| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| F 000 | INITIAL COMMENTS<br><br>For the standard Medicare/Medicaid survey started on 03/08/10 and completed on 03/10/10, the sample included three (3) residents for complete review, nine (9) residents for focused review, and one (1) closed record for review. The sample included six (6) additional residents added to the sample to verify specific concerns during the survey. | F 000 | | |
| F 156 SS=C | 483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES<br><br>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.<br><br>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. | F 156 | Souris Valley Care Center (SVCC) will post information leading where to find the names, addresses, and telephone numbers of all pertinent State client advocacy groups, written information regarding application and use of Medicare and Medicaid benefits in the front vestibule of the facility. The information will be located in the Solarium, which is a common area for residents and family members.<br><br>The receptionist will monitor the solarium to ensure the information is in place monthly, results will be reported to the Quality Assurance Committee.<br><br>SVCC will correct the deficient practice by April 26th, 2010. | 4-26-2010 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 4-13-10

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 156 | Continued From page 1<br>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.<br><br>The facility must furnish a written description of legal rights which includes:<br>A description of the manner of protecting personal funds, under paragraph (c) of this section;<br><br>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.<br><br>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.<br><br>The facility must comply with the requirements | F 156 | | |

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| F 156 | Continued From page 2<br>specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.<br><br>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.<br><br>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to post the names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the protection and advocacy network, and the Medicaid fraud control unit; and failed to post written information regarding application and use of Medicare and Medicaid benefits on 3 of 3 days of survey. Failure to provide this information has the potential to limit residents' and families' access to these agencies. | F 156 | | |

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| F 156 | Continued From page 3<br><br>Findings include:<br><br>Observations on March 08-10, 2010, showed the facility failed to visibly post the contact information for the State survey and certification agency, the State licensure office, the protection and advocacy network, and the Medicaid fraud control unit; and failed to post written information regarding application and use of Medicare and Medicaid benefits.<br><br>An observation on 03/08/10, at 4:30 p.m., showed a binder titled "Facility and State Contacts, Life Safety and State Survey Reports" located on a table in the Solarium. Unless a resident, family member or legal representative was directly by the binder, the location of this information would be unknown. Review of the binder lacked a toll free phone number for the State Ombudsman Program.<br><br>During review of the admission packet on 03/09/10, at 11:35 a.m., the list of State client advocacy groups lacked a current address for the State Ombudsman Program.<br><br>During the facility environmental tour, on 03/09/10 at 2:35 p.m., an administrative staff member (#4) confirmed the facility failed to post the required contact information.<br><br>During an interview on 03/10/10 at 1:05 p.m., an administrative staff member (#1) verified the facility failed to post the required contact information. | F 156 | | |
| F 167 SS=C | 483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE | F 167 | | |

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| F 167 | Continued From page 4<br>A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility.<br><br>The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to visibly post or indicate the location of the most recent State survey report for examination on 3 of 3 days of survey. Failure to post this information had the potential to limit residents' and families' access to this information.<br><br>Findings include:<br><br>Observation on March 08-10, 2010, showed the facility staff failed to post the results of the most recent health State survey conducted on 03/26/09.<br><br>During an interview on 03/10/10 at 1:05 p.m., an administrative staff member (#1) verified the facility failed to post the required survey result information. | F 167 | Souris Valley Care Center (SVCC) will post information leading where to find the most recent State survey report in the front vestibule of the facility. The information will be located in the Solarium, which is a common area for residents and family members.<br><br>The receptionist will monitor the solarium to ensure the information is in place monthly, results will be reported to the Quality Assurance Committee.<br><br>SVCC will correct the deficient practice by April 26th, 2010. | 4-26-2010 |
| F 253 SS=B | 483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES<br><br>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. | F 253 | | |

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| F 253 | Continued From page 5<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, and staff interview, the facility failed to ensure a sanitary interior regarding accumulated dust/debris on bathroom exhaust vents in 9 of 15 resident bathrooms in the 200 wing. Failure to keep the vents free of dust and debris limited the facility's ability to ensure a sanitary environment.<br><br>Findings include:<br><br>- Review of facility policy and procedure occurred the afternoon of 03/10/10. This policy titled "Resident Rooms - Routine Cleaning", dated 1995, stated, ". . . Wednesday: Bathroom extra cleaning a. Dust ceiling exhaust vent. . . ."<br><br>During a facility tour the afternoon of 03/08/10, observation identified dust/debris accumulation on bathroom exhaust vents in resident rooms 204, 205, 207, 208, 209, 212, 213, 214, and 216.<br><br>During the environmental tour, on 03/09/10 at 2:35 p.m., an administrative staff member (#4) and a maintenance staff member (#17) confirmed the vents needed cleaning. The administrative staff member (#4) stated he was unaware of a specific cleaning schedule. | F 253 | All vents in resident bathrooms have been cleaned by environmental services.<br><br>All residents have the potential to be affected by dusty vents.<br><br>The policy for cleaning bathroom exhaust vents is being reviewed. Environmental services staff will be in-serviced regarding bathroom vent cleaning.<br><br>Environmental services will be responsible for cleaning bathroom exhaust vents weekly. Quality Assurance will perform quarterly audits for one year on cleanliness of bathroom exhaust vents.<br><br>SVCC will correct the deficient practice by 4-26-2010. | 4-26-2010 |
| F 278 SS=E | 483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED<br><br>The assessment must accurately reflect the resident's status.<br><br>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. | F 278 | For Residents 1-12 (except resident 9, who was discharged), we will audit their next scheduled MDS and subsequent MDS for the next calendar year to insure accuracy of the MDS. The audit will be completed by the care team and HIM | |

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| F 278 | Continued From page 6<br><br>A registered nurse must sign and certify that the assessment is completed.<br><br>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.<br><br>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.<br><br>Clinical disagreement does not constitute a material and false statement.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, review of Appendix R (The Long-Term Care Facility Resident Assessment Instrument User's Manual revised December 2008), and staff interview, the facility staff failed to accurately complete portions of the Minimum Data Set (MDS) for 12 of 12 sampled residents (#1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, and #12). Failure to accurately complete portions of the MDS for each resident does not allow each resident the opportunity to receive care consistent with their individual needs, problems, and strengths; and does not allow each resident to maintain or improve in their level of functional abilities. | F 278 | prior to the MDS being transmitted. The MDS will be audited for sections E, G, H. K, M, O, and P.<br>All residents have the potential to be affected by this practice.<br><br>We will complete an audit on 4 random residents per quarter, besides the residents identified through survey. The audit will be completed by the care team and HIM prior to the MDS being transmitted, to insure accuracy of the MDS. The audit will check the accuracy of sections E, G, H, K, M, O, and P.<br><br>The MDS Coordinator will be responsible to monitor and assure the accuracy of the MDS. Quality Assurance monitoring will begin on April 13, 2010 with the next scheduled care team meeting. Results will be reported to the quality team monthly times 3 and then quarterly times 3. | 4-26-2010 |

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| F 278 | Continued From page 7<br><br>Findings include:<br><br>The Long-Term Care Facility Resident Assessment Instrument User's Manual Version 2.0, revised December 2008, page 1-7 states, ". . . This assessment system provides a comprehensive, accurate, standardized reproducible assessment of each long-term care facility resident's functional capabilities and helps staff to identify health problems . . .", page 1-25 states, ". . . The importance of accurately completing and submitting the MDS cannot be overemphasized. The MDS information is the basis for:<br>* The development of an individualized care plan for the resident . . .,<br>* Medicare Prospective Payment System,<br>* State Medicaid reimbursement programs,<br>* Quality monitoring activities such as Quality Indicator (QI) Reports, . . . and the quality measures used for public reporting,<br>* Research, and<br>* Policy development.<br>Primary responsibility for accuracy lies with the person selecting the MDS item response. Each person completing a section of the MDS is required to sign the Attestation Statement (AA9, AD, and AT7) that reads: I certify that the accompanying information accurately reflects residents assessment or tracking information for this resident . . . I understand that this information is used as a basis for ensuring that residents receive appropriate and quality care, and as a basis for payment from Federal funds . . ."<br><br>- Review of Resident #8's medical record occurred on March 8-10, 2010. | F 278 | | |

