Residents will continue to be asked at meal service if the temperatures of their beverage and food are at the proper temperature of their liking. Staff was educated on F364 at dietary staff meeting on October 18, 2010. QA&I data will be collected by the Dietary Manager to ensure the temperature of the milk is within normal limits, and results will be reported at the QA&I monthly meeting. (See attached Quality Assurance Monitoring Sheet) The deficiency has been corrected as of October 19, 2010. | |

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| F 364 | Continued From page 17<br>third of the cartons immersed in ice. At the end of meal service, this surveyor directed dietary staff to pour a glass of milk and measure its temperature. A dietary staff member (#1) used a facility thermometer to measure the temperature of the glass of milk and obtained a temperature of 60 degrees F.<br><br>Interview of the dietary staff member (#2) on 10/12/10 at 6:00 p.m., identified dietary staff measured the temperature of a beverage before tray line but did "not usually" measure the temperature of a beverage following tray line. Review of a form posted on the reach-in cooler titled "Beverage and Dessert Temperatures" showed a column for the temperature of the beverages. The dietary staff member (#2) identified dietary staff obtained these temperatures prior to tray line.<br><br>A dietary tour with an administrative dietary staff member (#4) and an administrative staff member (#5), occurred on 10/13/10 at 9:25 a.m. Observation of the walk-in cooler showed the tub of ice from breakfast containing open cartons of milk covered with a clean cloth. When interviewed, the administrative dietary staff member confirmed the use of a tub of ice would be comparable to use of a cold table. The staff member stated she trained dietary staff to fill the tub, used to hold the milk, full of ice. The staff member identified dietary staff did not measure the temperature of milk at the end of meal service. The staff member stated she would expect the temperature of the milk to be between "40 and 42 degrees" at the end of meal service. | F 364 | | |