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 _____	08/22/2012

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 August 19, 2012 and completed on August 22, 2012 the sample included five (5) residents for complete review, sixteen (16) residents for focused review, and three (3) closed records for review. The sample included twelve (12) additional residents to verify specific concerns during the survey.	F 000		
F 156 SS=C	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.	F 156		

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

9-20-12

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

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F 156	Continued From page 1 The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.	F 156	1. Residents #22 and #28 have been discharged. Resident #26 has expired. Resident #27 still resides at the facility. The correct form is being given to her guardian. The other residents did receive the information on how to appeal on the SNFABN form and verbally from the Medicare Coordinator, just not the Denial Letter. 2. All residents are informed, written descriptions given, and postings present as per regulation. Any resident admitted after March 2012 until August 22, 2012 had the potential to be affected. 3. Effective August 22, 2012, the SNFABN and Denial Letters are being used. The Medicare Coordinator will continue to attend workshops and trainings as indicated. She will continue to receive updates from AANAC and CMS regarding Medicare issues. Any further changes in format will be reviewed with the Elim Corporate QA nurse prior to implementation. She was notified of these measures to be effective immediately on September 17, 2012.	

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F 156	Continued From page 2 The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on record review, review of professional reference, and staff interview, the facility failed to provide appropriate liability and appeal notices for 4 of 5 closed resident billing records reviewed (Resident #22, #26, #27, and #28). Failure to provide residents with the appropriate notices did not allow them the option to request review of discontinued services by Medicare.	F 156	4. The Quality Assurance Coordinator will audit all Medicare A residents for appropriate SNFABN notification and Denial Letters from March 2012 through August 22, 2012 and send correct notices as applicable. She will then continue to audit like residents 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.	~~11/22/12~~ 10-10-12 HS per TC E Dor on. 9-25-12

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F 156	Continued From page 3 If a skilled nursing facility (SNF) provider believes on admission or during a resident ' s stay that Medicare will not pay for skilled nursing or specialized rehabilitative services and the provider believes that an otherwise covered item or service may be denied as not reasonable and necessary, the facility must inform the resident or his/her legal representative in writing why these specific services may not be covered and the beneficiary ' s potential liability for payment for the non-covered services. The Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN) and the Denial Letters also inform the beneficiary of his/her right to have a claim (i.e., demand bill) submitted to Medicare. The SNF must file a claim when requested by the beneficiary. The facility may not charge the resident for Medicare covered Part A services while the decision is pending. Findings include: Review of the Centers for Medicare & Medicaid Services internet site, cms.gov, occurred on 08/22/12. This site, modified on 04/16/12, stated "Medicare, Beneficiary Notices Initiative (BNI), FFS (Fee For Services) SNFABN (Skilled Nursing Facility Advanced Beneficiary Notice) and SNF Denial Letters . . . Skilled Nursing Facilities are required to issue a liability notice before extended care item(s) and/or service(s), are initiated, reduced or terminated and Medicare is not expected to pay. SNFs may use either the Skilled Nursing Facility Advance Beneficiary Notice or one of the five SNF denial letters. . . ."	F 156		

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F 156	Continued From page 4 Review of files for residents discharged from Medicare services occurred on 08/22/12. The files identified the facility provided these residents or their responsible parties with the notice of discharge from services and the end of services dates as follows: *Resident #22 - 06/26/12 and 06/30/12 *Resident #26 - 05/10/12 and 05/16/12 *Resident #27 - 06/26/12 and 06/30/12 *Resident #28 - 08/01/12 and 08/05/12 These resident files lacked the SNFABN or a Denial Letter which would provide the resident or their responsible party with an option for review by Medicare. During interview, on 08/22/12 at 12:30 p.m., a supervisory nursing staff member (#7) designated as responsible for providing the Beneficiary Notices to facility residents, reported the facility began combining notices of non-coverage in March 2012 and discontinued the use of the SNFABN and Denial Letters. The combined form referenced by the staff member (#7) is identified on the CMS internet site as applicable to Medicare Advantage only.	F 156		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced	F 246		