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| F 278 | Continued From page 8<br>Resident #8's quarterly MDS, completed on 02/19/10, identified the following:<br>* Section G.5. Modes of Locomotion - "wheeled self."<br>* Section H.3. Continence Appliances and Programs - no "pads/briefs used."<br>* Section M.5. Skin Treatments - no "pressure relieving device(s) for bed."<br><br>Resident #8's quarterly MDS, completed on 11/20/09, identified the following:<br>* Section E. Indicators of Depression, Anxiety, Sad Mood - as having "repetitive health complaints."<br>* Section G.5. Modes of Locomotion - "wheeled self."<br>* Section M.5. Skin Treatments - no "pressure relieving device(s) for bed."<br>* Section O.4. Days Received the Following Medication - no days of receiving a "Diuretic."<br><br>Resident #8's quarterly MDS, completed on 08/21/09, identified the following:<br>* Section G.5. Modes of Locomotion - "wheeled self."<br>* Section K.2, Height and Weight - as weighing "116" pounds.<br>* Section M.5. Skin Treatments - no "pressure relieving device(s) for bed."<br>* Section O.4. Days Received the Following Medication - no days of receiving a "Diuretic."<br><br>Inconsistencies were noted when comparing Resident #8's MDSs with other portions of his medical record, and when comparing these MDSs with observations made of Resident #8 during the survey. Examples of inconsistencies included the following:<br>* Observation throughout the day on 03/09/10 | F 278 | | |

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| F 278 | Continued From page 9<br>showed Resident #8 ambulating with a walker.<br>* Resident #8's weight record identified this resident to weigh 160 pounds on 08/13/09.<br>* The physician order sheet identified Resident #8 has received a diuretic since 11/20/08 (hydrochlorothiazide 25 milligrams by mouth 1/2 tablet daily).<br>* Observation on 03/09/10 at 9:30 a.m. showed Resident #8 had a pressure relieving mattress on his bed.<br>* Observation on 03/09/10 at 9:30 a.m. showed Resident #8 wearing incontinent briefs.<br><br>During an interview on 03/09/10 at 3:35 p.m., an administrative nursing staff member (#1) identified all the residents in the facility have a pressure relieving mattress on their bed. This included Resident #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11 and #12.<br><br>During an interview on 03/09/10 at 3:45 p.m., an administrative nursing staff member (#2) verified the MDS coding identified above was not accurate for Resident #8.<br><br>- Review of Resident #3's medical record occurred on March 8-10, 2010.<br><br>Resident #3's quarterly MDS, completed on 01/06/2010, identified the following:<br>* Section G.1. Physical Functioning and Structural Problems - ADL self-performance for walk in room coded as 2 (limited assistance).<br>* Section G.1. Physical Functioning and Structural Problems - ADL self-performance for walk in corridor coded as 2 (limited assistance).<br>* Section G.1. Physical Functioning and Structural Problems - ADL self-performance for locomotion on unit as 2 (limited assistance). | F 278 | | |

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| F 278 | Continued From page 10<br>* Section G.1. Physical Functioning and Structural Problems - ADL self-performance for locomotion off unit as as 2 (limited assistance).<br>* Section M.5. Skin Treatments - no "pressure relieving device(s) for bed."<br><br>Resident #3's annual MDS, completed on 10/06/09, identified the following:<br>* Section M.5. Skin Treatments - no "pressure relieving device(s) for bed."<br><br>Inconsistencies were noted when comparing Resident #3's MDSs with observations made of Resident #3 during the survey. Examples of inconsistencies included the following:<br>* Observation on the afternoon of 03/08/2010 and throughout the day on 03/09/10 showed Resident #3 required extensive assistance with transfers, locomotion and toilet use.<br>* Observation on 03/09/10 at 9:50 a.m. showed Resident #3 had a pressure relieving mattress on her bed.<br><br>During an interview on 03/09/10 at 3:35 p.m., an administrative nursing staff member (#1) verified the MDS coding identified above was not accurate for Resident #3.<br><br>- Review of Resident #2's medical record occurred on March 8-10, 2010. Resident #2's significant change MDS, completed on 12/04/09, identified the following:<br>* Section M.5. Skin Treatments - no "pressure relieving device(s) for bed."<br>* Section P.3. Nursing Rehabilitation/Restorative Care - "dressing or grooming" for 7 days.<br><br>Inconsistencies were noted when comparing | F 278 | | |

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| F 278 | Continued From page 11 | F 278 | | |

Resident #2's MDS with other portions of her medical record, and when comparing the MDS with observations made of Resident #2 during the survey. Examples of inconsistencies included the following:

* Observation on 03/09/10 at 9:40 a.m. showed Resident #2 had a pressure relieving mattress on her bed.

* Review of the restorative flow sheets identified Resident #2 did not receive 15 minutes of dressing or grooming for 7 days during the 7-day look back period (11/26/09 through 12/02/09).

During an interview on 03/10/10 at 10:30 a.m., an administrative nursing staff member (#1) verified the MDS coding identified above was not accurate for Resident #2.

- Review of Resident #12's medical record occurred on 03/10/10.

Resident #12's MDS, completed on 12/11/09, identified the following:

* Section G.5. Modes of Locomotion - "lifted mechanically."

* Section M.5. Skin Treatments - no "pressure relieving device(s) for bed."

Resident #12's quarterly MDS, completed on 09/30/09, identified the following:

* Section M.5. Skin Treatments - no "pressure relieving device(s) for bed."

Inconsistencies were noted when comparing Resident #12's MDS with other portions of her medical record, and when comparing the MDS with an observation made of Resident #12 during the survey. Examples of inconsistencies included

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| F 278 | Continued From page 12<br>the following:<br>* Review of the medical record lacked evidence Resident #12 was lifted mechanically during the look back period for the MDS completed on 12/11/09.<br>* Observation on 03/10/10 at 9:45 a.m. showed Resident #12 had a pressure relieving mattress on her bed.<br><br>During an interview on 03/10/10 at 11:45 a.m., an administrative nursing staff member (#2) verified the MDS coding identified above was not accurate for Resident #12.<br><br>- Review of Resident #4's medical record occurred on March 8-10, 2010. Resident #4's quarterly MDS, completed on 01/15/10, identified the following:<br>* Section G.6.b. - no "bed rails used for bed mobility or transfer."<br><br>Inconsistencies were noted when comparing Resident #4's MDS with observations made of Resident #4 during the survey. Examples of inconsistencies included the following:<br>* Observation of Resident #4's bed throughout the survey showed bilateral bed rails attached to the bed.<br><br>- Review of Resident #6's medical record occurred on March 8-10, 2010. Resident #6's annual MDS, completed on 02/12/10, identified the following:<br>* Section G.6.b. - no "bed rails used for bed mobility or transfer."<br><br>Inconsistencies were noted when comparing Resident #6's MDS with observations made of Resident #6 during the survey. Examples of | F 278 | | |

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| F 278 | Continued From page 13<br>inconsistencies included the following:<br>* Observation of Resident #6's bed throughout the survey showed bilateral bed rails attached to the bed.<br><br>- Review of Resident #11's medical record occurred on March 10, 2010. Resident #11's admission MDS, completed on 02/11/10, identified the following:<br>* Section G.6.b. - no "bed rails used for bed mobility or transfer."<br><br>Inconsistencies were noted when comparing Resident #11's MDS with observations made of Resident #11 during the survey. Examples of inconsistencies included the following:<br>* Observation of Resident #11's bed on March 8 and 10, 2010 showed bilateral bed rails attached to the bed. | F 278 | | |
| F 280 SS=E | 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP<br><br>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.<br><br>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 | F 280 | The care plans for residents 1, 4, 5, and 8 have been updated regarding areas noted during survey.<br><br>All residents are at risk for this practice.<br><br>Care plans will be audited by the care plan team and HIM during the care plan meeting, for the identified residents, as their care plans are reviewed with the completion of the MDS. The care team will also review 4 random care plans per quarter, to address the residents who have potential to be affected by this practice. | |

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| F 280 | Continued From page 14<br>each assessment.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, and staff interview, the facility failed to review and revise the comprehensive care plans for 4 of 12 sampled residents (Resident #1, #4, #5, and #8). Failure to review and revise the resident care plans limited the staff's ability to communicate the care needs of each resident and limited the staff's ability to ensure continuity of care for each resident.<br><br>Findings include:<br><br>- Observation of cares provided to Resident #1 revealed the following:<br>* On 03/08/10 at 4:00 p.m., a certified nurse assistant (CNA) (#14) removed Resident #1's incontinence pad, provided pericares, and placed a clean pad.<br>* On 03/09/10 at 11:00 a.m., a CNA (#15) removed the resident's incontinence pad, provided pericares, and placed a clean pad.<br><br>Resident #1's medical record, reviewed on March 8-10, 2010, identified the facility admitted the resident in June 2009. The resident's quarterly Minimum Data Set (MDS), dated 12/22/09, identified extensive assistance with toileting, bowel and bladder incontinence, on a scheduled toilet plan, and pads/briefs used.<br><br>Resident #1's current care plan, dated 12/14/09, stated, "Problem: . . . Alteration in elimination | F 280 | The Care Plan Team will be responsible to monitor and assure the accuracy of the care plan. Quality Assurance will begin on April 13, 2010 with our next scheduled care team meeting. Results of audits will be reported to the quality team monthly times 3 and then quarterly times 3. | 4-26-2010 |

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| F 280 | Continued From page 15 | F 280 | | |

incontinent of urine . . . Plan: Encourage/Assist resident with toileting upon arising, 1 hour within meals, bedtime, when states and at night . . . " The care plan failed to indicate the resident used incontinence products.

