STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355070	A. BUILDING _____ B. WING _____	07/01/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHEL LUTHERAN NURSING & REHABILITATION CENTER	1515 2ND AVE WEST WILLISTON, ND 58801

(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 The standard Medicare/Medicaid recertification survey, started on 06/28/10 and completed on 07/01/10, included 5 residents for complete review, 16 residents for focused review, and 3 closed records for review. The sample included 5 additional residents to verify specific concerns during the survey.	F 000		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to provide care in a manner which enhanced each resident's dignity for 3 of 21 sampled residents. Failure to toilet residents when requested (Resident #14), address the resident by their preferred name and provide privacy during cares (Resident #7), and appropriately assist with eating (Resident #4) does not enhance each resident's dignity and individuality. Findings include: - Resident #14's medical record, reviewed on June 29-July 1, 2010, identified diagnoses including late effects cerebral vascular accident with hemiplegia. A quarterly Minimum Data Set (MDS), dated 05/17/10, identified the resident as requiring extensive assistance with toileting and frequently incontinent of bowel and bladder.	F 241	**F241** 1. Resident #14 care plan has been reviewed as of July 1, 2010. Staff caring for Resident # 14 were informed of the deficiency and corrective action necessary to meet the toileting needs of resident on July 2, 7, and 8, 2010. Staff caring for Resident #7 have been re-educated on use of proper name, knocking on the resident's door before entering and use of adult language. Staff responsible to assisting Resident #4 in the dining room were informed of the deficient practice and re-educated on proper feeding technique. In-service was conducted on July, 2, 7, and 8, 2010. 2. Any resident has the potential to be affected. 3. Mandatory nursing staff in-services have been/will be conducted to re-educate staff on promoting and protecting resident dignity. Dates of the in-services were/are July 2nd and July 7th and 8th, 2010 and August 2nd, 3rd, and 4th, 2010. Toileting in-service was conducted on July 13, 2010 and will be repeated in August. The Bowel and Bladder Assessment policy has been revised and includes toileting techniques. Staff will be in-serviced on the policy changes on August 2nd, 3rd, and 4th, 2010.	08/06/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	7/29/10

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 241	Continued From page 1 Resident #14's care plan, dated 05/25/10, identified a problem "Self-Care deficit: Bathing, Toileting, Dressing and Personal Hygiene." Approaches to the problem included: "Toilet every 2-3 hours & PRN [as needed]. Bowel and bladder program. Put on toilet with PAL lift [a stand lift] 2 assist." The care plan also identified a problem "Potential for constipation, related to decreased mobility, secondary to aging." Approaches to the problem included: "Uses bed pan at HS [hour of sleep] Q [every] 2-3 hours. PAL Lift used for toileting PRN." On 06/29/10 at 9:26 a.m., observation identified three Certified Nursing Assistants (CNAs) (#31, #32, and #33) assisted Resident #14 to lie down using a Hoyer (full body) lift. Just after being assisted to bed, the resident stated she needed to use the bathroom. After the CNAs positioned the resident in bed, Resident #14 again requested to use the bathroom. One CNA (#31) stated, "Remember you can't sit on the toilet anymore." A second CNA (#32) stated the Hoyer would not fit in the bathroom and Resident #14 was "too weak" for the PAL lift. Staff failed to check the resident for incontinence or offer her the opportunity to use the bedpan. On 06/29/10 at 10:20 a.m., observation showed two CNAs (#31 and #33)assisted Resident #14 out of bed. When the CNAs checked Resident #14's brief, observation showed the resident incontinent of both bowel and bladder. When the surveyor asked if Resident #14 used the bedpan, one CNA (#33) stated, "I think that's for nights." On 06/29/10 at 12:40 p.m., observation showed two CNAs (#31 and #33) assist the resident back to bed. Prior to the transfer, Resident #14 again	F 241	4. The Neighborhood Manager (or designee) will be responsible to monitor resident dignity concerns. Monitoring will include observation of residents in dining rooms and observation of staff providing cares. Monitoring will be conducted weekly for three months. Results of the monitoring will be reported to the DON. The DON will report to the QA Committee monthly for three months. 5. August 6, 2010	

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F 241	Continued From page 2	F 241		

asked to use the bathroom and stated, "I need to go now." After transferring the resident to bed, the CNAs checked her brief and found it dry. One CNA (#33) stated "I wonder if we should put her on the bedpan." When placed on the bedpan, Resident #14 voided.

Failure to offer Resident #14 the bedpan on 06/29/10 at 9:26 a.m., when she stated she needed to use the bathroom, contributed to her subsequent incontinence of bowel and bladder and failed to enhance and respect her dignity and individuality.

- Resident #7's record review occurred on June 29-July 1, 2010, and indicated the diagnoses included left hemiparesis (paralysis), cerebral vascular accident (CVA), organic brain syndrome, and aphasia (inability to communicate). A quarterly MDS, dated 05/05/10, identified short and long term memory problems, moderate impairment with decisions, understands, and sometimes understood. The MDS indicated the resident required extensive assist with all activities of daily living and was frequently incontinent of urine.

Observation on 06/29/10 at 7:45 a.m., showed two CNA's (#7 and #8) assisting Resident #7 with toileting. The CNA (#7) stated to the resident "Squirrely Shirley, you're on the toilet. Can you go some more?"

Observation on 06/30/10 at 7:45 a.m., showed a CNA (#2) provided a bedbath for Resident #7. The CNA (#2) stated, "OK, Shirley my girlie. Let's get you washed up. Pew, pew, pew! You smell sweaty. I need to wash your hand again. It always stinks. You had a suppository this morning too.

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F 241	Continued From page 3 Did you go poo poo?" The CNA removed the resident's brief containing stool and urine, and stated, "Pew, pew, pew!" A CNA (#4) entered the resident's room without knocking or announcing herself while the CNA (#2) provided incontinence cares. The resident's exposed buttocks were positioned towards the door. An interview occurred with an administrative nursing staff member (#1) on 07/01/10 at 9:10 a.m. The staff member agreed the staff failed to maintain Resident #7's dignity. The staff failed to provide care in a manner and environment that maintained or enhanced Resident #7's dignity by not addressing the resident by given name, using inappropriate language, and entering the resident's room without knocking or announcing themselves. This has the potential to compromise the self-esteem and self-worth of the resident. - Observation of the dinner meal on 06/29/10 at 11:50 a.m., showed Resident #4 dropped green beans on her clothing protector while eating her meal. A CNA (#18) picked up the green beans with a fork and placed the green beans back on Resident #4's plate. The resident ate a few more bites of the green beans. The staff member failed to preserve Resident #4's dignity by placing food from her clothing protector back on her plate for consumption.	F 241		
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.	F 311	F311 1. Resident # 5 has had an Occupational Therapist evaluation conducted on July 8th. OT continues to provide care. Resident # 5 is refusing placement of gastrostomy tube at this time. Other suggested interventions (adaptive equipment such as built up utensils, etc.) have been refused by this resident. This resident has a diagnosis of multiple ~~myeloma and her condition is guarded.~~	08/06/10

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F 311	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident interview, and staff interview, the facility failed to assess, develop, and implement appropriate interventions to assist 1 of 3 sampled residents (Resident #5) with hemiparesis to maintain the ability to eat as independently as possible. Failure to assess Resident #5's eating ability as changes occurred, placed the resident at risk for poor/inadequate meal intake, weight loss, and a decrease in functional eating abilities. Findings include: - Review of Resident #5's medical record occurred June 29 - July 1, 2010. The resident's diagnoses included hemiparesis (paralysis), diabetic neuropathy, and dysphagia (swallowing problems). Review of the dietary progress notes identified the resident experienced a 5% weight loss from 03/16/10 to 06/15/10 due to the dysphagia. The resident's most recent Minimum Data Set (MDS) dated 06/15/10, indicated Resident #5 experienced no short or long term memory problems, independence in decision making, and had no problems with communication. The resident required extensive assist with bed mobility, transfers, dressing, toileting, personal hygiene, and bathing. The MDS identified the resident with a loss of voluntary movement of the affected upper extremity since the previous MDS dated 03/16/10. The MDS indicated the resident ate less than 25% of meals and experienced weight loss.	F 311	2. Any resident who is unable to eat independently has the potential to be affected 3. Mandatory nursing staff in-services were conducted on July 7th and 8th, 2010 and again August 2nd, 3rd and 4th, 2010. Staff were re-educated on proper feeding techniques and enhancing resident dignity and independence at mealtime. 4. The Neighborhood Manager (or designee) will be responsible to monitor residents in the dining areas. Observation will include assistance provided and use of adaptive equipment as appropriate. Monitoring will be conducted weekly for 3months. Results will be reported to the DON. The DON will report to the QA Committee monthly for 3 months. 5. August 6, 2010	

