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Division of Health Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355044	A. BUILDING _____ B. WING _____	08/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTRAIL BETHEL HOME	615 6TH ST SE STANLEY, ND 58784

(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 08/15/11 and completed on 08/17/11, the sample included 3 residents for complete review, 9 residents for focused review, and 2 closed records for review.	F 000		
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, and staff interview, the facility failed to ensure the residents' environment remained free of accident hazards for 8 of 8 sampled residents (Resident #1, #4, #5, #6, #7, #9, #11, and #12) identified with cognitive impairment residing in beds equipped with side rails, and 1 of 1 sampled resident (Resident #13) with cognitive impairment identified in a closed record who experienced a fall from a bed equipped with side rails. Failure to assess, and evaluate the risks associated with side rails has the potential to cause residents harm who may fall from beds with side rails present. In addition, failure to ensure appropriate spacing between rails could result in resident entrapment, injury, and/or death. Findings include:	F 323		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jail Ruasakka RN DON | TITLE | (X6) DATE: 9-9-11

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 323	Continued From page 1 Observation on survey showed three cognitively impaired sampled residents (Resident #4, #5, and #12) with padded side rails; and seven cognitively impaired sampled residents (Resident #1, #4, #6, #7, #9, #11, and #13) in beds equipped with side rails with falls or a history of falls and/or fractures. - Observations revealed the following: * On 08/15/11 at 4:15 p.m., Resident #1 asleep in bed. One half side rail raised on the exit side of her bed. Bed positioned near the wall. * On 08/16/11 at 10:05 a.m., Resident #1 asleep in bed. One half side rail raised on the exit side of her bed. Bed positioned near the wall. * On 08/17/11 at 8:03 a.m., one half side rail raised on the exit side of Resident #1's bed. Resident #1's medical record, reviewed August 15-17, 2011, identified diagnoses including Alzheimer's dementia, cerebral vascular accident, osteoporosis and history of falls with fractures (03/03/11). The resident's quarterly Minimum Data Set (MDS), dated 06/21/11, identified a Brief Interview for Mental Status (BIMS) score of 3; indicating a severe impairment, limited-to-extensive assist of one-to-two persons for bed mobility, transfer, walk in room/corridor, locomotion on/off unit, falls prior to admission, and restraints (bed rails) not used. Resident #1's current care plan revealed: * "COGNITIVE STATUS: . . . Approaches: . . . She . . . has both long and short term memory loss. She will need assistance with her decision making. . . . [Resident #1] has impaired vision and hearing; she may need things explained and	F323	1. Siderails for residents #1, 4,5, 6,7, 9, 11 and 12. were lowered and staff instructed to leave siderails down at all times. Resident #11 shortly afterward, requested to have siderail on upper left side up. Siderail assessment completed. Memo was issued to staff immediately following the state health department survey outlining need to discontinue use of siderails. 2. All residents have the potential to be affected by the use of siderails. Mountrail Bethel Home has now implemented a policy regarding use of siderails. A siderail assessment will be completed on admission to MBH, hospital return to MBH, quarterly with the MDS and with a significant change for those residents that request to use siderails. 3. MBH has developed a policy on siderail use and assessments. If a resident requests to have a siderail up, an assessment must be completed. Assessments will be done on admit, quarterly, with hospital return and with significant change. Interventions such as low beds, perimeter mattresses, soft mats beside the bed will also be used as indicated. Resident and/or POA will be informed of risks of siderail use. 4. QA Director, Director of Nursing or designated nursing staff will monitor all resident's beds for siderail use and that assessments have been completed for those residents that have requested siderail use. Monitoring to be done weekly X4 weeks,monthly X6 months for one year.	8/17/2011 8/20/2011 8/18/2011 8/17/2007 9/15/2011

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repeated. . . ."
* "FALLS: . . . Gripper socks at night. . . . Silent bed alarm/door alarm on at noc [night]. Has hx [history] turning off bed alarm at times. . . ."