- Observation of cares provided to Resident #5 revealed the following:
* On 03/09/10 at 9:15 a.m., a CNA (#9) removed the resident's incontinence pad, provided pericares, and placed a clean pad.
* On 03/09/10 at 9:50 a.m., Resident #5 received pureed foods and regular liquids on her breakfast tray.

Resident #5's medical record, reviewed on March 8-10, 2010, identified the facility admitted the resident in February of 2005. Current diagnoses included history of cerebral vascular accident (CVA), gastroesophageal reflux disease (GERD). The resident's annual MDS, dated 02/10/10, identified limited assistance with eating, chewing problem, mechanically altered diet, total assistance with toileting, bowel and bladder incontinence, and pads/briefs used.

Resident #5's current care plan, dated 12/14/09, stated, ". . . Problem: Potential for not receiving adequate nutritional body requirements. Does not eat 75% of meals. Requests foods throughout the day. Hx of PEG [percutaneous endoscopic gastrostomy] feeding . . . Plan: Serve foods preferred on regular diet. Prefers small portions. . . . Problem: I am incontinent of bowel and bladder. . . . Plan: Check and change me routinely. Encourage me to use the toilet. . . . " The care plan showed no evidence the resident had a problem chewing, that the facility served her ground foods, or that she used incontinence

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| F 280 | Continued From page 16<br>products.<br><br>During interview, on March 10, 2010, at 11:15 a.m., an administrative nursing staff member (#1), stated, "Those items are not on the care plan. I don't know why they weren't carried over."<br><br>Facility staff failed to revise/update Residents #1 and #5's care plans to reflect their current dietary and/or toileting care needs.<br><br>- Resident #4's medical record, reviewed March 8-10, 2010, identified the facility admitted the resident in 2008. The medical record showed the facility discontinued the use of an antianxiety medication in February 2009. The medical record showed the facility began the use of an antipsychotic medication on 01/08/10.<br><br>Resident #4's plan of care, last reviewed/revised 01/21/10, stated "Administer antianxiety med [medication] prn [as needed] monitor for side effects (nausea, headache, loss of appetite, constipation)." Facility staff failed to revise/update Resident #4's care plan to reflect the discontinuation of the antianxiety medication and then include the use of an antipsychotic medication, including monitoring for side effects.<br><br>Resident #4's plan of care, dated 01/21/10, also stated, ". . . My vision is reduced and I am not able to voice what I can and can't see. I use (sic) to wear glasses but not now." Observations of Resident #4 throughout all days of survey failed to show her wearing eyeglasses.<br><br>A quarterly Minimum Data Set (MDS), dated 01/15/10, identified Resident #4 uses visual appliances. The MDS defines visual appliances | F 280 | | |

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| F 280 | Continued From page 17<br>as glasses, contact lenses or a magnifying glass.<br><br>During an interview, on 03/10/10 at 1:40 p.m., an administrative staff member (#1) stated Resident #4 wears her glasses only when her sister visits and is able to sit with her, as the resident will remove her glasses and leave them places. This staff member stated the care plan does not reflect the actual use of Resident #4's eyeglasses, nor the current use of psychotropic medications by Resident #4.<br><br>- Resident #8's medical record, reviewed on March 8-10, 2010, identified the facility admitted the resident in 2002. The Interdisciplinary Progress Notes, dated 02/28/10, stated, ". . . he [a relative] is aware of res. [resident] status slowly declining, not eating well - feeling full all the time - loss of wt. [weight] . . ." Review of Resident #8's weight record identified on 10/28/09 Resident #8 weighed 152.5 pounds and on 03/03/10 he weighed 142 pounds.<br><br>Resident #8's current plan of care stated, "11/26/09 - I have a good appetite." Facility staff failed to revise/update Resident #8's care plan to reflect that he is not eating well and experiencing weight loss, and also failed to develop interventions to address this problem. | F 280 | | |
| F 281 SS=D | 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS<br><br>The services provided or arranged by the facility must meet professional standards of quality.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, review of facility policy and | F 281 | The facility will administer medications according to professional standards for resident #14 by obtaining a physician order for "Lactaid" and it will be administered by the licensed nurse. This started March 25, 2010. | |

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| F 281 | Continued From page 18<br>procedure, review of medical records, review of professional literature, and staff interview, the facility failed to administer medication according to professional standards for 1 of 1 supplemental residents (#14) observed receiving medications given by a dietary aide.<br><br>Findings include:<br><br>Drug Information Handbook for Nursing 2007, 8th Edition, Page 18, stated "Assessment is the primary action in the nursing process and it is also a vital part of optimal drug therapy. Assessment activities must precede administration of any medication. . . . Monitoring . . . at all times, the nurse responsible for administering the medication or instructing the patient about administration is also responsible for monitoring effectiveness and adverse effects and communicating these details to the prescriber.<br><br>Review of facility policy occurred on the afternoon of 03/10/10. This policy titled, "Administration of Medication" dated November 2002, stated "A physician's order for any medication is required . . . Medication administration is a nursing task. . . . the nurse assesses the resident . . . verifies that the medication aide is competent . . . and supervises the performance of medication administration. . . . Administration of an initial dose and the follow-up monitoring after the initial dose will be completed by a licensed nurse."<br><br>Observation on 03/09/10 at 12:00 p.m., showed a dietary staff member (#18) obtained a medication from a drawer in the kitchen and gave it to Resident #14 in the dining room. Observation of this medication bottle showed Lactaid Original. | F 281 | The facility has identified no other residents to be effected by this deficient practice as no other residents receive "Lactaid".<br>Education has been given to dietary and nursing staff that "Lactaid" needs a physician order and must be administered by a licensed nurse.<br>The MAR will be the tool used to monitor that nurses are administering the "Lactaid"as ordered. | 4-26-2010 |

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| F 281 | Continued From page 19<br>The bottle lacked a pharmacy label with resident information.<br><br>Observation on 03/09/10 at approximately 5:00 p.m., showed a pill in a souffle cup at a place setting in the dining room where Resident #14 normally sat for meals.<br><br>Review of Resident #14's medical record occurred on March 09-10, 2010 and revealed no physician order for Lactaid Original, nor any documentation of a lactose intolerance diagnosis. Resident #14's medication administration record (MAR) did not list Lactaid Original. The MAR did show an order for Tums and multivitamin administered by nursing staff.<br><br>Review of Resident #14's care plan, dated 01/21/10, stated "Lactose intolerant . . . Offer Lactaid or other med [medication] for lactose intolerance before meals." Review of the multidisciplinary notes showed an entry dated 01/20/10 by an administrative staff member (#5). This staff member documented, "Gets Lactaid with all meals."<br><br>During an interview on 03/10/10 at 8:30 a.m., a dietary staff member (#19) stated the dietary staff member (#18) had given Resident #14 her Lactaid pill before her breakfast this morning. This staff member (#19) stated, "We [the dietary department staff] give her Lactaid before all her meals."<br><br>During an interview on 03/10/10 at 1:05 p.m., an administrative staff member (#1) stated, "We don't look at it [Lactaid] as a medication. It's a dietary supplement." This staff member then stated iron supplements, calcium supplements | F 281 | | |

