STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355085	A. BUILDING _____ B. WING _____	08/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIM CARE CENTER	3534 UNIVERSITY DR S FARGO, ND 58104

(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 08/19/13 and completed on 08/22/13, the sample included 5 residents for complete review, 16 residents for focused review, and 3 closed records for review. The sample included 1 additional resident to verify specific concerns during the survey.	F 000	This plan of correction constitutes our written allegation of compliance for the deficiency cited. However, submission of this plan of correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted	
F 314 SS=G	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 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 staff interview, the facility failed to provide the necessary treatment and services to prevent the occurrence and promote the healing of pressure ulcers for 2 of 4 sampled residents (Resident #1 and #3) and 1 of 2 closed record residents (Resident #22) with facility acquired pressures ulcers, and failed to provide established interventions for 2 of 2 sampled residents (Resident #17 and #18) assessed at risk for pressure ulcer development. Failure to provide timely and appropriate interventions and ensure staff consistently implemented existing interventions contributed to the development of	F 314	to meet requirements established by state and federal law. 1. Resident #18 has been discharged. Resident #22 is deceased. The intervention to elevate heels was removed from the care plan of Resident #17 as the mattresses on this unit have a heel slope making this unnecessary. Residents #1 and #3 were seen by the consulting wound nurse on 9/5/13. Care plans have been updated. 2. All residents are identified as high risk and considered for preventative measures.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

T Hager, Administrator — 9-26-13

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355085	A. BUILDING _____ B. WING _____	08/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIM CARE CENTER	3534 UNIVERSITY DR S FARGO, ND 58104

(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 1 new pressure ulcers and the deterioration of existing pressures. Findings include: Review of the facility policy titled "Skin Protocol" occurred on 08/22/13. This policy, reviewed August 2013, stated, ". . . PREVENTION: 1. All residents will have a skin risk assessment done on admission and weekly for 4 weeks . . . a. Residents who score moderate risk and above will be considered for preventive measures. b. Dietary will be notified and the resident will be assessed for additional nutritional interventions. c. Interventions to be considered: 1. Individualized reposition [sic] schedule (off loading); every hour while sitting, every 2 hours or more frequent when lying . . . 5. Nutrition plan-increase protein, nutritional supplements, . . . " - Resident #3's medical record, reviewed on all days of survey, identified diagnoses including a pelvic fracture on 06/12/13 and pressure ulcer identified on 07/07/13. A quarterly Minimum Data Set (MDS), dated 04/04/13, identified the resident as cognitively intact, and independent with bed mobility, transfer, and ambulation. The MDS also identified the resident at risk for pressure ulcers, had no pressure ulcers, and a pressure reducing device for the bed. A significant change MDS, dated 06/19/13, completed after Resident #3's hospitalization for increasing pain and a subsequent diagnosis of a pelvic fracture, identified the resident as cognitively intact, and required extensive assist of two persons for bed mobility, transfer, and nonambulatory. The MDS also identified the resident at risk for pressure	F 314	3. The "Skin Protocol" policy was updated to reflect that all residents are identified as high risk. Steps for prevention including, but not limited to, identifying interventions and monitoring implementation of those as well as defined protocol once a pressure ulcer has been identified (facility acquired or noted on admission) were developed. Other modifications include the formation of an IDT Wound Team to ensure consistency with documentation, measurements, interventions and their implementation. Measures will be implemented to improve documentation as to whether a pressure ulcer is avoidable or unavoidable by use of a Skin Communication Form. All nursing staff will be educated at a meeting on September 18, 2013 regarding the updated "Skin Protocol" policy. They will be re-educated on use of the Interact "Stop and Watch Tool" for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355085	A. BUILDING _____ B. WING _____	08/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIM CARE CENTER	3534 UNIVERSITY DR S FARGO, ND 58104