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F 311	Continued From page 5 Observation of the breakfast meal in the resident dining room occurred on 06/29/10 at 7:45 a.m. Resident #5 used both hands to hold a regular spoon utensil, attempting to eat pureed sausage, but repeatedly dropped the spoon. Upon completion of the meal, the resident consumed her Ensure, and juice from two drinking glasses and none of the sausage. On 06/29/10 at 11:35 a.m., observation showed Resident #5 seated in the dining room. She made numerous attempts to scoop up mashed potatoes and pureed steak utilizing both hands to hold the utensil, but repeatedly dropped the spoon. The resident drank 100% of her Ensure and consumed a few bites from her potatoes and steak. Observation of the evening meal in the dining room occurred on 06/29/10 at 5:45 p.m. The resident attempted to eat vegetable soup from a bowl, applesauce, and mashed potatoes, but repeatedly dropped the spoon. Staff failed to offer the resident assistance during all observed meals on 06/29/10. An interview with Resident #5 occurred on 06/30/10 at 8:05 a.m. The resident stated she has a hard time using silverware at meal times. "My hands don't work very good anymore." The resident denied having tried built up silverware in the past. She stated, "I thought they would be too heavy to handle. If they were light, I'd like to try that. That would probably really help." An interview with dietary administrative staff members (#13 and #14) occurred on 06/30/10 at	F 311		

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F 311	Continued From page 6 3:00 p.m. The staff members stated Resident #5 had not been assessed for the need of adaptive eating utensils. Both staff members agreed the resident has lost weight, but stated they were unaware the resident was having difficulty handling silverware. The staff members agreed an assessment and offering of adaptive eating utensils would likely benefit Resident #5 and they would be addressing this concern.	F 311		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS 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. This REQUIREMENT is not met as evidenced by: Based on observation,and record review, facility staff failed to provide necessary assistance for 1 of 6 sampled residents (Resident #1) identified by the facility as requiring extensive to total assistance with eating. Failure to provide Resident #1 with assistance at mealtime placed the resident at risk for continuing weight loss, insufficient fluid intake, and potential complications related to inadequate nutrition and hydration. Findings include: Review of Resident #1's medical record occurred June 28 - July 01, 2010. A significant change Minimum Data Set (MDS) completed 06/24/10, and an annual MDS completed 03/25/10, showed Resident #1 had experienced a decline in	F 312	**F312** Comment: Resident # 1 was diagnosed with viral gastroenteritis on 04/28/10, urinary tract infection on 05/07/10 and C.Diff on 06/21/10. Weight on 04/21/10 was 122 pounds and on June 30th her weight was 104. The physician was kept up to date on this resident's status. Review of resident's record reveals: 1. Seen by doctor 04/28/10 2. Doctor notified of UTI symptoms and UA results on 05/07/10 3. Doctor notified increased anxiety on 05/14/10 4. Doctor notified Exelon patch discontinued 05/18/10 5. Doctor ordered Zyprexa 05/27/10 6. Doctor visit 06/03/10 7. Doctor informed of results of psychiatric visit 06/17/10 8. Doctor notified of diarrhea and medication ordered 06/18/10 9. Lab results sent to doctor 06/22/10 10. Doctor contacted facility regarding lab results 06/23/10.	08/06/10

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F 312	Continued From page 7 independence with eating from requiring limited assistance at the time of the 03/25/10 MDS to requiring extensive assistance at the time of the 06/24/10 assessment. Resident #1 also showed a significant weight loss from 124 pounds on the 03/25/10 MDS to 110 pounds on 06/24/10 MDS. Resident #1's plan of care included: "Problem: Original date 02/9/09. Nutrition and Hydration, at risk due to DX [diagnoses]: Hypertension, anxiety, dementia and diuretic use. Leaves 25% or more of food uneaten at most meals. . . . Original date 06/07/10. Therapeutic diet. Spitting out meat. Mechanical Soft Diet. . . . Original Date 06/16/10. Significant weight loss in 30/180 days. . . . Approaches: Serve personal food preferences. . . . Assist resident with all meals as needed. . . . Offer fluids throughout the day. Fluids with med pass and meals. . . . Straws PRN [as needed]." Observation at 8:50 a.m. on 06/29/10 showed two certified nurse assistants (CNAs) (#20 and #21) assist Resident #1 from bed to the dining room. A CNA (#21) stated the resident "said she was thirsty, so we figured she was hungry too, and decided to take her for breakfast." Without offering Resident #1 fluids in her room, the CNA (#20) transported Resident #1 to the dining room, and placed the resident at a table. The CNA(#20) placed a small container of yogurt, a bowl of cold cereal and milk, a glass of milk, a glass of juice and a glass of water on the table in front of Resident #1. After sitting down beside Resident #1, the CNA (#20) moved the yogurt directly in front of the resident, and handed Resident #1 her spoon. Resident #1 did not attempt to eat, placed the spoon back on the table, and began reaching toward the beverages.	F 312	Throughout the resident record there is documentation the resident requires "much encouragement" to take fluids, "refused meals", "few sips taken" and reluctant "to take fluids". Therefore this indicates the facility was well aware of the resident's needs and had care planned appropriately to meet these needs. 1. Staff assisting Resident # 1 with meals have been educated regarding this deficiency. In-services were conducted July 2, 7, and 8, 2010. 2. Any dependant resident requiring assistance at mealtime has the potential to be affected. 3. The Neighborhood Manager, charge nurse or designee will be responsible to monitor neighborhood dining areas on a weekly basis for three months. Weight Committee meetings are held at least monthly and all residents experiencing weight loss are reviewed. Residents who have a significant weight loss will be monitored for assistance at mealtime. 4. Results of the monitoring will be reported to the Director of Nursing. The DON will report to the QA Committee monthly for 3 months. 5. August 6, 2010	

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F 312	Continued From page 8 The CNA again handed and partially placed the spoon in Resident #1's hand. Resident #1 again placed the spoon back on the table, and began reaching toward her beverages. The CNA moved Resident #1's milk glass within reach of the resident, and Resident #1 lifted and tipped the glass towards her mouth three times, prior to being able to tip the glass enough to obtain a small sip of milk. Resident #1 attempted two additional times to drink her milk, each time getting only a small amount of milk in her mouth due to her inability to tip the glass sufficiently. At one point, the CNA (#20) stated to the resident, "I should get you a straw." The CNA did not obtain a straw for the resident, and did not offer the resident assistance with drinking her milk, juice, and water. Following Resident #1's attempts to drink her milk, the CNA (#20) fed the resident a spoonful of yogurt, which the resident ate. The CNA immediately offered another spoonful of yogurt which Resident #1 refused. No further attempt to assist Resident #1 with eating her breakfast meal occurred. At the conclusion of the breakfast meal, Resident #1 consumed only a teaspoonful of yogurt and three sips of milk, without offering and/or encouraging the resident to drink her juice, water, eat her cereal, or offer, and/or ask the resident if she wanted an alternative food/beverage item.	F 312	**F314 08/06/10** 1. Resident # 14 care plan was reviewed and revised. The care plan identifies the history of pressure ulcers and the resident's risk for developing further pressure ulcers. On July 2, 7, and 8, 2010 CNA's were re-educated on those residents at risk for developing pressure ulcers, the need to observe the resident's skin, especially over pressure points, and reporting to the charge nurse. Re-education also included the importance of following the resident's care plan/interventions. On July 2, 2010 a memo was sent to all nursing staff regarding proper technique for conducting a thorough skin assessment. The licensed nurses involved in this resident's care and skin assessments were counseled regarding appropriate skin assessment documentation on July 1, 2010. On July 2, 2010 the DON visited with L. Tharpe, Director of the WSC Nursing program, regarding this deficiency. Documentation and reporting by the student nurse to the charge nurse was addressed. 2. Any resident with an alteration in bed mobility (repositioning and turning) and/or ambulation, residents with motor or sensory deficits or incontinent residents have the potential to be affected.	
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that	F 314		