The "Resident Room Care Plan" further identified, ". . . Side Rails: . . . Top Half . . . Safety Devices: Secure care . . . Gripper sox [socks] NOC [at night]. . . Alarms: bed, Door . . . prn [as needed] . . ."

Resident #1's "Fall Assessment Form," dated 06/06/11, identified a total score of 14; indicating the resident as "at risk for falling."

Resident #1's "Interdisciplinary Progress Notes" revealed on 03/03/11 at 3:10 a.m., "Bed alarm going off - Found resident lying on the floor by night stand. . . . "

Review of Resident #1's record lacked evidence of an assessment for the potential risks verses the benefits for having side rails on the bed. The presence of the side rails on Resident #1's bed may pose a safety hazard due to her cognitive deficits and history of falls with fractures.

- Observation on the morning of 08/15/11 identified Resident #4's bed positioned against the wall (resident's right side) with two half rails in the upright position on the wall side; and one half rail up on the exit side of the bed. Observation showed none of the side rails padded. Observation showed the resident not in bed, a fall matt upright at the foot end of the bed, a bed alarm on the bed, and a perimeter mattress on the bed. Observation on the door frame showed a "Falling Star." identifying the the resident at a fall

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F 323	Continued From page 3 risk. On the afternoon of 08/16/11, and on the morning of 08/17/11, observation showed sheepskin padding on Resident #4's side rails. Review of Resident #4's record occurred on all days of survey. Resident #4's diagnoses included dementia, hemiplegia, osteoporosis, and convulsions. Review of Resident #4's annual Minimum Data Set (MDS), dated 06/09/11, identified the resident with severe cognitive impairment (BIMS score of three); required extensive assistance with bed mobility and transfers of two or more persons. The MDS identified the resident did not utilize any restraints, including bed rails, while in bed. Review of Resident #4's current care plan identified the following problems: * "COGNITIVE STATUS: . . . has impaired short and long-term memory skills. She is alert but confused much of the time with disorganized speech. Her mental functioning varies and she has a short attention span. Seizure-like activity may sometimes occur. Her decision-making skills are impaired and she requires cues/supervision on a daily basis. . . ." * "MOBILITY: . . . Bruises very easily related to her medications. . . ." with approaches including "Transfer with full body lift and assist of two. Being very careful due to her bruising very easily. Landing strip. beside bed. . . . " * "POTENTIAL FOR SKIN INTEGRITY IMPAIRMENT: . . . " with approaches including ". . . 1/2 padded side rail up when in bed to assist with turning. Variable Density Mattress. . . ."	F 323		

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F 323	Continued From page 4 * "POTENTIAL FOR FALLS: related to: use w/c [wheelchair], recent falls . . . seizure activity." with approaches of "Falling Star Program." Resident #4's "FALLS ASSESSMENT FORM," dated 06/08/11, identified a total score of 15; indicating the resident as "at risk for falling." Review of Resident #4's nurse's notes identified the following: * A fall occurred on 10/17/10 at 2:50 a.m. The post fall investigation identified staff found the resident on the floor next to the bed "attempting to transfer self from bed to chair." The post fall evaluation did not identify any injury occurred. * 07/23/11 at 10:30 p.m.: "Has had call lite [sic] on numerous times trying to crawl out of bed - wants up in chair now. Very insistent about seeing son. Told time of evening & [and] encouraged to sleep. Staff [with] her & settled to sleep after about [unreadable] minutes." During an interview with an administrative nursing staff member on the afternoon of 08/16/11, the staff member stated Resident #4's side rails should be padded. Review of Resident #4's record lacked evidence of an assessment for the potential risks verses benefits for Resident #4 having side rails on the bed. The presence of the side rails on Resident #4's bed may pose a safety hazard due to the resident's history of a fall, multiple attempts to get out of bed, skin integrity issues, and seizure history. The ability of the sheepskin padding to protect the resident is marginal. - Observation of care for Resident #6 on	F 323		

