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 _____	05/10/2012

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

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F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey started on May 7, 2012 and completed on May 10, 2012, the sample included 5 residents for complete review, 18 residents for focused review, and 3 closed records for review. The sample included 4 additional residents to verify specific concerns during the survey.	F 000	**F-176 Resident Self-Administer Drugs if Deemed Safe.** 1. Resident #27 is no longer in the facility. 2. All residents have the potential to be affected. 3. The "Self Administration of Medications" policy will be reviewed/revised, Nurses & CMAs will be educated on the policy. The policy states that we will not allow any medications at the bedside, including over-the-counter medications without multidisciplinary assessment and physician order. [Re-revised policy is attached]). All residents practicing self-administration of medications will be reviewed initially for appropriateness by the interdisciplinary team, then as per policy. 4. Residents practicing self-administration of medications will be randomly monitored for proper assessment/documentation monthly x3 months, then quarterly x12 months. (QA form: F-176 Resident Self Administration of Medications). Results of monitoring will be reported at the QA meetings. 5. Date of Completion: July 11th, 2012	
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: Based on observation, record review, review of facility policy and procedure, resident interview, and staff interview, the facility failed to determine the ability to safely self-administer medications (SAM) for 1 of 1 supplemental resident (Resident #27) who self-administered two medications. Failure to determine if SAM is a safe practice placed the resident at risk for improper spacing and/or missed doses of medication. Findings include: Review of the facility policy titled "Self Administration of Medications" occurred on 05/10/12. The policy, reviewed by the facility March 2012, stated: "Policy: Residents will have the right to self administer their own medications if the interdisciplinary team has determined this to be a safe practice. Procedure: 1. If a resident	F 176		7/11/12

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

[signature] CEO 6-14-12

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 expresses a desire to give his/her own medication, it will be determined by the Interdisciplinary team if the resident is capable of self administration. . . . 2. After the resident has been assessed by the multidisciplinary team and is found to be capable of self administering his/her own medications, the following criteria needs to [sic] addressed on the care plan . . . 3. Document on the Consolidated Order Form and the EMAR (Electronic Medication Administration Record) and in the nurse progress notes at least quarterly." During the initial tour, on 05/07/12 at 10:45 a.m., observation identified a medication cup containing four pills sitting on Resident #27's bedside table. When asked the contents of the cup, Resident #27 stated, "Those are to be take before meals. They are my pancreas medications and my vitamins." Review of Resident #27's medical record occurred on May 9-10, 2012. The resident's medical diagnoses included cerebrovascular disease and intestinal malabsorption. The resident's current care plan identified, "Focus: I have malabsorption syndrome . . . Interventions: . . . Pancrelipase before meals [and] snacks to help [with] absorption . . . Focus: I request to self administer my chloroseptic [sic] throat spray and genteal tears. . . . Interventions: Monitor continuously that I continue to be capable of self administering meds [medications]. Document continued capability of self administering medication per SCC [Sheyenne Care Center] policy. . . ." Resident #27's physician orders identified,"Order	F 176		

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F 176	Continued From page 2 Date: 02/17/12; Calcium Citrate - Vitamin D 315-250 MG-UNIT [milligram] Tablet By mouth . . . Everyday . . . Order Date: 02/16/12; Pancrelipase 5000 units By mouth . . . Everyday . . . 1-2 before all meals . . ." During an interview on 05/10/12 at 10:20 a.m., a pharmacy staff member (#7) described Pancrelipase as a prescription medication. During interviews on 05/09/12 at 9:30 a.m. and 05/10/12 at 10:30 a.m., a managerial nursing staff member (#8) confirmed the facility failed to assess/continuously monitor Resident #27's ability to safely self-administer medications and failed to obtain physician orders to self-administer the above named medications.	F 176		
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to assess the use of a physical restraint for 1 of 1 sampled resident (Resident #2) observed using a wheelchair pummel cushion. Failure to assess, monitor, and re-evaluate the necessity of the device limited the resident's freedom of movement and placed her at risk for decreased physical functioning, falls, and loss of dignity.	F 221		

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F 221	Continued From page 3 Findings include: Review of the facility policy titled "Physical Restraints" occurred on 05/10/12. This policy, revised July 2009, stated, "Policy: . . . Physical restraints are any manual method, physical . . . equipment . . . adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement. . . . Procedure: 1. Complete Restraint Assessment before initiating any . . . restraints . . ." Review of Resident #2's medical record occurred on May 7-10, 2012. Diagnoses included dementia with delusions, aphasia, difficulty walking, and osteoporosis. The current Minimum Data Set (MDS), dated 01/16/12, identified problems with short/long term memory, moderately impaired daily decision-making skills, and extensive assistance needed for transfers and locomotion on/off the unit. The current Care Plan, identified, "Focus: I have an ADL Self Care Performance Deficit r/t [related to] Dementia . . . Interventions: I have a pummel cushion for positioning purposes in my w/c [wheelchair]. I can still get myself up so it is not considered a restraint. . . ." Record review identified staff failed to complete a restraint assessment prior to implementing the use of the pummel cushion. On 05/09/12 at 8:45 a.m., an unidentified certified nursing assistance (CNA) requested the surveyor's presence in Resident #2's room. She stated, "[CNA #9] told me to tell you [Resident #2] is fidgety and attempting to get up." Observation showed a CNA (#9) preparing to transfer the resident using a stand lift. The resident had scooted forward on her bed and appeared to be	F 221	**F-221 Right To Be Free From Physical Restraints** 1. A restraint assessment has been completed for this resident, and OT has re-evaluated the need for the pummel cushion with this resident. The POA is in agreement with its use. 2. All resident with physical restraints have the potential to be affected. 3. The "Physical Restraint" policy will be reviewed/revised and nurses will be educated on the policy. (After careful consideration of the suggestion made by surveyor dated 6/21/12, the policy was re-revised and changes were made.) All residents with physical restraints will have a restraint assessment completed initially and quarterly thereafter with the reason for such and will be documented in their medical record using the restraint assessment form. 4. Resident with physical restraints will be assessed for appropriateness & will have documentation once in the next month, then every 6 months thereafter. (QA Form: F-323 Restraint – Side rails): Results of monitoring will be reported to the QA Committee. 5. Date of Completion: July 11th, 2012.	7/11/2012

