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 _____	C 02/10/2016

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 complaint survey started on 02/10/16 and completed on 02/10/16, the sample included 14 residents for focused review and 2 closed record reviews.	F 000		
F 309 SS=D	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: Based on record review, information received from the complainant, and staff interview, the facility failed to provide the necessary care and services to maintain overall well-being for 1 of 1 closed record resident (Resident #15) with a positive wound culture, and 1 of 14 sampled residents (Resident #5) with positive urine cultures. Failure to adequately monitor laboratory results may have contributed to delayed treatment of Resident #15's wound infection and continued pain and pressure ulcer deterioration and delayed treatment of Resident #5's urinary tract infection (UTI). Findings include: Information submitted by the complainant identified facility staff failed to promptly initiate antibiotic treatment after receiving wound culture	F 309	1. Residents #5, was treated with Antibiotics. Resident # 15 was a closed record. 2. All Residents at our facility who have labs completed are at risk for delayed treatment. 3. Our facility will attach lab notification slips to every lab sheet. When a lab order is received, the charge nurse receiving the order will complete the lab notification sheet and turn it in to the unit secretary, notifying her that she needs to be looking for lab results. Also, a copy of the original MD order for the lab will be placed in the respective nurse manager's folder so they also can be looking for follow up and making sure treatment is received in a	3/8/16

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

Electronically Signed | 02/29/2016

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F 309	Continued From page 1 results. The complainant identified a wound culture obtained on 01/15/16 was not treated with antibiotics until 01/21/16. The complainant identified contact made with the facility on January 16, 18, 19, and 21 regarding the results of the wound culture, and the facility reported the culture results were not available. - Review of Resident #15's medical record occurred on 02/11/16. Diagnoses included a Stage III pressure ulcer to the left ischium (first identified by the facility as a Stage III on 11/17/15) and a Stage II pressure ulcer to the sacrum (first identified by the facility on 12/29/15). Resident #15's nurses' notes and a "Patient Report Form" identified the following: *01/14/16 at 2:16 p.m.: ". . . Both areas to buttocks are open with scant amount of yellow/green drainage. . . . Cont. [continue] to monitor until resolved and call clinic in AM [morning] to get res. [resident] in and have area assessed. . . ." *A "Patient Report Form," dated 01/15/16 (the day Resident #15 saw the nurse practitioner (NP)), stated, ". . . Reason for visit: check ulcers to toes on L) foot [and] culture ulcers on buttocks [and] coccyx. . . ." *01/15/16 at 5:19 p.m.: ". . . Res. taken to see NP [NP name] at [name of clinic] for a second opinion on ulcers. [NP name] ordered a wound clinic consult, and to place a non-adherent dressing b/t [between] 4th and 5th digit toe as well as open areas on buttocks. Order to change daily and PRN [as needed]. It was also noted to not use duoderm because they rip skin. . . ." The facility failed to confirm with the NP whether	F 309	timely manner. If no results are received before the weekend, night, or holiday, the charge nurses have been educated to contact the on-call physician. Our facility's lab policy has been updated to include these measures. All of our Physicians were emailed a copy of our new process and will be updated if necessary outlining our new process. All of our physicians have been invited to attend our Medical Directors meeting on 3/8/16 where we will further discuss our POC. Our nurses were educated on 2/16/16, on the above new process on topics that were discussed during this meeting. On 2/17/16, 2/18/16, 2/24/16, and 2/25/16 CNA's and nurses were educated on state findings and possible F-tag. CNA's were educated that if they have difficulty obtaining urine or lab specimen for a combative Resident they need to report to the charge nurse immediately. Nurses were educated that they need to document all refusals of labs as they occur. 4.) All lab results will be monitored through our quality assessment procedure which we have already started. We will complete weekly QA for 1 month, then monthly for 3 months, and then quarterly until resolved. The quality assessments will be completed by the nurse managers and infection control nurse. Quality assessments will be reviewed monthly at our facility's QA meeting and every other month at our Medical Director's meeting.	

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F 309	Continued From page 2 the buttocks and coccyx wounds were cultured. *01/16/16 at 8:31 p.m.: ". . . left buttock wound draining copius [sic] amount of cream colored drainage . . ." *01/16/16 at 9:15 p.m.: ". . . Norco [a narcotic pain reliever] Tablet 10-325 mg [milligrams] . . . resident moaning during positional changes . . ." *01/17/16 at 8:08 a.m.: ". . . moderate effect noted as resident continue [sic] to moan during position changes. . . ." *01/17/16 at 10:17 a.m.: ". . . Norco Tablet 10-325 mg . . . Resident requested as is having pain all over. 'It hurts.' Will continue to monitor. . . ." *01/18/16 at 7:51 a.m.: ". . . Norco Tablet 10-325 mg . . . Res. yelling out in pain when being touched. . . ." *01/19/16 at 5:45 a.m.: ". . . Norco Tablet 10-325 mg . . . Moaning and groaning with movement. . . ." *01/19/16 at 10:57 a.m.: ". . . Res. still yelling out in pain. . . ." *01/19/16 at 10:58 a.m.: ". . . Res. yelling out in pain when this nurse checked open areas to buttocks. . . ." *01/19/16 at 4:47 p.m.: ". . . skin note . . . resident has open area on right [sic - left] lower buttock that is 10 cm [centimeters] deep and undermines in two places at 1200 [12:00] at 9 cm and at 900 [9:00] 8.5 cm. Copius [sic] amounts of drainage is coming out of this wound that is yellow and foul smelling. . . ." *01/19/16 at 6:17 p.m.: ". . . Res. has been having severe pain throughout the day. Received PRN hydrocodone [Norco] as well as scheduled hydrocodone. Res. telling [sic] out whenever staff touches her. . . . Ulcerrs [sic] to buttocks cont. to cause res. severe pain as well, dressings to ulcers on buttock and coccyx have needed to be	F 309	5.) Our completion date will be 3/8/16.	