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F 323	Continued From page 5 08/15/11, at 4:37 showed the resident lying in a low bed with a perimeter mattress with the bed positioned against the wall (resident's left side) with one half rail in the upright position on the wall side of the bed and the exit side of the bed. The two certified nurse aides (CNAs) (#5 and #6) assisting the resident out of bed, raised the level of the bed and assisted the resident to sit at the edge of the bed. The CNAs (#5 and #6) did not lower the side rail before assisting the resident to a sitting position and Resident #6 did not use the side rail to assist herself to sit up. Observation on 08/16/11, at 12:55 showed two CNAs (#4 and #7) assisted Resident #6 with cares and then assisted her to bed. Resident #6 requested to remain lying on her back after staff positioned her in bed. The CNAs (#4 and #7) lowered the bed to the lowest position then raised both half side rails. The side rails were not up for the resident to use for positioning as staff assisted her to bed. Review of Resident #6's medical record occurred August 15-17, 2011. Resident #6's diagnoses included macular degeneration, osteoarthrosis, spinal stenosis, dementia with behavioral disturbance, and urinary incontinence. A quarterly MDS, dated 06/10/11, identified Resident #6 with unidentified cognitive impairment (BIMS score 99, unable to interview); required extensive assistance of two staff for bed mobility and transfers; and did not walk in room or corridor. The MDS identified Resident #6 did not utilize any restraints, including bed rails (side rails) while in bed. Review of Resident #6's current care plan	F 323		

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F 323	Continued From page 6 identified the following: * "Activities of daily living and mobility . . . Falls potential: history of and recent falls . . ." with approaches of "Assist with bed mobility and transfers with 2. Standing lift with assist of 2 or full body lift PRN [as needed] . . . Bed and wheel chair alarms. . . . Falling star program. Low bed. . . ." * The "Resident Room Care Plan" identified "Side Rails: Top Half When in Bed . . . Fall Star Program: Yes. . ." Review of Resident #6 nurse's notes identified the following falls from bed: * "10/01/10 [9:30 p.m.] Resident found on her [left] side [at] end of bed. Bed alarm was sounding - Resident states she rolled out [and] onto her stomach. Resident confused unsure what she was getting up for. [No] injuries - good ROM [range of motion]. Returned to bed [with] assist of three. . . ." * "12/06/10 [10:45 p.m.] Found resident sitting on the floor next to the bed. did [sic] not hit head. Bed was in low position and alarming. Resident states 'I am getting up for the day', attempted to orientate resident to time of day. No apparent injuries. Incontinent of urine. . . ." * The "Post Fall Investigation" form for both of the above falls identified under the section "Mobility . . . Use an assistive device, if so list? Wheelchair" Staff identified side rails as assistive devices for bed mobility, but this information is not included in the investigation of the fall. Review of Resident #6's record lacked evidence of an assessment for the potential risks verses benefits for Resident #6 having side rails on the bed. The presence of the side rails on Resident	F 323		

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#6's bed may pose a safety hazard due to the resident's fall history and skin integrity issues. Failure of facility staff to lower the side rail while assisting Resident #6 to exit the bed created a barrier increasing the potential for injury.

- Review of Resident #7's medical record occurred on August 15-17, 2011. Diagnoses included osteoarthritis, osteoporosis, and Alzheimer's disease. The quarterly MDSs, dated 05/13/11 and 02/11/11, indicated short and long term memory loss, severely impaired decision-making skills, and extensive assist of 1 or more staff for bed mobility, transfers, and ambulation. Both MDSs identified the resident did not utilize any restraints, including bedrails (siderails) while in bed.

Resident #7's care plan, dated 05/26/00, included the problem "Activities of Daily Living [ADLs]: --Needs assist with all ADL's due to confusion/physical inabilities. --Limited ROM [range of motion] (R) [right] shoulder and (L) [left] leg. . . . Is at times resistive to assist with cares. She may strike out at her care givers." with approaches ". . . Assist of 1 or 2 with transfers and ambulation and gait belt. --1/2 side rails up when in bed to assist with bed mobility." The care plan included the problem "Mobility: . . . Balance problem.--may be dizzy when changing position.--At risk for falls due to: . . . thin bones/confusion . . . periods of restlessness/altered perception . . . complaints of dizziness . . ." with approaches ". . . Assist 1 with transfers. . . . Falling star program to alert staff she is at risk for falling. . . . Assist with bed mobility. . . . Has a w/c [wheelchair] alarm."