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F 221	Continued From page 4 attempting to rise. The CNA (#9) transferred the resident into the bathroom. Following toileting cares, she transferred the resident into her wheelchair with the pummel cushion in place. During interviews on 05/09/12 at 9:30 a.m. and 05/10/12 at 10:30 a.m., a managerial nursing staff member (#8) stated, "The pummel was put in place on 08/23/11. It was initially used for positioning. The resident did fall from her wheelchair [with the pummel cushion in place] on 11/12/11. She hasn't had any falls since. It [the pummel cushion] is keeping her safe." She confirmed, although initiated for positioning, the facility failed to consider/assess the pummel as a possible restraint.	F 221		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on review of employee files, professional reference, facility policy, and staff interview, facility staff failed to implement established policies and procedures for 2 of 6 recently hired employees (staff members #10 and #11). Failure to implement established policies and procedures resulted in the facility allowing direct care staff to work beyond four months without verifying they had achieved active registry status. Findings include:	F 226		

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F 226	Continued From page 5 Nurse Aide Training, Competency Evaluation, and Registry Rules, Chapter 33-43-01-11(3.a.), effective: 07/01/11, page 19, stated, "An individual who is in a nurse aide training and competency evaluation program may be employed to perform nursing or nursing related services under the supervision of a licensed nurse for no more than four months without obtaining registry status." Review of the facility policy titled "Resident Abuse/Neglect" occurred on 05/10/12. The policy, reviewed by the facility January 2008, stated: ". . . SCREENING OF APPLICANTS FOR EMPLOYMENT . . . Prior to employment: . . . Sheyenne Care Center will make reasonable efforts to solicit information regarding any past history of abuse, neglect, mistreatment or misappropriation of property. . . . 2. All potential employees will have registry/licensure checked for current certification/licensure in North Dakota. A copy of current certification card/license with valid expiration date will be obtained for employee file. . . ." During review, two of the six employee files (staff members #10 and #11) were found to be lacking the required reference checks with the North Dakota Abuse Registry. During interview on 05/09/12 at 4:30 p.m., an administrative nursing staff member (#1) provided the following information: * Staff member (#11) completed her nurse aide training program on 07/07/11, and worked as a certified nurse aide in the facility through	F 226	**F-226 Develop-Implement Abuse-Neglect, etc. Policies.** 1. The 2 employees mentioned have been verified for having an active status on the CNA Registry. 2. All employees will be tracked. 3. The "Abuse" policy will be reviewed/revised & administrative staff will be educated. All CNA's will be required to obtain registry status within 4 months of employment, or they will not be allowed to provide resident cares. 4. 20 CNA's will be randomly monitored for appropriate documentation of registry status quarterly x12 months (QA Form: F-226 Develop-Implement Abuse-Neglect Policy). Results of monitoring will be reported to the QA Committee. 5. Date of Completion: July 11th, 2012.	7/11/2012

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F 226	Continued From page 6 03/31/12. * Staff member (#10) completed her nurse aide training program on 08/11/11, and worked as a certified nurse aide in the facility through 05/08/12. The administrative nursing staff member (#1) confirmed the facility failed to determine staff members (#10 and #11) had obtained active status on the registry prior to providing resident cares.	F 226		
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of	F 280		

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F 280	Continued From page 7 professional reference, and staff interview, the facility failed to review and revise the comprehensive plan of care for 4 of 23 sampled residents (Resident #3, #11, #12, and #13). Failure to update the care plan to accurately reflect the residents' current status has the potential to negatively affect the residents' quality of care and limits continuity of care. Findings include: - On 05/08/12 at 1:45 p.m., observation showed a certified nurse aide (CNA) (#4) assisted Resident #11 to ambulate to the bathroom. The CNA changed the resident's wet underwear and discarded the wet incontinence pad. After the resident voided, the CNA assisted with pericares and placed a new pad, before assisting the resident back to her chair. Review of Resident #11's medical record occurred on all days of survey. Diagnoses included debility and urinary frequency. The annual Minimum Data Set (MDS), dated 04/01/12, indicated toilet use with extensive assistance of one person and frequently incontinent of urine. The CNA documentation of Resident #11's toileting, dated April 1 - May 9, 2012, indicated the resident wore an incontinence product and was incontinent one or more times daily on most days. The documentation also showed the resident continent of urine at least once daily. Resident #11's current care plan failed to address her problem of urinary incontinence and interventions to improve or maintain her level of	F 280	**F-280 Right To Participate Planning Care Revised** 1. Residents 11, 12, & 13 Bowel & Bladder assessments were completed and care plans were reviewed/updated to reflect current level of continence. Resident 12 care plan was updated to reflect current method of transfer. For resident #3, dietary has added interventions to address constipation; the care plan has been updated, and the pharmacist has been consulted for alternatives to aide with bowel elimination. 2. All resident have the potential to be affected. 3. The "Bladder & Bowel Assessment and Documentation" policy has been reviewed/revised and the nurses will be educated. Nurses will be educated to update care plans based on MDS/resident's current level of bladder/bowel function. 4. The MDS will be compared with Care Plan quarterly on a minimum of 15 residents to ensure congruence with function and plan of care on all residents and to determine appropriateness of interventions (QA Form: F-280 Bowel and Bladder). Results of monitoring will be reported to the QA Committee. 5. Date of Completion: July 11th, 2012.	

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F 280	Continued From page 8 continence. - On 05/08/12 at 11:45 a.m., observation showed a CNA (#5) wheeled Resident #12 into the bathroom and assisted the resident to stand, pivot, and sit on the toilet. At 12:00 p.m., the CNA (#5) assisted Resident #12 to stand, pivot, and sit in her wheelchair. Review of Resident #12's medical record occurred on all days of survey. Diagnoses included debility, osteoarthritis, and bladder hypertonicity. The quarterly MDS, dated 04/27/12, indicated transfer with extensive assistance of one person, walk in room did not occur, toilet use with extensive assistance of one person, not on a current toilet plan or trial, and frequently incontinent of urine. Resident #12's care plan, dated 01/31/12, stated, "Focus: I have an ADL [activities of daily living] Self Care Performance Deficit r/t [related to] Pain/osteoarthritis. . . . Interventions: . . . TOILET USE: I require extensive assistance, adjust clothing, clean self, transfer onto toilet and transfer off toilet with stand-up lift to use toilet. TRANSFER: I require extensive assist and a stand-up lift with transferring. . . . Focus: I have bladder incontinence r/t Hypertonicity of bladder. . . . Interventions: BRIEF USE: I use Yellow disposable briefs. Check/Change Q2h [every two hours] and prn [as needed]. INCONTINENT: Check me Q 2h and as required for incontinence. . . ." A care conference note, dated 04/30/12, stated, ". . . frequently incontinent bladder . . . toilet per her request. Staff also offer Q2h. . . . Transfer with	F 280		

