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	355077	A. BUILDING _____ B. WING _____	C 02/27/2013

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 complaint survey started on 02/26/13 and completed on 02/27/13 the sample included 17 residents.	F 000		
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 prevent accidents. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT CITATION FROM THE SURVEY CONDUCTED ON 05/10/12. 1. Based on observation, record review, review of the mechanical lift operator's instructions, review of facility policy, and staff interview, the facility failed to ensure staff used mechanical lifts appropriately for 2 of 10 sampled residents (Resident #3 and #4) observed transferred with a mechanical lift. Failure to ensure staff used the device appropriately placed the residents at risk for a fall and/or injury during transfers. Findings include: Review of the facility policy "Guidelines for Moving, Positioning, Lifting & [and] Transferring a Resident" occurred on 02/17/13. The policy, revised 01/11/13, stated, "POLICY: Residents will be moved or re-positioned in a manner that will	F 323	**F-0323 Free of Accidents Hazards/Supervision/Devices** **1.** Resident #4 has been reassessed by Nursing and is now being transferred with a Hoyer with all transfers and care plan has been updated. Staff member #12 was pulled from the floor and was placed in the CNA Class that began on March 4th and did not return to floor for further orientation until had completed the 75 hour class. Resident #3 has been reassessed by Nursing and is now being transferred with a Hoyer for all transfers and care plan has been updated. In regards to incident with resident #5: The door lock has been replaced with a keyless entry system so door is unable to be left unlocked. The "Elopement Prevention and Resolution" Policy has been reviewed and revised and staff will be educated on April 9th. **2.** All residents that transfer with an MSL have the potential to be affected. All residents that live in the Circle of Life Cottage have the potential to be affected. **3.** Initial education was provided to CNA/Nursing staff on March 19th and 21st regarding transferring according to	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Craig Thompson — TITLE: CEO — (X6) DATE: 4-2-13

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 323	Continued From page 1 ensure Resident comfort and not cause injury to Resident or Staff. . . . PROCEDURE: 1. Check with Unit Nurse or Resident Care Plan before attempting to move, lift or transfer resident. . . . 4. Mechanical Lifts: . . . b. Mechanical lifts must be used when transferring a resident when it has been determined necessary by the charge nurse or multi-disciplinary team. c. When a mechanical lift is determined necessary, it will be put on the resident's care plan. . . ." Review of the EZ Stand mechanical lift operating instructions occurred on 02/27/13. The instructions stated, " . . . Seat Strap To attach the Seat Strap, first fit and attach the harness in the normal fashion. Then position the loops on the Seat Strap away from the patient. Attach the loops at the end of the Seat Strap to the same hooks that the harness is hooked to. Lengthen the Seat Strap so that it will slide around and under the patient. Stand beside the patient, and with the hand control, press the up button. Raise the patient slightly. Now slide the Seat Strap around behind the patient and underneath the patient's buttocks. Press the button up again, and release it when the patient is in the standing position. . . . " - Observation, on 02/26/13 at 9:02 p.m., showed Resident #4 seated in his room in a wheelchair wearing socks, but no shoes. A staff member (#12) entered the room with a mechanical stand lift (MSL). When asked if she was a Certified Nursing Assistant (CNA) the staff member stated, "I was." then stated she had just returned to work after an absence of two years. A second CNA (#21) entered the room and the two CNAs assisted Resident #4 to stand using an MSL. As	F 323	care plans and the policy "Guidelines for Moving, Positioning, Lifting and Transferring a Resident" was reviewed. There will be another education meeting held on Tuesday, April 9th 2013 to review the policy and re-educate on the importance of following the care plan. The "Elopement Prevention and Resolution" Policy has been reviewed and revised and "Elopement Risk Assessment" was added to Point Click Care documenting for the nurses to complete. Initial education was provided to CNA/Nursing staff on March 19th and 21st regarding changes in" Elopement Prevention and Resolution" Policy and will be repeated on Tuesday April 9th. **4.** The "Monthly Q.A. Report Sheet" has been reviewed and revised and Q.A. will be done by the QA/Education Nurse. Q.A. findings will be reported to the Q.A. Committee. All Elopements will be documented in Risk Management and will be discussed with the Q.A. Committee. T.C. Craig Christianson Adm. 4/4/13 QA starting 3/4/13 x 1 month x 1yr.	4/9/13

