STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355066	A. BUILDING _____ B. WING _____	11/24/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WISHEK HOME FOR THE AGED	400 S 4TH ST WISHEK, ND 58495

(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 11/22/10 and completed on 11/24/10 the sample included four residents for complete review, nine residents for focused review, and two closed records for review.	F 000		
F 323 SS=D	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: Based on observation, record review, facility policy review, and staff interview, the facility failed to provide necessary assistive devices (e.g. foot pedals, gait belts) for 3 of 11 sampled residents (Resident #1, #3, and #5) requiring staff assistance with transfers and locomotion. Failure to utilize these assistive devices may result in falls and/or injury to residents. Findings include: Review of the facility policy "Gait Belts for Transfer" occurred on 11/24/10. This policy, dated 04/11/05, stated, ". . . STANDARD . . . It is the policy of the [facility name] for all CNA's [certified nursing assistants] and RA's [restorative aides] providing direct patient care with transfers and ambulation to utilize gait belts in a safe and	F 323	Resident # 1, #3,and #5 along with all residents of this facility will reside in an environment that remains free of accident hazards as much as possible. The current policy and procedure of the Wishek Home for the Aged as related to gait belts is consistent with standards of practice. Gait belts are accessible to all staff and are to be used with assisted transfers (see attachment #1). The CNA staff will be re-educated on the policy for gait belts at the Dec. 13th, 2010 monthly CNA/RA meeting. Nursing staff on December 20th, 2010 at the monthly nurses meeting. In regards to footpedal use when pushing residents in wheelchairs, pedals are expected to be on when pushing residents unless otherwise indicated. For resident # 5 there are no foot pedals for his wheelchair however his rock-n-go chair is to be reclined when pushing him to and from. The care plan for resident #5 was updated to indicate reclining the chair when pushing resident in the rock-n-go w/c.	12/20/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Gregory J. Salucci | TITLE: Administrator | (X6) DATE: 12/8/10

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 323	Continued From page 1 effective manner. . . . " - Review of Resident #3's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease and osteoarthritis. Resident #3's current Minimum Data Set (MDS), dated 10/19/10, showed extensive assistance of one person for locomotion. The resident's care plan indicated she could self-propel while in her wheelchair and did not mention the use of foot pedals. Observations of Resident #3 throughout the survey revealed the following: * 11/22/10 at 5:25 p.m.: An unidentified CNA pushed Resident #3 in her wheelchair into the dining room. Observation showed no foot pedals in place, the resident's feet brushed along the floor, and the CNA did not instruct the resident to lift her feet. * 11/23/10 at 11:35 a.m.: A CNA (#5) pushed Resident #3 from her room to the lounge area. The resident's feet brushed along the floor during the observation. The CNA stated to the resident, "Lift your feet, [Resident name]. Can you lift your feet?" Resident #3 did not lift her feet or respond to the CNA's comments. The CNA failed to apply foot pedals to the wheelchair. * 11/23/10 at 5:15 p.m.: A CNA (#6) pushed Resident #3 into the dining room. Observation showed Resident #3's right foot on a foot pedal and her left foot brushing on the floor behind the left foot pedal. The CNA failed to place Resident #3's left foot onto the pedal or give instruction to the resident to lift her foot. * 11/24/10 at 9:07 a.m.: An unidentified CNA pushed the resident down the hallway to her room. Observation showed Resident #3's right foot on a foot pedal and her left foot brushing on	F 323	For resident # 3, she self propels and it is acceptable to have foot pedals in the bag behind the w/c when she is self propelling. Then foot pedals are to be put on if staff is pushing resident. It has been understood here that this is standards of practice however a policy has been implemented regarding foot pedal use at this time (see attachment #2). The CNA staff will be re-educated on December 13th, 2010 at the monthly CNA meeting. All other staff will be re-educated at their department meetings. QA will monitor for facility compliance through general observation monthly x3and quarterly for nine months thereafter. Immediate correction action will be done if needed. All new hires will be educated on the above as it relates to their disciplines. If concerns are identified education will be done at monthly staff meetings by the DON or other respected department head personal. QA nurse will give a report of findings at quarterly QA meetings for the year 2011.	12/29/10

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F 323	Continued From page 2	F 323		

the floor behind the left foot pedal. The CNA failed to place Resident #3's left foot onto the pedal or give instruction to the resident to lift her foot.

Failure to place the resident's feet on foot pedals during staff-assisted wheelchair transfers may lead to the resident's feet catching on the floor and could cause a fall or injury.

During an interview on the morning of 11/24/10, a supervisory nursing staff member (#1) stated it is "understood with all residents" that staff apply foot pedals during wheelchair transfers between locations.

- Review of Resident #1's medical record occurred on all days of survey. Diagnoses included osteoarthritis, atrial fibrillation, and chronic knee/back pain. The resident's current MDS, dated 10/11/10, indicated extensive assistance of one person for transfers and limited assistance of one person for in-room ambulation. Resident #1's care plan, dated 10/19/10, stated, ". . . Transfers: Resident requires limited to extensive assist of 1 during transfers with gait belt. . . ." The "CNA Care Plan Report" (located in the resident's room and used by CNAs to provide care) failed to identify the use of a gait belt.

Observation on 11/22/10 at 8:53 a.m. showed a CNA (#4) assisted Resident #1 to transfer from the wheelchair to a recliner using a pivot transfer. The CNA stated, "She's [Resident #1] not care planned for a gait belt."

Observation on 11/22/10 at 10:48 a.m. showed a CNA (#4) assisted Resident #1 to the bathroom. The resident ambulated from her recliner to the

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F 323	Continued From page 3 bathroom using a walker and stand-by assistance from the CNA. The CNA failed to apply a gait belt. During an interview on the morning of 11/24/10, a supervisory nursing staff member (#1) stated she educates staff to use a gait belt with all transfers. - Review of Resident #5's medical record occurred on all days of the survey. Resident 5#'s diagnoses included, dementia with behaviors, anxiety, and joint pain. The current MDS, dated 08/28/10, indicated total assistance for locomotion off the unit (areas set aside for dining, activities, or treatment) and extensive assistance for transfers. Resident #5's current care plan, stated, "Problem * Resident at risk for falls secondary to unsteady gait, poor judgement, medications. Uses standup lift. Slides in w/c [wheelchair] pelvic thrusts & [and] extends legs out. . . Approaches . . . *Provide rock & go wheelchair. Problem * Resident requires extensive to total assist of 1-2 to complete ADL [activities of daily living] tasks d/t [due to] advanced dementia . . . Approaches . . . * Locomotion: Rock and go chair. Self propels at times. . . Problem Dx [diagnosis] of dementia. Has problem with memory loss & hearing . . . Short attention span. . . . " On 11/24/10 at 11:10 a.m., a facility staff member (#2) transported Resident #5, seated in a low, rock and go wheelchair, from the nurses station to the activity area. Observation showed the resident leaned to the right, his eyes closed, and his feet rubbed on the floor. The staff member #(2) stated, "lift your feet, lift your feet." A licensed staff member (#3) also stated, "lift your feet [resident name]." Resident #5 lifted his feet	F 323		

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F 323	Continued From page 4 enough to clear the floor. When the staff member #(2) reached the carpeted area, Resident #5's feet caught on the carpet. Again, the staff member (#2) instructed the resident to lift his feet. The staff member (#2) failed to tilt Resident #5's wheelchair back in a reclined position to lift his feet off the floor or apply foot rests on the wheelchair to transport him from one area of the facility to another.	F 323		