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 _____	11/02/2011

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

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F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey started on October 31, 2011 and completed on November 02, 2011 the sample included three (3) residents for complete review, nine (9) residents for focused review, and two (2) closed records for review.	F 000		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on observation, record review, and review of professional reference, the facility failed to conduct a comprehensive assessment for 1 of 2 sampled residents (Resident #3) who experienced a significant change in their physical and/or mental condition requiring interdisciplinary review and/or revision of the care plan. Failure to complete a Significant Change in Status Assessment (SCSA) in response to Resident #3's physical decline and mood changes placed the	F 274	For resident #3 along with all residents of the Wishek Home for the Aged who experience a major decline or improvement in their status will have a comprehensive assessment (SCSA) done to determine further interventions to ensure that the clinical interventions and careplan reflect interventions to assist the resident in achieving his/her highest practicable well-being. For resident #3 the multidisciplinary team completed a SCSA on Nov. 14th, 2011. The DON will review the RAI manual's chapter regarding SCSA with the MDS team on Nov. 21st,2011 at our weekly meeting.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Gregory J. Salmen	Admin.	11/16/2011

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 274	Continued From page 1 resident at risk for continued decline and the lack of appropriate interventions to restore or maintain physical and mental function. Findings include: The CMS Long-Term Care Facility Resident Assessment Instrument User's Manual, Version 3.0, October 2011, page 2-20 through 2-23 states, "Significant Change in Status Assessment . . . A SCSA is appropriate when: There is a determination that a significant change (either improvement or decline) in a resident's condition from his/her baseline has occurred as indicated by comparison of the resident's current status to the most recent Comprehensive assessment and any subsequent Quarterly assessments; and The resident's condition is not expected to return to baseline within two weeks. . . . Decline in two or more of the following: . . . Presence of a resident mood item not previously reported by the resident or staff and/or an increase in the symptom frequency . . . Any decline in an ADL [Activity of Daily Living] physical functioning area where a resident is newly coded as Extensive assistance, Total dependence, or Activity did not occur since last assessment . . . Resident's incontinence pattern changes . . . Emergence of a new pressure ulcer at Stage II or higher or worsening in pressure ulcer status . . ." Review of Resident #3's medical record occurred on all days of the survey. Diagnoses included depression, legally blind, foot ulcers, and dementia with behavioral symptoms. Comparison of Resident #3's admission Minimum Data Set (MDS), dated 04/03/11, with the quarterly MDS, dated 06/28/11, showed a decline in the following	F 274	The MDS coordinator will then randomly select 2 assessments quarterly x1 year for review and to determine if a significant decline or improvement occurred and if a SCSA was done. The results will be reported to the QA manager to be reviewed at the quarterly QA meetings.	11/22/11

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F 274	Continued From page 2 areas: Mood: Little interest or pleasure in doing things - symptom frequency over past two weeks increased from "never or 1 day" to "2-6 days (several days)." Functional Status: Walk in room - self performance and support declined from "limited assistance of one person" to "extensive assistance of two or more people." Functional Status: Walk in corridor - self performance and support declined from "limited assistance of one person" to "activity did not occur." Functional Status: Locomotion on unit - self performance and support declined from "limited assistance of one person" to "total dependence of one person." Functional Status: Eating - self performance and support declined from "supervision and setup help only" to "extensive assistance of one person." Bladder and Bowel: Urinary continence - declined from "always continent" to "frequently incontinent." Skin Conditions: Worsening in pressure ulcer status since prior assessment - increased from "none" to "two stage II" pressure ulcers. On 10/31/11 at 3:45 p.m., observation showed a certified nurse aide (CNA) (#1) transferred Resident #3 with a stand-up mechanical lift into the bathroom. The resident was incontinent of urine and also voided in the toilet. On 11/01/11 at 10:32 a.m., observation showed a licensed nurse (#7) changed the dressing on two Stage II ulcers on Resident #3's left heel. This is evidence the resident's assessed decline in June failed to return to his baseline.	F 274		