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he stood, the resident stated, "That's the worst." Observation showed Resident #4 stood with his left leg bent so his foot did not rest on the base of the lift. The CNA (#12) asked Resident #4 to straighten his leg, but he did not respond. The CNA (#12) stated, "What should we do?" and "I've been gone too long time and things have changed." The other CNA stated she thought Resident #4's should be transferred with a Hoyer lift and was not sure if the care plan had been updated, but stated he could walk to the bathroom with a walker and staff assistance. The CNAs then lowered Resident #4 back into the wheelchair.

One CNA (#12) placed a gait belt around Resident #4's waist and positioned his walker in front of the wheelchair at the bathroom entrance. The CNAs (#12 and #21) then ambulated the resident across the bathroom to the toilet using a gait belt and also holding the resident under his arms. The resident remained without shoes while ambulating. After toileting, the CNAs (#12 and #21) ambulated Resident #4 from the bathroom to his bed in the same manner. Observation showed Resident #4 leaned to the left while ambulating.

Observation, on 02/27/13 at 9:43 a.m. showed three CNAs (#22, #23, and #29) transferred Resident #4 from his bed to the wheel chair. The CNAs placed a gait belt around the resident's waist and positioned the walker in front of the resident, who was seated at the edge of his bed. The CNAs (#22 and #23) held the gait belt and under the resident's arms. Observation showed Resident #4 resisting assistance. He failed to stand upright, but half sat and the walker slid

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forward approximately two feet in front of the resident. The resident leaned forward as the walker moved forward. The CNAs then lifted the resident by the gait belt into his wheel chair.

Review of Resident #4's record occurred on 02/27/13. A quarterly Minimum Data Set (MDS), dated 12/01/12, identified the resident required extensive assistance with transfers, walking in the room, and toilet use. The MDS also showed Resident #4 displayed physical, verbal and other behaviors, and rejected care 1 to 3 days during the assessment period. The resident's current care plan identified a focus, dated 03/09/12, "I have an ADL [Activities of Daily Living] Self Care Performance Deficit r/t [related to] Dementia. . . ." Interventions for the focus included "MSL used for transfer. May allow assist extensive [sic] of [2] et [and] gait belt for transfer PRN [as needed]." (handwritten and dated 01/01/13).

An interview with two CNAs (#23 and #30) occurred on 02/27/13 at 8:55 a.m. When asked regarding work assignments, the CNAs stated they do not have assignment sheets or care cards in the resident's room. They stated if they are unfamiliar with a resident's care, they check the care plan.

During an interview on 02/27/13 at 3:17 p.m., an administrative nurse (#3) stated staff are to transfer Resident #4 with a mechanical stand lift. She stated Resident #4 has experienced a decline and staff should have discontinued the care plan intervention regarding gait belt transfers. The nurse (#3) stated staff are informed of the care needs for residents via the 24 hour report sheets and if unsure should

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F 323	Continued From page 4 consult the resident's care plan. When asked how staff are oriented after an absence from work, she stated the CNA (#12) received orientation upon her return to work and stated she would provide the orientation check list. On 02/27/13 at 5:05 p.m., the administrative nurse (#3) stated she could not locate the orientation check list for the CNA (#12). - Observation on 02/27/13 at 1:55 p.m. showed a CNA (#4) transferred Resident #3 from the bathroom to her recliner using a sit-to-stand mechanical lift. The resident did not bear weight and was in a seated position as she hung from the harness. As the harness straps pulled upward into Resident #3's axillae (armpits), her shoulders raised to ear level. In addition, the seat strap slipped forward directly behind her knees providing no additional support. Review of Resident #3's medical record on February 26-27, 2013 identified the resident's diagnoses included Alzheimer's dementia, anxiety, depression, history of femur fracture with internal fixation device, joint pain in the pelvic/thigh region, and tremor. The annual MDS, dated 01/12/13, identified short/long term memory deficits and extensive assistance from one person required for transfers, locomotion on/off unit, and toilet use. The fall risk assessment, dated 02/12/13, identified Resident #3 as "at risk for falls." Resident #3's current comprehensive care plan identified, "Focus . . . an ADL [activity of daily living] Self Care Performance Deficit . . .	F 323		

