STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355077	A. BUILDING _____ B. WING _____	05/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEYENNE CARE CENTER	979 CENTRAL AVE N VALLEY CITY, ND 58072

(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 05/20/13 and completed on 05/23/13, the sample included 5 residents for complete review, 17 residents for focused review, and 3 closed records for review. The sample included 1 additional resident to verify specific concerns during the survey.	F 000		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 05/10/12. Based on observation, record review, policy review, resident interview, and staff interview, the facility failed to assess the safety of self-administration of medication (SAM) for 2 of 2 sampled residents (Resident #10 and #13) observed with medication left at the bedside. Failure to determine if SAM is a safe practice has the potential to result in a medication error. Findings include: Review of the facility policy titled "Self-Administration of Medications" occurred on 05/23/13. This policy, dated June 2012, stated, "Policy: Residents will have the right to self-administer their own medications if the	F 176	**F0176 RESIDENT SELF-ADMINISTERS DRUGS IF DEEMED SAFE** 1. Both resident's #10 and #13 were evaluated and neither is able to self-administer medications. 2. All residents who receive medications have the potential to be affected. 3. The "Administration of Medications Orally" policy was reviewed/revised and Nurses and CMAs were educated on policy on 6/18/13. No medications will be left in rooms and Nurses/CMAs will observe resident taking medications unless care planned otherwise.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Lisa Christianson	CEO	6-21-13

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 176	Continued From page 1 interdisciplinary team, consisting of Social Services, Nursing, and Physician, has determined this to be a safe practice. Procedure: 1. . . . it will be determined by the Interdisciplinary team if the resident is capable of self-administration. The following criteria will be used: Adequate vision; Cognitive skills; Physical ability; and Literacy . . . 3. Document the assessment for appropriateness on the Consolidated Order Form, the EMAR [electronic medication administration record] and in the nurse progress notes at least quarterly. . . ." - On 05/21/13 at 9:55 a.m., observation showed Resident #13 in her room eating brunch. On the bedside table was a medication cup containing 6 to 7 pills. There were no staff in the room. The resident stated she takes the medication herself. Review of Resident #13's medical record occurred on all days of survey. Physician orders included the following daily or twice daily medications: Calcium with Vitamin D, Colace (stool softener), Diovan (antihypertensive), multivitamin, omeprazole (antiulcer), Tenormin (antihypertensive), triamterene hydrochlorothiazide (diuretic), and Zoloft (antidepressant). The record lacked an assessment and a physician's order for SAM. During an interview on 05/22/13 at 4:04 p.m., an administrative nurse (#5) stated no residents self administer medications on Resident #13's unit. The nurse stated if staff leave medications with a resident per the resident's request, staff should complete a SAM assessment. - On 05/21/13 at 5:15 p.m., observation showed Resident #10 with a medication cup on her	F 176	4. The "Administration of Medication" QA Form has been reviewed/revised. Residents receiving medications will be randomly monitored for proper medication administration to ensure that Nurses/CMAs are observing that a resident takes their medication. This QA will be done monthly for 3 months, then quarterly for 12 months. The QA will be completed by Nurse Managers, QA Coordinator and DON. 5. The date of completion is June 18, 2013	

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F 176	Continued From page 2 bedside table. The medication cup contained two pills. When questioned regarding these medications Resident #10 stated, "These are my pills. They leave them for me to take." Review of Resident #10's medical record occurred on May 21-22, 2013. The record lacked an assessment for self administration of medication. During an interview on the afternoon of 05/22/13, an administrative nurse (#1) confirmed the facility failed to assess Resident #10's ability to self administer medication.	F 176		
F 323 SS=E	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 prevent accidents. This REQUIREMENT is not met as evidenced by: 1. Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide supervision and assistive devices necessary to prevent accidents for 2 of 19 sampled residents (Resident #2 and #3) who required staff assistance with ambulation and transfers. Failure to ensure the safe transfer/ambulation of residents and implement fall prevention measures (a chair alarm) placed them at risk for avoidable falls and injuries.	F 323	**F-0323 FREE OF ACCIDENTS HAZARDS/SUPERVISION/ DEVICES** F-323 Regarding: Transfers 1. The care plan for resident #2 has been updated to include use of chair alarm as of 5/24/2013. 2. All residents who require assistance with transfers have the potential to be affected.	