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F 280	Continued From page 9 extensive assist of one or a stand up lift. . . ." During an interview on 05/10/12 at 9:55 a.m., a CNA (#6) stated sometimes the night shift use the stand lift to transfer Resident #12, and the night shift may check and change her, but the daytime staff take her to the bathroom as the resident tells them when she has to use the bathroom, usually before two hours pass. The CNA stated the resident dribbles, so is usually wet, wears a pad on days, and may wear a brief at night. When asked how staff know what type of toileting care each resident requires, the CNA (#6) replied staff share information during rounds or look in the resident's closet to see what type of incontinence products are stocked. Facility staff failed to ensure Resident #12's plan of care contained updated and consistent approaches to address her problem of urinary incontinence and the resident's current capability to transfer without the use of a stand lift. - Review of Resident #13's medical record occurred on all days of survey. Diagnoses included cerebrovascular disease with hemiparesis (weakness on one side of the body) and constipation. Medications included: Senokot S one daily (decreased from two daily on 04/17/12); MiraLax one scoop every three days; Ultram 50 milligrams four times daily for pain; and Calcium citrate with Vitamin D twice daily. "Nursing 2011 Drug Handbook," 31st ed., Lippincott, Williams & Wilkins, Pennsylvania, pages 773 and 1392, list "constipation" as an adverse reaction for Ultram and Calcium respectively.	F 280		

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F 280	Continued From page 10 Resident #13's quarterly MDS, dated 04/11/12, indicated extensive assistance of one person for toileting, not on a current toilet plan or trial, occasionally incontinent of urine, and occasional bowel incontinence. The CNA documentation of Resident #13's toileting, dated April 1 - May 9, 2012, indicated the resident wore an incontinence product and was incontinent one or more times daily on most days. The documentation also showed the resident continent of urine at least once daily. Review of the Interdisciplinary Progress (IDP) notes showed the following: * 07/15/11 at 9:57 a.m., ". . . Dx [diagnosis] of constipation but it is well controlled on senna s 1 tab BID [twice daily] and mirlax [sic] 17 gm [grams] Q [every] 3days. . . ." * 07/15/11 at 6:27 p.m., ". . . Did have a lg [large] loose stool after supper. . . ." * 07/17/11 at 8:29 a.m., ". . . LRD [licensed registered dietician] visited with resident and her son. Having increased difficulties with constipation. . . . Son requests prune jc [juice] qd [every day] at brunch and tomato jc at brunch and dinner. . . ." * 10/12/11 at 2:38 p.m., ". . . Occ [occasionally] will have invol [involuntary] loose stool. . . ." * 11/09/11 at 4:19 p.m., ". . . having loose stools today" *01/16/12 at 2:00 p.m., ". . . Resident's son noted that resident reported to have loose stools (diarrhea) last few days. Nursing noted to hold some of stool medications, such as Senokot and monitor if dosages need to be changed or cut back.	F 280		

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F 280	Continued From page 11 * 01/16/12 at 2:34 p.m., "Resident requested to not have prune juice qd [every day]" * 01/29/12 at 7:20 a.m., "senekot s [sic] - bid : Held d/t [due to] loose stools yesterday . . ." * 04/11/12 at 2:35 p.m., stated, ". . . [Resident #13] is continent of bowel but has had an increase with occasional bladder incontinance [sic]. Does require staff assistance with pericares, pad and pants placement. . . ." The care plan lacked evidence facility staff addressed Resident #13's problems of bowel incontinence, constipation, and loose stools, or identified interventions to improve or maintain her level of bowel function. - Resident #3's medical record, reviewed May 7-10, 2012, identified diagnoses including dementia with lewy bodies, depression, cerebrovascular disease, paralysis agitans, pain, mild dehydration risk, and constipation. The resident's annual MDS, dated 03/14/12, identified extensive assistance of one person required for toilet use, constipation present, frequent severe pain present, and as needed pain medication provided. The progress notes and faxed order requests identified the following: * 12/14/11 at 4:00 p.m., "Resident asked to speak to nurse. Resident related that she had been very constipated and had trouble with her BM today." * 12/22/11 at 9:20 p.m., ". . . had a small hard stool with rectal bleeding and with difficulty. . . . 11:00 p.m. . . . Resident continues to have problem [with] constipation. Hard stools - difficulty [with] evacuation and rectal bleeding. . . ." * 01/27/12 at 1:39 a.m., "I manually assisted	F 280		

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 _____	05/10/2012

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F 280	Continued From page 12 resident for removal of large hard stool. She tolerated procedure well. . . ." * 02/07/12 at 8:06 a.m., ". . . stool palpable when supp [suppository] given . . ." * 02/27/12 at 7:30 a.m., ". . . lg [large] results . . ." * 03/07/12 at 9:00 p.m., "Resident on toilet and having difficulty passing BM. Large amount soft BM in rectum. Res. [resident] bearing down but unable to pass stool. . . . Large amount soft BM manually removed. . . . Res. stated 'yes' when nurse asked if she was more comfortable. . . ." * 03/14/12 at 10:51 a.m., "MDS Coordinator Note . . . continent of bowel. Res. does have frequent constipation. . . ." * 03/28/12 at 8:14 p.m., "Resident unable to have BM on the toilet. Stool in rectum upon digital exam. . . ." * 04/08/12 at 6:00 a.m., ". . . Supp at 4:00 and XL [extra large] results . . . " * 04/18/12, ". . . Res had been having increasing difficulties with constipation. . . ." The current Care Plan, identified, "Focus: I have a mild dehydration risk. I have difficulties with constipation. . . . Interventions: . . . Offer whole wheat bread with meals . . . Routine and prn [as needed] laxatives as ordered. . . ." During an interview on 05/10/12 at 9:20 a.m., a managerial dietary staff member (#14) indicated she was not notified of Resident #3's increasing difficulties with constipation which resulted in two fecal impactions that required manual extractions. The managerial dietary staff member (#14) stated she had made "no notations indicating the resident did not want dietary interventions." She verified the resident's current care plan failed to adequately address constipation as a focus area.	F 280		

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F 280	Continued From page 13 When asked what types of interventions she typically initiates if/when a resident demonstrates difficulties with constipation, she stated, "Prune juice or prune whip, increased fluids, whole wheat bread, fresh fruit, and vegetables or salads." During an interview on 05/10/12 at 10:30 a.m., a managerial nursing staff member (#8) agreed the resident's current care plan failed to identify constipation as a focus area and failed to include dietary measures. (Refer to F309)	F 280		
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: 1. Based on record review, review of professional literature, review of facility policy, and staff interview, the facility failed to ensure 1 of 1 sampled resident (Resident #3), with a diagnosis of constipation and who required manual extraction of stool on two occasions, received effective interventions to maintain normal bowel elimination patterns to prevent constipation. Findings include:	F 309		