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F 246	Continued From page 5 by: Based on observation, record review, staff interview, and resident interview, the facility failed to ensure reasonable accommodation of individual needs regarding positioning at the dining table for 1 of 16 sampled residents (Resident #15) and two supplemental residents (Resident #29 and #30) and failed to accommodate individual needs for 1 of 1 sampled resident (Resident #10) with post-surgical hip precautions. Failure to provide a dining room table at appropriate height to meet individual needs and failure to position residents appropriately at the dining table limited the residents' access to meal items and may contribute to weight loss, limited quality of dining experience, and may cause discomfort related to improper positioning. Failure to accommodate Resident #10's individual needs with a pillow between his knees in bed and an elevated toilet seat placed the resident at risk of injury and hip dislocation. Findings include: - Observations of Resident #15 seated in a low reclining wheelchair in the Dakota Court Dining Room showed the following: * 08/20/12 at 8:00 a.m. and 11:30 a.m.. - Dining table positioned at upper chest level which required the resident to reach with shoulders elevated to access food. When reaching for food items on the table Resident #15 dropped food on her lap. Resident #15 reached a bowl of fruit and ate it while holding it in her lap. * 08/21/12 at 7:50 a.m. - Dining table positioned at shoulder level. Resident #15 reached with forearms on the table and shoulders elevated to	F 246	1. Documentation will be provided and care planned that Residents #15, #29 and #30 or their designees have been educated as to the risks and benefits of table positioning and what their preference is. Resident #15 was screened by OT due to her Broda chair. Resident #10 – Staff were educated regarding Hip Precautions and a toilet riser was placed in this bathroom. Resident was discharged with Hip Precaution education. 2. All residents eating in the dining rooms and on Hip Precautions have the potential to be affected. 3. A meeting will be held on October 10, 2012 for all nursing staff regarding proper positioning and Hip Precautions. This in-service will be conducted by the OT and PT therapists. Staff will be reminded of the use of the "Therapy Triggers for Referral" form. The "Dining Assistance" policy will be reviewed and updated as needed. Focus will include resident rights and honoring preferences for those that consistently choose to sit with those who do not allow for proper positioning. Choices of different	

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F 246	Continued From page 6 access a glass of juice and then set it at the edge of table. * 08/22/12 at 8:20 a.m. - Dining table positioned at mid chest level with her wheelchair back positioned at approximately a 70 degree angle. Resident #15 leaned forward and reached with elevated shoulders to access food. She dropped jelly and a sausage link on her clothing protector. Facility staff placed Resident #15 at three varying height tables during the above observations. Record review for Resident #15 occurred on August 20-22, 2012. Medical diagnoses included osteoarthritis, dementia, and dysphagia. The quarterly Minimum Data Set (MDS), dated 06/07/12, identified severe cognitive impairment, supervision with eating and set up help required, and extensive assist with locomotion on and off the unit. Resident #15's current care plan identified the following: " . . . Problem: Potential for discomfort R/T [related to] Osteoarthritis History of . . . shoulder pain . . . Evaluation Notes: . . . Continues to receive a duragesic patch for H/O [history of] arthritic pain. . . . " - Observation on 08/22/12 at 8:30 a.m. showed Resident #29 seated in a dining room chair with her legs dangling approximately two to three inches from the floor. Resident # 29 would occasionally rest her feet on the legs of the table. - Observation of Resident #30 eating meals in the dining room occurred on 08/21/12 at 5:40 p.m. and 08/22/12 at 8:40 a.m. Observation showed the table at Resident #30's chest level. The	F 246	seating options (chairs, overbed tables, etc.) will be offered, risks and benefits explained and decisions care planned. Residents with Hip Precautions will have those posted in their rooms and all equipment available. Emphasis will also be on following care profile and care plan. The facility is currently assessing new toilets for this area that are higher. 4. The Quality Assurance Coordinator will audit Resident #15 to assure OT recommend-ations are followed. She will conduct random audits in collaboration with the OT Therapist for proper positioning in the dining rooms weekly x 1 month, monthly x 3 months, and quarterly thereafter. Random audits for residents admitted with Hip Precautions will also be conducted 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.	10-10-12 11/22/12