(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 2 ulcers, had no pressure ulcers, a pressure reducing device for the bed and chair, and frequent pain effecting sleep and activities. Review of Resident #3's Care Area Assessment (CAA) for pressure ulcers, dated 06/20/13, stated, ". . . Analysis of Findings . . . Indicators reviewed and The Team has determined that a potential skin integrity problem is present which is demonstrated by this resident's need for extensive assist with bed mobility and has potential for pressure ulcers. Cause: deconditioning, decreased mobility, hx [history] of anemia, back pain, pelvic fx [fracture], Onset: Prior to admission and return from hosp [hospital] Expected prognosis skin problem: Skin will remain intact. Risk factors: Further alterations in skin integrity. The Team's course of action will be: Skin preventive and treatment measures per the plan of care . . ." Review of Resident #3's current care plan stated, ". . . Problem: Potential for skin breakdown r/t [related to] nutritional factors and hx of backache. Has ulcer to L [left] heel. Goal: Resident will have intact skin. Approach: Is followed by wound nurse. Cleanse and dry skin and skin folds thoroughly. Apply lotion to dry skin prn [as needed]. Encourage fluid intake. Observe condition of skin every shift during cares. Observe reddened area for return of usual skin color. Report changes in skin condition to charge nurse. pressure reduction mattress on bed. Keep skin/linens clean and dry . . . " Resident #3's Wound Assessment dated 07/07/13, identified a Stage II pressure ulcer on the resident's left heel measuring 0.5 centimeter (cm) x 0.5 cm. A Resident Progress Note,	F 314	CNAs to notify nurses of any resident changes, including skin. 4. The Quality Assurance Coordinator will audit residents #1, #3 and #17 to assure the "Skin Policy" is being followed. These residents will be audited weekly x 4 weeks, monthly x 3 months and quarterly thereafter. Any residents with facility acquired pressure ulcers noted from August 22, 2013 and on will be audited in the same fashion. Results will be immediately reported to the Director of Nursing. If concerns are identified immediate corrective action will be taken. The Quality Assurance Coordinator will report results to the Quality Assurance Committee at each scheduled meeting. 5. See "Completion Date" column.	9/25/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355085	A. BUILDING _____ B. WING _____	08/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIM CARE CENTER	3534 UNIVERSITY DR S FARGO, ND 58104

(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 3 entered by the wound nurse on 07/11/13, stated, "Nonstageable left lateral heel ulcer with attached dry eschar. No erythema or drainage noted. 0.5 x 0.5 cm will keep open to air and dry. Continue to elevate heel while in bed." Resident #3's Wound Assessment and Follow Up - Event Form identified the following weekly measurements: * 07/07/13 - 0.5 cm x 0.5 cm * 07/17/13 - 1.7 cm x 0.8 cm * 07/24/13 - 0.5 cm x 0.4 cm * 07/31/13 - 2.0 cm x 1.0 cm * 08/07/13 - 1.9 cm x 1.4 cm * 08/14/13 - 1.1 cm x 1.5 cm Review of Resident #3's physician's orders identified the following: * 07/11/2013, "leave (l) [left] heel ulcer open to air, elevate heels while in bed with pillow BID [twice a day] " * 07/17/13, "Measure Stage II to left heel and chart in Matrix Once A Day on Wed [Wednesday]" * 08/02/2013 "PROSTAT [a protein supplement] 30 ml [milliliters] BID [twice a day] DX [diagnosis]: ulcer, pressure, heel." This nutritional intervention occurred 26 days after staff identified the pressure ulcer. Review of a faxed communication to the physician on 07/14/13, [eight days after identification of the pressure ulcer] stated, ". . . unstageable pressure ulcer noted to L) heel. 0.5 cm x 0.5 cm dry eschar noted. Painful area. Sees wound nurse [nurse's name] Daughter is requesting we use a sheep skin boot or Prevlon [sic] [a pressure relieving device] boot to relieve pressure to area. Is this ok? . . . Yes."	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355085	A. BUILDING _____ B. WING _____	08/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIM CARE CENTER	3534 UNIVERSITY DR S FARGO, ND 58104

(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 4 A physician's progress note dated 07/16/13, stated, ". . . still not really weightbearing with the left leg. He now has a heel ulcer. We did order a Prevalon boot yesterday . . . " The following observations of Resident #3 occurred during the survey: * 08/19/13 at 4:45 p.m., resident sitting in his room wearing gripper socks and feet elevated on the foot rest of the recliner and heels resting directly on the foot rest. * 08/20/13 at 8:27 a.m., two certified nursing assistants (CNAs) (#9) and (#10) transferred the resident from his wheelchair into the recliner using a total body lift. Once in the recliner the CNAs raised the foot rest and the resident's heels rested directly on the foot rest. * 08/20/13 at 3:15 p.m., a staff nurse (#8) removed the resident sock and assessed the pressure ulcer on the resident's left heel. The nurse (#8) reported the pressure ulcer measured 1.6 cm by 0.8 cm. The first entry in the progress notes regarding "floating" of Resident #3's heel was 07/11/13, (4 days after the identification of the left heel pressure ulcer). During an interview on the morning of 08/22/13, a staff nurse (#7) stated that "floated" means they are to elevate his heels with a pillow in bed or the recliner. During an interview on the morning of 08/22/13, an administrative nurse (#6) stated Resident #3's "skin assessment after his hospitalization was clear so we didn't put anything in place." A staff member (#6) stated, "he is repositioned for toileting." Resident #3's medical record and observations during the survey showed a urinary	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355085	A. BUILDING _____ B. WING _____	08/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIM CARE CENTER	3534 UNIVERSITY DR S FARGO, ND 58104