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F 274	Continued From page 3 The record lacked evidence the staff completed a SCSA for the resident's decline in mood, functional status, bladder continence, and skin condition.	F 274		
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 record review, review of professional references, resident interview, and staff interview, the facility failed to provide a safe environment for 1 of 2 sampled resident (Resident #6) using heat applications. Failure to assess the resident, and monitor the use of the hot packs resulted in Resident #6 receiving a second degree burn. Failure to provide staff education regarding the use of hot packs placed all facility resident using these devices at risk for injury. Findings include: Berman, Snyder, Kozier, Erb, "Kozier & Erb's Fundamentals of Nursing Concepts, Process, and Practice", 8th Edition, Pearson - Prentice Hall, New Jersey, pages 722, 931-933, states the following: * " . . . Applying Heat . . . the nurse needs to	F 323	Resident #6 along with all residents of this facility will reside in an environment that is free of accident hazards as much as possible and each resident will receive adequate supervision and assistance devices to prevent accidents. Nursing will assess the residents comfort status and implement appropriate comfort interventions. If a warm pack is deemed appropriate the nurse will follow the warm pack guidelines (See attachment # 1). The nurses will be educated on these guidelines for use of warm packs at the monthly nurses meeting scheduled for November 21st, 2011 until then the warm packs have been removed and are not being used. QA will monitor for facility compliance through general observation monthly x3 and quarterly for nine months thereafter. Immediate corrective action will be done if needed. If concerns are identified then education will be done at monthly nurses meetings by the DON. QA manager will report the findings at quarterly QA meetings for the year of 2012.	11/22/201

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F 323	Continued From page 4 follow these guidelines: * Determine the client's ability to tolerate the therapy. * Identify conditions that might contraindicate treatment (e.g., . . . circulatory impairment). . . . * Assess the skin area to which the heat . . . will be applied. * Ask the client to report any discomfort. * Return to the client . . . and observe the local skin area for any untoward signs (e.g., redness). Stop the application if any problems occur. . . . Preventing Specific Hazards: . . . In health care agencies, the risk of . . . burns is greater for clients whose skin sensitivity to temperature is impaired. . . . burns can occur from therapeutic applications of heat. . . ." The Centers for Medicare and Medicaid Service (CMS) state "the severity of the harm to the skin is identified by the degree of burn. Second-degree burns involve the first two layers of skin. These may present as deep reddening of the skin, pain, blisters, glossy appearance from leaking fluid, and possible loss of some skin." - Resident #6's medical record, reviewed October 31, 2011 - November 2, 2011, identified diagnoses including peripheral neuropathy, neck pain, and a burn on her right shoulder. The Minimum Data Set (MDS), dated 09/21/11, identified a Brief Interview of Mental Status (BIM) score of 14; indicating the resident was cognitively intact, and required extensive-to-total assist of 1-to-2+ [or more] persons for all Activities of Daily Living (ADLs) except for eating. Resident #6's current Plan of Care identified the following: ". . . Problem: . . . Neck pain . . . Burn to rt [right] shoulder. . . . Approaches: . . . has very fragile skin, handle gently with cares . . ."	F 323		

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F 323	Continued From page 5 The Department Notes identified the following: * 05/29/11 at 7:22 p.m., "Resident noted to have a 3.5 x [by] 4cm [centimeter] reddened area noted to Rt shoulder with a 1 x 1cm blistered center. This area appears to be a burn related to use of hotpacks. Resident denies pain to area. It has been reported that resident has been utilizing hot packs to neck today for c/o [complaints of] neck discomfort and stiffness. Reddened area is located in the area that the end of the hotpack is laying on her neck. Will initiate TAO [triple antibiotic ointment] and light dressing to area bid [twice daily] x 7 days per S.O. [standing order] and weekly documentation of area till resolved." * 05/30/11 at 10:48 a.m., ". . . Does have PRN [as needed] vic. [Vicodin - narcotic medication] which has been utilized as well as hot packs and topical rx [treatment]. Nothing abnormal noted upon assessment. Will monitor. . . ." The Doctor's Progress Notes identified the following: * 06/08/11, ". . . She has a burn that developed on her right shoulder area from a heating pad. This area is about the size of a 50-cent piece with a center scabbed-over area. There is no active drainage. The patient denies any pain. This does not appear to be infected though we are going to place Silvadene cream b.i.d. to the shoulder burn times two weeks. We will follow up at that time and determine its effectiveness as well as if there is any further intervention that is needed. . . ." * 06/15/11, ". . . The patient has a burn on her right shoulder area which is felt to be related to a heating pad. We stopped the Silvadene a couple days ago considering the area was looking red and moist and now she just has a light dressing applied. Upon seeing it today this does appear to	F 323		

