STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355076	A. BUILDING _____ B. WING _____	10/12/2011

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

(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 October 10, 2011, and completed on October 12, 2011, the sample included 3 residents for complete review, 9 residents for focused review, and 2 closed records for review.	F 000		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy and procedure, and staff interview, the facility failed to implement it's policies and procedures regarding injuries of unknown origin for 2 of 2 sampled residents (Resident #6 and #7) with injuries of unknown origin. Failure of facility staff to investigate skin tears and bruises of unknown origin placed residents at risk for further injuries. Findings include: Review of the facility's policy and procedure, "PROCEDURES FOR INJURIES," occurred on 10/12/11. This document, revised April 2011, stated, ". . . POLICY: RNs [Registered nurses], LPNs [licensed practical nurses], and CNAs [certified nurse assistants] are to report all scrapes, bruises, skin tears, swollen areas etc. to their charge nurse AS SOON AS POSSIBLE. The	F 226	(F226) For Residents #6 and #7 and all other residents at NDHC, unexplained bruises and skin tears will be investigated per facility policy "Procedure for Injuries." (See attached) All new bruises and new skin tears will be monitored weekly for explanation of injury by the Assessment Coordinator. Any unexplained bruises, skin tears and other injuries will be reported to Director of Nursing. If DON has not already investigated per policy, investigation will be done at that time as a means of identifying potential abusive occurrences. (See Abuse Prohibition policy) Nursing staff will be educated regarding reporting and procedure for bruises greater than 5 times/week and procedure for explaining bruises or injuries and documentation that is required at educational meeting held 11/15/2011. Education will also be done regarding prevention of abuse.	11/14/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: CEO | (X6) DATE: 11/16/11

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 226	Continued From page 1 Charge Nurse shall assess the injury. If it has been charted before and investigated, no need to address again . . . There is no need to do protocol sheet if injury is explained. . . PROCEDURE: 1. Chart initial assessment in Nurses Notes. . . . 2. Chart description of injury on Skin Assessment per EMR [electronic medical record], indicating location of each injury. . . . 3. Measure bruise and record description on Skin Assessment per EMR. . . . 4. A registered nurse shall assess all bruises/injuries of unknown origin. . . . Criteria for further investigation include . . . bruise is larger than 2 cm [centimeters] . . . bruise, skin tear, scrape, etc. is unexplained. . . . 5. Do protocol sheet. A. Leave protocol sheet for DON [Director of Nursing] . . . d. Do Occurrence Report. . . ." Review of the facility policy and procedure "Occurrence Report Form" occurred on 10/12/11. This document, revised 05/01/09, stated "POLICY: An Occurrence Report shall be completed by the employee who discovers, witnesses, or becomes aware of circumstances indicative of an event. . . . PURPOSE: The Occurrence Report is a prompt and accurate account of the details of an event and provides a method for discovery and the means for an investigation of causes. . . ." Review of facility policy and procedure, "CHARTING GUIDELINES FOR SKIN ASSESSMENTS," occurred on 10/12/11. This document, revised April 2011, stated, ". . . POLICY: CNAs will report all scrapes, bruises, skin tears, blisters etc. to their Unit Nurse. . . . PROCEDURE: 1. Unit Nurse will assess the injury . . . Document on Skin Assessment/EMR the date, location, size, description and	F 226	QA data will be collected by QA nurse regarding bruises and skin tears and reported monthly to the QA&I Committee. (See attached)	