(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 5 catheter in place. The facility failed to implement a proactive approach to prevent Resident #3 from developing a pressure ulcer on his heel, when they had determined the resident's activities of daily living (ADLs) had changed from independent to extensive assist. This failure resulted in the development of an avoidable pressure ulcer on Resident #3's heel. - Review of Resident #1's medical record occurred on all days of survey. Diagnoses included a Stage 2 coccyx pressure ulcer (identified on 01/11/13), and a healed Stage 2 pressure ulcer to the top of the right foot. Observation showed a sore or abrasion on top of the resident's left foot. Physician's orders included the nutritional supplement Arginaid (a drink to promote wound healing) twice daily, Triad (an ointment to treat wounds) and gauze a dressing to the coccyx daily. The quarterly MDS, dated 07/30/13, identified Resident #1 required extensive assistance of two staff members for bed mobility, frequently incontinent of bowel and bladder, at risk for pressure ulcers, and one current Stage 2 pressure ulcer (coccyx). Resident #1's current care plan stated, "Problem: Alteration in skin integrity. Potential for skin breakdown. Skin breakdown. R/T [related to] Bony prominences. Pressure related to immobility . . . Ulcer to buttock . . . Approach: Keep towel between feet to help relieve pressure . . . Keep heels elevated off the bed with pillows . . . Observe condition of skin every shift during cares. Observe reddened area for return of usual	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355085	A. BUILDING _____ B. WING _____	08/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIM CARE CENTER	3534 UNIVERSITY DR S FARGO, ND 58104

(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 6 skin color. Pressure reduction cushion in wheelchair. Has gel in back and small pummel in front. Is resident's own cushion. pressure reduction mattress on bed. Prevent pressure on bony prominences. Report changes in skin condition to charge nurse. Turn and reposition 3 to 4 times q [every] shift and prn [as needed]. Wound care as ordered: See treatment sheet." The care plan failed to identify interventions to prevent the reoccurrence of the healed pressure ulcer on top of the Resident #1's right foot or the current sore or abrasion on top of her left foot. An initial wound assessment, dated 01/11/13, identified Resident #1's coccyx pressure ulcer measured 0.3 x 0.4 cm. Progress notes identified the pressure ulcer healed on 03/17/13, reopened on 04/08/13, and measured 4.0 x 1.8 cm and 0.3 cm in depth on 04/09/13. An assessment, dated 08/20/13, identified the unhealed coccyx pressure ulcer measured 1.0 x 0.3 cm and a depth of 0.4 cm. On 04/09/13, an initial wound assessment identified a Stage 2 pressure ulcer located on the top of Resident #1's right foot and measured 2.0 x 1.0 cm. The last assessment of this ulcer, dated 04/30/13, identified the ulcer measured 0.8 x 0.8 cm. The medical record showed no further documentation of the right foot pressure ulcer. Observation on 08/19/13 at 4:55 p.m. showed two CNAs (#9 and #10) positioned Resident #1 on the edge of the bed. One CNA (#10) informed the other CNA (#9) the need to put the resident's shoes on before they transferred her into the wheelchair. The CNA (#9) stated Resident #1 has a sore on top of her left foot and is not to wear shoes until the sore healed and the CNA (#10)	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355085	A. BUILDING _____ B. WING _____	08/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIM CARE CENTER	3534 UNIVERSITY DR S FARGO, ND 58104