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Interventions . . . I Transfer with a MSL [mechanical stand lift] and assist of one. I use a w/c [wheelchair] for mobility . . . Focus . . . history of falls . . . Interventions . . . Review my Fall Prevention Intervention Form . . . " The fall prevention intervention form, revised 06/30/12, identified, " . . . and if needed the lift for her safety . . . Use leg straps on MSL."

During an interview on the afternoon of 02/27/13, a managerial nurse (#5) confirmed staff failed to utilize the stand lift equipment appropriately, thereby placing Resident #3 at risk for harm/injury.

2. Based on observation, record review, and staff interview, the facility failed to ensure the environment remained free of accident hazards for 1 of 1 sampled resident (Resident #5) reported missing from The Circle of Life Cottage (dementia unit) in the past seven months (August 2012 - February 2013). Failure to complete an incident report limited the facility's ability to track and trend incidents. Failure to ensure staff implemented planned interventions following the episode placed Resident #5 and other residents residing The Circle of Life Cottage at risk for injury.

Findings include:

Review of Resident #5's record occurred on 02/27/13. A quarterly Minimum Data Set (MDS), dated 08/02/12, identified the resident with short and long term memory problems, displayed physical, verbal, and other behaviors, wandered and rejected cares 4 to 6 days during the assessment period. The MDS also identified

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F 323	Continued From page 6 Resident #5 required limited assistance with transfers, walking in the room, walking in the corridor and locomotion on and off the unit. Resident #5's current care plan identified a focus, dated 05/03/11: "I have hx [history] of persistent anger with self and others, can have unpleasant mood at times. Little interest or pleasure and short-tempered/easily annoyed. Trouble sleeping . . ." Interventions for the focus included "Allow me to wander safely" (dated 02/03/12). A progress note, dated 08/16/12 at 5:27 p.m., stated: "Type: Elopement. Investigation of incident . . . resident was noticed to have been missing at [4:10 p.m.] on 8/16/12 in the Circle of Life Cottage. Resident was last seen around 3:00 p.m. . . . Social worker was notified and a search was implimented [sic]. Resident was found by this nurse, locked in the maintenance room, located inside a storage room. Follow-up to prevent further elopement: All storage area doors will be locked and staff will need to use a key to enter. Rounds done at beginning and end of each shift to verify that the resident is accounted for and safe." The record lacked evidence staff performed an assessment of the resident's physical status or checked vitals signs when staff located her in the store room, approximately an hour and a half after last seen by staff. An interview with a social worker (#25) occurred on 02/27/13 at 3:00 p.m. The staff member stated the incident occurred when the facility was hosting a picnic and many visitors were in the	F 323		

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building. When asked for the incident report for the above elopement, the social worker (#25) stated staff do not complete reports if the resident is found within the unit.

Immediately following the above interview, a tour of the storage area occurred with the social worker. Observation identified the store room located in a hall west of the nurse's station in the Circle of Life Cottage. Observation showed both the door to the store room and the door to the inner room unlocked. The staff member (#25) stated both doors are to be locked at all times. Observation showed nursing supplies stored in the outer room. The inner room (where Resident #5 was found) contained large pipes with valves attached.

On 02/27/13 at 3:12 p.m. a tour of the area occurred with an administrative maintenance staff member (#26). The staff member stated the inner room contained the controls for the sprinkler system for the Circle of Life Cottage. Observation showed a tool chest with a hammer and a screw driver on top and the drawers unlocked. The staff member (#25) agreed staff should keep both doors locked, place the tools in the drawers, and lock the tool chest.