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F 226	Continued From page 2 explanation . . . Further investigation by DON/ADON [director of nursing/assistant director of nursing] required when . . . bruise is larger than 2 cm . . . bruise, skin tear, scrape etc. is unexplained . . . fill out Occurrence Report when accident or unexplained injury occurs." - Review of Resident #7's medical record occurred on October 10-12, 2011. The facility admitted the resident in December 2010. The resident's current diagnoses included frontal lobe dementia related to removal of a brain tumor, legally blind, and diabetes. Resident #7's quarterly Minimum Data Set (MDS), dated 07/04/11, identified he was cognitively intact, demonstrated behaviors including hitting or scratching himself, verbalizations/vocalizations such as screaming four to six days of the seven day assessment period, and required extensive assistance of two persons for transfers. Resident #7's current care plan, initiated in January 2011 and reviewed by facility staff on 07/07/11, stated, "Problem, I have a long standing mobility deficit. . . . Approach . . . all transfer[s] with the assist of two or use of the EZ stand [mechanical lift] . . . Problem, I currently have no skin issues . . . Approach . . . observe his skin for any areas of impairments or changes . . ." Resident #7's Skin Charting, dated 08/24/11, identified "Bruises, Left posterior hand - dull purple bruise 7 x [by] 4.4 cm." This report lacked an explanation how or when this bruise occurred. The resident's medical record, including nurse's notes, lacked explanation or evidence of an investigation regarding how the bruise, identified on 08/24/11, occurred.	F 226		

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F 226	Continued From page 3 Observation throughout the survey identified Resident #7 self-propelling his wheelchair in his room and in the hallways. During an interview on 10/12/11 at 11:30 a.m., an administrative nursing staff member (#7) reported she was uncertain if facility staff investigated the origin of Resident #7's bruise. Facility staff provided no additional information. Resident #7's MDS and medical record identified his verbalizations and behaviors were disruptive to other residents. Skin Charting identified a 7 x 4.4 cm bruise to the resident's left hand, without explanation or evidence of investigation. Failure to investigate Resident #7's left hand bruise limited the staff's ability to determine the cause and implement corrective action, including the potential for response by staff or other residents to his grabbing, slapping, and sometimes disruptive verbalizations. - Review of Resident #6's medical record occurred on October 10-12, 2011. The resident's current diagnoses included dementia and scoliosis. Resident #6's admission MDS, dated 08/07/11, identified short and long term memory problems, impaired range of motion (ROM) for upper and lower extremities, and required extensive assistance for all activities of daily living (ADLs). Resident #6's ADL Care Area Assessment, dated 08/15/11, identified the resident was dependent on staff for ADL and ROM deficits. Resident #6's current care plan, stated, "Problem, [Resident #6] is totally dependent on staff in all areas of cares.	F 226		

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F 226	Continued From page 4 [The Resident] requires the use of the EZ lift for all transfers . . . Problem [Resident #6] has stage two pressure ulcer in area of [the resident's] left shoulder. Resident has scoliosis with contractures, is incontinent of bowel and bladder and is thin. . . . Approach . . . reposition every one to two hours . . . implement any preventive measures as indicated . . . [revised 09/22/11] Geri sleeves [protective sleeves] bilateral arms. Review of Resident #6's EMR skin charting identified the following: * 09/17/11 - an anatomical diagram showed an arrow pointing to the inner crease of the right elbow and stated, "0.8 cm x 1.2 cm skin tear with dried blood at edges and dry skin flap at superior edge of skin tear. . . ." * 09/20/11 - an anatomical diagram showed an arrow pointing to the inner crease of right elbow and stated, "1.3 cm x 0.8 cm blister adjacent to a 1 cm x 0.8 cm scabbed skin tear. . . ." *9/22/11 - an anatomical diagram showed arrows pointing to each of the posterior left and right elbows and stated, ". . . Left lateral elbow - skin tear - scabbed 0.4 [cm] x 0.3 cm . . . Right medial elbow - skin tear and blister - scabbed 1.7 [cm] x 1.7 cm. Blister is broken and scabbed. . . ." Resident #6's nurses note, dated 09/22/11, identified Geri sleeves placed on the resident's bilateral arms to protect fragile skin. During an interview on 10/13/11 at 3:30 p.m., a staff nurse (#9) stated friction from Resident #6's clothing caused the residents' skin tears and identified the implementation of Geri sleeves. The staff nurse (#9) reported the facility did not complete an investigation regarding the cause of	F 226		