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be improving. It is dry. She has a small central area that is scabbed over but it does appear not appear to be cellulitic or inflamed. There is a culture pending and we are waiting for that to return. . . ."
* 06/22/11, ". . . The patient has a burn on her right shoulder. . . . The area was inspected today and she did have a scab centrally with some surrounding chronic erythema. I did go ahead and take off the dressing today and the central scab did debride off and there do not appear to be signs of any infection. This appears to be healing nicely and her culture was negative. . . . We will follow her up on a p.r.n. basis. . . ."

The Resident Incident Report, dated 05/29/11 at 11:09 p.m., identified, ". . . Type of Injury: 1st degree burn . . . Equipment: heating pad . . . Associate Involved: [blank] . . . Reported to Supervisor: no . . . Narrative: Resident noted to have a reddened area to Rt shoulder with a fluid filled blister to the center of it. Area caused from heating pad that resident has been requesting by staff to apply to her neck that has been causing discomfort today. Reddened area measures 3.5 x 4 cm and fluid filled blister measures 1 x 1 cm. . . . Immediate Actions Taken: Area cleansed and TAO and Telfa applied per standing order. . . . Pain Scale: 0"

During an interview on 11/02/11 at 11:30 a.m., a managerial nurse (#5) stated the resident requested hot packs for "neck pain" and staff used the "packs throughout the day." She stated, "You warm them in the microwave for a minute and a half." She further stated the hot packs "were not on there [her shoulder] long." She indicated the resident "didn't feel it" (burning) and

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F 323	Continued From page 7 "didn't call" (for assistance). She further stated, "When they took it [the hot pack] off, it [her shoulder] was reddened". During an interview on 11/02/11 at 1:45 p.m., Resident #6 stated at the time of the incident "It hurt, I could tell right away it was too hot. It doesn't hurt any more." When asked if she told staff members she was in pain, she stated, "Yeah. They were still here. They took it off." When asked if staff checked her skin both before and after applying the hot pack, she stated, "Just after." During an interview on 11/02/11 at 1:55 p.m., the managerial nurse (#5) was unable to identify which staff member had applied the hot pack, how long the hot pack had been heated in the microwave prior to it's use, and whether the staff member had assessed Resident #6's skin both before and after use of the hot pack. When asked if hot packs continued to be used as an intervention for Resident #6, she stated, "I don't think she used them anymore. She is a slow healer." When asked if staff working the day/evening shift on 05/29/11 received further education regarding hot pack use, she stated, "I don't know." Upon surveyor request of a facility policy regarding heat application, the managerial nurse (#5) indicated she was unaware of any facility policy and/or tracking log regarding hot pack application. During an interview on 11/02/11 at 2:05 p.m., an administrative nurse (#4) confirmed the facility does not have a facility policy and/or tracking log regarding hot pack application. When asked if staff working the day/evening shift on 05/29/11	F 323		

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received further education regarding hot pack use, she stated, "No. It was a fluke. The staff have had education on that. There is a sheet on the microwave with instructions." The administrative nurse (#4) walked the surveyor down the hall to the staff meeting room. The sign posted on the front of the microwave read, "Hot Packs. Do not heat for longer than 1 minute and 15 seconds." The facility failed to provide further evidence of staff education regarding application of hot packs. No further information regarding the microwave and/or hot packs was provided at the time of the survey.