Resident #7's nurse's notes, dated 01/08/11 at

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9:35 p.m., stated ". . . found lying on floor beside bed trying to sit up. . . ." A risk management note, dated 01/10/11, stated "attached to dolls and doll was on floor, and fell attempting to get doll off floor - not known to attempt to get out of bed on own. . . ."

On 08/16/11 at 9:30 a.m., observation showed a CNA (#11) assisted Resident #7 into bed. The bed contained a perimeter mattress and three half side rails in the up position, two at the head of the bed and one at the foot of the bed next to the wall.

The facility failed to complete an assessment for use of the side rails to determine if they should be considered a restraint. The facility failed to assess the safety risk in using side rails for Resident #7 due to her history of restlessness, resisting cares, striking out, and risk/history of falls.

- Observation on the morning of 08/15/11 identified Resident #11's bed positioned against the wall (resident's right side) one half rail up on the exit side of the bed. Observation showed the resident asleep in bed, bed alarm on the bed, and a perimeter mattress on the bed and an alarm on the outside door of the room. Observation on the door frame showed a "Falling Star."

Review of Resident #11's record occurred on 08/17/11. Resident #11's diagnoses included vascular and Alzheimer's dementia, osteoarthritis, and history of falls.

Review of Resident #11's admission MDS, dated 05/27/11, identified the resident with severe

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cognitive impairment (BIMS score of three); independent with bed mobility and transfers. The MDS identified the resident did not utilize any restraints, including bed rails, while in bed.

Review of Resident #11's current care plan identified the following problems:
* "Potential for falls related to the new environment, dementia, use of a four wheeled walker, and forgetting to use walker at times" with approaches including "Remind [resident] to use her walker . . . 7-7-11 door alarm; 7/19 Bed alarm; Keep floor free of objects"
* The "Resident Room Care Plan" identified "Side Rails: Top Half . . ."

Review of Resident #11's nurse's notes identified the following:
* A fall on 08/15/11 at 5:15 a.m. The note stated: "Found her lying on her left side by door to room entry with walker tipped over beside her - going to B/R [bathroom]. Denies pain anywhere in body . . ."

Review of Resident #11's record lacked evidence of an assessment for the potential risks verses benefits for having side rails on the bed. The presence of the side rails on Resident #11's bed may pose a safety hazard due to the resident's fall history and cognitive impairment.

- Observation on the morning of 08/15/11 identified Resident #5's bed positioned against the wall (resident's left side) with one half rail in the upright position on the wall side of the bed and the exit side of the bed. Facility staff padded both side rails with "sheepskin", and the bed had a perimeter mattress.

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Review of Resident #5's record occurred on August 15-17, 2011. Resident #5's diagnoses included osteoarthrosis, osteitis deformans, osteoporosis, non union of fracture, scoliosis memory loss, macular degeneration, and cataract. A quarterly MDS, dated 06/22/11, identified Resident #5 with moderate cognitive impairment (BIMS score of 12); required extensive assistance of two staff for bed mobility and transfers; and did not walk in room or corridor. The MDS identified the resident did not utilize bed rails (side rails) while in bed.

Review of Resident #5's current care plan identified the following:
* "Mobility: Diagnosis: Osteoarthritis/Paget's disease of the bones. Kyphosis back. . . " with approaches of "Weight bearing as tolerated with strict fall precautions. Do not push ambulation. Transfers with standing lift. . . . 1/2 side rail up when in bed to assist with bed mobility. Side rails padded as she chooses."

During an interview, on the morning of 08/17/11, an administrative nurse (#1) identified Resident #5's side rails were initially padded because she sleeps curled up and her legs lean against the side rails. The medical record lacked information addressing the use and padding of Resident #5's side rails, the nurse (#1) identified she would look for the information. The staff member failed to provide further information.