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F 226	Continued From page 5 Resident #6's skin tears. The facility staff did not provide additional documentation regarding an investigation of Resident #6's skin tears. Failure of the facility to assess, investigate, and evaluate the origin of Resident #6's skin tears limits the facility's ability to accurately implement interventions to prevent further injuries for Resident #6 as well as other residents who are dependent on staff for ADLs.	F 226		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to ensure 3 of 7 sampled residents (Resident #3, #6, and #7) and 1 of 2 supplemental residents (Resident #14) who required assistance with meals received care that maintained and enhanced each resident's dignity. Failure to inform Resident #7 of placement of meal items limited his ability to eat his meals independently in a dignified manner. Facial scraping and re-feeding Resident #3, #6, and #14 did not enhance their dignity. Findings include: - Review of Resident #7's medical record occurred on October 10-12, 2011. The facility admitted the resident in December 2010. Current	F 241	(F241) For Residents #3, #6, #7, #14 and all other residents at NDHC, staff will be educated on maintaining dignity during dining, including proper feeding techniques and appropriate assistance to maintain and enhance the resident's self esteem and self worth. Staff educational meetings will be conducted by Lisa Becker, licensed dietician, on November 15, 2011. Dining room observations will be conducted by staff in a variety of departments to gain observations from a variety of discipline's perspectives related to dignity and maintaining resident's own abilities, including using a napkin to wipe food off resident's face, as needed, not using utensil to scrape food off face, and explaining food placement for vision-impaired residents. QA data will be gathered during observations and reported monthly to the QA&I Committee.	11/14/11

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F 241	Continued From page 6 diagnoses included legally blind. The resident's quarterly Minimum Data Set (MDS), dated 07/04/11, identified he understood others and made himself understood, demonstrated behaviors including hitting or scratching himself and verbalizations/vocalizations such as screaming four to six days of the seven day assessment period, and required supervision and setup help with eating. Resident #7's Activities Care Area Assessment (CAA), dated 01/17/11, identified the resident could read large print headlines in the newspaper and required someone to read the newspaper articles to him. Resident #7's current care plan, initiated 01/18/11 and reviewed by facility staff on 07/07/11, stated "Problem, I have a vision deficit in that I can see large objects but I am unable to identify details in that object. . . . Approach . . . tell me what is on my plate when you serve me meals. . . ." Observation of Resident #7 in the 300 wing dining room for the evening meal on 10/10/11 and the breakfast, noon, and evening meals on 10/11/11 identified the resident seated in a wheelchair at a table by himself. During these meal observations facility staff members brought the resident his meal and drink items and failed to inform him of what was being served or the placement of the items, until the resident asked during the evening meal on 10/10/11. These observations included the following: *10/10/11, 5:35 p.m., evening meal - Resident #7 received his meal of salad, creamed beef on toast, and crackers in sealed plastic wrap. The resident pushed the plate and meal items with his fork and asked "What have you got here now?"	F 241		

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F 241	Continued From page 7 An unidentified staff member told him what the meal items were but failed to tell him of the placement. The resident struggled to open his crackers and then continued to eat his meal without opening the crackers. Facility staff members in the dining room failed to offer or open the crackers for him. *10/11/11, 11:55 a.m., noon meal - Resident #7 received his meal of steak, mashed potatoes, green beans, and cake with topping in a dish with a clear plastic cover. The resident attempted to eat the cake with his fork, however did not remove the cover. After repeated attempts to use his fork and the fork striking the clear plastic cover, Resident #7 did remove the cover and ate his cake. Facility staff members in the dining room failed to offer or remove the cover for him. - Observations in the 200 wing and 300 wing dining rooms identified the following: *300 wing, 10/10/11, 5:45 p.m. - An unidentified certified nursing assistant (CNA) staff member fed Resident #6 her evening meal. The CNA scraped food material from the resident's face and re-fed the scraped items to the resident. 10/11/11, 8:40 a.m. - A CNA staff member (#5) fed Resident #3 her breakfast meal. The CNA scraped food material from the resident's face, mixed the scraped material with the other meal items, and re-fed the mixture to the resident. 10/11/11, 12:00 noon - A CNA staff member (#5) fed Resident #3 her noon meal. The CNA scraped food material from the resident's face and re-fed the scraped material to the resident. 10/12/11, 8:35 a.m. - A CNA staff member (#10) fed Resident #3 her breakfast meal. The CNA scraped food material from the resident's face and re-fed the scraped material to the resident.	F 241		