During an interview on 11/02/11 at 2:10 p.m., a nursing staff member (#6) stated, "I came onto the night shift, and [staff name] passed it on." The nursing staff member (#6) was unable to identify which staff member had applied the hot pack. When asked if staff working the day/evening shift on 05/29/11 received education regarding hot pack use, he stated, "No, they're trained on how to use them. It is even posted on the microwave." When asked what the procedure is for applying hot packs, he stated, "You're supposed to wrap the hotpack and put it on top of their [the resident's] clothes. When asked when the resident's skin should be assessed, he stated, "It is common sense to peek first, and when you take it off, to make sure there is no reddened areas." When asked if Resident #6 experienced any pain secondary to the burn, he stated, "[Resident #6] is good at letting us know if she has pain. She has tender skin." When asked if hot packs continued to be used as an intervention for Resident #6, he stated, "I don't believe so. I haven't heard of anyone using them on her since." When asked how he would classify a

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F 323	Continued From page 9 wound with a blister, he stated, "A blister usually indicates a second degree burn." Facility staff described Resident #6 as having "very fragile" and "tender skin", and being "a slow healer." Record review identified the resident obtained a second degree burn from "a heating pad" on 05/29/11. The incident report was incomplete, but did indicate the incident was not reported at the time it occurred. It is unknown if the facility staff member assessed the resident's skin before applying the hot pack. Staff interview revealed no further education regarding heat application had been provided to the staff. Failure to monitor the hot pack application resulted in Resident #6 receiving a second degree burn to the right shoulder and dressing changes for a month and a half. Failure to provide staff education regarding the use of hot packs placed all facility residents using these devices at risk for injury.	F 323		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (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	F 441		

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F 441	Continued From page 10 (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to follow acceptable infection control standards for 2 of 8 sampled residents (Resident #4 and #8) observed during personal cares. Failure to offer hand hygiene following toileting has the potential to increase the spread of infections to residents, staff, and visitors. Findings include: - On 10/31/11 at 3:00 p.m., observation identified	F 441	For resident #4 and #8 along with all residents of this facility will live in a safe, sanitary and comfortable environment to help prevent the development and transmission of disease and infection. The current policies and procedures are consistent with standards of practice. We recognize it failed acceptable infection control for resident hygiene for resident #4 and # 8. We have revised our hand washing/hand hygiene policy which includes education on resident hand washing/hand hygiene (See attachment #2). The CNA staff was educated on Nov. 14th, 2011. The nursing staff will be educated on Nov. 21st, 2011. The residents will be educated at the monthly resident council meeting on Nov. 17th, 2011. QA will monitor for facility compliance through general observation and interview of residents and staff monthly x3 and quarterly thereafter for 9 months. Immediate corrective action and or education will be done if needed. If concerns are identified the QA manager will review infection control policies at	

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F 441	Continued From page 11 a certified nurse assistant (CNA) (#1) assisted Resident #8 to the bathroom. Observation showed Resident #8 voided in the toilet and used tissue to wipe the perineal area. The CNA (#1) assisted the resident off the toilet and failed to offer hand hygiene to Resident #8. Upon leaving the bathroom, the CNA (#1) handed a piece of wrapped chewing gum to the resident, who unwrapped and placed the gum in her mouth. During an interview on 11/02/11 at 1:55 p.m., an administrative nurse (#4) identified the facility lacked a policy on handwashing and expected CNAs to offer hand hygiene to residents. - During an observation of personal cares on 11/01/11 at 9:30 a.m., two CNAs (#2 and #3) assisted Resident #4 to stand after toileting. The CNA (#2) provided perineal cares for Resident #4. During these cares, the resident scratched his genitals. After applying a clean brief and pulling up the resident's pants, the CNAs assisted the resident out of the bathroom. Both CNAs (#2 and #3) failed to cue or offer Resident #4 hand hygiene after using the bathroom. - During an observation of personal cares on 11/01/11 at 11:25 a.m., a CNA (#2) assisted Resident #4 to stand after toileting. The CNA provided perineal cares for Resident #4. During these cares, the resident scratched his genitals. After applying a clean brief and pulling up the resident's pants, the CNA assisted Resident #4 to his wheelchair and took the resident to the dining room for the noon meal. The CNA (#2) failed to cue or offer Resident #4 hand hygiene after using the bathroom.	F 441	departmental meetings. The infection control policy is also reviewed during annual all staff education. The QA nurse will give a report of findings at quarterly QA meetings.	11/22/2011