(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 7 applied slippers to the resident's feet instead. Resident #1's plan of care failed to identify Resident #1 had a sore or abrasion on top of her left foot and lacked the intervention of "no shoes," as a part of the treatment plan for this sore or abrasion. Observation on 08/20/13 at 8:33 a.m. showed two CNAs (#12 and #13) assisted Resident #1 from the toilet to a wheelchair and transported her to an area adjacent to the nurses station. Observation showed the resident's feet crossed, placing pressure on the top of her feet. The CNAs failed to place a towel between the resident's feet. Observation on 08/20/13 at 12:07 p.m. showed three CNAs (#9, #10, and #11) transferred Resident #1 from the her wheelchair to bed. The CNA (#10) positioned the resident on her right side and placed a pillow under her right calf. Observation showed Resident #1's feet crossed and resting directly on the bed. The CNAs failed to elevate the resident's heels off the bed (as care planned) and failed to place a towel between her feet. Observation on 08/20/13 at 2:45 p.m. showed a nurse (#8) removed the sock from Resident #1's left foot and stated, ". . . getting smaller." The nurse then put the sock back on her foot. Observations on 08/21/13 at 11:25 a.m., 1:15 p.m., and 2:25 p.m., showed Resident #1 seated in her wheelchair, her feet pointed inward and crossed, placing pressure on the top of her feet. The staff failed to place a towel between the resident's feet per the care plan. The lack of developing and implementing	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355085	A. BUILDING _____ B. WING _____	08/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIM CARE CENTER	3534 UNIVERSITY DR S FARGO, ND 58104

(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 8 preventive approaches to address Resident #1's history and risk for pressure ulcers places the resident at risk for additional avoidable pressure ulcers. - Review of Resident #22's closed medical record occurred on August 21-22, 2013 and identified the facility admitted the resident to Hospice on 06/16/13 and she expired on 08/10/13. Diagnoses included dementia, weakness, a coccyx pressure ulcer (07/05/13), and right ischium pressure ulcer (07/25/13). The significant change MDS, dated 06/21/13, identified the resident required extensive assistance of two staff members for bed mobility, frequently incontinent of bowel and bladder, and at risk for pressure ulcers. Resident #22's current care plan identified the following problems and interventions: * "Nutrition . . . Open areas . . . Provide supplements: Boost pudding one can BID [twice daily] r/t [related to] open areas . . ." (Initiated on 07/25/13, 10 days after the identified of the coccyx pressure ulcer). * "Potential for skin breakdown. R/T . . . immobility . . . Apply lotion to dry skin prn. Apply skin barrier to peri area with AM and HS [bedtime] cares and after incontinence episodes. Cleanse and dry skin and skin folds thoroughly. Encourage fluid intake. Keep heels elevated off the bed with pillows. Keep skin/linens clean and dry. Observe condition of skin every shift during cares. Observes reddened area for return of usual skin color. pressure reduction mattress on bed. Prevent pressure on bony prominences. Report changes in skin condition to charge nurse." The care plan failed to address Resident #22's	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355085	A. BUILDING _____ B. WING _____	08/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIM CARE CENTER	3534 UNIVERSITY DR S FARGO, ND 58104

(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 9 coccyx and right ischium pressure ulcers, wound treatments, and the necessary repositioning needs for for this resident who required extensive assistance for bed mobility. Review of Resident #22's wound assessments identified the following: * 07/05/13 - Initial wound assessment - Stage 2 coccyx pressure ulcer - Size: 1.0 cm by 1.0 cm (length by width) - Percent [%] of tissue type: 75% epithelial (new pink or shiny tissue that grows in from the edges on the ulcer surface) and 25% slough (yellow or white tissue that adheres to the ulcer bed) - surrounding tissue intact * 07/12/13 and 07/19/13 - Stage 2 coccyx pressure ulcer - Size: 1.0 cm by 1.0 cm - Percent of tissue type: 75% epithelial and 25% slough * 07/26/13 - Initial wound assessment - Stage 2 right ischium pressure ulcer - Size: 1.0 cm by 1.0 cm and 0.25 cm in depth - Percent of tissue type: 75% epithelial * 08/02/13 - Stage 2 right ischium pressure ulcer - Size: 7.0 by 4.0 cm and 0.35 cm in depth - Percent of tissue type: 95% slough and 5% eschar/necrotic - Surrounding skin status: erythematous - * 08/09/13 - Unstageable right ischium pressure ulcer - Size: 17.0 cm by 8.0 cm and 0.4 cm in depth - Percent of tissue type: 95% slough and 5% eschar/necrotic A dietary progress note, dated 07/25/13 (10 days after the onset of the coccyx pressure ulcer), stated, "Noted two Stage II open areas coccyx/ischium. Protein needs 73 GM's [grams], protein intake approx [approximately] 30-60 GM's per day. Meal intake inconsistent. H/O [history of] no [sic] accepting nutritional supplements, will attempt to provide. Also will request MVI/minerals	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355085	A. BUILDING _____ B. WING _____	08/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIM CARE CENTER	3534 UNIVERSITY DR S FARGO, ND 58104

