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 _____	03/29/2012

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 03/26/12 and completed on 03/29/12, the sample included 2 residents for complete review, 9 residents for focused review, and 1 closed record for review. The sample included 2 additional residents to verify specific concerns during the survey.	F 000	Preparation and Execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in this 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 allegation 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 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy and procedure, and staff interview, the facility failed to ensure residents remained free from physical restraints for 1 of 1 sampled resident (Resident #7) with a pommel cushion in her wheelchair. A pommel cushion is a positioning device that fits between a resident's thighs that may reduce a resident forward sliding or getting up out of a chair. Failure to accurately identify physical restraints, perform an initial and ongoing assessment, obtain a physician's order, and care plan may result in the resident experiencing a decline in physical functioning and/or mood and an increased risk of developing a pressure sore. Findings include: Review of the facility policy titled "RESTRAINTS:	F 221	Nursing will do a nursing assessment as a narrative note in the IDP notes when the uses of a pommel cushion are considered. If a pommel cushion is determined to be used an assessment must be completed to see if it considered a physical restraint. If it's considered a physical restraint then the policy and procedure will be followed and completed. If the assessment shows it's not a physical restraint the pommel cushion will be added to the care plan. Resident #7 was assessed for the use of the pommel cushion. The assessment showed the pommel cushion was used to reduce the resident from sliding forward within wheelchair. Care plan has been updated for resident. Any resident with a pommel cushion has the potential to be affected in this area. No other resident has a pommel cushion. DNS or designee will audit physical restraint procedure monthly for six months to ensure compliance. Survey issue will be addressed and managed during monthly Quality Assurance meeting.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kaylene Kitzinger	Administrator	4-12-12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 221	Continued From page 1 PHYSICAL" occurred on 03/29/12. This policy, revised August 2008, stated, "PURPOSE: To ensure appropriate use of restraints. DEFINITIONS . . . Physical Restraints may include, but are not limited to . . . using devices in conjunction with a chair . . . that prevent a resident from rising. . . PROCEDURE: . . . d. Contact the physician and describe the rationale, alternatives tried and recommendations. e. Obtain the physician order for the appropriate restraint, times to be used and the medical symptom for use. f. . . . Permission will be obtained from a person authorized to sign for the resident. g. Update the resident care plan to include the reason for the restraint, the required monitoring and a measurable goal relating to the rationale for its use. . . ." - Observation on all days of the survey identified Resident #7 sitting in a high-back wheelchair with a pommel cushion in place preventing the resident from sliding out of her wheelchair. Review of Resident #7's medical record occurred on March 26-28, 2012. Diagnoses included depression, and dementia. A significant change Minimum Data Set (MDS), dated 01/27/12, failed to identify Resident #7's pommel cushion as a physical restraint. During an interview on 03/28/2012 at 2:30 p.m., an administrative nurse (#1) stated he did not know who put the pommel in Resident #7's wheelchair or when staff placed it there.	F 221	and managed during monthly Quality Assurance meeting.	

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F 221	Continued From page 2 The facility failed to complete the Physical Restraint Assessment, failed to contact the physician and obtain an order for the pommel, failed to contact and obtain permission from a person authorized to sign for the resident, and failed to update Resident #7's care plan. These failures resulted in Resident #7 restrained in her wheelchair.	F 221		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident interview, the facility failed to ensure staff placed the resident's call light in a location accessible to the resident for 1 of 11 sampled residents (Resident #2) and 1 supplemental resident (Resident #14). Failure to ensure the resident had access to the call light could result in the resident unable to obtain assistance when needed. Findings include: During the initial tour of the facility, on the morning of 03/26/12, a social services staff member (#2) stated Resident #2 and #14, a married couple, shared a room. The staff	F 246	All staff will be educated at in-service on April 23rd about all call lights must be within reach by all residents at all times. With new admissions to center the admission staff will ensure that residents call light can reach resident at all times. If cord isn't long enough then admission staff will notify maintenance for cord extension. For resident # 2 and 14 a cord extension for call light was ordered and was placed in room so both residents are able to obtain assistance when needed. All residents may potentially be affected by this issue. All current residents' call lights have been checked and proper procedure was followed if an extension was needed. Safety Coordinator will do random weekly audits of placement of call lights in resident's room for 1 month to ensure compliance. If no concerns are noted, at that time, we will continue with random monthly audits for a total of 6 months. Survey issue will be addressed and managed during monthly Quality Assurance meeting.	5/03/12

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F 246	Continued From page 3	F 246		

member stated Resident #14 sometimes provides physical assistance to his wife (Resident #2) and needs to be reminded to allow staff to assist her. Observation showed Resident #14 with an ankle/foot orthosis (AFO) splint on his left foot/ankle.