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| F 281 | Continued From page 20<br>and Tums must be given by nursing staff. The staff member agreed that "nursing staff should probably be the ones who administer the Lactaid." The staff member stated Resident #14 is not able to self administer her medications due to cognitive function. | F 281 | | |
| F 309 SS=D | 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>1. Based on record review, anonymous interview, staff interview, review of facility policy and procedure, and review of professional literature, the facility failed to ensure 1 of 1 resident (Resident #9) with physician ordered continuous oxygen received proper respiratory care regarding the availability of oxygen. Failure to ensure the oxygen tank was turned on and an adequate supply was available during activities placed the resident at risk for complications such as anxiety and hypoxia. [Hypoxia is insufficient oxygen anywhere in the body.]<br><br>Findings:<br><br>The American Association for Respiratory Care (AARC) Guideline: Oxygen Therapy in the Home or Alternative Site Health Care Facility, Repiratory Care, August 2007, Volume 52, Number 1, pages | F 309 | The facility will ensure that all residents receive 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 by ensuring residents on continuous oxygen therapy will not run out of oxygen and residents will not be offered or given fluids unless in the appropriate position to facilitate proper swallowing.<br><br>Resident #9 has been discharged to home as of March 27th, 2010. All residents who receive continuous oxygen therapy are at risk for this deficient practice. Currently no residents have orders for continuous oxygen.<br><br>Resident #5 is not being offered or given fluids unless she is sitting in appropriate position. Her care plan has been updated to include this.<br>All residents who recline are at risk for staff offering them fluids while in this position. | |

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| F 309 | Continued From page 21<br>1063-1068 stated, ". . . OT-CC 11.0 Monitoring 11.2 . . . supervision: All oxygen delivery equipment should be checked at least once daily by the . . . caregiver. Facets to be assessed include . . . remaining liquid or compressed gas content, and backup oxygen. . . . OT-CC 12.0 Frequency . . . Oxygen therapy use in chronic obstructuve pulmonary disease for the treatment of chronic hypoxemia should be administered continuously . . ."<br><br>The Fundamentals of Nursing Concepts, Process, and Practice 8th Edition by Berman, Snyder, Kozier and Erb copyright 2008 by Pearson Education, Inc., pages 1372-1377 stated, ". . . Clients who have difficulty ventilating all areas of their lungs, those whose gas exchange is impaired . . . may benefit from oxygen therapy to prevent hypoxia . . . Performance: . . . 7. Assess the client regularly . . ."<br><br>Review of the facility policy titled "Oxygen Administration with Nasal Cannula, Face Mask or Face Tent" occurred on 03/10/10. This policy, dated February 2005, stated, "Purpose To administer various levels of 02 [oxygen] concentration . . . in a safe manner. . . . Procedure<br>Assess resident . . . at regular intervals depending on resident's condition . . . "<br><br>Review of the facility policy titled "Oxygen Administration" occurred on 03/10/10. This policy, dated November 2002, stated, "Purpose To administer oxygen in a safe manner. . . . Policy . . . A licensed nurse . . . will be responsible for the correct administration of oxygen to the resident . . ." | F 309 | Education to include appropriate positioning while eating or drinking will be done.<br>Education to include the proper oxygen monitoring to insure that a resident with orders for continuous oxygen will not be without oxygen. "Note: Have Reserve Tank Readily Available" added to O2 Procedure<br>An audit to include proper positioning (while eating or drinking while staff performs cares)and the continuous oxygen availability and usage will be completed monthly times 3 and quarterly thereafter x 3. | per DON 4-15-10 DM LT<br><br>4-26-2010 |

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| F 309 | Continued From page 22<br><br>The survey team received information while onsite from a person who wished to remain anonymous indicating Resident #9 did not always receive oxygen as ordered.<br><br>Observation on 03/09/10 at 3:30 p.m., showed Resident #9 ran out of oxygen while in a group interview. She stated, "I think I am out of oxygen." The surveyor called for a nursing assistance. Resident #9 appeared very short of breath, anxious, and her lips were blue. In approximately 5 minutes, nursing staff replaced her oxygen cannister.<br><br>Resident #9's medical record, reviewed on March 8-10, 2010, identified the facility admitted the resident in February of 2010. Current diagnoses included supplemental oxygen, emphysema, chronic obstructuve pulmonary disease [COPD], muscle weakness, vertigo and anxiety. The resident's annual Minimum Data Sets (MDS), dated 02/11/10, identified moderately independent in daily decision making skills, limited assistance with activities of daily living, use of antianxiety medication and oxygen therapy.<br><br>Resident #9's current care plan, dated 02/15/10, stated, ". . . Problem: I need to have 02 on at all times. . . . Approach: Oxygen per nasal prongs. Monitor saturations prn [as needed] dyspnea. Assess lung sounds as needed. . . . Problem: I am able to perform most of my cares but need assist due to my vertigo and severe SOB [shortness of breath]. When I get SOB, I get anxious. . . . Approach: . . . Report anxiousness to nurse. Encourage her to take deep breath through her nose. Check 02 to make sure it | F 309 | | |

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| F 309 | Continued From page 22<br><br>The survey team received information while onsite from a person who wished to remain anonymous indicating Resident #9 did not always receive oxygen as ordered.<br><br>Observation on 03/09/10 at 3:30 p.m., showed Resident #9 ran out of oxygen while in a group interview. She stated, "I think I am out of oxygen." The surveyor called for a nursing assistance. Resident #9 appeared very short of breath, anxious, and her lips were blue. In approximately 5 minutes, nursing staff replaced her oxygen cannister.<br><br>Resident #9's medical record, reviewed on March 8-10, 2010, identified the facility admitted the resident in February of 2010. Current diagnoses included supplemental oxygen, emphysema, chronic obstructuve pulmonary disease [COPD], muscle weakness, vertigo and anxiety. The resident's annual Minimum Data Sets (MDS), dated 02/11/10, identified moderately independent in daily decision making skills, limited assistance with activities of daily living, use of antianxiety medication and oxygen therapy.<br><br>Resident #9's current care plan, dated 02/15/10, stated, ". . . Problem: I need to have 02 on at all times. . . . Approach: Oxygen per nasal prongs. Monitor saturations prn [as needed] dyspnea. Assess lung sounds as needed. . . . Problem: I am able to perform most of my cares but need assist due to my vertigo and severe SOB [shortness of breath]. When I get SOB, I get anxious. . . . Approach: . . . Report anxiousness to nurse. Encourage her to take deep breath through her nose. Check 02 to make sure it | F 309 | Education to include appropriate positioning while eating or drinking will be done.<br>* The oxygen procedure has been updated. Education to include the updated procedure for proper oxygen monitoring to insure that a resident with orders for continuous oxygen will not be without oxygen.<br><br>An audit to include proper positioning (while eating or drinking while staff performs cares)and the continuous oxygen availability and usage will be completed monthly times 3 and quarterly thereafter x 3.<br><br>4-26-2010<br>12 40 pm<br>*Call to DON on 4-15-10 asking her to clarify what changes re: $O_2$ were made to procedure DON stated "NOTE: HAVE RESERVE TANK READILY AVAILABLE" was added in BOLD to the $O_2$ procedure. | |



4-14-10 Admin gone. Spoke by telephone with DON. I explained to her the following:
1.) Pg 21 - Nothing in place to show how facility will make sure other res. on continuous oxygen do not run out of $O_2$.
2.) Pg 27 - Random audits of CNA's will be carried out by WHOM?
3.) Pg 33 - "Nursing OR PT" will do ltr assessments. How will each department know exactly which one is to do the assessment?

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| F 309 | Continued From page 23<br>works. . . ."<br><br>Resident #9's Physicians Orders, dated 02/04/10, stated, ". . . Continuous oxygen to keep sats [saturations] about 90%. 02 sats prn. . . ."<br><br>Resident #9's Daily Skilled Notes identified the following:<br>* 02/08/10 - 03/09/10: Several entries identified the resident became anxious when short of breath and required assistance with all cares due to shortness of breath.<br>* 02/13/10: "D [days] . . . 02 on cont. [continuously], off AM for toileting [and] sats [fell] to 66 [at] Rm [room] [sic] quickly. . . ."<br>* 02/17/10: "days: . . . Becomes anxious when SOB has Valuim to help calm her. . . ."<br>* 02/21/10: "2 p [At 2:00 p.m.], . . . Using 02/NC continuously . . . 02 - drops immediately when 02 off - to refill tank. . . ."<br><br>During an interview on 03/10/10 at 1:30 p.m., an administrative staff member (#3) stated she spoke with nurse who worked the 02/13/10 day shift on which Resident #9's saturations fell to 66%. The administrative staff member (#3) said, "She [nurse] said her [Resident #9's] sats were off a little bit, but with oxygen they came back up."<br><br>Facility staff failed to ensure Resident #9 did not run out of oxygen. On 02/13/10 Resident #9's oxygen was "off" during toileting, and her saturations fell to 66%, and on 03/09/10 at 3:30 p.m., her oxygen supply ran out during a group activity.<br><br>2. Based on observation, record review, staff interview, review of facility policy and procedure, and review of professional literature, the facility | F 309 | | |

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failed to ensure 1 of 3 sampled residents (Resident #5), who was offered liquids during personal cares, received the care and services necessary to prevent aspiration. Failure to provide appropriate positioning while eating/drinking has the potential to affect the resident's overall swallow safety and limit her nutritional intake. Residents should sit at or as close to 90 degrees as possible while eating/drinking. Even a slightly reclined position while eating greatly increases the risk of premature loss of food over the back of the tongue.