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F 309	Continued From page 14 Berman, Snyder, Kozier, Erb, "Fundamentals of Nursing, Concepts, Process, and Practice," 9th edition, Pearson Education, Inc., New Jersey, pages 1349-1350, stated,"Constipation may be defined as fewer than three bowel movements per week. This infers the passage of dry, hard stool or the passage of no stool. . . . Many causes and factors contribute to constipation. Among them are the following: Insufficient fiber intake, Insufficient fluid intake, Insufficient activity . . . Neurologic conditions, . . . stroke, or paralysis, Emotional disturbances such as depression . . . Medications such as opioids [for pain]. . ." Review of the facility policy, titled "Bowel Program," occurred on 05/10/12. The policy, reviewed by the facility January 2008, stated: ". . . Purpose: Attempt to avoid constipation and the potential for a bowel obstruction. Procedure: . . . 4. The day nurse needs to check the BM [bowel movement] book before the end of her shift and leave a list of residents who have not had a BM in the last three days. These residents will be put on a list for the PM [evening] nurse to administer laxatives. 5. The night nurse is responsible to check if the resident has had results from the laxative, if not, she needs to give the resident a suppository. If still no results, consult Physician." Resident #3's medical record, reviewed May 7-10, 2012, identified diagnoses including dementia with lewy bodies, paralysis agitans, pain, mild dehydration risk, and constipation. The resident's annual Minimum Data Set (MDS), dated 03/14/12, identified extensive assistance of one person required for toilet use, constipation present, frequent severe pain present, and as	F 309	**F-309 Provide Care- Services For Highest Well Being.** 1. Resident #3 bowel status has been assessed and updated as indicated and the care plan has been adjusted. Resident #2 need for adaptive equipment has been reviewed, the care plan was updated and the staff has been educated on the use of his/her adaptive equipment. For resident #3, dietary has added interventions to address constipation; the care plan has been updated, and the pharmacist has been consulted for alternatives to aide with bowel elimination. 2. All resident with changes in bowel status or those using adaptive equipment have the potential to be affected. 3. The "Bladder & Bowel Assessment and Documentation" policy has been reviewed/revised and the nurses/CMA's will be educated. (After careful consideration of the suggestion made by surveyor dated 6/21/12, the policy was re-revised and changes were made.) The "Adaptive Equipment Usage" policy will be reviewed/revised and the nursing and dietary staff will be educated. A list of residents using adaptive equipment will be reviewed/updated by the dietary clerk & nursing and dietary staff will be educated on such. Dietary will place all	

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F 309	Continued From page 15 needed pain medication provided. Upon request, the facility provided the most current bowel assessment, dated 06/15/10, which stated, ". . . Resident is currently continent of bowel . . ." The progress notes and faxed order requests identified the following: * 12/14/11 at 4:00 p.m., "Resident asked to speak to nurse. Resident related that she had been very constipated and had trouble with her BM today." * 12/22/11 at 9:20 p.m., ". . . had a small hard stool with rectal bleeding and with difficulty. . . . 11:00 p.m. . . . Resident continues to have problem [with] constipation. Hard stools - difficulty [with] evacuation and rectal bleeding. . . ." * 01/27/12 at 1:39 a.m., "I manually assisted resident for removal of large hard stool. She tolerated procedure well. . . ." * 02/07/12 at 8:06 a.m., ". . . stool palpable when supp [suppository] given . . ." * 02/27/12 at 7:30 a.m., ". . . lg [large] results . . ." * 03/07/12 at 9:00 p.m., "Resident on toilet and having difficulty passing BM. Large amount soft BM in rectum. Res. [resident] bearing down but unable to pass stool. . . . Large amount soft BM manually removed. . . . Res. stated 'yes' when nurse asked if she was more comfortable. . . ." * 03/14/12 at 10:51 a.m., "MDS Coordinator Note . . . continent of bowel. Res. does have frequent constipation. . . ." * 03/28/12 at 8:14 p.m., "Resident unable to have BM on the toilet. Stool in rectum upon digital exam. . . ." * 04/08/12 at 6:00 a.m., ". . . Supp at 4:00 and XL [extra large] results . . . " * 04/18/12, ". . . Res had been having increasing	F 309	adaptive equipment on the appropriate place setting during all meals. 4. A minimum of 15 residents per quarter will be monitored for excessive laxative use and appropriate follow-up. Their MDS will also be compared with their care plan to ensure consistency (QA Forms: F-280 Bowel & Bladder; Dining Checklist). All dining rooms will be monitored by the Dietitian/designee monthly for appropriate use of adaptive equipment. Result of monitoring will be reported to the QA Committee. 5. Date of Completion: July 11th, 2012.	7/11/12

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F 309	Continued From page 16 difficulties with constipation. . . ." The 12/01/11-05/09/12 Bowel Movement [BM] Record and Legend Report, as well as the 04/01/12-05/09/12 BM List showed the resident failed to have a bowel movement on the following days: * 12/06/11-12/13/11: 8 days * 12/24/11-12/30/11: 7 days * 01/06/12-01/13/12: 8 days * 01/16/12-01/19/12: 4 days * 01/28/12-01/31/12: 4 days * 02/02/12-02/06/12: 5 days * 02/08/12-02/21/12: 14 days * 02/28/12-03/06/12: 8 days * 03/09/12-03/12/12: 4 days * 04/13/12-04/17/12: 5 days * 04/19/12-04/22/12: 4 days (Upon request, the facility failed to provide the 12/01/11-03/31/12 BM List.) The physician's orders, dated 04/17/12, identified the following: * Order Date of 06/14/10: 5 milligrams (mg) Dulcolax tablet as needed, 10 mg Dulcolax rectal suppository as needed, 7 grams (gm)/118 ml Fleet enema as needed, and 30 ml Milk of Magnesia (MOM) as needed for constipation * Order Date of 12/15/11: 50 mg Tramadol as needed for pain (Adverse reactions of Tramadol include constipation.) * Order Date of 12/23/11: 100 mg Colace twice daily for constipation * Order Date of 03/22/12: 50 mg Tramadol daily * Order Date of 04/19/12: 8.5 gm Miralax daily for constipation (Miralax had been previously prescribed for 28	F 309		