Review of Resident #2's medical record occurred on March 26-28, 2012. Diagnoses for Resident #2 included spinal stenosis, chronic back pain, and macular degeneration. An annual Minimum Data Set (MDS), dated 02/17/12, identified the resident as cognitively intact, frequently incontinent of urine, and required extensive assistance with bed mobility, transfers, and toilet use.

An interview occurred with Resident #2 and #14 on 03/26/12 at 3:55 p.m. Observation of the room showed the two beds positioned with the sides touching, creating one large bed, with the residents' call lights attached to 1/4 rails in the middle (where to two beds touched each other), making it difficult to reach the call lights unless seated/lying on one of the beds.

At the conclusion of the interview, Resident #2 stated she needed to use the bathroom. When asked how she would call for assistance, her husband (#14) stated he would call for assistance by sitting on the bed and reaching across the bed to activate the call light. Both residents confirmed staff consistently attached the call lights to the 1/4 rails between the beds and left them in that location throughout the day.

Observation on all days of survey showed the residents' call lights remained attached to the 1/4

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F 246	Continued From page 4 rail between the two beds.	F 246		
F 278 SS=F	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. 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. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual (Version 3.0) dated October	F 278	DNS/MDS Coordinator will do a MDS Query on all Restorative dining program and modify all residents MDS to show accuracy to reflect the residents status. MDS Coordinator was given education on making sure assessment is accurate before signing and certifying the assessment. All appropriate staff will be educated on making sure accuracy of care plan. Resident # (3,4,6,8,10,11) we re-assessed After completion of assessment proper procedure was followed for residents to determine if they met the criteria for a restorative dining program. If resident was not appropriate for the program then the residents MDS and Care plan was modified. Care plan team will audit all MDS's that trigger for any RA program during the care planning conference for 6 months to ensure accuracy of MDS's. Survey issue will be addressed and managed during monthly Quality Assurance meeting.	5/03/12

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F 278	Continued From page 5 2011, and staff interview, the facility failed to ensure the Minimum Data Sets (MDSs) accurately reflected the residents' status for 6 of 6 sampled residents (Resident #3, #4, #6 #8, #10 and #11) identified by the facility to be participating in a restorative dining program. It was determined assessments completed for the six sampled residents were incorrectly coded indicating a system problem existed related to coding restorative dining. Failure to accurately code the MDSs for these residents has the potential to affect their level of care and services. Findings include: The Long-Term Care Facility RAI User's Manual stated on: * Page O-34, "Training and Skill Practice . . . Eating and/or Swallowing Code activities provided to improve or maintain the resident's self-performance in feeding oneself food and fluids, or activities used to improve or maintain the resident's ability to ingest nutrition and hydration by mouth. These activities are individualized to the resident's needs, planned, monitored, evaluated, and documented in the resident's medical record." - Review of Resident #3's medical record occurred on all days of survey. A quarterly MDS, dated 03/06/2012, identified the resident required supervision with eating, and received restorative training and skill practice for "Eating and/or swallowing" 7 of the past 7 days. The medical record lacked evidence of a planned restorative dining program for Resident #3. - Review of Resident #4's medical record	F 278		