Review of Resident #5's record lacked evidence of an assessment for the potential risks verses benefits for having side rails on the bed. The presence of the side rails on Resident #5's bed

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may pose a safety hazard due to her reported sleeping habits and potential injuries from leaning against the side rail.

- Review of Resident #12's medical record occurred on 08/17/11. Diagnoses included Alzheimer's disease, hallucinations, delusional disorder, anxiety, and psychosis. The annual MDS, dated 06/03/11, and the quarterly MDS, dated 03/04/11, indicated short and long term memory problems, severely impaired decision-making ability, total assist of two or more staff for bed mobility and transfers, and does not walk. Both MDSs identified the resident did not utilize bedrails (siderails) while in bed.

Resident #12's care plan, dated 12/22/05, included the problem "Mobility: Non-ambulatory and unable to stand. Assist with bed mobility and transfers due to back problems . . ." with approaches "Assist with 2 and total body lift for transfers. Has 1/2 side rails (padded with sheep skin) up when in bed per request for assist with bed mobility. . . ." The care plan included the problem "At risk for falls due to: history of falls/thin bones/confusion/impaired judgement/mental function varies/incontinence/arthritis . . . restlessness/resists cares . . ." with approaches "Assist of 2 with total body lift for transfers, and Falling star program." The MDS and care plan information regarding Resident #12 requiring total assist with bed mobility contradicts with the care plan's reason for 1/2 side rails up to assist with bed mobility.

On 08/17/11 at 11:00 a.m., observation showed a perimeter mattress and two padded side rails on

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTRAIL BETHEL HOME	615 6TH ST SE STANLEY, ND 58784

(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
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Resident #12's bed at the head of the bed. A certified nurse aide (CNA) (#10) stated the rails are padded to protect her skin as she can be combative.

The facility failed to complete an assessment for the use of the side rails to determine if they could be considered a restraint. The facility failed to assess the safety risk in using side rails for Resident #12 due to her history of bruising, resisting cares, and risk for falls.

- Observations on 08/17/11 identified the following:
* At 12:45 p.m., one half side rail raised on the right side of Resident #9's bed.

Resident #9's medical record, reviewed August 16-17, 2011, identified diagnoses of dementia, paranoid schizophrenia, legally blind, osteoporosis and history of falls with fractures (05/11/11 and 08/15/11). The resident's quarterly Minimum Data Set (MDS), dated 06/21/11, identified a BIMS score of 3; indicating a severe impairment, extensive assist of one-to-two persons for bed mobility, transfer, walk in room/corridor, locomotion on/off unit, falls since admission, and restraints (bed rails) not used.

Resident #9's current care plan revealed:
* "COGNITIVE STATUS: . . . Approaches: . . . [Resident #9] will need things . . . explained repetitively due to her memory loss. . . . She does not always make the best/safest decisions - so will need staff . . . for . . . guidance. . . . because of [Resident #9's] impaired vision, she requires daily assistance with her ADLs [activities of daily living]. . . ."

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F 323	Continued From page 13 * "FALLS: . . . Encourage . . . call for help . . . Assist to keep room free of clutter, Falling Star Program, Use of gripper socks at night. . . ." The "Resident Room Care Plan" further identified, ". . . Side Rails: . . . Top Half . . . Safety Devices: Secure care . . . Gripper sox NOC . . . Mobility: . . . Walker . . . Assist of 1 . . ." Review of Resident #9's record lacked evidence of an assessment for the potential risks verses the benefits for having side rails on the bed. The presence of the side rails on Resident #9's bed may pose a safety hazard due to her cognitive deficits, visual deficits, and history of falls with fractures. - Review of Resident #13's closed record occurred on 08/17/11. Resident #13's diagnoses included cerebral degeneration, dementia, osteoporosis, and history of a hip fracture. An admission MDS, dated 04/25/11, identified Resident #13 with moderate cognitive impairment (BIMS score of nine); required extensive assistance of two staff for bed mobility and transfers; and did not walk in room or corridor. The MDS identified the resident did not utilize bed rails (side rails) while in bed. Review of Resident #13's care plan, current at time of stay, identified the following: * "Self care deficit related to adl's [activities of daily living]" with approaches of "Assist of 2 with bed mobility and transfer, per Physical [sic] therapy recommendation. . . ." * "Mobility:/ with potential for falls" with approaches of "Assist of 2 for transfers and bed activity. RCNA [restorative certified nurse aide]	F 323		