(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 [multivitamin with minerals] Care plan revised." Although the facility identified Resident #22's risk for pressure ulcers on 06/21/13, the plan of care did not include any identified problem and preventive approaches/interventions related to the resident's risk factors. During an interview on 08/22/13 at 9:45 a.m., an administrative nurse (#6) stated she expected the direct care staff to reposition residents with pressure ulcers every couple of hours and report any skin problems to the nurse. The facility's failure to develop preventive interventions, implement established interventions, and communicate the interventions to all staff members may have contributed to Resident #3 and #22's pressure ulcers. - Review of Resident #17's medical record occurred on August 19-22, 2013. Diagnoses included nutritional deficiency, debility, muscle weakness, and history of pubic fractures. The admission MDS, dated 08/09/13, identified the resident as having severely impaired cognition and requiring extensive assistance for bed mobility, transfers, walking in room, locomotion on/off unit, dressing, toilet use, and personal hygiene. The Pressure Ulcers CAA, also dated 08/09/13, further identified, ". . . a potential skin integrity problem is present which is demonstrated by this resident's need for extensive assist with bed mobility and resident's potential for pressure ulcers. . . ." Resident #17's current care plan stated, "Problem: Skin Integrity . . . Approach: . . . Keep heels elevated off the bed with pillows. . . ."	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355085	A. BUILDING _____ B. WING _____	08/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIM CARE CENTER	3534 UNIVERSITY DR S FARGO, ND 58104

(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 11 Review of Resident #17's progress notes identified the following: * 08/06/13 - ". . . Resident has [a] small blanchable reddened area to R) [right] heel. . . ." There were no further notations regarding the area identified on Resident #17's right heel in the progress notes. Observations on 08/21/13 at 3:30 p.m. and 4:18 p.m. showed Resident #17 in bed with her heels resting directly on the bed. Staff failed to elevate the resident's heels off the bed with pillows. - Review of Resident #18's medical record occurred on August 19-22, 2013. Diagnoses included nutritional deficiency, muscle weakness, and history of a hip fracture. The admission MDS, dated 07/25/13, identified the resident as having moderately impaired cognition and requiring extensive assistance for bed mobility, transfers, locomotion on/off unit, dressing, toilet use, and personal hygiene. The Pressure Ulcers CAA, also dated 07/25/13, further identified, ". . . a potential skin integrity problem is present which is demonstrated by this resident's need for extensive assist with bed mobility, frequent incontinence, and resident's potential for pressure ulcers. . . ." Resident #18's current care plan stated, "Problem: Skin Integrity . . . Approach: . . . Keep heels elevated off the bed with pillows. . . ." Observation on 08/22/13 at 9:50 a.m. showed a CNA (#4) transferred Resident #18 into bed, and placed a pillow beneath his knees. The resident laid on his back with his heels resting directly on the bed. Staff failed to elevate the resident's heels	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355085	A. BUILDING _____ B. WING _____	08/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIM CARE CENTER	3534 UNIVERSITY DR S FARGO, ND 58104

(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 12 off the bed with pillows. During an interview 08/22/13 at 10:10 a.m., a nursing staff member (#5) confirmed, "[Resident #17] and [Resident #18] heels should be floated. Their heels should be off the pillow and off the bed. It's preventative." Failure to float Resident #17 and #18's heels when in bed may result in the residents developing skin breakdown and/or worsening of Resident #17's reddened heel.	F 314		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced	F 425	1. Resident #25 receives his medication from the VA via the mail. All mail is delivered to the front desk where it is sorted by the receptionist and distributed by activity staff. Receptionists and activity staff were notified regarding the policy "Pharmacy-Ordering and Receiving Medications." 2. All residents who receive their medications via the mail have the potential to be affected. 3. The "Pharmacy-Ordering and Receiving Medications" policy was reviewed with no changes noted. All staff will be educated regarding #6 of this policy at a meeting on September 18, 2013.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355085	A. BUILDING _____ B. WING _____	08/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIM CARE CENTER	3534 UNIVERSITY DR S FARGO, ND 58104