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F 314	Continued From page 9 they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy and procedure, and staff interview, the facility failed to promptly and consistently implement interventions for a pressure ulcer for 1 of 3 sampled residents (Resident #14) with a current facility acquired pressure ulcer. Failure to promptly implement measures for an identified Stage 1 pressure ulcer contributed to the ulcer advancing to a Stage 2. Findings include: Review of the facility policy "Pressure Ulcers" occurred on 07/01/10. The policy, dated 01/03, stated, "The responsibility of all caregivers is to prevent, care for, and provide treatment for pressure ulcers. . . . Nursing judgment may be used to determine what preventive measures are to be used for each resident. These measures are included in the Resident Care Plan. . . . Assessment of Residents at Risk 1. Identify resident [sic] who are particularly prone to the development of pressure ulcers, including the following: . . . residents with an alteration in mobility . . . residents with motor or sensory deficits (diabetic, orthopedic, neurologic . . .) . . . incontinent residents . . . 2. Daily, examine residents prone to decubitus for development of redness, discoloration, or blisters over pressure areas. These areas include the following: . . . heels . . .	F 314	3. The policy and procedure Pressure Ulcer and Skin Integrity Record has been reviewed and revised. The PUP (Pressure Ulcer Prevention) Committee meets monthly to review all residents with pressure ulcers. The committee identifies residents at greatest risk for developing pressure ulcers (Braden Score of 12 or less) and assure appropriate interventions are in place. The committee discusses use of the skin care report cards also. All CNAs will be issued "Skin Care Report Cards" for documentation and reporting of impaired skin integrity of residents. Mandatory nursing in-services were conducted on July 2, 7, 8 and will be held August 2, 3, 4, 2010. 4. The Neighborhood Manager, Infection Control Nurse and/or charge nurse will review a randomly selected sample of residents. A comparison will be made to skin assessment documentation and actual skin condition. The Neighborhood Manager (or designee) will also observe actual care being provided and will compare this to the resident care plan. Monitoring will be done weekly for 4 weeks. Results will be reported to the QA Committee by the Infection Control Nurse and/or DON. 5. August 6, 2010	

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(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 314	Continued From page 10 Pressure Sore Prevention 1. Institute a preventive plan for any resident who has a potential for developing a pressure ulcer . . . This plan may include the following: . . . multipodis boot [for pressure relief] to support the heels and decrease shearing pressure . . . Provide and ensure that resident receives optimum nutrition . . . Observe skin condition on each shift. . . . Treatment Protocols . . . Stage I is defined as inflammation or reddening of the intact skin. . . . Use preventive measures. . . . Monitoring skin condition for the following: . . . signs of increased involvement and deterioration of area . . . Stage II is defined as skin blister or superficial skin break. . . . Notify charge nurse, nursing supervisor of change in condition of resident. . . . Continue preventive measures. . . . Documentation is made by licensed staff member as follows: . . . Record on Skin Integrity Record weekly or as condition or level of care warrants. . . ." The medical record for Resident #14, reviewed June 29-July 1, 2010, identified diagnoses including late effects cerebral vascular accident (CVA) with hemiplegia, diabetes mellitus, multi-infarct dementia, vascular disease, peripheral neuropathy, history of a pressure ulcer on the left heel, and a current Stage 2 pressure ulcer on the left heel. A quarterly Minimum Data Set (MDS), dated 05/17/10, identified the resident as requiring extensive assistance with bed mobility, transfers, toilet use, and personal hygiene. The MDS also indicated Resident #14 was frequently incontinent of bowel and bladder and had a Stage 2 pressure ulcer. Braden Scales - For Predicting Pressure Sore Risk, dated	F 314		

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F 314	Continued From page 11 02/18/10 and 05/17/10, identified the resident at mild risk for pressure ulcers. Resident #14's interdisciplinary progress (IDP) notes identified the following note, dated 04/23/10 at 9 a.m. - (written by a student nurse and co-signed by an instructor) ". . . Resident has an ulcer on L [left] heel. I noticed she does not wear heel lift boots and nothing was keeping heel off bed when I got her up. Reported to floor nurse. . . ." The note failed to identify measurements or staging of the ulcer. The record lacked evidence a facility nurse assessed Resident #14's left heel on 04/23/10. A physician's progress note, dated 04/28/10, stated, ". . . skin exam, left heel which is hemiplegic side has silver dollar sized area basically Stage 1 decubitus which looks bruised. There is no opening or ulceration and no drainage. It is a little bit tender on manipulation. . . ." The record lacked evidence of an assessment of the heel by a facility nurse on 04/28/10. Resident #14's IDP notes identified facility staff failed to address the ulcer on her left heel until 05/06/10 at 4 p.m., when the notes stated, "Staff reported area on Lt [left] heel. Said nurse assesed [sic] area to Lt heel measure [sic] 3.1 cm [centimeters] (W) [width] x 3.3 cm (L) [length]. Derma Savors [sic] [a type of heel protector] applied, heels off bed." Review of Resident #14's Skin Integrity Records identified staff documented "Skin intact" on 04/22/10 and 05/02/10. On 05/06/10, the record identified "Pressure area Lt heel, blood blister intact . . ."	F 314		

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F 314	Continued From page 12 Resident #14's care plan, dated 02/27/10, identified the following problems: ". . . History of left heel ulcer. Restless legs, does not keep them in good position on footrest of wheelchair. . . 5/6/10 Blister on (L) heel." "Skin integrity, impaired: actual related to diabetes, weakness, dementia . . . 5/6/10 Blister Lt heel." Approaches to the problem included, "Reposition/shift weight every 2-3 hours. . . . Observe for signs of skin breakdown (intactness, color, sensation, temperature). . . . Diabetic thick socks on when in bed & prn [as needed]. DermaSaver heel guards when in bed and prn every shift. Resident will ask to have both the socks and the heel guards on at the same time PRN. 5/7/10 Pillow under calves of both legs when in bed to elev. [elevate] heels off bed. . . ." "Nutrition and Hydration, at risk due to . . . diabetes . . . CVA . . .5-10-10 Pressure ulcer (L) heel." Review of dietary notes identified, on 05/10/10 the dietician implemented protein powder as an intervention for the pressure ulcer. IDP notes, dated 06/23/10 at 5:20 a.m. stated, "Res. [resident] continues to have 3.1 (W) x 3.3 (L) cm area to (L) [left] heel. Area extremely sore if touched or brushed against (such as when putting on dermasavers.) Area black in color [with] peeling skin surrounding." A physician's progress note, dated 06/23/10, stated, ". . . Only concern nursing staff has is patient has developed a left heel decubitus which they are treating with padding, etc and routine cares. She has had this in the past and it has healed up in the past. Complicating this issue is some vascular disease and diabetes, and most certainly some peripheral neuropathy. Compounding that as well is her prior history of	F 314		

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F 314	Continued From page 13 significant stroke. . . . Skin exam shows half silver dollar sized area Stage 2 decubitus left heel. . . ." Observation during the survey identified the following: On 06/29/10 at 9:26 a.m., three Certified Nursing Assistants (CNAs) (#31, #32, and #33) assisted Resident #14 to lie down using a Hoyer (full body) lift. The CNAs placed a pillow under Resident #14's left leg, but failed to apply the DermaSaver heel guards or to put a pillow under the right leg, as identified in the care plan. On 06/29/10 at 10 a.m., Resident #14 rested in bed with both heels directly on the mattress and no heel guards on. The pillow remained in the bed, but did not keep the heels floated. On 06/29/10 at 10:20 a.m., two CNAs (#31 and #33) assisted Resident #14 out of bed. Observation showed bilateral DermaSavers on. When requested, the CNAs removed Resident #14's DermaSavers and socks. Observation identified a dry black area approximately 3 x 3 cm on the left heel with peeling skin surrounding the area. An interview with an administrative nurse (#1) occurred on 06/30/10. The nurse stated the staff nurse working on 04/23/10 (when the student nurse identified the pressure ulcer) did not recall being notified of the pressure ulcer. She further stated the 24 hour report sheet (for staff to communicate issues) for 04/23/10 did not identify the ulcer. Facility staff failed to assess the pressure ulcer identified by a student nurse on 04/23/10 and the physician on 04/28/10; failed to identify the ulcer on a skin assessment completed on 05/02/10; failed to implement interventions to keep	F 314		