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F 278	Continued From page 6 occurred on all days of survey. A quarterly MDS, dated 02/22/12, identified the resident required limited assistance with eating, and received restorative training and skill practice for "Eating and/or swallowing" 7 of the past 7 days. A quarterly MDS, dated 11/22/11, identified the resident required extensive assistance with eating, and received restorative training and skill practice for "Eating and/or swallowing" 7 of the past 7 days. The medical record lacked evidence of a planned restorative dining program for Resident #4. - Reviews of Resident #11's medical record occurred on March 28-29, 2012. A Significant Change in Status MDS, dated 02/10/12, identified the resident required extensive assistance with eating, had signs/symptoms of a swallowing disorder, and received restorative training and skill practice for "Eating and/or swallowing" 4 of the past 7 days. The medical record lacked evidence of a planned restorative dining program for Resident #11. - Review of Resident #6's medical record occurred on March 26-29, 2012. A quarterly MDS, dated 01/12/12, identified the resident required extensive assistance with eating, and received restorative training and skill practice for "Eating and/or swallowing" 6 of the past 7 days. The medical record lacked evidence of a planned restorative dining program for Resident #6. - Review of Resident #8's medical record occurred on March 28-29, 2012. An admission MDS, dated 02/14/12, identified the resident required total dependence with eating, and restorative training and skill practice for "Eating	F 278		

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F 278	Continued From page 7 and/or swallowing" 6 of the past 7 days. The medical record lacked evidence of a planned restorative dining program for Resident #8. - Review of Resident #10's medical record occurred on March 28-29, 2012. A quarterly MDS, dated 03/18/2012, identified the resident required total dependence with eating, and restorative training and skill practice for "Eating and/or swallowing" 7 of the past 7 days. The medical record lacked evidence of a planned restorative dining program for Resident #10. During an interview on 03/28/12 at 2:30 p.m., an administrative nurse (#1) stated we don't have anyone on a restorative dining program.	F 278		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to provide dining assistance to maintain or improve the resident's ability for 1 of 3 sampled residents (Resident #1) with a diagnoses of hemiplegia (weakness of one side of the body). Failure to implement interventions/assistive devices to promote Resident #1's independence with dining does not allow the resident to reach his highest practicable level of physical, mental, and psychosocial well-being.	F 311	All staff will be educated at in-service on April 23rd about how to set-up food and adaptive equipment to ensure the residents dinning experience. Resident #1 was assessed and determined that a plate guard would benefit the residents dining experience. Residents care plan was updated. All residents that receive setup assist or adaptive equipment for dining have potential of being affected by this issue. These residents will be reassessed to make sure care plan is current. Occupational Therapy or designee will do weekly audit for three months to ensure residents dining needs are being met. Survey issue will be addressed and managed during monthly Quality Assurance meeting.	5/03/12

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F 311	Continued From page 8 Findings include: Observation during the initial tour of the facility, on the morning of 03/26/12, showed Resident #1 seated in a wheel chair with his right arm secured to an "arm trough" (a positioning device to provide arm support in a wheel chair). Resident #1's medical record, reviewed on all days of survey, identified diagnoses including cerebral vascular accident with right hemiplegia. A Significant Change in Status MDS, dated 03/08/12, identified Resident #1 required limited assistance of one person with eating. A dietary "Interdisciplinary Assessments and Summary Reviews," dated 12/05/11, stated, ". . . continues to feed self with set up assist. Items are placed to his left side due to unable to use right hand. . . ." Resident #1's current interdisciplinary care plan, dated 01/31/12 included approaches to observe for choking and eating too fast, but lacked the intervention of placing the food to the left of the plate. Observation in the dining room, on 03/27/12 at 8:50 a.m., showed Resident #1 feeding himself his breakfast using his left hand. His right arm remained in the arm trough. Observation showed Resident #1's scrambled eggs located on the right side of his plate. As the resident fed himself, pieces of egg fell off the right side of the plate onto the table, with one piece landing on the floor. As he ate, Resident #1 used his fork to push the eggs to the left, then placed the fork on its side along the right edge of the plate. He then used a spoon and pushed the eggs against the fork as he filled the spoon with each bite of egg. (Using	F 311		