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	355076	A. BUILDING _____ B. WING _____	10/12/2011

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F 241	Continued From page 8 *200 wing, 10/11/11, 12:05 p.m. - A CNA staff member (#6) fed Resident #14 her noon meal. The CNA scraped food material from the resident's face and re-fed the scraped material to the resident. During interview, on 10/12/11 at 11:30 a.m., a supervisory nursing staff member (#7) confirmed facility staff should provide Resident #7 with assistance during meals and should inform him of the meal items served and the placement of the meal items. This staff member agreed facility staff should not scrape food material from residents' faces, should not mix the material with food and feed it to the residents, and should have used napkins to wipe the residents' faces. Failure to inform Resident #7 of the meal items served, the placement of the meal items, and failure to provide him with assistance during meals, did not maintain or enhance his personal dignity.	F 241		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review, resident group interview, family interview, and staff interview, the facility failed to assess the behavior exhibited by 1 of 7 sampled residents (Resident #7) requiring	F 250	(F250) For Resident #7 and all other residents at NDHC, medically related social services will be provided to attain/ maintain highest practicable physical, mental and psychosocial well-being of each resident. A policy has been developed to identify, track and manage behaviors for all residents in LTC at NDHC. (See attached policy)	11/14/11

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F 250	Continued From page 9 the use of behavior altering medications, develop and implement specific individualized interventions, and monitor the effectiveness of the interventions used in response to specific behaviors. Failure to assess the contributing factors/causative reasons for Resident #7's verbally abusive and physically abusive behaviors towards other residents. These failures did not allow the resident the opportunity to experience a potentially attainable improved quality of life and placed Resident #7 at risk of retaliation from other residents. Findings include: - On 10/11/11 at 10 a.m., a group interview occurred with seven residents identified by the facility as interviewable. During this interview, one resident (A) expressed concern about Resident #7 hollering out frequently. Resident A indicated he/she is not able to spend time in his/her room during the day because Resident #7's hollering out is disruptive to him/her. Resident A indicated he/she has talked with staff about his/her concerns, but does not feel any changes have occurred. - Review of Resident #7's medical record occurred on October 10-12, 2011. The facility admitted the resident in December 2010. Admission diagnoses included frontal lobe dementia related to removal of a brain tumor, delusions, and legally blind. The resident's quarterly Minimum Data Set (MDS), dated 07/04/11, identified the resident as cognitively intact and demonstrating behaviors, including hitting or scratching himself and verbalizations/vocalizations such as screaming	F 250	Interdepartmental staff will be educated regarding Behavior Management policy on November 15, 2011, at an all staff education meeting. Resident #7 will have Behavior Observation Form and 24 Hour Behavior Monitoring log completed and individualized interventions added to care plan. (See attached forms and care plan) QA data will be collected regarding completion of Behavior Observation Form, 24 Hour Behavior Monitoring log and appropriate interventions care planned. This data will be collected by Social Services staff and LTC QA RN and submitted to QA&I Committee monthly.	

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F 250	Continued From page 10	F 250		

four to six days of the seven day assessment period.

Resident #7's current care plan, initiated in January 2011 and reviewed by facility staff on 07/07/11, stated "Problem, Psycho-Social Wellbeing . . . I had a brain tumor which has taken away most of my eye sight and has changed my personality. . . . Approach . . . Let me know what activities are happening so that I can attend the things I like. . . . Allow me to talk about the losses I have had and how I am feeling. . . . Problem, Behaviors, I am fixated with the younger female CNA's [certified nursing assistants]. . . . Approach . . . [Multiple approaches related to behaviors towards staff.] . . . Make referral for psychiatric evaluation as needed. . . . Problem . . . I have lived her [sic] before. . . . I do like to visit with others . . . Approach . . . I like to go outdoors, keep up with the news, listen to music, watching movies and be with people. . . . [revised 09/12/11] Please visit me 3 x [times] a week. Mornings are best as I'm more agitated and calling out when I first get up. . . ." The care plan failed to identify Resident #7's verbal behaviors, the effect on other residents, or approaches for dealing with these behaviors.