An interview occurred with a quality assurance staff member (#4) on 02/27/13 at 4:50 p.m. When asked about the incident, the staff member stated she did not recall discussing the elopement at a quality assurance meeting.

An interview with an administrative nurse (#24) occurred on 02/27/13 at 5:05 p.m. The nurse provided a blank form to be completed when an

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F 323	Continued From page 8 elopement occurs, but stated staff did not complete the form when Resident #5 eloped on 08/16/12. The nurse (#24) confirmed the quality assurance committee did not discuss the incident.	F 323	**F-0441 Infection Control, Prevent Spread, Linens** 1. Initial education was conducted at CNA/Nurse Meetings held on March 19th and 21st on "Hand Hygiene" Policy. 2. All residents have the potential to be affected. 3. Initial education was conducted at CNA/Nurse Meetings held on March 19th and 21st on "Hand Hygiene" Policy. CNAs and Nurses will be educated again on the "Hand Hygiene" Policy on April 9th. Education provided on the importance of washing hands with soap and water after completing any care done in the perineal area. 4. The "Monthly Q.A. Report Sheet" has been reviewed and revised and Q.A. will be done by the QA/Education Nurse. Q.A. findings will be reported to the Q.A. Committee. T.C. Craig Christianson QA starting 3/4/13 4/4/13 2 weeks x 3 months then monthly x 1 year	4/9/13
F 441 SS=E	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 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.	F 441		

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F 441	Continued From page 9 (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, and staff interview, the facility failed to follow infection control practices for 5 of 9 sampled residents (Resident #6, #7, #12, #13, and #17) observed during perineal care. Failure to follow infection control practices has the potential to spread infection to residents, staff, and visitors. Findings include: Review of the facility policy titled "Hand Hygiene" occurred on 02/27/13. This policy, revised March 2012, stated, ". . . HAND HYGIENE WITH HAND SANITIZER SHOULD BE PRACTICED: . . . Before and after resident contact . . . Before and after assisting a resident with meals . . . Before and after assisting a resident with personal care . . . Upon and after coming in contact with a resident's intact skin . . . After handling soiled or used linens . . . After handling soiled equipment or utensils . . . HAND WASHING WITH SOAP AND WATER SHOULD BE DONE: . . . Before and after assisting a resident with toileting (cleansing/wiping perineal area or providing incontinent cares) . . . Every time you remove gloves once any care is given in the peri-area. . . ." - Observation on 02/26/13 at 9:25 p.m. showed a	F 441		

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F 441	Continued From page 10 certified nursing assistant (CNA) (#18) transferred Resident #17 to the toilet with a mechanical lift. The resident's brief contained urine and stool. The CNA (#18) completed perineal care, placed a new brief, removed her gloves, and transferred the resident from the toilet to his bed. Once Resident #17 was in bed, the CNA (#18) repositioned the resident, lowered his bed, covered him with a blanket, placed his call light, gave the resident a moist towel for his sore neck, and bagged the garbage. The CNA (#18) then took the linen and garbage to the soiled utility room and sanitized her hands. The CNA (#18) failed to perform hand hygiene after assisting Resident #17 with perineal care and prior to exiting the resident's room. - Observation on 02/26/13 at 9:25 p.m. showed a CNA (#16) assisted Resident #12 with bedtime cares. The CNA donned gloves and provided perineal care, removed her gloves, donned another pair of gloves, and attempted to remove Resident #12's dentures. The CNA failed to perform hand hygiene after providing perineal care and before attempting to remove the resident's dentures. - Observation on 02/27/13 at 1:45 p.m. showed a CNA (#1) assisting Resident #13 to toilet. The CNA donned gloves, performed perineal cares, removed her gloves, and ambulated the resident in the hallway. Interview during these observations confirmed Resident #13 voided and had a bowel movement. When the resident finished ambulating, the CNA assisted the resident into her wheelchair and pushed her into the dining room. The CNA provided Resident #13 with a glass of juice. The CNA proceeded to the	F 441		

