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

PRINTED: 04/29/2014
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
	355122	A. BUILDING _____ B. WING _____	R 04/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHARDTON HEALTH CENTER INC	212 3RD AVENUE WEST RICHARDTON, ND 58652

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{F 000}	INITIAL COMMENTS An on-site revisit was conducted April 21, 2014 to determine compliance with the deficiencies identified during the February 3-6, 2014 certification survey. The revisit sample included 8 sampled residents and 1 supplemental resident for focused review of the areas of non-compliance. The tag numbers enclosed in {} denote citations that remain not met as determined by the on-site revisit.	{F 000}	**F-157 SS=D** 1. Resident #2 Nurse has notified the MD/Provider and family of the incident that occurred on 4-15-14. 2. The failure to notify MD/Provider and family of an incident can negatively affect all residents. 3. The nurse who responded to the incident on 4-15-14 with resident #2 will be re-educated to the requirement in 483.10(b)(11) that all incidents involving residents where there is potential injury or has the potential for requiring MD/Provider involvement must notify MD/Provider and family of the incident. All nurses will be re-educated to the Policy and Procedures regarding "Assessment of Residents and Notification of Physician and Responsible Party". The Policy and Procedure will be changed to reflect both potential for injury and/or change of condition. Policy and Procedure will be discussed with nursing staff on or before May 12, 2014. 4. May 12, 2014	
{F 157} SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of	{F 157}		

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

Administrator | 5-6-14

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 157}	Continued From page 1 this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review, review of the facility's Plan of Correction (POC), and staff interview the facility failed to notify the family for 1 of 1 sampled resident (Resident #2) with a fall. Failure to notify the family when a resident falls does not provide the opportunity for the family to be fully informed of incidents that occur in the facility. Findings include: The facility's POC stated, ". . . Resident #2's nurse re-educated on timely notification of family . . . or resident status change. . ." Review of Resident #2's medical record occurred on 04/21/14. Resident #2's nursing progress notes stated the following: * 04/15/2014 - 4:20 p.m. "[name of nurse practioner] called to nurse to help her with this resident as she was sitting on the floor in front of her recliner. Resident states she was sitting on the edge of her chair to get up to the bathroom and slid off to the floor. Denies "falling" and states she has no pain. . . ." Resident #2's record lacked evidence the facility notified the resident's family of the fall.	{F 157}	**F-157 SS=D Continued** 5. Administrator, DON or designee will monitor incidents requiring MD/Provider or family notification weekly X four then monthly X 11 months. If concerns are identified immediate corrective action will be implemented. The DON will submit a report of the QA monitoring to the QA committee at each scheduled meeting. per DON 5/7/14 dl	

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{F 157}	Continued From page 2 During an interview on the afternoon of 04/21/14 an administrative staff member (#2) stated the above incident is considered a fall and staff are expected to complete an incident report and notify the family when a resident falls.	{F 157}	**F-318 SS=E** 1. Resident #3 had ROM done daily with AM Cares prior to being transferred to his geri-chair. The ROM was not charted as being given by the CNA's. All other residents receiving ROM were charted on as required, but resident #3's charting was forgotten. 2. All residents receiving ROM have the potential for the deficient practice to have their ROM not charted as given. 3. CNA's will be re-educated on the necessity to chart all ROM as given and review policy on ROM on or before May 12, 2014. CNA's will sign off on education materials. 4. May 12, 2014 5. DON will monitor all charts of residents who receive ROM weekly X four then monthly X 11 months, with results given to the QA committee monthly for review. per DON 5/7/14 dl	
{F 318} SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of the facility's Plan of Correction (POC), and staff interview, the facility failed to ensure 1 of 1 sampled resident (Resident #3) with limited range of motion (ROM) received the restorative therapy program developed by the facility's consultant therapy staff. Failure to provide restorative therapy services as recommended did not provide the resident the opportunity to maintain his ROM, balance, strength, endurance, and mobility; and placed him at risk of increased pain. Findings include: The facility's POC stated, ". . . Resident #3 is receiving lower extremity range of motion as recommended per therapist. . . ." Review of Resident #3's medical record occurred	{F 318}		

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{F 318}	Continued From page 3 on April 21, 2014 and diagnoses included history of a cerebrovascular accident, chronic pain, and Alzheimer's dementia. The quarterly Minimum Data Set, dated 03/29/14, identified the resident required total assistance of two or more staff members for bed mobility and transfers, demonstrated impaired ROM in both lower extremities, and had a current Stage II pressure ulcer. The current care plan stated, ". . . Problem: ADL [activities of daily living] Functional/Rehabilitation Potential . . . Approaches: . . . Follow PT/OT [physical therapy/occupational therapy] recommendations. . . ." Observation of Resident #3 throughout the day on April 21, 2014 identified contracted bilateral lower extremities. Resident #3's Physical Therapy Progress Reports stated the following: *10/30/13 - "Consult orders received re: [regarding] LE [lower extremity] tone . . . Tone has increased significantly since prior to hospital stay [September 20-30, 2013] in all 4 extremities & neck, left LE tone worse than right. Left LE I was able to extend to 70 [degrees] of flexion, right to 25 [degrees]. . . . Attempts of stretching aggravated [Resident #3] . . . med [medication] intervention should be followed by therapy for short term to ensure ROM progression & then daily maintenance ROM & stretch by CNA [certified nursing assistant] staff." *12/24/13 - "PT consult re: transfer . . . Resident also needs to be stretched daily as previously requested. . . ." Review of the resident's ROM charting from April 07-21, 2014 identified five days facility staff failed	{F 318}		