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F 309	Continued From page 17 days starting 01/27/12) The medication administration record (MAR) identified the following: * 12/06/11-12/13/11: Colace daily, Dulcolax tablet 12/08/11, 12/11/11, 12/13/11, Dulcolax suppository 12/12/11 * 12/24/11-12/30/11: Colace daily, Dulcolax suppository 12/27/11 * 01/06/12-01/13/12: Colace daily, Dulcolax suppository 01/09/12 * 01/16/12-01/19/12: Colace daily * 01/28/12-01/31/12: Colace daily, Miralax daily, Dulcolax tablet 01/30/12, 01/31/12 * 02/02/12-02/06/12: Colace daily, Miralax daily, Dulcolax tablet 02/06/12 * 02/08/12-02/21/12: Colace daily, Miralax daily, Dulcolax tablet 02/11/12, 02/17/12 * 02/28/12-03/06/12: Colace daily, Dulcolax tablet 03/06/12, Dulcolax suppository 03/02/12 * 04/13/12-04/17/12: Colace daily, Dulcolax tablet 04/16/12, Dulcolax suppository 04/17/12, MOM 04/15/12, 04/17/12 * 04/19/12-04/22/12: Colace daily, Dulcolax tablet 04/22/12 The current Care Plan, identified, "Focus: I have a mild dehydration risk. I have difficulties with constipation. . . . Interventions: . . . Offer whole wheat bread with meals . . . Routine and prn [as needed] laxatives as ordered. . . ." During an interview on 05/10/12 at 9:20 a.m., a managerial dietary staff member (#14) indicated she was not notified of Resident #3's increasing difficulties with constipation which resulted in two manual extractions. The managerial dietary staff member (#14) further indicated she had made	F 309		

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F 309	Continued From page 18 "no notations indicating the resident did not want dietary interventions." She verified the resident's current care plan failed to adequately address constipation as a focus area. When asked what types of interventions she typically initiates if/when a resident demonstrates difficulties with constipation, she stated, "Prune juice or prune whip, increased fluids, whole wheat bread, fresh fruit, and vegetables or salads." During an interview on 05/10/12 at 10:30 a.m., a managerial nursing staff member (#8) agreed the resident's current care plan failed to identify constipation as a focus area and failed to include dietary measures. The facility failed to notify the dietary department, and assess and implement effective approaches/interventions to Resident #3's plan of care following the above described episodes of fecal impaction. 2. Based on observation, record review, review of professional literature, and staff interview, the facility failed to ensure 1 of 1 sampled resident (Resident #2) demonstrating symptoms of dysphagia received the care and services necessary to attain the highest degree of safety possible while being fed in the dining room. Failure to provide the appropriate adaptive equipment has the potential to affect the resident's overall swallow safety, placing her at greater risk of aspiration and limiting her nutritional intake. Findings include:	F 309		

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F 309	Continued From page 19 Nancy B. Swigert, The Source for Dysphagia: Third Edition, LinguiSystems, Inc, 2007, pages 9-15, stated, "Signs and Symptoms of Dysphagia: Drooling . . . Weight loss . . . Changes in diet . . . Neurological Causes [of dysphagia]: Stroke . . ." Resident #2's medical record, reviewed May 7-10, 2012, identified diagnoses including dementia with delusions, aphasia, chewing difficulties, and history of weight loss. The resident's annual MDS, dated 01/16/12, identified extensive assistance of one person required for eating. The current Care Plan, identified, "Focus: . . . I have chewing difficulties. I have a hx [history] of weight loss. I receive assistance with nutrition and use adaptive equipment. . . . Interventions: . . . Offer Regular diet with pureed consistency as per MD [medical doctor] ordered. Offer sippy cups and coated and thermo spoons w [with] /meals . . ." Observation on 05/08/12 at 11:15 a.m. showed a certified nursing assistant(CNA) (#9) feeding Resident #2. Resident #2 reached for her sipper cups (containing supplement, milk, prune juice, and water) between bites of pureed food. The CNA (#9) removed the sipper lids from the cups and offered fluids via cup-sip. Resident #2 began drooling with the increased volume of liquids. Observation on 05/09/12 at 8:45 a.m. showed a CNA (#9) feeding Resident #2. The CNA (#9) presented the resident's supplement in a small glass (without a sipper lid). Resident #2 demonstrated a slight amount of fluid loss at the corner of her mouth as she drank her	F 309		

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F 309	Continued From page 20 supplement. The staff member failed to use the proper equipment and/or use the equipment appropriately when offering Resident #2 a beverage. During interviews on 05/09/12 at 9:30 a.m., a managerial nursing staff member (#8) agreed staff should have utilized adaptive equipment (sipper cup) while feeding the resident.	F 309		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on record review, policy review, review of standards of practice, and staff interview, the facility failed to provide the necessary services to prevent pressure ulcers for 1 of 3 sampled residents (Resident #6) with current pressure sores. Failure of the facility to contact the physician for instructions regarding the use of the CAM (controlled ankle movement) boot resulted in Resident #6 developing facility-acquired, avoidable pressure sores.	F 314		

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F 314	Continued From page 21 Findings include: The Long-Term Care Facility Resident Assessment Instrument User's Manual, Version 3.0, April 2012, Page M-7 defines a Stage I pressure sore as reddened areas of tissue that do not turn white or pale when pressed firmly with a finger or device. Page M-22 defines an unstageable pressure sore as dead or devitalized tissue that is hard or soft in texture; usually black, brown or tan in color, and may appear scab like. Necrotic tissue and eschar are usually firmly adherent to the base of the wound and often the sides/edges of the wound. Review of the facility policy titled "Skin care policy - pressure area prevention/care" occurred 05/10/12. The policy, revised March of 2012, stated, "All residents will be assessed for their level of risk for developing pressure areas at admission, quarterly, significant change, and readmission. Efforts will be aimed at early intervention and prevention. Efforts will be made to ensure a resident who enters without a pressure area will not develop one unless the individual's clinical condition demonstrates that it is unavoidable. . ." - Review of Resident #6's medical record occurred on all days of survey. Diagnoses included peripheral neuropathy, peripheral vascular disease, congestive heart failure (CHF), and Parkinson's disease. The record also identified Stage II pressure ulcers to the right heel and the right ankle (onset date 01/31/12). Resident #6's current Minimum Data Set (MDS), dated 04/01/12, identified two Stage II pressure ulcers, one unstageable pressure ulcer, and	F 314	**F-314 Treatment/Services To Prevent/Heal Pressure Sores.** 1. The physician has been contacted for instructions regarding the use of the CAM boot. 2. All resident using external assistive devices have the potential to be affected. 3. The "Skin Care" policy will be reviewed/revised and the nursing staff will be educated. All residents with [adaptive] equipment having the potential to cause pressure ulcers will be assessed daily for skin integrity while the device is in place. 4. All residents with adaptive devices having the potential to cause pressure ulcers will initially be monitored for appropriate documentation & physician's orders; then 10% of residents with adaptive devices will be monitored quarterly (QA form: Avoidable Pressure Ulcers). Results of monitoring will be reported to the QA committee. 5. Date of Completion: July 11th, 2012.	7/11/12