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F 441	Continued From page 11 nurses' station, made a phone call, and then went to Resident #7's room. The CNA (#1) failed to perform hand washing after completing perineal care and returning Resident #13 to a safe position, and prior to exiting the resident's room. - Observation on 02/27/13 at 2:15 p.m. showed a CNA (#1) entered Resident #7's room. The CNA (#1) grasped the resident's water glass and held it up to his mouth. The CNA (#1) then changed the resident's wet brief, completed perineal care, placed a clean brief, and removed her gloves. Without performing hand hygiene, the CNA (#1) repositioned the resident, placed pillows to protect his extremities, covered him with a blanket, lowered the bed, and bagged the garbage. After exiting the room, the CNA (#1) disposed of the garbage in the soiled utility room and went to the kitchen to get the resident a snack. The CNA (#1) failed to perform hand hygiene prior to initially providing care to Resident #7, after completing perineal care, and prior to exiting the resident's room. - Observation on 02/27/13 at 2:45 p.m. showed two CNAs (#17 and #19) checked and changed Resident #6's pad. The pad was wet with urine and liquid stool. After performing perineal care, the CNA (#17) removed her gloves, placed a new pad, pulled the resident's pants up, placed the sling for the mechanical lift, repositioned the resident, lowered the bed, and placed her call light. The CNA (#17) then opened the resident's door to see if the lift was in the hallway, bagged the resident's garbage, and then washed her hands. The CNA (#17) failed to perform hand hygiene immediately after completing perineal care.	F 441		

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	355077	A. BUILDING _____ B. WING _____	C 02/27/2013

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F 441	Continued From page 12 During an interview on 02/27/13 at 3:20 p.m., an administrative nurse responsible for infection control (#2) confirmed she expected staff to wash their hands after providing perineal care and ensuring the residents' safety.	F 441	**F-0495 Nurse Aide Work / 4 MO Training/Competency** 1. Staff members #4, #5, #6, #, 7, #8, #9, #10, #11, #, 12, #13, #14 and #15 were pulled from the floor until completion of the 75-hour CNA Training Class. 2. All residents have the potential to be affected. 3. The Policy "Certified Nurse Assistant Training Program" was reviewed and revised and administrative staff was educated on new policy and how the training program will be conducted. The "Certified Nursing Assistant Training Course" was reviewed and 4. Any new hires wishing to be employed as a CNA and are not currently certified will be placed in the next available class being offered. They will be required to complete the 75-Hour CNA Class with a State approved instructor prior to having direct contact with residents. T.D. Craig RD Christianson ~~and Susan DON~~ 4/4/13 QA Nurse will review 3 month for a year	2/28/13
F 495 SS=F	483.75(e)(4) NURSE AIDE WORK < 4 MO - TRAINING/COMPETENCY A facility must not use any individual who has worked less than 4 months as a nurse aide in that facility unless the individual is a full-time employee in a State-approved training and competency evaluation program; has demonstrated competence through satisfactory participation in a State-approved nurse aide training and competency evaluation program or competency evaluation program; or has been deemed or determined competent as provided in §§483.150(a) and (b). This REQUIREMENT is not met as evidenced by: Based on review of facility personnel records and staff interview, the facility failed to ensure 12 of 12 staff members (staff members #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, and #15), hired within the past four months, were enrolled in a department-approved nurse aide training program and deemed competent to provide hands-on care to residents. Failure to ensure certification/competency of caregivers has the potential to affect resident care. Findings include: Review of facility personnel records on 02/27/13 identified the following:	F 495		