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F 314	Continued From page 14 Resident #14's heels off the mattress until 05/07/10 (two weeks after the initial identification of the ulcer); and failed to implement additional protein to assist with healing until 05/10/10. In addition, the student nurses's note and observations during the survey identified staff not consistent with applying the DermaSavers and floating Resident #14's heels off the mattress. These failures contributed to the resident's Stage 1 pressure ulcer progressing to a Stage 2 over the two week period from 04/23/10, when the student nurse identified the ulcer, to 05/06/10 ,when staff identified the ulcer on their assessment; and may have contributed to the resident's heel pain increasing from "a little bit tender" on the physician's note of 04/28/10 to "extremely sore" on the nurse's note on 06/23/10.	F 314		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEYS COMPLETED ON 08/27/09 and 08/21/08. Based on observation, record review, review of facility policy and procedure, and staff interview, the facility failed to provide adequate supervision and assistive devices to prevent accidents for 3 of	F 323	F323 1. Resident # 4 care plan and NA flowsheets were reviewed. The care plan has been revised to reflect residents current physical abilities and mobility. The CNA involved was counseled regarding this deficient practice. Staff caring for Resident #1 were re-educated on gait belt use July 2, 7, and 8, 2010. Staff caring for Resident # 10 were re-educated on gait belt use and need to lock the wheelchair during transfer. Resident # 24 closed record. 2. All residents requiring staff assist have the potential to be affected. 3. The Assessment/Fall Prevention policy and procedure was reviewed. The Transfer and Gait belt policy/procedure was reviewed. Revisions were made as needed. CNA group sheets/assignment sheets for all neighborhoods are being revised and changes made as needed and the night NA group sheets for all	08/06/10

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F 323	Continued From page 15 9 sampled residents (Resident #1, #4, and #10) and 1 of 3 closed record residents (Resident #24) who experienced falls. Failure of staff to utilize appropriate assistive devices (e.g. gait belt, wheelchair breaks) when transferring residents resulted in avoidable falls and injuries to Resident #4 (who experienced a hip fracture), and Resident #24 (who experienced a head injury), and placed other residents at risk for serious harm/injury. Findings include: Review of the facility policy titled "Assessment: Fall Prevention" occurred on 06/30/10. This policy, revised October 2001, stated, "Policy: [name of facility] strives to ensure an environment as free of accident hazards as possible and each resident receives adequate supervision and assistance devices to prevent accidents. Procedure: 1. On admission the Fall Prevention Assessment is completed. The resident is scored according to category . . . 2. If it is determined the resident is "at risk", review suggested interventions (back of Fall Prevention Assessment Form). Interventions will be selected, documented on the care plan and implemented. Any changes to the resident's care plan will be communicated to appropriate staff (e.g. communication log, CNA [certified nursing assistant] assignment sheet, shift report). 3. If the resident is found to be "At Risk", the Fall Prevention Assessment is completed at least annually. If the resident is found to be "Not At Risk", the Fall Prevention Assessment is completed at least quarterly. 4. The Fall Prevention Assessment will be completed after a significant change and anytime deemed necessary. 5. The Charge Nurse, Nursing	F 323	neighborhoods have been revised to more specifically identify resident care needs. (i.e. use of gait belts, number of staff required for assist, assistive devices) The Restraint Review Committee meets at least monthly. Residents who have experienced two or more falls in the past month are reviewed. On July 2, 7, 8, 2010 staff were educated on the scheduled care plan review process and the importance of the need to meet as a team. The Care Plan team will be responsible to make changes to the care plan assignment sheets and NA flow sheets. 4. Care Plan Checklists will be completed according to the care plan schedule. Licensed nurses as assigned will observe cares and compare cares provided with resident care plan, NA assignment sheets and NA flow sheet (documentation). The results of the care plan checklist review and observation of staff will be reported to the DON weekly for 4 weeks then monthly thereafter. The DON will report to the QA Committee at least quarterly. 5. August 6, 2010	

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F 323	Continued From page 16 Supervisor and/or Director of Nursing may initiate completion of the Fall Prevention Assessment form based on resident need. 6. A fall alert sign will be placed outside resident room to alert all staff to those residents at risk for falls. Residents to have a fall alert sign include at least but not limited to: 1. Bed and/or chair alert in place." Review of the facility policy titled "Transfer/Gait Belts, Use Of" occurred on 06/30/10. This policy, revised June 2006, stated, "PURPOSE: Ensure safety for residents and staff. PROCEDURE: 1. Criteria for Use 1.1. Staff transferring residents will properly apply and use a transfer/gait belt when ambulating or transferring residents whose: 1.1.1. Ability to ambulate or transfer is unknown. 1.2.2. Balance is impaired. 1.1.3. Muscle tone and/or strength is decreased. 1.1.4. Care plan identifies use of the transfer/gait belt with special care instructions. . . ." Review of the facility policy titled "Transfers" occurred on 06/30/10. This policy, revised March 2006, stated, "Procedure: . . . 2. Pivot transfer-wheelchair to bed. 2.1. Explain procedure to resident. 2.2. Put gait belt on resident unless care plan indicates other wise . . . 2.4. Lock wheelchair brakes and remove foot pedals . . . 2.15. Reverse procedure to return to the chair. 2.16. Use same procedure for commode/toilet transfers and chair-to chair transfers. 2.17. Pivot transfers are only used when a resident is able to assist by bearing some weight on their legs. . . ." - Review of Resident #4's medical record occurred on June 28 - July 01, 2010. The facility admitted Resident #4 in January of 2009, and diagnoses included chronic obstructive pulmonary disease, chronic renal insufficiency, osteoporosis,	F 323		

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F 323	Continued From page 17 osteoarthritis, a humeral neck fracture on 02/09/10, and a hip fracture resulting from a fall on 05/11/10. The most recent quarterly Minimum Data Set (MDS), dated 06/01/10, identified Resident #4 as having short and long term memory problems, and moderate impairment in daily decision making. During the assessment period, the resident experienced moderate pain less than daily to her hip area. Accidents included a fall in the past 30 days, a fall in the past 31-180 days, a hip fracture in the last 180 days, and another fracture in the last 180 days. The quarterly MDS (completed 06/01/10) indicated the resident required extensive assistance of two or more people to physically assist with bed mobility and transfer. This represents a decline from the significant change MDS (completed 04/16/10), which identified the resident only required extensive assistance from one person, and the annual MDS (completed 01/15/10), which indicated independence after set up help. The following information showed inconsistencies with the resident's current care plan and the nurse assistant flowsheets (which CNAs use to direct care). Review of Resident #4's care plan occurred on 06/28/10. This care plan, dated 06/08/10, identified the resident used a reclining back wheelchair for mobility (initiated on 05/19/10), and a PAL lift prn (initiated on 05/25/10). The care plan showed, "pivot transfer with 2 assist [and] gaitbelt" (initiated on 05/24/10) yellowed out and discontinued. A revision to the care plan, dated 06/30/10, stated "Pivot transfers [with] assist of [one] or [two] [with] gaitbelt."	F 323		

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F 323	Continued From page 18 The Nurses Assistant Flowsheet (a CNA driven care plan) for May 2010 identified "Ambulate with gait belt, FWW [front wheel walker] [and] 1-2 assist in room" prior to fall on 05/11/10. After Resident #4's fall/fracture on 05/11/10, the Nurses Assistant Flowsheet stated "Pivot transfer with 2 assist [and] gaitbelt . . . Reclining back w/ch [wheel chair] for mobility . . . Pal lift prn." Review of Resident #4's Interdisciplinary Progress Notes identified the following: * 05/11/10 at 3:00 a.m.- "Called to res [resident's] rm [room] as she had fallen when CNA was going to take her to the BR. Had lg [large] amount bleeding from area on back of head. Also noted Rt leg remained drawn; when palpating area, she cried out oh it hurts [sic]. Called [at] 0200 [2:00 a.m.] to send to ER [emergency room], per [Physician's Name]. [At] 0215 [2:15 a.m.] - Notified daughter and called for ambulance, [at] 0230 [2:30 a.m.] ambulance here, and [at] 0245 [2:45 a.m.], res transferred to hosp [hospital]." * 05/11/10 at 8:00 a.m.- " . . . resident admitted to hospital, having surgery for fractured [right] femur . . ." * 05/19/10 at 11:00 a.m.- "Returned per w/c [wheel chair] . . . from hosp . . ." * 06/08/10 at 5:20 p.m.- "Resident continues [with] 2 assist [and] use of Pal lift. Lower legs continue to have 4 [plus] edema. Ted hose have been ordered . . ." Review of the physician's Emergency Room Note on 05/11/10, stated " . . . 1.5 centimeter in diameter laceration over the mid left occiput with mild to moderate bleeding . . . laceration site was cleansed with three Betadine swabs . . .	F 323		

