DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 _____	03/18/2015

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 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey, started on 03/16/15 and completed on 03/18/15, the sample included 2 residents for complete review, 8 residents for focused review, and 1 closed record for review.	F 000	Preparation and Execution of this response and plan of correction does not constitute an admission of agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. For the purposes of any allegations that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the State Operations Manual.	
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to ensure care in a manner to prevent urinary tract infections (UTIs) for 3 of 3 sampled residents (Resident #1, #2, and #8) with an indwelling catheter. Failure to keep catheter drainage bags off the floor may have contributed to the development of UTIs. Findings include: - Review of Resident #1's medical record occurred on all days of survey and included diagnoses of urinary retention and UTI. The admission Minimum Data Set (MDS), dated 03/12/14, and annual MDS, dated 02/27/15,	F 315		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	4/2/15

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 315	Continued From page 1 identified an indwelling catheter. The current care plan stated: "The resident has indwelling catheter R/T [related to] urine retention E/B [evidenced by] indwelling catheter, hx [history] of UTI." The record identified antibiotic treatment for UTIs on 09/02/14 and 10/08/14. Observations identified the following: * 03/16/15 at 10:20 a.m. - Resident #1 sleeping in bed and his catheter bag laying on the floor about ten inches from the bedside. * 03/16/15 at 2:05 p.m. - Resident #1 sleeping on his bed and one catheter bag resting on the floor next to the bed. * 03/17/15 at 9:00 a.m. - a certified nursing assistant (CNA) (#16) transferred Resident #1 from his wheelchair to the bed. The CNA (#16) hung the resident's bag on the side of the bed. While the CNA (#16) lowered the resident's bed down to the lowest position, the resident's catheter bag laid flat on the floor while hooked to the side of the bed. * 03/17/15 at 12:07 p.m. - Resident #1 sat on the edge of his bed with his catheter bag laying on the floor about ten inches from the bedside. - Review of Resident #8's medical record occurred on 03/18/15 and included diagnoses of UTI and urinary retention. The admission MDS, dated 01/14/15, and significant change MDS, dated 02/06/15, identified an indwelling catheter. The current care plan stated: "The resident has indwelling catheter R/T urine retention E/B inability to empty bladder . . . Goal . . . Resident will be/remain free from catheter-related trauma. The medical record identified antibiotic treatment for a UTI from 02/25/15 through 03/23/15." Observations identified the following:	F 315	Resident #2 has passed away since the survey. For residents #1 and #8 catheter drainage bags were placed in a cloth bag and secured to bed or wheelchair so that the bag and the tubing are not touching or lying on the floor. More cloth bags were obtained so that there is an adequate supply and they are readily available for use. Any resident with an indwelling foley catheter has the potential to be affected by this practice. All nursing staff will be required to complete an online in-service on proper catheter cares for infection control. All other staff will be educated on the importance of making sure catheter bags do not touch the floor and to report it to the charge nurse if they see a catheter bag on the floor or not secured in a cloth bag. Audits will be completed by infection control nurse or designee weekly for four weeks and then monthly for one quarter to make sure catheter bags and tubing are secured properly. QA committee will follow up for monitoring and modification.	4/22/15

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F 315	Continued From page 2 * 03/18/15 at 11:40 a.m. - Two CNAs (#13 and #14) transferred Resident #8 from bed to a wheelchair with a mechanical lift. While Resident #8 sat in the wheelchair, a CNA (#14) placed the catheter bag on the floor while she removed the catheter tubing and mechanical lift sling from under the resident's leg. The CNA (#14) then picked up the catheter bag and placed it in a canvas bag underneath the wheelchair. - Review of Resident #2's medical record occurred on March 16-18, 2015. Diagnoses included urinary retention treated with the placement of a Foley catheter. The record identified the treatment of a urinary tract infection in February and March 2015. Observation identified the following: * 03/16/15 at 2:25 p.m. - Resident #2 in bed, his catheter drainage bag hooked to the side of the bed and resting on the floor. * 03/16/15 at 4:43 p.m. - Two CNAs (#1 and #2) and a nurse (#3) assisted Resident #2 with personal cares. Throughout care, the resident's catheter drainage bag, hooked to the side of the bed, rested on the floor. The CNA (#3) emptied the catheter bag, without unhooking it from the bed frame, but failed to position it off the floor afterwards. * 03/17/15 at 10:00 a.m. - CNA (#4) assisted Resident #2 with morning cares. The resident's catheter drainage bag, hooked to the side of the bed, rested on the floor through most of the cares. After cares, Resident #2 was transferred to his wheelchair and the CNA (#4) placed the drainage bag in a cloth bag under the wheelchair, leaving the drainage tubing laying on the floor. As the CNA (#4) positioned Resident #2's wheelchair beside the bed, observation showed the	F 315		

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F 315	Continued From page 3 wheelchair rolled over the catheter tubing twice. During an interview on 03/18/15 at 10:40 a.m. an administrative nurse (#15) stated staff should never allow the catheter bags to touch the floor and they should always place the catheter bag in a canvas bag.	F 315		4/22/15
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, review of manufacturer's guidelines, and staff interview, the facility failed to clean and sanitize 1 of 1 ice machine per manufacturer recommendations. Failure to clean and sanitize the ice machine has the potential to cause foodborne illness. Findings include: Review of the manufacturer's guidelines for the facility's "Scotsman Ice System" occurred on 03/18/15. These guidelines, dated May 2001, pages 17-18, stated, "Dispense Area Sanitation. The dispense area; spouts, sink, grill and splash panel will need periodic cleaning and	F 371	There were no residents identified that were affected by this practice. All residents have the potential to be affected by this deficient practice. The ice machine was cleaned and sanitized on 4/2/15. The ice machine will also be cleaned semi- annually and the ice storage bins will be sanitized quarterly. The dispensing area of the ice machine will be cleaned weekly. A cleaning schedule has been created. Environmental services staff will be provided education on procedure for cleaning and sanitizing the ice machine. An audit will be completed weekly for four weeks and then monthly for one quarter by infection control nurse or designee. QA committee will follow up for further monitoring and modification.	

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F 371	Continued From page 4 maintenance. . . . It is the user's responsibility to see that the unit is properly maintained . . . . Maintenance and Cleaning should be scheduled at a minimum of twice per year. Sanitizing of the ice storage bin should be scheduled for a minimum of 4 times a year." During the dietary kitchen tour on 03/18/15 at 10:10 a.m., the dietary manager (#5) identified the facility ice machine in a nourishment center near the nurse's station. The dietary manager (#5) stated maintenance takes care of the ice machine. During the dietary tour the maintenance supervisor (#7) identified he could not remember the last time the ice machine was cleaned/sanitized. During interviews on the morning or 03/18/15, three housekeeping staff members (#9, #10, and #11) identified how they cleaned the ice machine. All staff members identified different cleaning styles and all agreed they did not have a system for cleaning the ice machine. During an interview on 03/18/15 at 11:55 a.m., three administrative staff members (#7, #8, and #12) and the maintenance supervisor (#7) confirmed the facility did not have a system to clean and sanitize the ice machine. When the manufacturer's recommendations were shared with the maintenance supervisor (#7) he identified he was unaware of these guidelines.	F 371		