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F 495	Continued From page 13 * Staff #5 hired on 11/05/12, had 256.50 hours of hands-on contact with residents between 11/05/12 - 01/13/13; prior to enrollment in the 01/13/13 CNA class. * Staff #10 hired on 11/05/12, had 247.50 hours of hands-on contact with residents between 11/05/12 - 01/13/13; prior to enrollment in the 01/13/13 CNA class. * Staff #15 hired on 11/05/12, had 178 hours of hands-on contact with residents between 11/05/12 - 01/13/13; prior to enrollment in the 01/13/13 CNA class. * Staff #4 hired on 12/24/12, had 183.75 hours of hands-on contact with residents between 12/24/12 - 02/13/13; prior to enrollment in the 02/13/13 CNA class. * Staff #6 hired on 12/17/12, had 265 hours of hands-on contact with residents between 12/17/12 - 02/13/13; prior to enrollment in the 02/13/13 CNA class. * Staff #11 hired on 11/15/12, had 266 hours of hands-on contact with residents between 11/15/12 - 12/13/13; prior to enrollment in the 02/13/13 CNA class. * Staff #14 hired on 12/14/12, had 265 hours of hands-on contact with residents between 12/14/12 - 02/13/13; prior to enrollment in the 02/13/13 CNA class. * Staff #7 hired on 01/28/13, had 29 hours of hands-on contact with residents between 01/28/12 - 02/21/13; prior to enrollment in the March CNA class. * Staff #8 hired on 01/28/13, had 55 hours of hands-on contact with residents between 01/28/13 - 02/24/13; prior to enrollment in the March CNA class. * Staff #9 hired on 02/04/13, had 57.50 hours of hands-on contact with residents between	F 495		

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F 495	Continued From page 14 02/04/13 - 02/24/13; prior to enrollment in the March CNA class. * Staff #12 hired on 01/28/13, had 50.25 hours of hands-on contact with residents between 01/28/13 - 02/26/13; prior to enrollment in the March CNA class. * Staff #13 hired on 02/11/13, had 38.25 hours of hands-on contact with residents between 02/11/13 - 02/27/13; prior to enrollment in the March CNA class. The facility failed to ensure the staff hired to provide direct hands-on resident care were enrolled in a State approved Nurse Aide Training Program, under the supervision of a licensed nurse, and were trained and proficient for the tasks to which they were assigned prior to providing direct hands-on care to residents. See F323.	F 495		
F 496 SS=D	483.75(e)(5)-(7) NURSE AIDE REGISTRY VERIFICATION, RETRAINING Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless the individual is a full-time employee in a training and competency evaluation program approved by the State; or the individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered. Before allowing an individual to serve as a nurse	F 496		

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F 496	Continued From page 15 aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act the facility believes will include information on the individual. If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program. This REQUIREMENT is not met as evidenced by: Based on information from the state nurse aide registry, facility personnel records, and staff interview, the facility failed to ensure 2 of 2 direct care staff (Staff member #27 and #28) working with residents in the facility renewed their certified nurse aide registration within the designated 24 month period. Failure to ensure recertification of caregivers has the potential to affect resident care. Finding included: - Information from the North Dakota Nurse Aide Registry identified staff member #27's CNA certification expired on 05/02/12 and review of facility records on 02/27/13 identified this staff member provided 1,478 hours of hands-on contact to residents from 05/03/12 - 02/12/13 without being recertified.	F 496	**F-0496 Nurse Aide Registry Verification, Retraining** 1. The current list of employed CNAs obtained from Human Resources has been double-checked by verifying name, social security number and registrant number and have been placed on an Excel Spreadsheet. All were found to be active on the Registry. 2. All residents have the potential to be affected. 3. The list has been double-checked and the CNAs name will be verified by cross-checking the Registry with name, social security number and Registrant number. The "Abuse Policy" has been reviewed and revised. 4. The CNA Registrant number will be placed into the payroll system and an e-mail will be automatically generated and sent to and be monitored by the Nurse Managers, Staffing Secretary, QA Coordinator and DON at the end of each pay period to monitor for upcoming renewal needs. If the renewal is not completed by expiration date the CNA will be pulled from schedule and not be allowed to provide resident care until valid proof of certification can be obtained.	4/12/13

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F 496	Continued From page 16 - Information from the North Dakota Nurse Aide Registry identified staff member #28's CNA certification expired on 02/15/12 and review of facility records on 02/27/13 identified this staff member provided 608 hours of hands-on contact to residents from 02/16/12 - 06/19/12 prior to obtaining recertification on 06/19/12. The facility failed to ensure the CNAs hired to provide direct hands-on resident care were recertified according to state/federal law.	F 496		