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F 246	Continued From page 7 resident held her elbows at shoulder level while cutting her food and reaching for food items. An interview with an administrative staff member (#9) occurred on 08/22/12 at 8:45 a.m. When asked for dining room seating assessments for Resident #15, #29, and #30 the staff member referred to a "Therapy Triggers For Referral" form. She stated the triggers on the form alert staff members to notify therapy if assessment is needed. Triggers included "Feet do not touch floor" and "To [sic] far from table due to wheelchair." The facility provided no further information regarding seating assessments. An administrative staff member (#9) confirmed dining room tables are at varying heights, staff should place Resident #15 at a lower table, and Resident #29 should have a lower chair. - Review of Resident #10's medical record occurred on August 20-22, 2012. The facility admitted the resident in June 2012. Admission diagnoses included post-surgical left hip replacement. The medical record identified the resident's left hip was previously surgically replaced and dislocated on at least two occasions before dislocating and requiring surgical replacement in May 2012. The resident's 30 day MDS, dated 07/17/12, identified Brief Interview for Mental Status (BIMS) score of "12" indicating moderate cognitive impairment, no short or long term memory problems, fluctuating disorganized thinking, required extensive assistance of two or more persons for bed mobility, transfers, and toileting, and was 68 inches tall. The facility identified Resident #10 was interviewable and anticipated discharge to his home on 08/21/12.	F 246		

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F 246	Continued From page 8 Resident #10's physician orders included the following: *06/19/12 - ". . . TOTAL HIP PRECAUTIONS . . . Special Instructions: 2 pillows between knees in bed at all times." *06/19/12 - "No bending past 90 degrees. No crossing legs, no twisting of legs/hips. . . .." Resident #10's current care plan, dated 06/19/12, stated "Problem, Alteration in elimination r/t [related to] incontinence of bladder and bowel . . . Approach . . . Prompt toilet with 1 assist . . . Problem, Alteration in mobility r/t mobility dysfunction, impaired sense of balance, limited ROM [range of motion], weakness. . . . Approach, Is full weight bearing to left leg. TOTAL HIP PRECAUTIONS. See illustrated sheets placed in resident's room re: hip precautions. . . ." Observation on August 20-22, 2012 failed to identify the "illustrated sheets" available for Resident #10 or facility staff. Resident #10's Resident Profile, used as a care guide by the facility's certified nursing assistants (CNAs), identified the Approaches from the resident's care plan. Resident #10's Profile also stated, dated 07/17/12, "ADL [Activities of Daily Living]: Toileting: Uses toilet, assist [of] 1 to transfer . . .;" and, dated 08/20/12, "ADL: Bed Mobility: Independent w/ [with] side-side, legs in/out, Independent up to HOB [head of bed]." The resident's care plan and Resident Profile did not identify use of a toilet seat riser. A toilet seat riser would prevent the resident from sitting too low and bending his hip greater than 90 degrees. Observation identified Resident #10 in bed without a pillow between his knees as follows:	F 246		

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F 246	Continued From page 9 *08/19/12, approximately 1:35 p.m. during the initial tour, supine. *08/20/12, 8:38 a.m. - self transferred, supine. *08/20/12, 2:20 p.m. - supine. *08/20/12, 3:10 p.m. - left side lying. *08/20/12, 4:55 p.m. - supine. *08/21/12, 8:55 a.m. - supine. Observation of Resident #10's private bathroom identified a toilet of approximately 15 inches in height without an elevated toilet seat. Observation showed the resident seated on the toilet with staff assistance. Observation showed the resident seated with his hip at or greater than 90 degrees bend as he leaned forward to stand up. The elevated toilet seat would prevent him from sitting too low and minimize his need to lean forward to stand up. During interview, on 08/20/12 at 8:40 a.m., Resident #10 reported "They need risers on the toilet seats." indicating he has some difficulty rising from the toilet and he has an elevated toilet seat at home. During observation, on 08/20/12 at 3:15 p.m., after completion of toileting with the assistance of a CNA (#10) Resident #10 stated "Should have higher toilet, that's what I have at home." During interview, after toileting, the resident reported the facility staff did not provide him with pillows between his knees. He reported he was aware of the importance of pillows between his knees and did use them at home on occasion. Resident #10 reported he dislocated his hip on three or four occasions at home when he did not have a pillow between his knees in bed.	F 246		