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F 323	Continued From page 3 Findings include: Review of the facility policy titled "Guidelines for Moving, Positioning, Lifting & Transferring a Resident" occurred on 05/23/13. This policy, revised 04/08/13, stated, ". . . POLICY: Residents will be moved or re-positioned in a manner that will ensure Resident comfort and not cause injury to Resident or Staff. PROCEDURE: . . . Gait belts: a. Gait belts must be used when hands-on assist is needed for transferring and ambulating residents. b. If resident refuses that a gait belt be used on her/him, it must be brought to the attention of the Nurse and be identified on the care plan. c. CNA's [certified nursing assistants] must have gait belts with them when on duty except for break time. . . ." - Review of Resident #2's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease, generalized pain, degenerative joint disease, and a history of falls. The current Minimum Data Set (MDS), dated 05/02/13, identified short and long term memory problems, moderately impaired daily decision-making skills, and extensive assistance from two or more people for transfers and ambulation. Resident #2's current care plan stated, ". . . I have an ADL [activities of daily living] Self Care Performance Deficit r/t [related to] Dementia . . . I require supervision to limited assist with ambulation in my room at times . . . I require extensive assist 1-2 staff participation to toilet. . . . Supervision to limited assist with transfers. . . ."	F 323	3. The "Guidelines for Moving, Positioning, Lifting and Transferring a Resident" policy was reviewed/revised to include that the Bath Aides carry and use gait belts. CNAs/Bath Aides were educated on updated policy on 6/20/2013. 4. The "Resident Transfer" QA form has been reviewed/revised and will include QA on both CNAs and Bath Aides. This QA will be done monthly for 3 months then quarterly for 12 months. The QA will be completed by the QA Nurse, QA Coordinator and Nurse Managers. 5. The date of completion is June 20, 2013	

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F 323	Continued From page 4 Nurses' notes stated the following: *05/14/13 at 9:43 a.m.: ". . . Care Conference Note . . . Walking is starting to slow quite a bit and needing assistance from staff. When very weak staff assist goes up to 2 and discussion of lift has been talked about. . . ." *05/13/13 at 6:45 p.m.: ". . . Fall Note . . . Res. [Resident] was found in other res. room by the recliner. Res. was sitting on bottom, holding her knees. . . . Res. was assisted off the floor via Hoyer lift [a mechanical lift] and assist of 2. . . . Chair alarm was put under res. for staff to be able to make note of where res. is and where res. is going. . . ." *05/07/13 at 9:55 a.m.: ". . . MDS Coordinator Note . . . The resident is limited-extensive assist of one to meet her daily ADL . . . During this assessment period she has had an increase in pain to her lower extremities which has made ambulation difficult for her. Staff have assisted resident with transfers and monitor her gait. . . ." *03/10/13 at 10:17 p.m.: ". . . Fall Note . . . Res. was in bedroom in her chair when she went to stand up and her leg gave out and she lost her balance and slid to the floor. . . . New interventions put in place to prevent further occurrence [sic]: Res. to have chair alert and bed alarm. PM [evening] CRA's [certified resident assistant] have been asked by this nurse to bring res. out in the dining room to be supervised when able to. . . ." Observations throughout the survey showed Resident #2 sat in the dining room area (unsupervised at times) without a chair alarm in place. The resident's current care plan failed to identify the use of a chair alarm.	F 323		

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F 323	Continued From page 5 Observation on 05/21/13 at 8:08 a.m. showed Resident #2 sat on the edge of her bed and a CNA (#6) entered the room to assist with morning cares. The CNA asked Resident #2 to get up from the bed; however, the resident was unable to do so. The CNA took Resident #2's hand and put her other arm around the resident's shoulders. Observation showed the CNA did not have a gait belt with her. The CNA assisted Resident #2 to stand by pulling on her shoulders and hand. She then assisted Resident #2 to ambulate to the bathroom by holding her hand. Observation showed the resident ambulated with short, shuffling steps and her knees bent. Once inside the bathroom, the CNA pulled down the resident's pajama bottoms and brief to her ankles and instructed the resident to back up to the toilet. Observation showed the resident stood approximately 2 feet from the toilet, took a step backwards, and then started to sit down. The CNA stated, "A few more steps," and guided Resident #2 backwards to the toilet by grabbing her hips. Observation on 05/21/13 at 2:25 p.m. showed a CNA (#6) assisted Resident #2 from the dining room to the bathroom and back to the dining room by holding on to her hand. The resident ambulated with short, shuffling steps and her knees bent. The CNA failed to use a gait belt and did not carry one with her. During an interview on 05/21/13 at 2:59 p.m., a CNA (#6) stated, "She did good yesterday. [pause] She was kind of hunched over. It depends on the day. Maybe her knee is bothering her again."	F 323		