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F 323	Continued From page 19 laceration was then repaired by means of three staples . . . right hip fracture . . ." Resident #4's operative report showed the resident required an open reduction internal fixation surgery on 05/13/10 for a preoperative diagnosis of "intersubtrochanteric fracture of the right hip." An accident/incident report provided by the facility regarding the fall on 05/11/10 identified Resident #4 fell at 1:50 a.m. The incident report stated, "called to rm [room], found res [resident] on the floor by her easy chair, Rt [right] leg was drawn up, hollering . . . head was laying in pool of blood. Cleansed the area as much as possible, unable to tell." The witness account of events stated "While transferring resident to the bathroom Resident lost her balance. I then lost my balance when correcting hers, which then the fall had occurred." The Investigation of Event and Intervention(s) section of the incident report identified the following "CNA was walking Res to BR without a gait belt. Res started to lose her balance and CNA tried to help her but also lost her balance." During an interview on 06/30/10 at 1:45 p.m., a CNA (#25) stated the CNAs look at their CNA group sheets they carry with them to find out how residents ambulate and transfer. She stated they also ask those more familiar with the residents if they have any questions. The current CNA group sheet/chart for the NOC shift identified Resident #4's bathroom schedule as "Calls; Pull ups; 1-2 assist" and listed the following under comments "FWW [front wheel walker] gait belt; SBA [stand by assist] . . ." The current CNA group sheet for the day shift identified "BR [bathroom] SCHEDULE: 2 assist . .	F 323		

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F 323	Continued From page 20 . AMBULATION: Gait belt stand by assist. Pal lift prn [as needed]". The "TRANSFERS" sections remained blank. The CNA group sheet/chart still contained inaccurate and inconsistent information, as the resident no longer uses a FWW and stand by assist to transfer. The facility failed to accurately revise the CNA group sheets for all shifts to reflect the resident's current status and transfer needs, which has the potential to result in additional falls and further harm/injury. On 07/01/10 at 8:20 a.m., when asked if the facility monitors to ensure staff members follow care plans and use gait belts when indicated, an administrative nurse (#1) stated the charge nurses or unit managers do periodic rounding (monitoring) of staff working with the residents to check for things like that. She stated the roundings are not documented when completed. The facility staff failed to follow Resident #4's plan of care regarding gaitbelt usage for transfers which led to Resident #4 experiencing a fall on 05/11/10. This resulted in a laceration to her head and a right femur fracture. The resulting fracture contributed to a decline in function and mobility, and increased pain and edema. The facility failed to implement the changes identified on the accident/incident report after Resident #4's fall on 05/11/10, as the CNA group sheets continue to contain inaccurate information. This has the potential to result in additional harm as the staff use the information on the CNA group sheets to direct the residents' care. - Review of Resident #1's medical record occurred June 28 - July 01, 2010. A significant change Minimum Data Set (MDS) completed 06/24/10, and an annual MDS completed	F 323		

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F 323	Continued From page 21 03/25/10, showed Resident #1 experienced a decline from requiring limited assistance of one person on 03/25/10 to requiring extensive assistance of one person with transfer and ambulation on 06/24/10. Resident #1's plan of care included: "Original Date - 11/5/2008. Problem: Potential for impaired physical mobility. At risk for falls. Unsteady gait at times. . . . Episode of knees buckling and body going limp during ambulation. Is variable with assist needed for bed mobility, transfers, locomotion and walking. Episode of dizziness. Goal: 06/13/10 - Will transfer with gait belt and assist of staff without injury - Will ambulate short distances with gait belt and assist. Approaches: 06/01/10 - Gait belt and 1 assist for ambulation and transfers." In addition, the plan of care for Resident #1 showed revision dated 06/13/10 to include "Gait belt and 2 assist." Interdisciplinary Progress Notes (IDPN) indicated Resident #1 experienced a fall on 06/09/10. The "Accident/Incident Report" included the following witness' account of the fall: "I was getting [Resident #1] up out of her recliner, was holding her hands then her feet went out from under her and she fell onto the floor, she fell mostly on her right hip. I didn't have a gait belt on her." The "Accident/Incident Report" identified the following action to prevent recurrence: "Staff instructed to use gait belt for ambulation and transfers." Observation occurred at approximately 9:30 a.m. on 06/29/10, as a CNA (#20, the same CNA involved in the 06/09/10 fall) assisted Resident #1 into her bathroom. Prior to beginning to assist Resident #1 with transfer from wheelchair onto the toilet, the CNA (#20) stated, "I should wait for	F 323		

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help, but if I wait it may be too late." The CNA, using a gait belt, attempted to bring Resident #1 to a standing position without waiting for the additional staff member as identified on the resident's careplan. Observation showed Resident #1 requiring full physical support of the CNA (#20), and the CNA struggling to maintain support of the resident, while also lowering the residents slacks and underwear. At that point, another CNA (#21) entered the bathroom and said to the CNA (#20), "I could have helped you." The CNA (#21) proceeded to assist the other CNA (#20) with the completion of Resident #1's transfer and toileting needs.

Observation at 3:35 p.m. on 06/29/10 showed two certified nurse assistants (CNAs) (#23 and #24) assist Resident #1 with transfers from her wheelchair to the commode and from the commode to bed. During the transfer from wheelchair to the commode, observation showed a gait belt already in place and hanging loosely around the resident's hip area. Upon beginning the transfer of Resident #1 to a standing position, one of the CNAs (#23) stated, "It's [the gait belt] is too loose." Neither CNA tightened the gait belt. As the CNAs grasped the gait belt and began pulling Resident #1 to a standing position, the gait belt moved upward to the resident's axilla, hyperextending the resident's shoulders and upper arms above shoulder level throughout the transfer.

Following Resident #1's use of the commode, and without tightening or using the gait belt, the CNAs (#23 and #24) placed their hands/arms under the resident's armpits and while hyperextending the resident's shoulders/upper arms above shoulder level, lifted/pulled Resident #1 to a standing

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F 323	Continued From page 23 position, supported the resident during perineal hygiene, rearranged the resident's clothing, ambulated the resident several feet, and transferred the resident to bed. At no time during this transfer did staff utilize the gait belt observed to be on the resident. The above referenced observations showed a lack of the effectiveness of the corrective action taken (staff education) following the fall experienced by Resident #1 on 06/09/10, a failure of staff to implement the resident's plan of care, and placed the resident at risk for further harm/injury/unnecessary pain. - Review of Resident #24's medical record occurred on July 1, 2010. Diagnoses included congestive heart failure and hypertension. The resident's most current MDS, dated March 9, 2010 indicated Resident #24 required extensive assistance from one person for transferring, ambulating, and locomotion. The MDS also identified the resident as having an unsteady gait, a fall in the past 30 days, and a fall in the past 31-180 days. Resident #24's care plan, last updated March 15, 2010, stated, ". . . PROBLEM . . . Impaired physical mobility . . . At risk for falls . . . APPROACHES . . . Reclining back wheelchair with anti-tips & [and] with Oxygen on back for mobility . . . Chair alert. Move chair alert to lounge chair when resident sits there . . . Transfer with gait belt & 2 assist, & FWW [front-wheeled walker] prn . . ." An "Accident/Incident Report" dated January 15, 2010, stated the following, "[Resident #24's name] was in dining area by his table. One of his breaks [sic] were locked. Resident tried to get out of chair and side of chair, where break [sic] was	F 323		

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F 323	Continued From page 24 not locked, slide [sic] bak [sic] causing resident to fall towards [sic] wall hitting head, then landed on floor. . . ." The "Accident/Incident Report" confirmed that Resident #24 had a chair alarm; however, the portion of the report that asked if the alert sounded at the time of the fall was marked "N/A- wasn't in bed." The report also stated the following, ". . . Followup [sic]/Intervention . . . Make sure Resident Brakes are locked properly and Resident should be assisted in the dining room and taken out when staff leave DR [dining room] . . . Educated on making sure bed alert/chair alert on @ [at] times . . ." - Review of Resident #10's medical record occurred on June 29-30, 2010. Medical diagnoses included cerebellar ataxia/unable to walk (uncoordinated muscle movement) and vascular dementia. The most recent (quarterly) MDS, the significant change MDS, and the admission MDS, dated 04/21/10, 04/02/10, and 01/25/10 respectively, showed the resident transferred with extensive assist of two staff, and walking in the room and in the corridor did not occur. The MDS, dated 04/21/10, identified the resident fell in the past 30 days and in the past 31-180 days. Resident #10's careplan, dated 01/12/10, showed, "PROBLEM: Impaired physical mobility: ataxia, pressure ulcers to left leg, general debility . . . At risk for falls . . . APPROACHES: PAL [Patient Assist Lift] Lift prn [as needed] . . . Transfer with gait belt & [and] 2 assist prn . . ." On 06/29/10 at 9:37 a.m., observation showed a CNA (#32) transported Resident #10 into the bathroom per his wheelchair, while another CNA (#31) waited in the resident's room. The resident	F 323		

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held the grab bar, stood halfway up, and while the CNA attempted to pull the resident's pants and brief down, he sat onto the toilet. The CNA assisted the resident up off the toilet by holding him under the axilla and then pulled his pants and brief to his knees before setting him back on the toilet. The CNA (#32) failed to have the other CNA (#31) assist and failed to use a gait belt with the transfer. At 9:45 a.m., Resident #10 stood up with encouragement from the CNA (#32), however he sat back on the toilet after two seconds. The resident stood again while pericares were completed and brief and pants pulled up by the CNA (#32). The resident sat in the wheelchair guided by the other CNA (#31), who then wheeled the resident over to his bed. The CNAs (#31 and #32) held the resident under each arm, stood him up, and pivoted him onto the bed. The resident's legs bent at the knees with standing and the wheelchair rolled backwards. The CNAs failed to lock the wheelchair brakes and failed to use a gaitbelt.