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F 246	Continued From page 10 During interview, on 08/20/12 at 4:15 p.m., a physical therapy staff member (#11) reported the facility was aware of the need for higher toilets for some residents. The staff member (#11) agreed Resident #10 would benefit from a higher toilet seat as a safety measure to limit his hip bending greater than 90 degrees and to aid in rising due to his height. This staff member also reported the facility had used toilet seat risers that did not fit well on the toilets in the facility and was in the process of ordering others that would fit the toilets. The staff member was unaware of any options being considered or used until arrival of the new toilet seat risers. During this interview, physical therapy staff member (#11) reported Resident #10 should have a pillow between his knees while in bed, as ordered. This staff member reported a copy of the hip surgery precautions and instructions are provided in the resident's room and will be provided to Resident #10 and his family at the time of discharge, anticipated 08/21/12. The staff member provided a copy of the discharge instructions. Review of the discharge instructions for Resident #10, provided by physical therapy staff member (#11) occurred on 08/21/12. The instructions stated ". . . PRECAUTIONS, To practice safe movement until your hip replacement has fully healed, you will need to take several precautions to avoid dislocation: 1. Do not bend your operated hip beyond a 90 [degree] angle. . . . 3. Do not cross your operated leg. . . . Do Not Cross Your Operated Leg or Ankle Over Your Non-Operated Leg. While sleeping or lying	F 246		

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F 246	Continued From page 11 in bed, keep a pillow between your legs to prevent hip dislocation. . . ." During interview, on 08/21/12 at 7:45 a.m., a supervisory nursing staff member (#7) confirmed the physician's orders regarding a pillow between the knees are included on Resident #10's Resident Profile used by the CNAs. This staff member reported a toilet seat riser had been used in the past for Resident #10 and she was uncertain why it was not used now. Failure to ensure use of pillows between Resident #10's knees and failure to care plan and provide an alternative toilet seat riser until a permanent solution was determined did not accommodate Resident #10's individual needs and may have placed him at risk of injury and dislocation of his surgically repaired left hip.	F 246		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to provide an ongoing, individualized, and meaningful activity program to meet the needs of 1 of 5 sampled residents	F 248		

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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 248	Continued From page 12 (Resident #12) with impaired cognition. Failure to implement an individualized activity program to respond to the interests and current capabilities of the resident has the potential to negatively affect the resident's psychosocial well-being. Findings include: Observation of Resident #12 showed the following: 08/20/12 * 8:45 a.m. - Resident #12 in the Fireside Room in a Broda chair holding a stuffed animal with the television (TV) on * 9:55 a.m. - Resident #12 taken to her room for cares and returned to the Fireside Room with the TV on * 11:30 a.m. - Resident #12 asleep in the wheelchair in the Fireside Room with the TV on. * 3:15 p.m. - Resident #12 in bed with a blanket over her face * 4:00 p.m. - Resident #12 taken to the Fireside Room with the TV on * 5:30 p.m. - Resident #12 in the Fireside Room with the TV on a news channel 08/21/12 * 7:30 a.m. - Resident #12 in the Fireside Room with the TV on a news channel * 8:00 a.m. - Resident #12 taken to her room for medications and returned to the Fireside Room with the TV on * 12:30 p.m. - Resident #12 in the Fireside Room 08/22/12 * 8:30 a.m. - Resident #12 in the Fireside Room, with the TV on a news station.	F 248	1. Resident #12 has been placed on weekly 1-1 visit schedule. Resident's care plan has been updated to reflect this. 2. Recreation Department has developed a 1-1 visit policy to insure all residents are met. 3. All recreation staff will be in-serviced on this policy on October 10, 2012. 4. Director of Recreation will audit the implementation of the policy monthly for the first quarter and once a quarter for the rest of the year. 1-1 Policy will be reviewed yearly. 5. See "Completion Date" column.	daily Per TC Recreation Director on 10-1-12 10/10/12