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program for gait with w/c [wheelchair] follow up. . . . Turn resident every 2-3 hours when she is in bed."
* The "Resident Room Care Plan" identified "Side Rails: Top Half When in Bed . . . Fall Star Program: Yes . . ."

Review of Resident #13 nurse's notes identified the following regarding a fall from bed:
* "04/29/11 [12:50 a.m.] Resident heard yelling help: Resident lying on floor. Resident states 'she thought she could get up and walk' Pt [patient] states 'she forgot she needs help.' [No] injury. Pt states she doesn't hurt anywhere. Pt states 'she did not hit head.' Resident appears not [sic] have hit head."
* "05/01/11 [7:30 p.m.] CNA [certified nurse aide] reported finding bruises - has a 2 cm [centimeter] purple bruise on Rt [right] hand and 4 cm purple bruise on lf [left] forearm. Denies tenderness. Did have fall on 04/29/11."

Review of Resident #13's record lacked evidence of an assessment for the potential risks verses benefits for having side rails on the bed. The presence of the side rails on Resident #13's bed may have posed a safety hazard due to the resident's fall history and staff concerns that Resident #13 may not consistently use her call light and wait for assistance.

During an interview on the morning of 08/16/11, an administrative staff member (#1) stated the facility does not have a side rail policy or side rail assessment policy or procedure.

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F 323	Continued From page 15 2. Based on observation, record review, review of product labels, and staff interview, the facility failed to ensure the resident environment remained as free of accident hazards as possible on 2 of 2 days of observation (August 16-17, 2011). Failure to secure hazardous chemicals placed residents at risk of exposure to and potential injury from unauthorized use or misuse of the chemicals. Findings include: Random observation of the facility environment occurred on 08/16/11, and a tour occurred with an administrative maintenance staff member (#8) and a housekeeping staff member (#9) at 9:30 a.m. on 08/17/11. Observation showed two doors on Dirty Laundry Room cupboards and three doors on Activity Room cupboards with plastic child-proof latches that failed to latch properly. The staff member (#8) stated the plastic locks only last so long and need to be replaced when broken. Observation showed the door to the soiled utility room with a key pad lock. On 08/16/11 at 10:58 a.m., 12:20 p.m., 1:01 p.m., 3:03 p.m., 5:09 p.m. and on 08/17/11 at 7:55 a.m., observation showed the door closed to the edge of the latch but not all the way, preventing the door from locking. With each observation, the surveyor pulled the door shut to lock. On 08/17/11 during the environmental tour, an administrative maintenance staff member (#8) pushed open the unlocked door to the soiled utility room, and stated the door should be locked	F323	1. Plastic child proof locks were replaced immediately in the Dirty Laundry room cupboards and on the 3 doors in the Activity Room prior to the end of the survey. Door to the soiled utility room with the key pad was repaired. Memo was issued to staff outlining need to keep chemicals away from residents and locked up. Plan to address at next staff meetings for housekeeping and nursing at the end of September. 2. All residents have the potential to be affected by the failure to secure hazardous chemicals and memo was issued to staff outlining this. 3. Child proof locks were replaced immediately to the identified areas in the dirty laundry room and activity room. Memo was issued to staff stating the need to report broken latches and doors that do not close properly to environmental services immediately. Staff also informed that they need to ensure resident safety by ensuring doors close securely behind them. 4. Environmental services, specifically the head housekeeper, will monitor the above areas--dirty laundry room and activity room weekly X4 weeks and then monthly for 1 year.	8/17/2011 8/17/2011 9/20/2011 8/17/2011 8/17/2011 9/15/2011

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due to hazardous chemicals stored in the room. This staff member stated the high humidity caused the door to swell and staff should pull the door shut until it locks.