On 06/29/10 at 11:36 a.m., observation showed two CNAs (#32 and #33) sat Resident #10 on the edge of the bed. One CNA (#33) stood in front of the resident and placed the resident's hands on her hips. The CNA then reached under the resident's arms, lifted the resident up, and pivoted him into his wheelchair. Both CNAs (#32 and #33) then lifted the resident under the arms and adjusted his position in the wheelchair. The CNAs failed to use a gaitbelt with the transfer.

A nurse's note, dated 03/12/10 at 7:00 p.m., stated, "Res. [Resident #10] became unsteady during transfer. Staff - assist lower to floor. . . . ROM WNL [range of motion within normal limits]. [No] redness or marking noted. [No] c/o

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F 323	Continued From page 26 [complaint of] pain or discomfort by Res." During an interview on 06/29/10 at 5:40 p.m., an administrative nurse (#1) indicated the report (of Resident #10's fall on 03/12/10) showed only one staff assisted with the transfer, and following the incident an administrative nurse (#22) re-educated staff regarding the requirement of two staff to transfer Resident #10. The report failed to indicate if a gait belt was used or not. Failure of staff to follow the careplan and utilize two staff when transferring Resident #10 has resulted in a fall. Failure of staff to use a gaitbelt, lock wheelchair brakes, and use two staff for transfers has the potential to cause falls and injury to both the resident and the staff.	F 323		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature	F 431	**F431** 1. There were no residents identified in this deficiency. 2. Any resident has the potential to be affected. 3. The pharmacy involved was notified of need for expiration dates. "Ordering and Receiving Medication from Pharmacy" policy has been reviewed and revised. A licensed nurse will be responsible for placing received medication in a double locked drawer. Licensed nurses will be in-serviced on changes to the policy/procedure on August 2, 3, 4, 2010. 4. The DON or designee will randomly monitor receipt of medications from the pharmacy and review contents of double locked drawer for 2 months. Neighborhood managers (or designee) will be responsible for monitoring medication's expiration dates. This will be done weekly for 4 weeks. Results of the review will be reported to the QA Committee monthly. 5. August 6, 2010	08/06/10 8/6/10

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F 431	Continued From page 27 controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, review of facility policy, and review of professional reference, the facility failed to ensure medications were appropriately labeled with expiration dates in 2 of 7 medication carts (located in the Harmony Square and Legacy Square units) and failed to ensure only authorized personnel had access to keys for 3 of 3 medication storage drawers located at the receptionist's desk. Failure to properly label medications may result in residents receiving outdated and potentially ineffective medications. Failure to ensure only authorized staff had keys to medication drawers could result in unauthorized access to controlled medications. Findings include: The Centers for Medicare and Medicaid Services (CMS) has outlined the standards of practice regarding the labeling and storage of drugs and biologicals. The facility must secure all medications in locked storage areas and limit	F 431		

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F 431	Continued From page 28 access to authorized personnel. Storage areas may include drawers, cabinets, medications rooms, refrigerators, and carts. The facility must have a system to limit who has security access and when access is used. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. Medication labeling identifies, at a minimum, the medication's name, strength, expiration date when applicable, and lot number, and provides instructions as necessary for safe administration. The facility ensures that medication labeling in response to order changes is accurate and consistent with applicable state requirements. - Observation of the Harmony Square medication cart occurred on 06/29/10 at 4:45 p.m. The medication cart contained resident's medications, packaged by the pharmacy, in punch cards containing a 30 day supply. The following medications lacked an expiration date: Singulair, Prilosec, Ativan, Celexa, Baclofen, Compro, Aldactone, Lasix, Ultram, Trazodone, Doxepin, Ambien, Multivitamin, Diltiazem, Lisinopril, and Abilify. A nursing staff member (#10) confirmed these medications lacked expiration dates. - Observation of the Legacy Square medication cart occurred on 06/30/10 at 2 p.m. with a staff nurse (#35). Observation identified the following carded medications lacked an expiration date: Furosemide, Carvedilol, and Fluoxetine. The staff nurse (#35) confirmed the medications lacked expiration dates.	F 431		

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During an interview on 07/01/10 at 9:15 a.m., an administrative nurse (#1) agreed medication labels should contain expiration dates.

Review of the facility policy "Ordering and Receiving Medication from Pharmacy" occurred on 07/01/10. The policy, dated 05/10, stated, ". . . 2. Receiving Medications 21. Pharmacy deliveries will be received at the front office (receptionist area). The date and time of the delivery will be recorded by the receptionist. . . . 2.2 Medications will be locked in a secured drawer, controlled medications will be double locked. Charge nurses will pick up the medications for their respective stations. . . ."

- Observation of medication storage for Legacy Square occurred on 06/30/10 at 2 p.m. with a staff nurse (#35). When asked who receives medications delivered from pharmacies, the nurse stated the pharmacies deliver the medications to the reception desk. She stated the receptionist office has locked cupboards for storage of the medications, until the nurses take them to the units.

Observation of the receptionist's office occurred on the afternoon of 06/30/10 and identified three locked drawers in a cabinet near the receptionist's desk. When asked who has the keys, the receptionist (unidentified) indicated the keys were in a drawer in her desk. Observation showed the drawer equipped with a lock with the key in the lock. The receptionist opened the drawer and handed a ring containing three keys to the nurse (#35). The nurse then unlocked the three drawers. One key opened drawers #1 and #2. The second key opened drawer #3. The third

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F 431	Continued From page 30 key opened the narcotic storage in drawer #2. When asked if the receptionists are licensed staff, both the nurse (#35) and receptionist stated they are not. Failure to ensure only authorized personnel have access to medications, including controlled medications could result in unauthorized use of the medications.	F 431	**F441** 1. The DON has discussed urinalysis results with our medical director on June 17, 2010. The DON discussed with Medical Director the culture results of resident # 5, # 1, #2, #4, #17 and #21 and decision was made to monitor for signs/symptoms of urinary tract infection and a urine specimen for analysis will be obtained as indicated. Due to the number of residents identified in F441, on July 2, 7, and 8, 2010 all nursing staff were re-educated in appropriate hand hygiene, transmission based precautions and infection prevention practices. Mandatory nursing staff (licensed and CNA) in-services were held July 7th and 8th and will be held on August 2, 3, 4, 2010 These education sessions included a review of the deficiency F441, proper hand hygiene and infection prevention practices and general food preparation and handling. Resident #12 medicated powder was discarded and the staff member was counseled regarding this contamination of the medication container. 2. Any resident has the potential to be affected.	08/06/10
F 441 SS=E	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. (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	F 441		8/6/10

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F 441	Continued From page 31 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: `1) Based on observation, review of facility policy/procedure, record review, and staff interview, the facility staff failed to implement acceptable infection control practices during the provision of personal resident care and dining/eating assistance, and provide appropriate storage/cleanliness of resident personal care equipment for 8 of 24 sampled residents (Resident #1, #6, #7, #12, #13, #14, #16, #20, and #21) and 5 supplemental residents (Resident #25, #26, #27, #28, and #29). Findings include: Review of the facility's policy/procedure "Hand Hygiene" occurred on 07/01/10. The policy, last reviewed/revised March 2010, stated: "Policy Statement: Hand Hygiene shall be regarded by this organization as the single most important means of preventing the spread of infections . . . Policy Interpretation and Implementation. 1. All personnel shall follow our established hand hygiene procedure to prevent the spread of infection and disease to other personnel, patients, and visitors. 2. Appropriate fifteen (15) second handwashing must be performed under the following conditions: . . . g. After contact with	F 441	3. A walk through of all resident bathrooms was conducted and bed pan washers have been ordered for remaining resident bathrooms. Bathroom shelves were ordered for storage of resident care equipment. The policy and procedure for urine specimen collection (mid stream, straight cath and indwelling catheter) has been developed. On July 7th and 8th Certified Nursing Assistants and Licensed Nursing staff were in-serviced on midstream urine collection. Licensed nursing staff will be educated on the policy/procedure August 2, 3, 4, 2010. All infection control policies/procedures will be reviewed and revised as needed. All nursing staff will be educated on infection control policy/procedure at mandatory in-services August 2, 3, 4, 2010. 4. The Infection Control Nurse or designee will randomly monitor on a weekly basis: a. Staff infection prevention practices: handwashing, glove use, transmission based precautions, care and cleaning of resident equipment and proper food handling in the resident dining rooms. b. Urine specimen collection and lab results. Results will be reported to the DON and Infection Control Committee at least monthly for 3 months. 5. August 6, 2010	

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blood, body fluids, excretions, secretions, mucous membranes, or nonintact skin; h. After handling items potentially contaminated with blood, body fluids, excretions, secretions, or mucous membranes; . . . l. After removing gloves; . . . m. Whenever in doubt; . . . Before and after touching food products. 3. The use of gloves does not replace handwashing."