Resident #7's Activities Care Area Assessment (CAA), dated 01/17/11, identified the resident could read large print headlines in the newspaper and required someone to read the newspaper articles to him.

Resident #7's Activity Attendance Record for the 30 day period September 12, 2011 through October 12, 2011, showed the resident "hollaring" while attending group activities, independent

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F 250	Continued From page 11	F 250		

grooming in his room, and talking to himself in his room. Resident #7's nurse's notes included nearly daily entries identifying behaviors including "hollaring," and removal from group activities.

Resident #7's medical record included scheduled psychiatric visits, most recently on 09/14/11. These visits identified medication implemented to manage the resident's behaviors and lacked recommendations for approaches for facility staff regarding behaviors affecting other residents.

Resident #7's medical record identified he grabbed or slapped other residents on 08/31/11, 10/10/11, and 10/11/11. The record also identified episodes several times each week, of up to a full day duration, of the resident loudly calling out or talking to himself without any care needs expressed.

During interview, on 10/11/11 at 11:35 a.m., Resident #7's family member (A) reported he visits the resident nearly every day; the resident worked as a bookkeeper, including the use of computers, until the effects of his dementia limited his function; the resident has been medically and psychiatrically evaluated and his verbalizations are part of his dementia; and, treatment recommendations have been limited to medications. The family member (A) reported he believes the resident grabs or slaps others when they do not respond to his conversation and the resident is not able to clearly see the other person.

Observation throughout the survey showed Resident #7 self propelling his wheelchair in his room. The resident talked to himself when in his

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	355076	A. BUILDING _____ B. WING _____	10/12/2011

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

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F 250	Continued From page 12	F 250		

room, loud enough to be heard in the hall and several rooms away. Observation, on 10/11/11 at 9:45 a.m., identified the resident quietly seated in his wheelchair in the Activity Room while a staff member read to him from a book. Resident #7 responded appropriately to his name, used a loud voice in his responses, and, at times, repeated what was spoken to him.

During interview, on 10/12/11 at 1:15 p.m., a supervisory activities department staff member (#3) reported the staff offered Resident #7 one-to-one visits three times each week at the time of admission. This staff member reported the facility then stopped this due to the resident having frequent visitors and resumed the one-to-one visits three times each week on 09/12/11. This staff member reported resumption of one-to-one visits due to Resident #7's increase in verbal behaviors. This staff member also reported the resident may be loud and disruptive during group activities and is then returned to his room without activities. This staff member reported the facility had not attempted activities such as assistance with computer skills or talking books.

During interview, on 10/12/11 at 3:30 p.m., a supervisory social work department staff member (#4) reported Resident #7 receives individual attention when he is "loud" in a group or talking to himself. Resident #7's medical record lacked evidence of social services involvement in addressing his medically related social needs.

During the interviews on 10/12/11 at 1:15 p.m. (staff member #3) and at 3:30 p.m. (staff member #4), these staff members reported the facility did

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F 250	Continued From page 13 not have a multi-disciplinary approach to assist the staff and Resident #7 to manage his behaviors and to reduce the effects of these behaviors on other residents. Resident #7's diagnosis of frontal lobe dementia limits his judgment and ability to control his behaviors. Facility residents voiced their concern regarding the impact his behaviors have on their daily activities. The facility staff and the resident's family member (A) identified the resident enjoyed the newspaper, but required someone to read the articles to him due to his limited vision, worked with computers until limited by his illness, and remained cognitively intact. Resident #7's behavior management plan consisted of one-to-one visits three times each week, medications as prescribed by the physician, and returning him to his room in response to his behaviors. Failure to provide a multi-disciplinary behavior management program for Resident #7 placed the resident at risk of retaliation by other residents, placed other residents at risk of verbal and physical abuse by Resident #7, limited facility residents' ability to spend time in their rooms as they wished, and limited the mental and psychosocial well-being of Resident #7 and other residents who attended activities and resided near his room.	F 250		
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	F 323	(F323) For Resident #6 and all other residents at NDHC, a side rail assessment will be completed to determine the most appropriate use of side rails for the individual resident. (See attached assessment)	11/14/11