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F 314	Continued From page 22 extensive assistance from two people with bed mobility, transfer, and toileting. Resident #6's care plan, dated 02/07/12, identified the following: ". . . Problem: Pressure areas on [right] heel, [right] ankle dorsal surface, and returned from hospital [with] lateral aspect [right] ankle. Approaches . . . Float heels [and] keep all pressure off [right] lateral aspect of [right] ankle. . . Review of Resident #6's Progress Notes identified the following: *01/13/12 (11:23 p.m.) ". . . Resident was walking to the bathroom with assist of 2, walker and gait belt. Resident got to the doorway and was unable to go farther. She was lowered to the floor with help and landed on her right foot tucked underneath her. . . orders to transfer per ambulance to ER [emergency room] for x-ray of foot." *01/23/12 (3:30 p.m.) ". . . Resident to see [Doctor] for follow-up x-ray. . . Returned with orders . . . remain NWB [non-weight bearing] times 5 weeks; re-check appt [appointment] in 5 weeks." *01/23/12 (5:03 p.m.) "Nurse from [health care facility] called to inform this nurse that residents x-ray did show a fracture to right ankle." *01/25/12 (6:45 a.m.) ". . . Cam Walker on R Lower Leg for Fx [fracture] Support " *01/26/12 (1:51 p.m.) ". . . Cam Walker Boot on R ankle" *01/28/12 (3:35 p.m.) ". . . NWB on Rt) foot. cont (continue) to have cam boot on. . ." *01/31/12 (10:46 a.m.) "Type of Skin Condition: Res [resident] c/o [complaint of] pain to rt [right] heel area. Cause of skin condition: from boot to	F 314		

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	355077	A. BUILDING _____ B. WING _____	05/10/2012

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F 314	Continued From page 23 stabilize fracture to rt foot. Location, size, drainage and shape/appearance of wound: Noted res area to heel is blackened 4 by 7.7 [centimeter] area. Skin is closed. stage 1 ulcer. No drainage noted. Also noted skin tear 3 cm [centimeters] to front of foot. area dressed and protective dressing placed over it. Interventions used to promote healing: dressing placed for protection and appt made at clinic for this afternoon. . ." *01/31/12 (10:30 p.m.) ". . . The skin tear on the dorsum of the right foot was dressed using Bacitracin and wrapped with Kerlix to cushion the heel. Moderate amount of serosanguienous [sic] drainage through the Kerlix dressing that was removed. Skin tear is about 3 cm and the area is red and macerated. The right foot boot was removed @ [at] HS [hour sleep] and her right foot is floating off the pillow. . ." *01/31/12 (10:30 p.m.) ". . . Written orders from [name] from clinic appt. from today: Boot needs to come off @ HS. . . recheck in 2 weeks. . ." A Physician Progress Note, dated 02/14/2012 stated ". . . she had fallen and had complaints of pain. . . She was placed on nonweightbearing. Two days later she was seen in the clinic. x-rays were repeated and she was found to have a lateral bimalleolar fracture. She was placed in a CAM Walker and again in a nonweightbearing status. Unfortunately, the CAM Walker was not removed for some time. Subsequently, the patient developed a pressure sore on her heel as well as an initial skin tear over the dorsum of her foot. . ." A consultant podiatrist note, dated 02/14/12, stated ". . . She has been nonweightbearing on the right side in a Cam boot. Unfortunately, at the	F 314		

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F 314	Continued From page 24 [facility] they did not remove the CAM boot for a period of 1 week. It was left on at all times. She [Resident #6] developed a decubitus heel ulcer and an ulcer over the tibialis anterior tendon on the anterior aspect of her right ankle in addition to the ankle fracture. . . I did measure the anterior ulceration on the tibialis anterior component. This measured 4.5 cm x 2.5 cm, had a black stable eschar. The borders were jagged and actually some weeping was noted, a serous drainage. No malodor. A decubitus heel ulceration is on the posterior plantar aspect of the right heel, measure 6.5 cm x 3 cm . . . " Failure of the facility to contact the physician for instructions regarding the use of the CAM boot resulted in the resident acquiring avoidable pressure ulcers.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, record review, and staff interview, the facility failed to adequately assess the individual	F 315		

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F 315	Continued From page 25 incontinence needs, and develop and implement an appropriate individualized program to assist 3 of 11 incontinent sampled residents (Resident #11, #12, and #13) to restore or maintain as much urinary continence as possible. Findings include: Review of the facility policy, titled "Bladder [and] Bowel Policy," occurred on 05/10/12. The policy, reviewed by the facility March 2012, stated: ". . . POLICY: It is the policy of Sheyenne Care Center that the facility will ensure that each resident that is incontinent of bladder . . . is identified and assessed, given the opportunity to achieve continence or restore as much normal bladder . . . function as possible. . . . PROCEDURE: 1. Implement Bladder . . . assessment on admission or whenever there is a change in cognition, physical ability or urinary tract or bowel function. . . . 4. If deemed appropriate, scheduled toileting or bladder retraining program and/or the bowel toileting or retraining program will be implemented. The following factors will also be evaluated: a. . . . causes of incontinence. b. The ability of the resident to make decisions and call for assistance to use the toilet. c. The ability of the resident to sense urge sensation . . . and respond to voiding prompt. d. The presence of permanent physical impairment or disease which could prohibit restoration of normal bladder function . . ." - On 05/08/12 at 1:45 p.m., observation showed a certified nurse aide (CNA) (#4) assisted Resident #11 to ambulate to the bathroom. The CNA changed the resident's wet underwear and discarded the wet incontinence pad. After the	F 315	**F-315 No Catheter, Prevent UTI, Restore Bladder.** 1. Residents 11, 12 & 13 have had Bowel & Bladder assessed and the care plans adjusted to reflect their current level of continence and needs. 2. All resident have the potential to be affected. 3. The "Bladder & Bowel Assessment and Documentation" policy has been reviewed/revised and the nurses will be educated. Resident with a significant change in condition will be assessed for bladder function with the care plan updated as indicated. 4. The MDS will be compared with Care Plan quarterly on a minimum of 15 residents to ensure congruence with function and plan of care on all residents and to determine appropriateness of interventions (QA Form: F-280 Bowel and Bladder). Results of monitoring will be reported to the QA Committee. 5. Date of Completion: July 11th, 2012.	7/11/12