Review of the facility's policy/procedure "Incontinence Care" occurred on 07/01/10. The policy/procedure, last reviewed/revised January 2007, stated:
"Incontinence Care. . . . Procedure: 1. Wash hands before and after procedure. . . . 4. Apply gloves. 5. Remove soiled brief, roll up, and place in plastic liner. 6. Cleanse perineal area, . . . 7. Remove gloves. 8. Apply clean brief. 9. Wash hands. . . . "

- During the initial tour at approximately 1:45 p.m. on 06/28/10, an administrative nursing staff member (#22) indicated Resident #1 had been "diagnosed with C Diff [Clostridium Difficile] [a bacteria causing severe diarrhea] a few days ago."

Review of Resident #1's medical record occurred June 28- July 01, 2010. Resident #1's plan of care included the following: "Contact Precautions: Bedside Commode, dispose in toilet - sanitize surfaces with bleach solution 1:10 - replace q [every] 24 hours . . . gown/glove use. No alcohol sanitizer use. Must wash hands with soap/water. Avoid splashes and sprays. Avoid touching/contaminating sink and surroundings with soiled, gloved hands. . . . "

Observation showed Resident #1 shared a

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BETHEL LUTHERAN NURSING & REHABILITATION CENTER	1515 2ND AVE WEST WILLISTON, ND 58801

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semi-private room and shared a bathroom with her roommate and two residents in the adjoining room. The staff member (#22) indicated Resident #1 did not use the bathroom toilet, but "only the portable commode" located at the foot of the the resident's bed.

Observation at 9:30 a.m. on 06/29/10, showed a CNA (#20) assist Resident #1 to her room and into the resident's bathroom. Prior to entering the resident's room, the CNA donned a gown and gloves from a cart outside the resident's room. Once in the resident's room observation showed:

* The CNA pushed the resident in her wheelchair into the shared bathroom, and assisted the resident to a standing position at the toilet and began lowering the resident's slacks.
* Another CNA (#21) entered the room and informed CNA #20 the resident needed to use the portable commode.
* After Resident #1 voided on the commode, the CNAs (#20 and #21) assisted Resident #1 to a standing position and CNA #21 cleansed the resident's perineal area, removed her gloves, and assisted CNA #20 with transferring the resident into her wheelchair.
* While Resident #1 washed her hands in the bathroom, CNA #20 emptied the commode into the waste receptacle in the resident's room, removed the plastic liner from the waste receptacle, and placed it in a "biohazard bag."
* Without removing her gloves and washing her hands, CNA #20 opened the resident's room door, disposed of the biohazard bag in a red waste receptacle in the corridor, and obtained a spray bottle of sanitizer (bleach solution) from the isolation cart in the corridor.
* Following sanitizing of the portable commode, the CNA (#20) removed her gloves

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F 441	Continued From page 34 and gown and washed her hands prior to leaving the resident's room. - Observation on 06/29/10 at 7:45 a.m., showed two CNAs (#5 and #6) assisted Resident #7 into the bathroom. The CNA (#5) removed the resident's urine soaked brief without wearing gloves, donned gloves, and provided pericares following toileting. The CNA removed her gloves, pushed the resident to the activity room by wheelchair, failing to wash her hands before leaving the resident's room. - Observation on 06/29/10 at 9:30 a.m., identified CNAs (#29 and #30) assisting Resident #6 to the toilet using a standing lift. After Resident #6 voided, the CNA (#29) performed pericare, applied a clean pad, and adjusted the resident's clothing. The CNA (#29) removed her gloves, tied the garbage bag, carried the bag down the hall to the dirty supply room and entered another resident's room. The CNA (#29) failed to use appropriate hand hygiene upon the completion of personal cares or before entering another resident's room. - On 06/29/10 at 9:51 a.m., observation showed two CNAs (#32 and #33) assisted Resident #13 onto his bed using a stand-up mechanical lift, removed the sling, laid the resident down, and placed a pillow under his left leg. After the resident was settled, one CNA (#32) washed her hands. The other CNA (#33) failed to wash her hands or use hand sanitizer before leaving the room. - On 06/29/10 at 12:40 p.m., observation identified two CNAs (#31) and (#33) assisted Resident #14 to use the bedpan. After the	F 441		

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F 441	Continued From page 35 resident voided, one CNA (#31) placed the bedpan on the bedside stand. The CNA then performed perineal care and removed her gloves. While the other CNA (#33) emptied the bedpan, the CNA (#31) gave the resident a drink of water, without first performing hand hygiene. The CNA (#31) then left the room without cleaning the bedside stand. - Observation on 06/30/10 at 2:20 p.m., showed a CNA (#3) assisted Resident #21 off the bedpan. Observation showed stool and urine in the bedpan. The CNA (#3) completed pericares then rinsed the bedpan in the resident's sink three times and dumped the contents into the toilet. The CNA (#3) placed the resident's bedpan on a shelf in the bathroom. The CNA failed to clean the sink or the bedpan prior to leaving the room. - On 06/29/10 at 3:15 p.m., observation identified two CNAs (#33) and (#36) assisted Resident #14 to use the bedpan. Observation showed the resident incontinent of urine and stool. One CNA (#33) wiped stool from the perianal area using the resident's soiled brief, and placed the bedpan under Resident #14. After the resident voided, the CNA (#33) removed the bedpan and placed it on the wastebasket. Observation showed a large amount of stool on the outside of the bedpan. After completing resident cares, the CNA (#33) rinsed the bedpan, wiped the outside with toilet tissue, and placed the bedpan on the bathroom floor. The CNA failed to clean the outside of the bedpan, which had been smeared with stool. - On 06/29/10 at 3:55 p.m., observation identified a CNA (#37) and a licensed nurse (#9) assisted Resident #12 with cares. The nurse (#9) donned gloves and washed and dried the resident's	F 441		

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axillae. She then removed a plastic shaker of nystatin powder from a ziplock bag and applied the powder to Resident #12's axillae. The staff members then removed Resident #12's brief. Observation showed the groin area reddened and the skin peeling. Observation also identified the resident incontinent of stool. At that point, an unidentified staff member knocked on the door and stated a physician wanted to speak with the nurse on the phone. The nurse (#9) removed her gloves, cleansed her hands with ABHR, and left the room.

While the nurse was out of the room, the CNA (#37) performed perineal cares, with visible stool on the periwipes. When the nurse returned, she washed her hands and donned gloves. She then cleansed the groin area with periwipes. Observation showed visible stool on the wipes. With the same gloved hand, the nurse picked up the nystatin shaker, applied it to Resident #12's groin, and placed it back in the ziplock bag. The nurse failed to clean the outside of the nystatin shaker prior to placing it in the ziplock bag. The nurse then washed her hands and left the room.

On 06/29/10 at 4:35 p.m. the surveyor informed an administrative nurse (#1) of the above observation including the potential contamination of the nystatin powder container. The nurse stated she would follow-up.

When interviewed on 06/30/10 at 8:55 a.m., an administrative nurse (#1) stated Sani-wipes are available for cleaning surfaces and should be used for cleaning bedpans, etc. She stated the CNA should have cleaned the bedside stand with a Sani-wipe after placing the bedpan on it.