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F 323	Continued From page 14 prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy and procedure, and staff interview, the facility failed to ensure the environment remained free of accidents and hazards for 1 of 4 sampled residents (Resident #6) with side rails that function as a grab bar when in the "up" position, or as a side rail in the "down" position. Side rails in the "down" position limit the normal exiting pattern from a bed creating a hazard when residents attempt to independently get out of bed. Failure to accurately evaluate and analyze the use of assistive devices poses a potential risk for entrapment and injury. Findings include: Review of the facility's policy and procedure, "PROCEDURE FOR INJURIES," occurred on 10/12/11. This document, revised April 2011, stated, ". . . POLICY: RNs [Registered nurses], LPNs [licensed practical nurses], and CNAs [certified nurse assistants] are to report all scrapes, bruises, skin tears, swollen areas etc. to their charge nurse AS SOON AS POSSIBLE. The Charge Nurse shall assess the injury. If it has been charted before and investigated, no need to address again. . . . There is no need to do protocol sheet if injury is explained. . . . PROCEDURE: 1. Chart initial assessment in Nurses Notes. . . . 2. Chart description of injury on Skin Assessment per EMR [electronic medical	F 323	The assessment will be completed upon admission, quarterly with each MDS assessment, and if any injury occurs. A Side Rails policy has been developed and implemented. (See attached) Nursing, Maintenance, Therapy and Social Services staff will be educated regarding the Side Rails policy and their role in maintaining a safe environment for all residents at NDHC at meeting on November 15, 2011. QA data will be collected regarding proper use of side rails by QA RN and LTC staff nurses and reported to QA&I Committee monthly. (See attached)	

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F 323	Continued From page 15 record], indicating location of each injury. . . 3. Measure bruise and record description on Skin Assessment per EMR. . . ." Review of facility policy and procedure, "CHARTING GUIDELINES FOR SKIN ASSESSMENTS," occurred on 10/12/11. This document, revised April 2011, stated ". . . POLICY: CNAs will report all scrapes, bruises, skin tears, blisters etc. to their Unit Nurse . . . PROCEDURE: 1. Unit Nurse will assess the injury. . . . If not yet charted . . . Document on Skin Assessment/EMR the date, location, size, description and explanation . . . Further investigation by DON/ADON [director of nursing/assistant director of nursing] required when . . . bruise is larger than 2 cm [centimeters] . . . bruise, skin tear, scrape etc. is unexplained . . . fill out Occurrence Report when accident or unexplained injury occurs." Review of facility policy and procedure, "PHYSICAL RESTRAINT USE," occurred on 10/12/11. This policy, revised in April 2004, stated, " . . . every resident has the right to be free from any physical restraint imposed for purposes of discipline or convenience, and not required to treat the resident' s medical symptoms. . . . DEFINITIONS: A physical restraint is defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident' s body that the individual cannot remove easily which restricts freedom of movement. . . .These can include . . . full side rails. There may also exist facility practices which could be defined as a restraint if the intended purpose in individual resident circumstances is to restrict freedom of	F 323		