Findings include:

The Source for Dysphagia: Third Edition by Nancy B. Swigert copyright 2007 LinguiSystems, Inc, pages 9 and 125, identified the following:
* "Signs and Symptoms of Dysphagia: . . . Coughing/Choking - coughing and choking are very obvious symptoms of dysphagia. . . ."
* "Compensatory Treatment Techniques: . . . 1. Appropriate Seating - During the oral intake of medicines, foods and/or liquids, it is optimal for a patient to be seated at a 90 degree angle, whether in a bed or in a chair. . . ."

Review of the facility policy titled "Dysphagia" occurred on 03/10/10. This policy, dated January 2009, stated, "1. . . . Nursing staff will observe for signs and symptoms of dysphagia when interacting with residents. . . . Signs and symptoms of dysphagia are as follows: . . . coughing or choking when ingesting food or liquid . . . 2. Nursing staff will notify the . . . charge nurse if any of the . . . risk factors for dysphagia are present. . . ."

Review of the facility policy titled "Dining Room

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Guidelines" occurred on 03/10/10. This policy, dated February 2004, stated, ". . . 6. NO resident should be allowed to eat or be fed in a reclining position . . . 12. All staff must be alert to any signs of choking and swallowing difficulty, and immediately alert the nurse . . . when problems occur . . . "

Random observations on 03/09/10 at 9:13 a.m., showed a Certified Nurse Assistant (CNA) (#9) transferred Resident #5 to her bed using a gaitbelt and walker. The CNA (#9) offered Resident #5 a glass of water to drink after she was lying down. Resident #5 accepted the glass, and proceeded to drink from the straw. She instantly began coughing. The CNA (#9) encouraged her to "drink more" twice, as she continued to cough. The CNA (#9) did not attempt to reposition the resident at any time during the observation.

Resident #5's medical record, reviewed on March 8-10, 2010, identified the facility admitted the resident in February of 2005. Current diagnoses included history of cerebral vascular accident (CVA), gastroesophageal reflux disease (GERD), and nausea. The resident's annual MDS, dated 02/10/10, identified short term memory loss, moderately impaired daily decision making skills, limited assistance with eating, chewing problem, and mechanically altered diet.

Resident #5's current care plan, dated 12/14/09, stated, ". . . Problem: Potential for not receiving adequate nutritional body requirements. . . . Requests foods throughout the day. Hx of PEG feeding . . . "

During an interview on 03/10/10 at 1:30 p.m., an

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| F 309 | Continued From page 26<br>administrative nursing staff member (#1) agreed residents should not be offered liquids while they are lying down. | F 309 | The facility will provide necessary services to the resident who is unable to carry out their own activities of daily living to maintain good grooming and personal hygiene by providing appropriate perineal care (stool and urine) to all residents who need assist with incontinence cares. Residents #1, 4,5,7,10 have been checked for risk factors to include skin breakdown, irritation and infections.<br><br>All residents who require toileting assist are at risk for this deficient practice.<br><br>Education to include appropriate perineal cares and techniques will be provided to all staff that provides cares to residents.<br><br>An audit to include observation of 5 random certified nursing assistants perineal cares of incontinent residents will be completed monthly x 3 then quarterly thereafter x 3. | 4-26-2010 |
| F 312 SS=E | 483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS<br><br>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, staff interview, and review of professional literature, the facility failed to provide proper perineal care for 5 of 10 sampled residents (Resident #1, #4, #5, #7 and #10) who required assistance with personal hygiene. Failure to provide appropriate perineal care placed the residents at risk for skin irritation, skin breakdown, and infection.<br><br>Findings include:<br><br>Berman, Snyder, Kozier, Erb, "Fundamentals of Nursing, Concepts, Process, and Practice," 8th edition, Pearson Education, Inc., New Jersey, page 756, stated: ". . . For females . . . Use separate quarters of the washcloth for each stroke, and wipe from the pubis to the rectum. . . . Take a clean wipe for each stroke. Rationale: Using separate quarters of the washcloth or new wipes prevents the transmission of microorganisms from one area to the other. Wipe from the area of least contamination (the pubis) to that of greatest (the rectum)." | F 312 | | |

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| F 309 | Continued From page 26<br>administrative nursing staff member (#1) agreed residents should not be offered liquids while they are lying down. | F 309 | | |
| F 312 SS=E | 483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS<br><br>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, staff interview, and review of professional literature, the facility failed to provide proper perineal care for 5 of 10 sampled residents (Resident #1, #4, #5, #7 and #10) who required assistance with personal hygiene. Failure to provide appropriate perineal care placed the residents at risk for skin irritation, skin breakdown, and infection.<br><br>Findings include:<br><br>Berman, Snyder, Kozier, Erb, "Fundamentals of Nursing, Concepts, Process, and Practice," 8th edition, Pearson Education, Inc., New Jersey, page 756, stated: ". . . For females . . . Use separate quarters of the washcloth for each stroke, and wipe from the pubis to the rectum. . . . Take a clean wipe for each stroke. Rationale: Using separate quarters of the washcloth or new wipes prevents the transmission of microorganisms from one area to the other. Wipe from the area of least contamination (the pubis) to that of greatest (the rectum)." | F 312 | The facility will provide necessary services to the resident who is unable to carry out their own activities of daily living to maintain good grooming and personal hygiene by providing appropriate perineal care (stool and urine) to all residents who need assist with incontinence cares. Residents #1, 4,5,7,10 have been checked for risk factors to include skin breakdown, irritation and infections.<br><br>All residents who require toileting assist are at risk for this deficient practice.<br><br>Education to include appropriate perineal cares and techniques will be provided to all staff that provides cares to residents.<br><br>An audit to include observation of 5 random certified nursing assistants perineal cares of incontinent residents will be completed monthly x 3 then quarterly thereafter x 3 by the Quality Assurance Committee or designee. | 4-26-2010 |

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| F 312 | Continued From page 27<br>- Observation of incontinence cares provided to Resident #1 revealed the following:<br>* On 03/08/10 at 4:00 p.m., showed a certified nurse assistant (CNA) (#14) transferred Resident #1 from her wheelchair to the bathroom. The CNA (#14) lowered her pants and brief, cued the resident to sit down, and then removed her brief. Observation showed the brief as soiled with urine. After the resident voided, the CNA (#14) assisted the resident to stand and provided pericares using a pre-soaked wipe. The CNA (#14) cleansed the resident's perineum from the pubis to the rectum three times without turning the wipe to a clean area. The CNA (#14) failed to use a different area of the cleansing wipe or to obtain fresh wipes before cleansing from the pubis to the rectum.<br>* On 03/09/10 at 11:00 a.m., showed a CNA (#8) assisted Resident #1 to the bathroom using her walker. As the resident stood, a CNA (#15) lowered her pants and removed her brief. Observation showed the brief as soiled with loose watery stool. The CNA (#8) cued the resident to sit down. After a CNA (#8) assisted the resident to stand, a CNA (#15) provided pericares using a pre-soaked wipe. The CNA (#15) cleansed the resident's perineum from the pubis to the rectum, cleansed the rectal area and buttocks, then cleansed from the pubis to the rectum again, without turning the wipe to a clean area. The CNA (#15) failed to use a different area of the cleansing wipe or to obtain fresh wipes before cleansing from the pubis to the rectum after cleansing the rectum/buttocks.<br><br>Resident #1's medical record, reviewed on March 8-10, 2010, identified the facility admitted the resident in June of 2009. The quarterly Minimum Data Sets (MDS), dated 12/22/09, indicated | F 312 | | |