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F 323	Continued From page 6 The facility failed to ensure a consistent transfer approach for Resident #2 and instead allowed direct care staff to determine the transfers needs of Resident #2 with each transfer/ambulation - Review of Resident #3's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease, osteoporosis, generalized pain, and a history of falls. Observation on 05/21/13 at 2:10 p.m. showed a CNA (#6) assisted Resident #3 to the bathroom. Once inside the bathroom, the CNA pulled the resident's pants and brief down to her ankles. The resident stood approximately two to three feet from the toilet. The CNA encouraged the resident to back up and sit on the toilet. Resident #3 took three to four shuffling steps backwards with her pants/brief around her ankles. The CNA placed her hand on the resident's back and guided her to the toilet. During an interview on 05/23/13 at 11:10 a.m., a supervisory nurse (#5) stated the above transfers were unsafe, and she would add the use of a gait belt to Resident #2's care plan. 2. Based on observation and staff interview, the facility failed to ensure 2 of 3 resident care areas maintained acceptable ranges for hot water temperatures. Failure to maintain acceptable ranges creates the potential for burn injuries to residents and staff. Findings include: Observation of water temperatures occurred on	F 323	F 323 Regarding: Water Temperatures 1. The Temperature Controller was replaced on 5/21/2013, during the survey. 2. All residents have the potential to be affected.	

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F 323	Continued From page 7 05/21/13 from 7:50 a.m. to 8:00 a.m. In resident bathrooms on second and third floors temperatures were as follows: Room 2122 at 132 degrees Fahrenheit (F) Room 3105 at 127.4 F Room 3124 at 128.7 F Observation of water temperature occurred on 05/21/13 at 3:45 p.m. with the environmental director (#3). In a resident bathroom on third floor the temperatures was 125 F in room 3124. During an interview on the afternoon of 05/21/13, the environmental director (#3) stated water temperatures are monitored on a quarterly basis and should be maintained between 110 F to 115 F. A review of the "Semi-Annual Domestic Hot Water" form occurred on 05/22/13. This form dated 01/10/13 revealed hot water temperatures on second and third floors ranged from 111 F to 125 F. The facility lacked documentation on hot water temperatures above 120 F. The environmental director (#3) stated staff are to communicate by a written form or verbally to maintenance staff if water temperatures "felt too warm" in resident care areas. The director stated he has not received any recent communication from staff regarding water temperatures.	F 323	3. The hot water temperatures throughout the building will be monitored by Environmental Services on a monthly basis. Checkpoints have been identified where hot water would show temperatures rise the fastest and also at various points to monitor all areas. Water will be monitored to ensure temperature is maintained under 119 F. Maintenance staff was educated on new monitoring QA on 6/12/2013. 4. A "Monthly Hot Water Test" QA form was initiated on 6/12/2013. This QA will be done monthly rather than semiannually by Maintenance staff and the Environmental Services Coordinator will monitor QA to ensure the temperature checks are done monthly and are at the correct temperatures. 5. The date of completion is June 13, 2013.	
F 356 SS=B	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for	F 356		

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F 356	Continued From page 8 resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to prominently post the actual hours worked per shift by registered nurses (RNs), licensed practical nurses (LPNs), and certified nurse aides (CNAs) for 4 of 4 days of survey in 2 of 5 resident care areas (second floor and third floor). Findings include: Observation on all days of survey showed the listing of licensed staff working each shift posted	F 356		

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

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FORM APPROVED
OMB NO. 0938-0391

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F 356	Continued From page 8 resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to prominently post the actual hours worked per shift by registered nurses (RNs), licensed practical nurses (LPNs), and certified nurse aides (CNAs) for 4 of 4 days of survey in 2 of 5 resident care areas (second floor and third floor). Findings include: Observation on all days of survey showed the listing of licensed staff working each shift posted	F 356	**F-0356 Posted Nurse Staffing Information** 1. Posted staffing hours will be moved from the nurses' station doors to the main bulletin board on each floor. 2. All staffing hours will be placed on all activity bulletin boards in all areas. 3. QA will be done quarterly for a year in all areas. QA will be included in our quarterly walk through form. 4. DON, QA nurse and nurse managers will be responsible to monitor staffing hours.	6/25/13

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F 356	Continued From page 9 on a door inside the second and third floor nursing stations. To view the listing, visitors/residents would have to go into the nurses' station area. During interviews on 05/21/13 at 8:00 a.m. and on 05/23/13 at 10:15 a.m. two licensed nursing staff (#1 and #4) stated the listing of nurse staffing has always been posted on the door inside of the nursing stations on second and third floor.	F 356		