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F 311	Continued From page 9 the fork as a barrier to keep the eggs on the plate.) In this manner, he consumed 100 % of his meal. On 03/28/12 at 8:20 a.m., observation in the dining room showed Resident #1 feeding himself breakfast with his eggs located on the left side of the plate. During this observation, small pieces of egg fell off the plate onto the table. On 03/28/12 at 12:15 p.m., observation in the dining room showed Resident #1 fed himself a pureed diet. Observation identified a container of frozen supplement, unopened on the table. The resident consumed all the food on his plate, but none of the unopened supplement. When the resident backed his chair away from the table, a Certified Nursing Assistant (CNA) (#6) assisted him by placing his foot pedals on the wheel chair. The CNA (#6) did not offer to open the supplement or encourage Resident #1 to eat the supplement before he left the table. During an interview, on 03/28/12 at 3:00 p.m., a dietary manager (#4) agreed staff should have positioned Resident #1's plate with his food to the left. She stated dietary has not attempted an assistive device, such as a plate guard, for Resident #1.	F 311		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.	F 441	All staff will be trained on proper hand washing techniques on April 23rd. They will be educated on the policy and procedure. Water pitcher will be placed in all rooms with bedpans, urinals and commodes used. Staff will ensure proper policy and procedure are being followed for disinfecting of commode.	5/03/12

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F 441	Continued From page 10 (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy and procedures, and staff interview, the facility failed to ensure staff followed appropriate infection control practices during 4 of 11 observations of personal cares (Resident #1	F 441	Resident #1 and #4 are being cared for by receiving personal cares with staff using gloves and proper hand washing technique when using urinals, bedpans, or commodes. All residents receiving personal cares have potential to be affected by this issue. Infection Control nurse or designee will do weekly audits for one month watching staff properly cleaning commode, bedpans, and urinals. If no concerns noted at that time, will resume monthly audits for a total of 6 months. Survey issue will be addressed and managed during monthly Quality Assurance meeting.	

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F 441	Continued From page 11 and #4). Findings include: Review of the facility procedure "Hand Hygiene and Handwashing" occurred on 03/29/12. The procedure, revised November 2011, stated, "Hand washing . . . 5. Rinse hands with water and dry thoroughly. 6. Use a paper towel to turn off water faucet." Review of the facility procedure "Bedpan, Urinal and Commode" occurred on 03/29/12. The procedure, revised November 2009, stated, "Procedure - Urinal . . . 8. Empty urinal in bathroom. . . . 10. Rinse urinal and clean thoroughly. Store urinal covered in resident's unit area separate from resident items. 11. Remove and dispose of gloves and wash hands. . . . Procedure - Commode . . . 7. Cover commode bucket and empty. 8. Rinse commode with water and clean thoroughly, using a disinfectant. Sanitize weekly. Dry with paper towels; store in designated area. . . ." - Observation on 03/27/12 at 8:20 a.m. showed a Certified Nursing Assistant (CNA) (#3) assisting Resident #1, donned gloves and emptied Resident #1's catheter bag into a urinal. The CNA (#3) then took the urinal to the bathroom Resident #1 shared with his roommate, emptied the urine into the toilet, partially filled the urinal with water from the handwashing sink and rinsed out the urinal. The CNA (#3) then washed her hands in the same sink. When she attempted to obtain a paper towel from the automatic dispenser, it	F 441		

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 _____	03/29/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 441	Continued From page 12 failed to dispense a towel. The CNA (#3) went back to Resident #1's room and assisted him to drink juice. Observation in the Resident's bathroom showed a container of dry, disposal wash cloths on the toilet tank and two cloth towels on the paper towel dispenser that could have been used to dry the CNA's hands. - Observation on 03/27/12 at 10:20 a.m. showed a CNA (#3) preparing to shave Resident #3 in his bathroom. The CNA used her hands to put shaving cream on the resident's face. She then washed the shaving cream off her hands. When the CNA (#3) attempted to obtain a paper towel from the automatic dispenser, it failed to dispense a towel. Observation showed the disposable wash cloths and the cloth towels remained available in the resident's bathroom. but were not used by the CNA following handwashing. - Observations on 03/27/12 at 9:10 a.m., and on 03/28/12 at 1:25 p.m., of personal cares, showed, after Resident #4 used the commode, a CNA (#5) took the bucket, poured the urine into the toilet, set the bucket into the handwashing sink, ran water into the bucket and dumped the water into the toilet. Following this process, the CNA failed to rinse the bucket with a disinfectant. An interview with an infection control nurse (#7) occurred on 03/28/12 at 1:45 p.m. The nurse stated she expects staff to use a pitcher to obtain water from the sink for rinsing urinals and commodes and not obtain water for the urinal or commode directly from the residents' sinks. The nurse (#7) also stated she expects staff to dry their hands after handwashing.	F 441		5/03/12