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| F 312 | Continued From page 28<br>extensive assistance with toileting, bowel and bladder incontinence, on a scheduled toilet plan & pads/briefs used.<br><br>- Observation of incontinence cares provided to Resident #5 revealed the following:<br>* On 03/09/10 at 9:15 a.m., showed a CNA (#9) transferred Resident #5 from her bed to the bathroom using her walker. The CNA (#9) lowered her pants and brief, cued the resident to sit down, and then removed her brief. Observation showed the brief as soiled with urine. After the resident voided, the CNA (#9) assisted the resident to stand and provided pericares using a pre-soaked wipe. The CNA (#9) cleansed the resident's perineum from the pubis to the rectum, cleansed the rectal area and buttocks, then cleansed from the pubis to the rectum again without turning the wipe to a clean area. The CNA (#9) failed to use a different area of the cleansing wipe or to obtain fresh wipes before cleansing from the pubis to the rectum after cleansing the rectum/buttocks.<br><br>Resident #5's medical record, reviewed on March 8-10, 2010, identified the facility admitted the resident in February of 2005. The annual MDS, dated 02/10/10, identified total assistance with toileting, bowel and bladder incontinence, and pads/briefs used.<br><br>Resident #5's current care plan, dated 12/14/09, stated, ". . . Problem: I am incontinent of bowel and bladder. I lack motivation to go to the bathroom. I will refuse to go with you. I have a history of UTI's. . . . Plan: . . . Report concentrated urine, foul smelling urine, frequent urgency to void to charge nurse . . . Report any reddened areas on my skin to the CN [certified | F 312 | | |

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| F 312 | Continued From page 29<br>nurse]. . . . "<br><br>- Observation of incontinence cares provided to Resident #7 revealed the following:<br>* On 03/10/10 at 8:15 a.m., showed a CNA (#8) assisted Resident #7 to the bathroom using her walker. As the resident stood with the assistance of two CNAs (#8 and #11), another CNA (#16) lowered her pants and removed her brief. Observation showed the brief as soiled with stool. After the resident voided, two CNAs (#8 and #11) assisted the resident to stand. A CNA (#16) provided pericares using a pre-soaked wipe. The CNA (#16) cleansed the resident's perineum from the pubis to the rectum two times without turning the wipe to a clean area. The CNA (#16) failed to use a different area of the cleansing wipe or to obtain fresh wipes before cleansing from the pubis to the rectum.<br><br>Resident #7's medical record, reviewed on March 8-10, 2010, identified the facility admitted the resident in December of 2006. Current diagnoses included dementia, incontinence, and a history of urinary tract infections (UTIs). The resident's significant change MDS, dated 02/12/10, identified total assistance with toileting, bowel and bladder incontinence, and pads/briefs used.<br><br>Resident #7's current care plan, dated 02/12/10, stated, ". . . Problem: I do not tell you when I need to use the bathroom. I am incontinent of bowel and bladder. I have a history of UTI's. . . . "<br><br>The Monthly Report of Resident Infections in Center, dated October 2009 and November 2009, identified: ". . . Name: [Resident #7's Name] . . . Date of Infection: 10-28-09 . . . Site of Infection: Bladder . . . Culture Taken: Yes . . . Causative | F 312 | | |

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| F 312 | Continued From page 30<br>Agent: 09-08-09 Viridans Strep [and] Mixed Flora Contamination . . . Antibiotic Treatment: 10-29 Cipro and 11-11 Cipro . . . Cautionary Measures: Take to BR [bathroom] and Routinely change incont. [incontinence] pad . . . Center Acquired: Yes . . ."<br><br>During an interview, on 03/10/10 at 1:30 p.m., an administrative staff member (#1) agreed facility staff should use separate quarters of the cleansing wipe for each wipe to the perineum.<br><br>- Observation of incontinence care provided to Resident #10, on 03/10/10 at 10:42 a.m., showed a CNA (#16) assisted Resident #10 from her wheelchair to the bathroom. The CNA (#16) lowered the resident's pants and brief, the resident sat down on the toilet, and the CNA (#16) removed the brief. When asked, the CNA (#16) identified the brief as soiled with urine and stool. Resident #10 informed the CNA (#16) she was done. The CNA (#16) obtained toilet paper, applied wash cream to the toilet paper and assisted the resident to stand. The CNA (#16) cleansed Resident #10 from the pubis to the rectum, cleansed the rectal area and buttocks, then cleansed from the pubis to the rectum again without turning the toilet paper to a clean area. The CNA (#16) failed to use a different area of toilet paper or to obtain fresh toilet paper before cleansing from the pubis to the rectum after cleansing the rectum/buttocks.<br><br>- Observation of incontinence cares provided to Resident #4, on 03/09/10 at 2:42 p.m. showed two CNAs (#12 and #13) transferred Resident #4 from her wheelchair to the toilet using a gait belt and walker. The CNAs (#12 and #13) lowered the resident's pants and brief, cued the resident to sit | F 312 | | |

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| F 312 | Continued From page 31<br>down, and removed her brief. When asked, the CNA (#13) identified the brief was wet. The CNA (#13) provided pericares after the resident voided. The CNAs (#12 and #13) assisted the resident to stand, and a CNA (#13) cleansed Resident #4 from the pubis to the rectum one time using toilet paper. The CNA (#13) removed her gloves, pulled up the resident's pad and pants, and the CNAs (#12 and #13) transferred her back to her wheelchair. The CNA (#13) failed to cleanse all skin exposed to urine from the wet brief.<br><br>Failure to provide appropriate perineal care stool and/or urine incontinence placed Resident #1, #5, #7, #10 and #4 at risk for skin irritation, breakdown, and/or infection. | F 312 | | |
| F 323 SS=E | 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>1. Based on observation, record review, staff interview, and review of facility policy, the facility staff failed to ensure an environment as free of accident hazards as possible for 1 of 1 resident (#6) identified as entrapped in a bed rail. Failure to follow facility policy regarding resident incidents and to assess the resident for continued use of the bed rail placed Resident #6 at risk of possible future entrapment. | F 323 | The facility will ensure that the residents environment remain as free of accident hazards as is possible and that each resident will receive adequate supervision and assistance devices to prevent accidents.<br><br>Resident # 6 has had positioning rail removed and her care plan has been updated to include this. Residents at risk for this deficient practice are persons who have positioning bars and do not have cognition to properly use them. | |

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| F 323 | Continued From page 32<br><br>Findings include:<br><br>Review of the facility's policy "Resident/Visitor Incident Report", occurred on 03/10/10. The policy, dated 08/05, stated,<br>"Use: Required<br>Purpose: To document an occurrence or event involving a resident or visitor and to ensure a thorough investigation of the occurrence. . . .<br>Completed By: Staff member discovering the incident completes Sections A through D of the Incident Details . . . Narrative of Incident section is completed by staff member who witnessed incident or the staff member who first discovered the incident. Investigation section is completed by the immediate supervisor when the incident does NOT involve allegations of abuse, neglect or misappropriation of resident property. . . .<br>When Completed: Incident Details and Narrative of Incident sections are completed at the time when the incident occurs. Investigation section is completed as soon as possible. . . ."<br><br>- Observation of Resident #6's room during the initial tour on 03/08/10, beginning at 10:30 a.m., showed a grab bar/bed rail, a device the resident can use to assist when turning side to side in bed, on both sides of the resident's bed. The location of the grab bars were near the head of the bed.<br><br>During a care observation on 03/08/10 at 4:43 p.m., Resident #6 received cares while in bed. The CNAs (#6 and #7) assisting Resident #6 turned her from side to side to complete the cares. Observation failed to show Resident #6 utilized the grab bars/bed rails to assist in turning while receiving cares in bed. | F 323 | Nurses will receive education on incident reporting to address the need to fill out the incident report for entrapment with positioning bars. Education will be provided on the proper use of positioning bars to include the ability to properly use them or remove them off the bed.<br><br>Nurse Quarterly MDS review to include mobility positioning bars on the beds and determine if they are properly being utilized.<br><br>Resident # 1 and 6 are now being propelled with their foot rests on. Other residents at risk are identified as all who are assisted with wheelchair propelling.<br><br>Education to all staff that assist residents with wheelchair propelling that the resident must have the footrests on or be able to physically hold their legs up for the distance. Residents wishing to self propel will have a choice not to use the leg rests. The residents care plan will reflect this choice.<br><br>Quality Assurance will audit the transport of residents to meals monthly x 3 and then quarterly x 3.<br><br>Resident #11 will be assessed for proper lift usage by therapy staff. All residents who transfer with a sit to stand type of lift are at risk for this deficient practice. Quarterly the therapy or nursing staff will | |