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F 309	Continued From page 3 changed 3 times this shift d/t [due to] drainage leaking out. . . ." *01/20/16 at 3:15 p.m.: ". . . Norco Tablet 10-325 mg . . . Res. yelling out in pain with repositioning. . . ." *01/21/16 at 4:00 a.m.: ". . . Resident had small emesis of Dk [dark] green liquid that smelled like bile. Relates tummy hurts. Abdomen is slightly firm/distended with very hypoactive BS [bowel sounds] heard to upper quadrants and none heard over lower abdomen. Unable to assess and move res. related to extreme amts. [amounts] of pain. Does have fentynyl [sic] patch on and receiving Norco TID [three times per day] PRN. Hot to touch. T [temperature] = 101.2 . . . Notified daughter [name] of resident declining condition (fever, pain, and emesis). Discussed Hospice, sending to ER [emergency room], or starting a morphine line for comfort. . . . Did call [physician name] and discussed resident's condition. Orders received and noted to start SQ [subcutaneous] line of morphine at this time. . . ." *01/21/16 at 10:25 a.m.: ". . . Call was placed to [name of clinic] for [primary care provider] at 0800 [8:00 a.m.]. Left message for clinic to return call. Called clinic again at 0945 [9:45 a.m.] and spoke with [primary care provider] nurse. . . . Will continue to attempt to contact physician as residents condition is deteriorating. . . ." *01/21/16 at 12:49 p.m.: ". . . Resident's appointment at wound clinic has been cancelled [sic]. Res. has Staph. [staphylococcus] infection to pressure ulcers. . . ." *01/21/16 at 1:09 p.m.: ". . . [primary care provider] here to see res . . . dressing changed per [primary care provider] on bottom. He packed lt [left] hip wound too. . . . Levaquin 500 mg [milligrams] po [by mouth] QD [daily]. DRSG	F 309		

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F 309	Continued From page 4 [dressing] change orders. . . ." *01/21/16 at 5:08 p.m.: ". . . fax returned stating levaquin 500 mg po QD for 10 days . . ." A fax to the physician sent 01/21/16 identified the staff requesting clarification as to the duration of the course of Levaquin. Record review identified the physician did not specify the length of antibiotic treatment on the original order. *01/22/16 at 12:15 p.m.: ". . .infection note . . . Lg amt copious drainage. Odor noted with dressing change. Res did c/o [complain of] discomfort with dressing change. . . ." *01/24/16 at 4:44 a.m.: ". . . Wounds to coccyx and buttock with scant drainage and wound to (L) [left] hip with copius [sic] amount purulent drainage and odorous. . . ." *01/25/16 at 10:48 a.m.: ". . . Res continues with copious amt of purulent drainage to lower lt buttock wound. Res did c/o pain with drsg change as well as with repositioning. Odor noted with drsg change. . . ." The laboratory report regarding the wound culture identified a culture obtained from Resident #15's left buttock pressure ulcer wound on 01/15/16 at 2:10 p.m. The lab report further identified preliminary results available on 01/16/16 at 2:34 p.m., 01/17/16 at 12:13 p.m., and 01/18/16 at 10:55 p.m., with the final result available on 01/19/16 at 11:30 a.m. The final culture report identified a positive result for Staphylococcus aureus. The record lacked evidence the facility monitored preliminary lab results and/or contacted a healthcare provider regarding preliminary or final results of the culture. The medication administration record (MAR) identified 500 mg	F 309		

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F 309	Continued From page 5	F 309		

Levaquin administered to Resident #15 at 7:00 p.m. on 01/21/16 (six days after the wound culture was obtained).

During an interview on the afternoon of 02/10/16, a supervisory nurse (#4) identified the facility was unaware a wound culture was obtained, even though a Patient Report Form, dated 01/15/16, identified facility staff requested wound cultures from Resident #15's buttocks and coccyx ulcers. Another supervisory nurse (#3) identified the unit secretary has access to laboratory reports, and monitors for incoming results.

Failure to confirm whether or not the NP obtained wound cultures from Resident #15's wounds and monitor for laboratory results may have contributed to delayed treatment, continued pain, and pressure ulcer deterioration.

- Review of Resident #5's medical record occurred on 02/10/16. A progress note, dated 12/24/15 at 10:22 a.m., stated, "dtr [daughter] here and stating that her mother is c/o burning with urination. CRAs [certified resident aids] state that she [Resident #5] is having frequency with toileting and was taken 3 times in an hour. Hx of UTIs. Dtr wants UA. . . "

The facility obtained Resident #5's urine specimen on 12/24/15. A culture report, dated 12/26/15, verified a UTI. Resident #5 received her first dose of Cipro (an antibiotic) on 12/28/15 at 8:00 p.m., two days after the facility received the culture report.

During an interview on 02/10/16 at 5:15 p.m., an administrative nurse (#2) stated the facility did

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F 309	Continued From page 6 not receive the order for Resident #5's antibiotic until 12/28/15 because of the holiday weekend. The facility failed to have a system in place for obtaining/monitoring laboratory results from outside clinics for Resident #5 and #15.	F 309		