(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 425	Continued From page 13 by: Based on observation, review of policies/procedures, and staff interview, the facility failed to ensure medications for 1 of 1 resident (Resident #25) received by mail order were promptly secured when delivered to 1 of 3 nurses' stations (Station One). Not properly securing medications has the potential for drug diversion by staff, visitors, and residents. Findings include: Review of the facility policy titled "Pharmacy-Ordering and Receiving Medications" occurred on 08/22/13. This policy, dated November 2012, stated, ". . . 6. Receiving medications: Medications brought in to/delivered to the facility may be accepted by a licensed nurse. . . Medications are stored in a secure area until checked in. . . ." On 08/21/13 from 10:50 a.m. to 11:10 a.m. observation of the counter at Station One, located near the facility's front entrance, revealed two large, white envelopes, one opened and one unopened, from a mail order pharmacy addressed to Resident #25. Observation showed staff, visitors, and residents passed by Station One with the envelopes assessable on the counter. Staff entered Station One several times but failed to secure the medications. During an interview at 11:10 a.m. on 08/21/10, a nursing staff member (#1) stated medications by mail order should be placed in the locked medication room in that nurses' station when received and should not be left on the counter. The nurse then opened the envelope which contained a large bottle labeled Folic Acid 1	F 425	4. The Quality Assurance Director will audit resident #25 for proper distribution of mail order medications according to the policy. These audits will be conducted weekly x 1 month, monthly x 3 months and quarterly thereafter. New admissions who receive medications via the mail will be audited in the same manner. Results will be immediately reported to the Director of Nursing. If concerns are identified, immediate corrective action will be taken. The Quality Assurance Coordinator will report results to the Quality Assurance Committee at each scheduled meeting. 5. See "Completion Date" column.	9/25/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355085	A. BUILDING _____ B. WING _____	08/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIM CARE CENTER	3534 UNIVERSITY DR S FARGO, ND 58104

(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 425	Continued From page 14 milligram (mg) and a large bottle labeled Potassium 10 milliequivalents. The other already opened envelope contained a large bottle labeled Trazadone 100 mg forty-five tablets. During an interview on 08/22/13 at 9:30 a.m., an administrative nurse (#2) stated nursing staff are required to lock all medications left at the nurses' station in the medication room.	F 425		
F 502 SS=D	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on observation, review of policies/procedures, and staff interview, the facility failed to ensure laboratory (lab) supplies of vacutainers (blood draw vials) in 1 of 3 medication rooms (5th Avenue) were not expired. Using expired collection tubes for blood analysis of residents has the potential for inaccurate lab results. Findings include: Review of the facility policy titled "Central Venous Cath [catheter] - PICC [peripherally inserted central catheter]" occurred on 08/22/13. This policy, dated August 2012, stated, ". . . E. BLOOD DRAW. . . 5. Lab supplies are provided by an outside vendor. Staff are to check supplies for expiration date prior to drawing blood. . . ."	F 502	1. No residents were affected 2. All residents with a Port, PICC, or Central Venous Catheter (single/multi lumen/Hickman) have the potential to be affected. 3. The facility policies for blood draws for residents with a Port, PICC, or Central Venous Catheter were reviewed with no changes noted. All nurses will be educated regarding the checking of all vacutainers (tubes) for expiration dates prior to use at a meeting on September 18, 2013. All vacutainers will be stored in a central area. The expiration dates will be checked monthly and re-ordered as needed by the Supply Clerk.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355085	A. BUILDING _____ B. WING _____	08/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIM CARE CENTER	3534 UNIVERSITY DR S FARGO, ND 58104

(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 502	Continued From page 15 On 08/21/13 at 11:25 a.m. an observation in the 5th Avenue medication room revealed seventy-one expired vacutainers including: * Lavender top - twenty-three expired July 2013 * Gold top - forty-one expired March 2013 * Red top - two expired December 2012 * Blue top - five expired December 2012 During an interview on 08/21/13 at 11:30 a.m., a nursing staff member (#3) stated supply order staff and/or night nurses are to check the medication room for expired medications/supplies. In addition, nursing staff are also to check expiration dates before using medications/supplies, but there is a potential to miss an expired vacutainer. She stated vacutainers are used more on the 5th Avenue wing than other wings due to residents having intravenous and PICC lines.	F 502	4. The Quality Assurance Director will audit the vacutainer supply weekly x 1 month, monthly x 3 months and quarterly thereafter. Results will be immediately reported to the Director of Nursing. If concerns are identified, immediate corrective action will be taken. The Quality Assurance Coordinator will report results to the Quality Assurance Committee at each scheduled meeting. 5. See "Completion Date" column.	9/25/13