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| F 323 | Continued From page 33<br>Observation of two CNAs (#8 and #9) assisting Resident #6 to lay down on 03/09/10 at 1:57 p.m. showed Resident #6 made no attempt to use the grab bars/bed rails during the transfer to bed or during positioning on the bed.<br><br>Review of the medical record for Resident #6 occurred March 8-10, 2010. Diagnoses included dementia, cataracts and macular degeneration. A nurse's note, dated 01/29/10, identified the following:<br>"Res [resident] found [with] [right] forearm stuck in bed railing. Reddened mark on Dorsal side of forearm found, [no] bruising [at] this time, [no] other injuries."<br><br>An annual Minimum Data Set (MDS), dated 02/12/10, identified Resident #6 experienced long and short-term memory problems, required extensive assist of one staff for bed mobility, and extensive assist of two staff for transfers. This same MDS failed to identify the use of bed rails for bed mobility at section G.6.b.<br><br>The care plan for Resident #6, dated 11/12/09, identified a problem related to the potential for injury related to a history of falls. Approaches to prevent falls included: "Positioning bar for mobility independence."<br><br>The medical record lacked a portion of the incident report and an assessment for the continued safe use of the bed rails by Resident #6 after she became caught in the rail. Review of the resident's medical record showed the facility included portions of incident reports in the medical record. Failure of facility staff to complete an incident report and assess the safe use of the bed rail by Resident #6, placed her at risk of | F 323 | do a lift assessment to insure the continued need for a lift. Education will be provided to all that use the lift to ensure that it does not put pressure on the residents' axillae.<br><br>Resident #4 will be ambulated using the gait belt properly. The other residents at risk for this are all that are ambulated with a gait belt.<br><br>Education will be provided to all staff that ambulate residents using a gait belt on the proper application and use of gait belts.<br><br>Quarterly audit will be done for one year on proper gait belt usage. Findings to be submitted to Quality committee.<br><br>Room # 105 and # 216 have been inspected and repaired.<br><br>All doors that have the vinyl edge protector are at risk for the sharp edges.<br><br>Maintenance will identify and fix any other doors with sharp edges. This will be included on routine safety audits of the environment and problems identified submitted to Quality committee. | 4-26-2010 |

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| F 323 | Continued From page 34<br>further injury if she became trapped in the railing again.<br><br>During an interview, on 03/10/10 at 1:40 p.m., an administrative staff member (#1) stated she could not recall hearing of Resident #6 being "stuck" in the bed railing. This staff member (#1) stated she keeps a log of injuries, as described for Resident #6, and she does not recall entering the injury on the log. After a request for further information, the facility failed to provide information regarding the facility's response to Resident #6's incident with the bed rail.<br><br>2. Based on observation, record review, review of facility policy, and staff interview, the facility failed to ensure residents received adequate supervision and assistance devices to prevent accidents for 2 of 8 sampled residents (#1 and #6) observed being transferred in a wheelchair without foot rests; for 1 of 3 sampled resident (#11) observed being transferred with a lift; and for 2 of 9 sampled residents (#3 and #4) observed being transferred/ambulated using a gait belt. Failure of the facility to ensure staff used transfer devices properly placed the residents at risk for possible accidents and/or injury.<br><br>Findings include:<br><br>FOOT RESTS<br>Review of the facility policies titled "Wheelchair Positioning" and "Bed-to-Chair Transfer Technique" occurred on 03/10/10, and identified the following:<br>* The "Wheelchair Positioning" policy, dated March 2007, stated, ". . . Correct Wheelchair Positioning Checklist . . . Feet are flat on the foot pedals . . ." | F 323 | | |

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| F 323 | Continued From page 35<br>* The "Bed-to-Chair Transfer Technique" policy, dated February 2005, stated, ". . . Procedure: Bed to Chair . . . 8. Replace foot pedals . . . Chair to Chair . . . 7. Assist resident to sit erect in chair with feet supported . . ."<br><br>- During care observations for Resident #6, on 03/08/10 at 4:43 p.m. (CNAs #6 and #7), 03/09/10 at 11:30 a.m. (CNAs #8 and #9), and 1:57 p.m. along with random observations of staff wheeling Resident #6, staff did not secure foot rests to the wheelchair to assist Resident #6 in keeping her feet off the floor as staff propelled the wheelchair. During these observations the foot pedals were located in a bag on the back of Resident #6's wheelchair. Observation of Resident #6 on 03/09/10 at 11:30 a.m. showed staff wheeling the resident in her wheelchair with foot pedals in place and being used by Resident #6. Observations of Resident #6 showed her feet in full contact with the floor when sitting in the wheelchair with out the food pedals in place. Resident #6 can be injured if she puts her feet down while being wheeled by staff. Observation showed staff did not remind Resident #6 to lift her feet prior to wheeling her, or assess the need for foot pedals prior to wheeling her.<br><br>Review of the medical record for Resident #6 occurred March 8-10, 2010. Diagnoses included dementia, diabetes, peripheral vascular disease and polyneuropathy. An annual MDS, dated 02/12/10, identified the resident experienced long and short-term memory problems, required extensive assist of one staff for locomotion on/off the unit, wheelchair is primary mode of locomotion, and other person wheeled.<br><br>During an interview, on 03/10/10 at 1:40 p.m., an | F 323 | | |

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| F 323 | Continued From page 36<br>administrative staff member (#1) identified pouches on the back of Resident #6's wheelchair contain foot pedals readily available for staff use. This administrative staff member (#1) did not expect staff to use foot rests every time for Residents #6, but staff were to determine the need to use the foot pedals prior to wheeling the resident.<br><br>- Random observations revealed the following:<br>* On 03/08/10 at 3:15 p.m., a facility support staff member (#20) assisted Resident #1 to the activity room/lounge by pushing her wheelchair. Resident #1 did not lift her feet, leaving them to glide along the surface of the floor. Halfway to the activity room/lounge, the facility support staff member (#20) cued the resident to lift her feet. Resident #1 lifted her feet for a few seconds, then lowered them again.<br><br>Resident #1's medical record, reviewed on March 8-10, 2010, identified current diagnoses included lower leg joint pain and diabetes. The resident's quarterly MDS, dated 12/22/09, identified short and long term memory loss, severely impaired daily decision making skills, and extensive assistance with transfers (moving a resident from bed to chair, chair to chair, and chair to bed).<br><br>Resident #1's current care plan, dated 12/14/09, stated, "Problem: . . . I am unable to transfer and walk by myself because I am very weak and unable to understand your cues . . ."<br><br>During an interview, on 03/10/10 at 1:30 p.m., an administrative staff member (#1) provided no further information regarding how facility staff should safely move Resident #1 in her wheelchair without foot rests. | F 323 | | |

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| F 323 | Continued From page 37<br><br>USE OF A LIFT TO TRANSFER<br>Review of the user's manual for the facility's sit-to-stand lift occurred on 03/10/10. The user's manual, date not provided, stated, "Section 4 - Using the Lift . . . 4.11 . . . 4 - Lean the patient forward and position the harness with the washing label to the top with the harness at the low back level. 5 - Wrap the harness around the patient and attach in front by snapping the two part buckle together. Ensure the harness is square by pulling forward on the two loop sections so they extend out equally. The front safety strap should be below the sternum level. Tighten the safety strap by pulling on the free end so that the harness is adjusted to a point where it fits snugly around the chest. . . ."<br><br>Review of "Pal Value Series" document provided by the facility regarding the use of the sit-to-stand lift occurred on 03/10/10. This document, not dated, stated, "Applying Butterfly Sling To Person: The most important part of the lifting experience is applying the butterfly sling properly. The first step is to lean the person slightly forward just enough to insert the sling behind the back. NOTE: Place the sling as far down as you can. Position the wings of the sling under the arms and make sure they are centered. Secure the buckle as low as possible around the lower abdomen. . . ."<br><br>- Observation of care for Resident #11 occurred on 03/10/10 at 11:16 a.m. The CNA (#11) failed to secure the sling snugly around the resident's chest and as Resident #11 was raised to an upright position, the CNA (#11) pulled on the loose strap to tighten the sling. The strap did not tighten all the way and the weight of Resident #11 coming to a standing position caused the sling to | F 323 | | |

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| F 323 | Continued From page 38 | F 323 | | |

shift up putting pressure on both axillae raising her shoulders and holding her elbows away from her body. When transferred back to the wheelchair, the sling shifted and again put pressure on both axillae lifting the residents shoulders up and elbows away from the body.