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F 315	Continued From page 26 resident voided, the CNA assisted with pericares and placed a new pad, before assisting the resident back to her chair. Review of Resident #11's medical record occurred on all days of survey. Diagnoses included debility and urinary frequency. The annual Minimum Data Set (MDS), dated 04/01/12, indicated intact cognition, walk in room with limited assistance of one person, toilet use with extensive assistance of one person, and frequently incontinent of urine. The resident's urinary continence declined from the previous annual MDS, dated 04/02/11, which indicated occasional incontinence. The CNA Intervention/Task Record of Resident #11's toileting, dated April 1 - May 9, 2012, indicated the resident wore an incontinence product and was incontinent one or more times daily on most days. The documentation also showed the resident continent of urine at least once daily. Resident #11's most recent "Bladder Assessment Form," dated 07/02/07, indicated the resident currently continent of bladder. During an interview on 05/09/12 at 10:15 a.m., a nurse manager (#3) stated staff complete bladder assessments on admission and with a change in continence. The record lacked evidence facility staff completed a bladder assessment when the resident's continence status changed, failed to add the problem of urinary incontinence to Resident #11's care plan, and failed to develop interventions to improve or maintain her level of continence. - On 05/08/12 at 11:45 a.m., observation showed	F 315		

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F 315	Continued From page 27 a CNA (#5) wheeled Resident #12 into the bathroom and assisted the resident to stand, pivot, and sit on the toilet. At 12:00 p.m., the CNA (#5) assisted Resident #12 to stand, pivot, and sit in her wheelchair. Review of Resident #12's medical record occurred on all days of survey. Diagnoses included debility and bladder hypertonicity. The quarterly MDS, dated 04/27/12, indicated moderate cognitive impairment, transfer with extensive assistance of one person, walk in room did not occur, toilet use with extensive assistance of one person, not on a current toilet plan or trial, and frequently incontinent of urine. The resident's urinary continence declined from the annual MDS, dated 02/03/11, which indicated occasional incontinence. Resident #12's most recent "Bladder Assessment Form," dated 01/23/10, indicated the resident as currently incontinent of bladder, with urine leakage on way to bathroom, clothes or incontinence pad wet, urgency - unable to suppress, and nocturia (greater than two times at night). The assessment form showed the type of incontinence as "Urge" and "Functional," with "Scheduled toileting/habit training" checked as the treatment program, and "Yes" answered for "Able to Participate in Bladder Program." The record lacked evidence facility staff completed another bladder assessment with the resident's decline in continence. Resident #12's care plan, dated 01/31/12, stated "Focus: I have bladder incontinence r/t [related to] Hypertonicity of bladder. Goals: I will decrease frequency of urinary incontinence. Interventions: .	F 315		

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F 315	Continued From page 28 . . . I use Yellow disposable briefs. Check/Change Q2h [every two hours] and prn [as needed]. INCONTINENT: Check me Q 2h and as required for incontinence. . . ." A care conference note, dated 04/30/12, stated, ". . . frequently incontinent bladder . . . toilet per her request. Staff also offer Q2h. . . ." The care plan failed to address a toileting plan other than check/change, or interventions to improve or maintain continence. The CNA Intervention/Task Record of Resident #12's toileting, dated April 1 - May 9, 2012, indicated the resident wore an incontinence product and was incontinent one or more times daily on all days. The documentation also showed the resident continent of urine at least once daily about half of the days. This record lacked evidence staff toileted or checked/changed the resident every two hours. During an interview on 05/10/12 at 9:55 a.m., a CNA (#6) stated the night shift may check and change [Resident #12], but the daytime staff take her to the bathroom as the resident tells staff when she has to use the bathroom, usually before two hours pass. The CNA stated the resident dribbles so is usually wet, wears a pad on days, and may wear a brief at night. When asked how staff know what type of toileting care each resident requires, the CNA (#6) replied staff share information during rounds or look in the resident's closet to see what type of incontinence products are stocked. - Review of Resident #13's medical record occurred on all days of survey. Diagnoses included spinal stenosis and cerebrovascular disease with hemiparesis (weakness on one side	F 315		

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F 315	Continued From page 29 of the body). The quarterly MDS, dated 04/11/12, indicated moderate cognitive impairment, walk in room with limited assistance of one person, toilet use with extensive assistance of one person, not on a current toilet plan or trial, and occasionally incontinent of urine. The resident's urinary continence remained unchanged from the admission MDS, dated 07/15/11, which indicated occasional incontinence. The CNA Intervention/Task Record of Resident #13's toileting, dated April 1 - May 9, 2012, indicated the resident wore an incontinence product and was incontinent one or more times daily on most days. The documentation also showed the resident continent of urine at least once daily. Resident #13's most recent "Bladder Assessment Form," dated 07/11/11, indicated the resident as currently continent of bladder, which contradicts the admission MDS, dated 07/15/11, noted above as occasional incontinence. An Interdisciplinary Progress (IDP) note, dated 07/15/11, stated, ". . . usually continent of bowel and bladder seems to have some incontinence during the night. She does wear a pull-up . . ." An IDP note, dated 04/11/12 at 2:35 p.m., stated, ". . . has had an increase with occasional bladder incontinance [sic]. Does require staff assistance with pericares, pad and pants placement. . . ." The record lacked evidence facility staff completed a bladder assessment reflecting Resident #13's occasional incontinence, including assessment of the potential causes, type of incontinence, contributing factors, and a plan to reduce incontinence. Resident #13's current care	F 315		

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F 315	Continued From page 30 plan failed to address her incontinence, and failed provide adequate services to improve or maintain her level of continence.	F 315		
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: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 06/30/11. Based on observation, record review, staff interview, and review of facility policy, the facility failed to provide adequate supervision and assistive devices for 2 of 5 sampled residents (Residents #2 and #18) observed being transferred with a stand lift and for 1 of 1 sampled resident (Resident #4) and 3 supplemental residents (Residents #28, #29, and #30) observed being transported by staff via wheelchairs with no foot pedals on 3 of 4 days of survey. Failure of the facility staff to ensure proper use of assistive devices (lift buttock strap and/or wheelchair foot pedals) placed residents at risk for possible accident and/or injury. Findings include: Review of the facility policy titled "Gait	F 323		