Observation during the tours showed unsecured chemicals in the following areas:
Soiled Utility Room:
* Aloe Vista body wash/shampoo
* Disinfectant deodorant x 2 cans
* Quat 256 spray bottle
* Quat H spray bottle
* Febreeze spray bottle
* CBC Plus - Bowl Cleaner
* 70% Isopropyl alcohol
* Odor counteractant/air neutralizer

Dirty Laundry Room cupboards
* Odor counteractant/air neutralizer x 2 cans

Activity Room cupboards
* Mousse/hairspray x several cans
* Stencil Adhesive Spray
* Preen Weed Preventer
* Quat 256 spray bottle
* Plastic Clean and Shine
* Mold Armor - patio furniture spray cleaner
* Comet Heavy Duty Abrasive Cleanser
* Cook Top Magic
* Epsom Salts carton
* Miracle Gro - all purpose plant food

The manufacturer's labels included these warnings: "May cause eye irritation," "Keep Out of Reach of Children," "Hazardous," "Extreme Danger," "Hazard to Humans: Danger: Corrosive. Causes irreversible eye damage or skin burns. Harmful if swallowed or absorbed through the

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F 323	Continued From page 17 skin or inhaled," "Harmful or fatal is swallowed," "Danger- flammable," and "Extreme Danger - extremely flammable. Vapors are harmful if concentrated and inhaled. Keep out of reach of children." When asked the morning of 08/17/11 for a policy addressing chemical storage, the facility provided a memo to staff, dated 09/02/08, stating, "As part of the plan of correction, all the chemicals that we routinely use need to be out of reach of the residents and placed in an area in which wandering residents could NOT gain access. . . ."	F 323		
F 356 SS=C	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 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,	F356	1. Form used for the posting of staff data was revised for ease of use. Memo was issued to nursing staff outlining that the staffing form must be completed at the beginning of the shift and must include resident census on each shift. Staff also informed per memo issued that the credentials of the nursing staff need to be written on the white board for residents and family members to read. 2. As above. 3. Staffing form was revised to ensure that resident census was also included at the beginning of each shift as well as nursing and Certified Nursing Assistant hours. 4. QA department and/or Director of Nursing will monitor weekly X4 weeks, monthly X 6 months.	8/17/2011 8/18/2011 8/17/2007 8/18/2011

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F 356	Continued From page 18 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, review of the facility's posting of staff, and staff interview, the facility failed to post the total number and the actual hours worked per shift on 3 of 3 days of survey (August 15-17, 2011) by registered nurses (RNs), licensed practical nurses/licensed vocational nurses, (LPNs/LVNs), and certified nurse aides (CNAs) directly responsible for resident care on a daily basis at the beginning of each shift. The facility also failed to post the resident census on a daily basis. Findings include: On all days of survey, observation showed a white board located across from the nurse's station with three columns, one for each eight-hour shift. The day and evening shift columns contained two names and the night shift column contained one name, all with unidentified credentials. These were followed by the heading "CNAs" and six names listed in the day and evening columns and two names in the night column. A sheet of paper with rows labeled for each shift followed by RNs, LPNs/LVNs CNAs, and Other,	F 356		

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F 356	Continued From page 19 and with columns labeled "Number of staff," "Actual hours worked this shift," and "Total Hours" hung by the white board. The sheet also contained the heading "Resident Census at Start of Shift." The facility failed to fill in the sheet with staffing information prior to the beginning of each shift and failed to complete the census section on all three days. During an interview on 08/17/11 at 12:20 p.m., an administrative nurse (#1) stated staff are supposed to transfer the information from the white board to the staffing sheet at the end of each shift, and agreed staff failed to post the census and staffing information as required.	F 356		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an 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	F 441		