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F 323	Continued From page 16 movement. . . . PROCEDURE: 1. The decision to apply physical restraints will be based on an assessment of each resident's capabilities . . .The plan of care will contain a schedule or plan of rehabilitative training to enable the progressive removal of restraints, or the progressive use of less restrictive means. . . . This systematic approach will assure that restraints are not being applied for purpose of discipline or convenience. . . . 5. The use of therapeutic interventions will be identified in the care planning process . . . 6. Prior to the use of the restraint. . . . Explanation of potential negative consequences associated with the use of the restraint will be discussed with resident, legal representative or interested family member. 7. Provision will be made for the use of a restraint or therapeutic intervention which provides each individual resident with the maximum amount of freedom of movement. . . ." Review of Resident #6's medical record occurred on October 10-12, 2011. The resident's current diagnoses included dementia, osteoporosis, and scoliosis. An admission Minimum Data Set (MDS), dated 08/07/11, identified short and long term memory problems and extensive assistance of one person for all activities of daily living (ADLs). The MDS failed to identify the use of a restraint. A nurse's note, dated 08/22/11 at 1:02 a.m. stated, "Resident has a bruise to the left knee and shin due to one leg being out of bed and being up against the side rail of the bed as resident sleeping on right side." A nurse's note dated 09/09/11 at 3:39 p.m. stated, "Resident #6 found on left side with legs off edge of bed and attempting to get up."	F 323		

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F 323	Continued From page 17 Resident #6's current care plan identified the resident had the potential for falls and stated, ". . . Found [with] feet over the edge of the bed," and the approaches, dated September 2011, included ". . . low riser bed, landing pads on both sides of bed - when in bed." These interventions would not prevent Resident #6 from additional injury when the side rail is in the "down" position. Observation throughout the survey identified left and right side rails on Resident #6's bed positioned in the "up" grab bar position and capable of being placed in the middle of the bed in the "down" position. Observations at 11:05 a.m., 1:40 p.m., and 3:15 p.m. on 10/11/11 identified Resident #6 held on to the grab bars to reposition during cares. During an interview, on 10/13/11 at 11:30 a.m., an administrative nurse (#7) agreed facility staff could move the side rail from the "up" grab bar position to the "down" position in the middle of the bed. This staff member (#7) confirmed the side rail in the "down" position would limit the resident trying to get out of bed. An interview, with a staff nurse (#9) at 3:30 p.m. on 10/13/11, identified the facility lacked a side rail or restraint assessment for Resident #6 as the staff did not consider the side rail as a restraint from Resident #6. Staff nurse (#9) failed to provide additional information regarding corrective action implemented related to the bruise on Resident #6's leg. The facility staff identified Resident #6 experienced a bruise on 08/22/11 to her left leg	F 323		

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F 323	Continued From page 18 from the side rail. Failure to identify, assess, and care plan the side rail as a restraint and accident hazard placed Resident #6 and all facility residents with this type side rail at risk of unnecessary use of restraints or injury.	F 323		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure a safe and sanitary environment for residents, staff, and the public regarding the lack of anti-siphon backflow valves on the hand held hoses for 2 of 2 shampoo sinks in the facility barber/beauty shop. Failure to ensure anti-siphon backflow valves were in place created the potential for siphoning contaminated water into the potable (drinking) water system in the event of loss of water pressure causing widespread contamination of the facility and community water system. Findings include: Observation during the environmental tour, on 10/12/11 at 9:15 a.m., identified two shampoo sinks in the facility's barber/beauty shop. Both sinks included rinse hoses placed on the bottom of the sinks. Observation identified both rinse hoses lacked anti-siphon backflow valves. A supervisory maintenance staff member (#8)	F 465	(F465) Anti-siphon backflow valves were installed 11/7/11 on the hand held hoses for two of two shampoo sinks in the barber/beauty shop. On 10/12/11 all other hoses that can lay in the sink basin were checked for anti-siphon backflow valves. (See attached QA sheet) To ensure that we remain in compliance, staff will be made aware of the necessity of anti-siphon backflow valves for hoses that can lay in the sink basin by presenting the information in the Daily Briefs for one week, and be requested to report any hoses without anti-siphon backflow valves to Facility Services. A line item regarding anti-siphon backflow valves will be added our NDHC Safety Inspections for the Beauty Shop and Housekeeping. (See attached forms)	11/14/11

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F 465	Continued From page 19 present during the tour confirmed the rinse hoses lacked anti-siphon backflow valves and agreed they should be in place.	F 465		