Review of the medical record for Resident #11 occurred March 10, 2010. Diagnoses included difficulty walking and generalized weakness. An annual MDS, dated 01/21/10, identified the resident experienced long and short-term memory problems, required extensive assist of two staff for transfers and toilet use, and partial loss of voluntary movement in her arms.

During an interview, on 03/10/10 at 1:40 p.m., an administrative staff member (#1) stated staff are to place the sling so that it does not put pressure on the residents' axillae.

GAIT BELTS
Review of the facility's policy "Gait (Transfer) Belt," occurred on 03/10/10. The policy issued January 2000 and last revised 01/09, stated,
"Purpose: To safely transfer or ambulate resident. To aid resident in maintaining balance. To avoid injury to both resident and staff member. Note: Gait belts used unless medically contraindicated.
Procedure: . . . 4. Make sure belt is securely buckled so it does not slide. Belt should not be twisted and should be just snug enough so you can get your fingers under it. 5. When holding the belt an underhand grasp should be used. . . ."

Review of the facility's policy "Assistance with Ambulation," occurred on 03/10/10. The policy, revised 02/05, stated,

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| F 323 | Continued From page 39<br>". . . Assisting with Ambulation: Gait belt - Unless contraindicated a gait belt should be utilized for all residents who require assistance with ambulation. The caregiver would typically walk on the resident's affected side. . . ."<br><br>- Observation of Resident #4 ambulating with a restorative nursing aide (#12) occurred on 03/09/10 at 10:15 a.m. The staff member (#12) assisted Resident #4 to a standing position from her wheelchair using a gait belt. The staff member (#12) let go of the gait belt as she bent to release the wheelchair brakes and Resident #4 began to ambulate down the hall without the staff member (#12). The staff member (#12) caught up to Resident #4, taking hold of the gait belt with two finger tips in an underhand grip on the gait belt. Resident #4 ambulated approximately 50 to 60 feet with the staff member (#12) holding the gait belt in this fashion.<br><br>Earlier observations of Resident #4 showed the resident would attempt to sit down without a chair to sit on, if the two CNAs assisting her had not held tightly the gait belt she would have sat on the floor. This staff member's (#12) fingertip grip, maintained during the ambulation observed, would not have prevented Resident #4 from sitting on the floor if she attempted to sit without assuring her wheelchair was behind her. The staff member (#12) placed Resident #4 at risk of injury by failing to use the gait belt correctly.<br><br>Review of the medical record for Resident #4 occurred March 8-10, 2010. Diagnoses included dementia, hip pain, and history of left and right hip fractures. A quarterly MDS, dated 01/15/10, identified the resident experienced long and short-term memory problems, required extensive | F 323 | | |

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| F 323 | Continued From page 40<br>assist of one staff for walking in the corridor, did not walk in her room; and test for balance, balance while standing, not able to attempt test without physical help.<br><br>- Review of Resident #3's medical record occurred on March 08-10, 2010. Resident #3's medical diagnoses included osteoarthrosis and pain.<br><br>Review of Resident #3's quarterly MDS, dated 01/06/10, identified Resident #3 had short and long-term memory loss, required extensive assistance with transfers, and had an unsteady gait.<br><br>Resident #3's current care plan identified the problem of "Potential for injury r/t [related to] history of falls d/t [due to] weakness, alzheimers . . ." with an approach of ". . . 02/13/10 Use mechanical lift for transfers and assist of [one] or [two] . . ."<br><br>Observation on 03/08/10 at 4:15 p.m. showed two CNAs (#7 and #12) toileted Resident #3 in the bathing room. The CNAs applied a gait belt. When transferring Resident #3 from the wheelchair to the toilet and from the toilet to a standing position, the CNAs did not utilize a mechanical lift as identified in Resident #3's current care plan. Rather, these transfers occurred with the assistance of the two CNAs. In addition, when transferring Resident #3 from the toilet to a standing position, and then assisting her to ambulate to a chair by the activity room, the CNAs did not hold onto the gait belt. Instead, the CNAs held onto the resident's hands and underneath her arms. | F 323 | | |

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| F 323 | Continued From page 41<br>Facility staff placed Resident #3 at risk for injury by failing to use the mechanical lift as identified in this resident's plan of care, and by failing to use the gait belt in the proper manner.<br><br>3. Based on observation and staff interview, the facility staff failed to ensure the environment remained as free of accident hazards as possible in regard to sharp door edges on 1 of 3 days of survey in which the doors to the entrance of residents' rooms were observed. Failure to repair sharp edged resident room doors has the potential to cause skin tears to residents' fragile skin.<br><br>Findings include:<br><br>- During initial tour on 03/08/10 at 10:15 a.m., observation showed sharp door edges near the door handles of resident rooms 105 and 216. The sharp door edges placed the residents at risk for skin tears and injury.<br><br>An environmental tour with an administrative staff member (#4) occurred on 03/09/10 at 2:15 p.m. This staff member agreed that the door edges to rooms 105 and 216 were very sharp, stating, "I can see how this could hurt someone." | F 323 | | |
| F 371 SS=E | 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY<br><br>The facility must -<br>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and<br>(2) Store, prepare, distribute and serve food under sanitary conditions | F 371 | The nourishment center is rearranged and maintenance checked and set the fridge to operate at or below 40 degrees.<br><br>All residents have the potential to be affected by the deficient practice. | |

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| F 371 | Continued From page 42<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, policy and procedure review, professional literature review, and staff interview, the facility failed to store food in a safe and sanitary manner in 1 of 1 nourishment center. Failure to follow safe food sanitation practices has the potential to result in food borne illness and can affect all residents who consume food stored in this area.<br><br>Findings include:<br><br>The Centers for Medicare and Medicaid Services (CMS) has outlined standards of practice regarding safe food storage of Potentially Hazardous Food (PHF) or Time/Temperature Control for Safety (TCS) food. Refrigeration prevents food from becoming a hazard by significantly slowing the growth of most microorganisms. Inadequate temperature control during refrigeration can promote bacterial growth and may cause a foodborne illness if consumed.<br><br>Review of facility policy and procedure occurred on the afternoon of 03/09/10. This policy and procedure titled "Food Storage", dated January 2001, stated, " . . . In the refrigerator, the temperature will be kept between 35 and 40 degrees. . . . Internal temperatures of potentially hazardous foods will be taken after 24 hours in refrigerator. . . . Internal temperatures of the refrigerators and freezers, in all locations . . . will be recorded daily on the Refrigerator/Freezer Temperature Log (GSS #464). Improper | F 371 | The food storage policy has been reviewed. Nursing and Dietary departments are will be in-serviced regarding food storage policy.<br><br>Temperatures will be checked according to policy to ensure internal temperatures are kept at or below 40 degrees by nursing department each day. Dietary manager will check documentation and compliance monthly and report results to Quality Assurance quarterly. Problems will be reported to environmental services. Quality Assurance will complete quarterly temperature audits for one year. If concerns are identified, immediate corrective action will be implemented. | 4-26-2010 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 355109 | A. BUILDING _____ B. WING _____ | 03/10/2010 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SOURIS VALLEY CARE CENTER | 300 MAIN ST S VELVA, ND 58790 |

| (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 371 | Continued From page 43<br>temperatures will be brought to the attention of the director of dietary services (DDS) and/or maintenance staff. The DDS is responsible for monitoring and validating temperature records. . . ."<br><br>- During a tour of the nourishment center on 03/08/10 at 3:07 p.m., a refrigerator, fully stocked with protein supplements and milk products, showed a temperature at 55 degrees Farenheit (F). A review of the refrigerator temperature at 4:00 p.m. on this date showed a temperature reading of 50 degrees F. Documented daily temperatures posted on the refrigerator showed temperatures above 40 degrees F. on 40 of the last 66 days.<br><br>An interview occurred on the afternoon of 03/08/10. An administrative staff member (#5) stated she had not been notified of any unacceptable temperatures in the nourishment center refrigerator by staff.<br><br>An interview occurred on 03/08/10 at 4:05 p.m. An administrative staff member (#4) stated he would expect the refrigerator temperatures to be no higher than 40-42 degrees F. The administrative staff members (#1 and #4) confirmed the refrigerator exceeded an acceptable safe temperature on multiple dates over the last 3 months, and should have been reported. A staff member (#1) immediately discarded the multiple nutritional supplements and milk products from the refrigerator. | F 371 | | |