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F 441	Continued From page 37 - On 06/30/10 at 4:25 p.m., observation identified a CNA (#38) responded to Resident #16's call light. Observation showed Resident #16 seated at the edge of his bed with urine on the floor and the resident's pants wet. Observation identified a urinal partially filled with urine on the overbed table. The CNA donned gloves and cleaned the urine from the floor. She changed her gloves, performed perineal cares, and assisted the resident to change his pants. The CNA (#38) changed her gloves again, emptied the urinal, wet a wash cloth with water from the sink, and wiped the overbed table with the wash cloth. She then placed a paper towel on the overbed table and put the urinal on the paper towel. The CNA failed to clean the overbed table or perform hand hygiene before leaving the room. During an interview on 07/01/10 at 9:10 a.m., an administrative nurse (#1) agreed staff should perform hand hygiene before and after toileting residents. * Review of the facility policy "General Food Preparation and Handling" occurred on June 30, 2010. This undated policy stated, ". . . g. Bare hands should never touch raw food directly . . ." - Observations during breakfast on June 29, 2010 at 7:56 a.m. showed a CNA (#11) feeding Resident #20 toast with gloved hands. The CNA touched the resident's shoulder, patted his arm, and handed the resident his napkin. Wearing the same gloves, the CNA then put jelly on Resident #25's toast and handed it to her to eat. - During observation of the breakfast meal on 06/29/10 at 8:05 a.m., a nursing staff member (#28) peeled a banana and with bare hand	F 441		

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F 441	Continued From page 38 contact, broke it into two pieces and handed half to Resident #6. - On 06/29/10 at 8:20 a.m., observation showed a CNA (#31) assisting two residents with breakfast. The CNA tore Resident #28's toast in pieces with her bare hands and fed pieces of the toast to Resident #28. The CNA then tore Resident #29's toast in pieces and fed pieces of it to Resident #29. The CNA (#31) failed to wear gloves or use other barriers when handling the residents' food and failed to use hand hygiene after assisting one resident to eat and before assisting a second resident. - During the evening meal on 06/29/10 at 5:30 p.m., observation showed a staff member (#12) feeding Resident #26 and Resident #27. The staff member touched Resident #27's bread with her bare hands and handed it to the resident. The resident shook her head "no", so the staff member took the bread back and placed it on the resident's plate. The staff member then held Resident #26's bread with her bare hands and fed it to the resident. During an interview on 07/01/10 at 8:50 a.m., an administrative nurse (#1) stated, "Staff have been educated to wear gloves while feeding residents, or to cut food with a knife and feed with a fork." She agreed staff should not tear toast and feed residents with their bare hands. During an interview on 07/01/10 at 9:15 a.m., a nursing staff member (#1) stated staff were expected to wear gloves when handling ready to eat foods and to change gloves between residents.	F 441		

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F 441	Continued From page 39 2) Based on record review and staff interview, the facility failed to ensure 6 of 7 sampled residents with physician ordered urinalysis (UA) culture and sensitivity (C&S) testing (Resident #1, #2, #4, #5, #17, and #21) had urine specimens collected/handled in a manner that provided useful/necessary information to aid in the treatment and potential source/cause of the residents' potential urinary tract infections (UTIs). Findings include: Review of the medical records for Resident #1, #2, #4, #5, #17, and #21 occurred June 28-July 01, 2010, and showed each resident had a history of urinary tract infections with physician ordered urine C&S test results identified as "contaminated" or "mixed flora." Specific findings for each resident included: * Resident #21's physician ordered a urine C&S on 08/17/09 for possible UTI. Laboratory analysis indicated "Contaminated". * Resident #21's physician ordered another urine C&S on 08/26/09. Laboratory findings indicated "Mixed Flora - Contaminated". * The physician ordered a UA and C&S for Resident #2 and began antibiotic treatment for a possible UTI on 03/25/10. Laboratory test results of the urine specimen submitted for the C&S on 03/25/10 indicated, "Contaminated." * The facility collected a urine sample from Resident #4 on 04/07/10, following a physician's order for a C&S. The physician ordered antibiotic treatment the same day. Laboratory test results of the urine specimen submitted for the C&S on 04/07/10 indicated, "Mixed Flora of 3 or more colony types suggests contamination." * Resident #5's physician ordered a UA and C&S for a possible UTI on 04/30/10. Laboratory	F 441		

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F 441	Continued From page 40 test results of the urine specimen submitted revealed "Mixed Flora". * Resident #1's physician ordered a UA and C&S, and prescribed antibiotic treatment for the resident on 05/07/10. The laboratory test results for the C&S specimen collected by the facility on 05/07/10 indicated, "Contamination." * Resident #5 had a urine sample collected by the facility and sent to the laboratory for C&S for possible UTI on 05/10/10. Results showed "Mixed Flora". * The facility collected a urine sample from Resident #17 on 05/10/10, following a physician order for culture and sensitivity. The physician ordered antibiotic treatment on 05/11/10. Laboratory test results of the urine specimen submitted for the C&S on 05/10/10 indicated, "Mixed flora of 3 or more colony types suggests contamination." * Resident #5's physician ordered a urine C&S for possible UTI on 06/24/10. Laboratory analysis revealed "Mixed Flora". When interviewed, on the afternoon of 06/30/10, an administrative nurse (#1) stated the facility did not have a policy and procedure for obtaining clean catch urine specimens the the physician orders a urinalysis and/or a C&S. During an interview with an infection control nurse (#27) at 3:40 p.m. on 06/30/10, the nurse did not provide information which indicated the facility had investigated the cause/reason(s) for the contamination of urine specimens collected by the facility for culture and sensitivity testing. In addition, the staff member provided no information showing the facility implemented corrective actions through the their infection control program to improve the culture and	F 441		

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F 441	Continued From page 41 sensitivity testing for diagnostic and treatment purposes. The culture and sensitivity reports in the above described instances did not provide information regarding the causative organism/bacteria, and did not allow the resident the opportunity to receive the most effective treatment and/or isolation precautions. Treatment without identification of the causative organism increases the risk of the resident(s) developing an antibiotic resistant infection. In addition, the facility failed to track and investigate the cause of the contaminated specimens through their infection control program. The failure to obtain test results identifying the causative organism/bacteria does not provide information necessary to identify service/care related areas requiring action/ needed improvement in the prevention and control of infections.	F 441		
F 454 SS=D	483.70 LIFE SAFETY FROM FIRE The facility must be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel and the public. This REQUIREMENT is not met as evidenced by: Based on observation and review of professional reference, the facility failed to comply with Life Safety Code requirement NFPA 99 for Health Care Facilities to protect the health and safety of residents, personnel, and the public, regarding oxygen storage for 1 of 1 resident (Resident #11) observed on initial tour with an unsecured oxygen tank. Findings include:	F 454	F454 1. As noted on the CMS 2567. The oxygen tank for Resident # 11 was placed upright and secured in a canvas carrier. 2. Any resident receiving oxygen therapy has the potential to be affected. 3. Maintenance and Nursing staff were reminded/re-educated regarding oxygen safety and especially handling of the oxygen cylinders. Maintenance staff will be educated regarding the importance of timeliness of securing the oxygen tanks/cylinders for resident and staff safety. Tanks/cylinders are to be secured with cloth straps or metal oxygen carriers for the wheelchairs. 4. The Maintenance Supervisor or designee will monitor all residents receiving oxygen therapy. This will be done on a weekly basis with corrective action taken immediately. Results will be reported to the QA Committee monthly for 3 months. 5. August 6, 2010	08/06/10 8/6/10

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F 454	Continued From page 42 Life Safety Code requirements state, "Nonflammable medical gas systems and equipment used for the administration of inhalation therapy and for resuscitative purposes comply with National Fire Protection Association (NFPA) 99, 13-5.1, 7-1.2, NFPA 70." Standard for Storage, Use, and Handling of Compressed Gases and Cryogenic Fluids in Portable and Stationary Containers, Cylinders, and Tanks, NFPA 55, 7.1.4.4 state, "Securing Compressed Gas Containers, Cylinders and Tanks. Compressed gas containers, cylinders, and tanks in use or in storage shall be secured to prevent them from falling or being knocked over by corralling them and securing them to a cart, framework, or fixed object by use of a restraint, unless otherwise permitted by 7.1.4.4.1 and 7.1.4.4.2.7." During initial tour of the facility on 06/28/10 at approximately 3:00 p.m., observation showed a small cylinder oxygen tank laying at a 45 degree angle on its side in the wire basket of Resident #11's walker. A cloth strap surrounded the tank and tied it to the walker basket, but it remained unsecured and moved about freely when touched. Contact occurred with an administrative nurse (#1) at approximately 3:30 p.m. on 06/28/10 regarding the above observation. Observation before leaving the facility, at approximately 5:45 p.m. on 06/28/10, showed the oxygen tank upright and secured in a canvas carrier on Resident #11's walker.	F 454		