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F 323	Continued From page 31 Belts/Mechanical Lifts" occurred on 05/10/12. This policy, reviewed by the faciliy on 07/19/11, stated, ". . . When a mechanical lift is determined as necessary, it will be put on the residents care plan. . . . When using the standing lift the belt should be secured tightly to prevent it from riding up under the residents arms. . . . If the resident needs added support use the support strap that fits under buttocks. . . ." When requested, the facility failed to provide a policy regarding wheelchair foot pedals. - Review of Resident #18's medical record occurred on May 9-10, 2012. Diagnoses included cerebral vascular accident (CVA) with right sided weakness, dysarthria, and diabetes with polyneuropathy. Review of the Minimum Data Set (MDS), dated 04/19/12, identified Resident #18 required extensive assistance of one person for transfers and toilet use, and moderately impaired with daily decisions. Resident #18's care plan stated, "Focus. . . I have ADL Self Care Performance Deficit r/t [related to] hx [history] of CVA WITH RIGHT HEMIPARESIS Date initiated 02/09/11. . . 05/10/12 Res [resident] will refuse butt strap [at] x's [times] encourage res to use for safety . . . Interventions . . .TRANSFER: I require one to two staff and stand-up lift with all transfers. . . . initiated: 02/09/11 . . .05/10/12 use butt strap [at] all times [with] transfers . . ." Review of a document titled "[Resident's name] cares evening" posted on Resident #18's bedroom wall occurred on 05/09/12. This document dated 12/2011, stated, "3. . . Put him	F 323	**F-323 Free of Accident Hazards/supervision/Devices** 1. Residents 2, 4, 28, 29& 30 have had their care plan adjusted to include using foot pedals with transport and staffs were educated to use accordingly. Wheelchair bags have been obtained and placed on the wheelchairs to hold the foot pedals when they are not in use. Resident 18 has been assessed for use of lift and the care plan has been updated accordingly. per Telephone Resident #~~18~~ 2 has been assessed for use of Cynthia Smith, DON lift, and the care plan has been updated 7/12/12 at 1:30 pm accordingly. 2. All resident using wheelchairs or mechanical lifts have the potential to be affected. 3. The "Guidelines for Moving, Positioning, Lifting and Transferring a Resident" policy will be reviewed/revised and all facility staff will be educated. All residents using wheelchairs will have wheelchair bags placed on their wheelchairs to hold the foot pedals when they are not in use. All residents requiring the use of a buttock support strap when using a lift will be care planned for such. 4. 6 residents will be randomly monitored for use of footrests during transporting monthly x3 months, then quarterly x12	

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F 323	Continued From page 32 on lift, using butt strap, take to bathroom . . . . 6 . . . butt sling on. 7. take to bed . . ." Observation on 05/09/12 at 3:40 p.m. showed a certified nurse assistant (CNA) (#2) transferred Resident #18 via a stand lift to and from the toilet. The CNA failed to place the support strap underneath the residents buttocks. Observation showed the support strap in the resident's room. The CNA (#2) stated during the observation that the resident did not need to use the strap any longer. During an interview on 05/10/12 at 12:15 p.m., an administrative nurse (#3) verified that Resident #18 should have the strap placed under his buttocks during transfers. - Resident #2's medical record, reviewed May 7-10, 2012, identified diagnoses including dementia with delusions, aphasia, osteoporosis, and difficulty walking. The resident's annual MDS, dated 01/16/12, identified extensive assistance of one person required for transfers and locomotion on/off unit. The current Care Plan, identified, "Focus: I have an ADL Self Care Performance Deficit r/t [related to] Dementia . . . Interventions: . . . TRANSFER: I require extensive physical assistance with transferring using mechanical standing lift. . . ." Observation on 05/08/12 at 10:00 a.m. showed a CNA (#9) transferred Resident #2 via a stand lift to and from the toilet. Resident #2 kept her eyes closed and her head bent forward. The CNA (#2) placed the resident's right hand on the lift handle, and stated, "Depending on her mood, she will	F 323	months (QA Form: F-323 Resident Positioning). 6 residents will be randomly monitored for proper use of lift device during transfer monthly x3 months, then quarterly x12 months (QA Form: Resident Transfers) Results of monitoring will be reported to the QA Committee. 5. Date of Completion: July 11th, 2012.	7/11/12

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F 323	Continued From page 33 hold on with her left hand." The resident did not reach for the lift with her left hand. The CNA (#2) also stated, "She always lifts her leg," as Resident #2 raised her leg mid-transfer. The CNA failed to place a support strap under the resident's buttocks. The staff member failed to request assistance from the nurse so that he/she could assess the resident's level of fatigue/alertness level prior to transferring her with the stand lift, place both of the resident's hands on the lift handles, ensure both of the resident's feet/shoes remained on the foot plate throughout the transfer, and use the accessory support strap under the resident's buttocks. - Resident #4's medical record, reviewed May 7-10, 2012, identified diagnoses including osteoporosis. The resident's admission MDS, dated 02/28/12, identified extensive assistance of one person required for locomotion on/off unit. Observation on 05/07/12 at 10:45 a.m. showed a CNA (#12) transporting Resident #4 in her wheelchair down the hallway towards her room. Resident #4's right shoe caught and bounced on the carpeting as staff transported her down the hallway. - Resident #28's medical record, reviewed May 9-10, 2012, identified diagnoses including Alzheimer's disease. The resident's quarterly MDS, dated 03/02/12, identified extensive assistance of one person required for locomotion on/off unit. Observation on 05/07/12 at 10:45 a.m. showed	F 323		

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F 323	Continued From page 34 an unidentifed CNA transporting Resident #28 in her wheelchair down the hallway towards her room. Resident #28's shoes made an audible noise as they came in full contact with the carpeting as staff transported her down the hallway. - Resident #29's medical record, reviewed May 9-10, 2012, identified diagnoses including closed fracture of the pelvis, spinal stenosis, osteoarthrosis, and peripheral neuropathy. The resident's quarterly MDS, dated 03/20/12, identified limited assistance of one person required for locomotion on/off unit. Observation on 05/07/12 at 10:45 a.m. showed an unidentified CNA transporting Resident #29 in her wheelchair down the hallway towards her room, and the evening of 05/08/12 showed a CNA (#9) transporting Resident #29 in her wheelchair down the hallway towards the dining room. The toes of Resident #29's socks slid along the surface of the carpeting as staff transported her down the hallway. - Resident #30's medical record, reviewed May 9-10, 2012, identified diagnoses including dementia and abnormal movement disorder. The resident's quarterly MDS, dated 01/19/12, identified limited assistance of one person required for locomotion on/off unit. Observation in the evening of 05/08/12 showed a CNA (#13) transporting Resident #30 in his wheelchair down the hallway towards the dining room. Resident #30's shoes caught and bounced on the carpeting as staff transported him down the hallway.	F 323		

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 _____	05/10/2012

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

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F 323	Continued From page 35 Staff members failed to place the residents' foot pedals on their wheelchairs, cue the residents to lift their feet/shoes, and ensure the residents' feet/shoes cleared the floor during transport to avoid catching the residents' feet on the flooring. During interviews on 05/09/12 at 9:30 a.m., a managerial nursing staff member (#8) agreed staff should have utilized assistive devices (lift buttock strap and/or wheelchair foot pedals) during transfer/transport.	F 323		