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F 441	Continued From page 20 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/procedure, and staff interview, the facility failed to follow acceptable infection control practices during 2 of 2 observations of glucometer (blood glucose) testing and during 1 of 2 care observations when a commode was utilized. Failure to sanitize the glucometer and appropriately clean the commode pail has the potential to spread pathogens to other residents, staff, and visitors. Findings include: Review of the facility policy titled "Diabetes Care Procedures and Techniques" occurred on 08/16/11. This policy, dated December 2009, stated, "Purpose: To insure safe injection practices to prevent patient/resident - to - patient/resident transmission of bloodborne	F441	1. Any resident at MBH that requires blood glucose monitoring or uses a commode could have been affected. Specifically, resident #6, was affected by the failure to clean the commode pail properly. A memo was issued to all nursing staff, certified nurses aides and travel staff outlining the proper procedure for cleaning of the glucometer with each instance of use and between each resident. Also outlined in the memo was the proper procedure for cleaning the commode pails. Travel staff were involved in both instances. Travel agency and their staff involved were given copy of policy and procedure in regards to the cleaning of glucometers and cleaning of commode pails. 2. Any resident that requires blood glucose montioring or uses a commode has the potential to be affected. 3. Infection Control procedures for cleaning of the glucometer and rinsing of commode pails were reviewed with all nursing staff via a memo. Travel staff are also required to read all memos posted for MBH staff. Travel agency and their staff involved were given copy of policy and procedure in regards to the cleaning of glucometers and cleaning of commode pails. 4. QA Director, Director of Nursing and/or designated nursing staff will monitor weekly X4 weeks, monthly X6 months for one year.	8/17/2011 8/19/2011 9/15/2011

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pathogens. . . . 6. Glucometer will be cleaned and disinfected in between resident contact with MBH [Mountrail Bethel Home] approved disinfectant. . . ."

- On the evening of 08/15/11, observation showed a nurse (#2) exiting a resident room holding a glucometer. The nurse disposed of used supplies, placed the glucometer on the medication cart, removed disposable gloves, and sanitized her hands. Without disinfecting the glucometer, the nurse place the glucometer into a case and closed the case.

Later on the evening of 08/15/11, observation showed a different nurse (#3) exiting a resident room holding a glucometer. The nurse disposed of used supplies, placed the glucometer on the medication cart, removed disposable gloves, and sanitized her hands. The nurse documented in the medication administration record, moved the cart to another hall, and leaving the soiled glucometer on top of the cart, went down the hall to another resident's room. When the nurse (#3) returned to the cart she obtained supplies for the glucometer, and without cleansing the glucometer, entered another resident's room. Upon exiting the resident's room, the nurse (#3) disposed of used supplies, placed the glucometer on the medication cart, removed disposable gloves, sanitized her hands, and then sanitized the glucometer using small white pads.

During an interview on 08/16/11 at 2:55 p.m., the nurse (#3) observed cleansing the glucometer identified she cleansed the glucometer with alcohol pads. The same nurse (#3) identified the facility provides another form of cleanser for the

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glucometer and pointed to a container of Cavi-Wipes on the medication cart. This nurse (#3) identified both the wipes and alcohol pads are disinfectants, and she uses the alcohol pads.

During an interview on 08/16/11 at 5:50 p.m., an administrative nurse (#1) identified the MBH approved disinfected for cleansing a glucometer as Cavi-Wipes, not alcohol pads.

Failure to sanitize the glucometer posed a potential for exposure to possible bloodborne pathogens that may have contaminated the meter.

- During an observation of care on 08/16/11 at 9:15 a.m., a certified nurse aide (CNA) (#4) rinsed urine from the commode pail water from Resident #6's bathroom faucet. Two residents share this bathroom, and the other resident accesses the bathroom independently at times. The CNA (#4) rinsing the commode pail identified when the bathroom lacks a rinsing arm, staff can use water from the sink faucet, but staff would take a commode pail containing stool to the soiled utility room for cleaning.

During an interview on 08/17/11 at 9:27 a.m., an administrative nurse (#1) identified staff are expected to place all soiled commode pails in a plastic bag, bring them to the soiled utility room to rinse, and then return the pails to the residents' rooms.