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{F 318}	Continued From page 4 to perform daily stretching/ROM to Resident #3's lower extremities. During an interview on the afternoon of 04/21/14, an administrative nurse (#22) stated Resident #3 needed daily stretching and ROM and confirmed staff failed to perform the exercises on five days in April.	{F 318}	**F-327 SS=D** 1. Resident #6 is no longer in the facility. 2. All residents have the potential for dehydration and can be negatively impacted by not receiving adequate hydration. 3. Nursing staff will be re-educated on the need to offer residents fluids at every opportunity to help keep them properly hydrated. Nursing staff will be individually trained on or before May12, 2014. Nursing staff will acknowledge training completion with their signature. 4. May 12, 2014 5. DON will maintain a list of staff who have completed the training and will report training accomplishments to the monthly QA committee. DON will also continue to monitor compliance with Policy entitled "Nutrition and Hydration" weekly X four and then monthly with results provided to the QA Committee. X 11 months Per DON 5/7/14 dl	
{F 327} SS=D	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of the facility's Plan of Correction (POC), and staff interview, the facility failed to ensure 1 of 3 sampled residents (Resident #6) who were dependent on staff to access fluids, received fluids during cares. Failure to offer fluids to dependent residents who are at risk of dehydration placed these residents at greater risk of dehydration, pressure sores, and weight loss. Findings include: The facility's POC stated, ". . . Resident . . . #6 offered fluids with cares and between meals. . . . All nursing staff educated to offer fluids to residents during cares and between meals, particularly those residents that are dependent on staff to access fluids and those residents with altered fluid consistency. . . ."	{F 327}		

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{F 327}	Continued From page 5 - Resident #6's medical record, reviewed on 04/21/14, identified diagnoses of Alzheimer's dementia, Parkinson's disorder, and dysphagia. The quarterly Minimum Data Set (MDS), dated 04/07/14, identified the resident had severely impaired cognition, required total assistance for eating, and on a mechanically altered diet. The current care plan stated, ". . . Problem: Risk for imbalanced fluid volume (dehydration) R/T [related to] poor food/fluid intake and diuretic medication. . . . Approach: . . . Offer fluids when resident is awake: during cares and between meals." Observations showed the following: * 04/21/14 at 12:30 p.m., two Certified Nursing Assistants (CNAs) (#10 and #23) took turns feeding Resident #6 during dinner. The resident took three sips of coffee via nosey cup during the meal. The CNAs transported Resident #6 to the lounge, after he refused more food/drink. * 04/21/14 at 1:37 p.m., two CNAs (#10 and #23) transferred the resident into bed, checked his brief, repositioned him, placed a pillow between his knees, lowered the bed, washed/sanitized their hands, and exited his room. The CNAs (#10 and #23) failed to offer Resident #6 fluids while providing cares. During an interview on 04/21/14 at 4:00 p.m., three administrative staff members (#3, #4 and #22) agreed staff should offer fluids while providing cares.	{F 327}	**F-441 S=D** 1. Staff nurse discarded a lancet into a trash can and not into an approved sharps container on the first of 3 finger sticks. All sharps must be disposed into approved sharps containers. 2. Proper disposal of sharps is important to resident, staff, and others safety in the nursing facility. Improper disposal of sharps is an Infection Control issue that can negatively affect everyone. 3. Staff nurse was re-educated on April 21,2014 that all sharps must be disposed into approved sharps containers. All other nurses will be re-educated individually on or before May 12, 2014. 4. May 12, 2014 5. The DON or designee will randomly observe incidents or situations where sharps are used and need to be disposed of properly in an approved sharps container weekly X 4 and monthly x 11 months	
{F 441} SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an	{F 441}		

per DON 5/7/14 dl

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{F 441}	Continued From page 6 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 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: Based on observation, review of facility policy,	{F 441}	**F-441 SS=D Continued** thereafter, to ensure proper disposal of sharps. Results will be reported to the QA Committee monthly for review.	

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{F 441}	Continued From page 7 and staff interview, the facility failed to follow infection control standards regarding hazardous medical waste disposal during 1 of 3 observations (Resident #9) of blood glucose monitoring. Failure to dispose of a used lancet (needle) properly may result in needlestick injuries and exposure to bloodborne pathogens. Findings include: Review of the facility policy titled "How To Perform A Finger Stick For Blood Sugar Step-By-Step" occurred on 04/21/14. This policy, dated 03/26/14, stated, ". . . 10. Discard the lancet in the sharps container . . ." Observation on 04/21/14 at 11:55 a.m. showed a licensed nurse (#22) obtained a blood glucose monitor and entered Resident #9's room. The nurse obtained a blood sample by fingerstick using a lancet. The nurse then wrapped the lancet in her glove, and threw the lancet in the garbage. During an interview on the afternoon of 04/21/14, an administrative nurse (#2) stated she expected staff to discard the lancet in a sharps container.	{F 441}		