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	355085	A. BUILDING _____ B. WING _____	08/22/2012

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F 248	Continued From page 13 Review of Resident #12's medical record occurred on August 20-22, 2012. Diagnoses included intellectual disability, aphasia, and anxiety. Resident #12's Minimum Data Set (MDS), dated 07/18/12, identified the resident as severely impaired with daily decisions, required total assistance with locomotion on and off the unit, and had no behaviors. Resident #12's current care plan, updated on 04/24/12, stated " . . . Problem: Resident attends group programs, but usually just watches from the sidelines with little or no actual participation. Goal: Resident will attend activity programs as an observer only such as music programs, chapel services, current events, trivia and story time 3x [times] week by next re-evaluation date. Approach: Encourage family/significant others to visit as often as possible. Invite and encourage family to attend activities with resident. Encourage participation in group activities of interest. Assist to activities consistent with past interests. Resident enjoys having her back and head rubbed, likes to people watch and enjoys watching television. Resident loves stuffed animals, blankets and dolls. . . ." Review of the "Activity Routine and Preferences Short Assessment" report, dated 07/18/12, identified " . . . Leisure interests: . . . music . . . talking or conversing . . . watching TV/movies . . . Resident's Preferred Program Style:1:1 [one to one], Large groups, Independent leisure . . . Resident is out of her room for much of the day. She spends her time in the lounge area watching TV as well as observing the happenings around her. Resident often has a stuffed doll and blanket with her. Resident will place the blanket over her	F 248		

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F 248	Continued From page 14 head when she does not want to be bothered or is tired. Resident enjoys the one to one attention she receives from staff as they will often times rub her head and neck for her. On a regular basis, resident receives massages from a massage therapist. Resident will occasionally attend special music programs, sing-a-longs and religious services. Resident has a diagnosis of mental retardation and is unable to communicate verbally; she does respond with noises and smiles though. Resident is dependent on staff to escort her to and from programs. . . . " Review of Resident #12's activity progress notes from 05/30/12 to 08/18/12 lacked documentation of Resident #12 attending any activities. Review of Resident #12's Activity Participation Chart identified the following: January 2012 - TV is documented as the only activity for 16 of 31 days with two days of no activities documented. February 2012 - TV is documented as the only activity for 16 of 29 days. March 2012 - TV is documented as the only activity for 13 of 28 possible days with two days of no activities documented. April, May, and June 2012 - An administrative activity staff member (#18) stated he was unable to locate activity documentation for these months. July 2012 - TV is documented as the only activity for 8 of 31 days with three days of no activities documented. August 2012 - TV is documented as the only activity for 9 of 21 possible days. During an interview on 08/22/12 at 11:10 a.m., an administrative activities staff member (#18) stated	F 248		

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F 248	Continued From page 15 staff do not bring Resident #12 to religious services as she had been disruptive at times. During an interview on 08/21/12 at 11:40 a.m., an activity staff member (#19) stated Resident #12 really enjoys the one to one attention from another resident and agreed that staff could provide more one to one activities for Resident #12.	F 248		
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: 1. Based on observation, review of manufacturer's instructions, policy and procedure review, record review, and staff interview, the facility failed to properly administer medication to 1 of 1 sampled resident (Resident #8) and 5 of 5 supplemental residents (Resident #32, #33, #34, #35, and #36) who received insulin via an "insulin pen" (a small pen shaped device prefilled with insulin) and failed to properly administer an inhaler medication to 1 of 1 supplemental resident (Resident #31). Failure of facility staff to follow the manufacturer's instructions of properly "priming" (a procedure to expel the air from the needle attached to the insulin pen) prior to giving the injection has the potential for residents to receive the incorrect dose of insulin. Failure to wait one minute between puffs of inhalant medication may prevent the second puff from fully penetrating the resident's lungs.	F 281		

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F 281	Continued From page 16 Findings include: Review of the "Prefilled Insulin Delivery Device User Manual," occurred on 08/22/12. These manufacturer's instructions, dated April 17, 2009, stated, ". . . follow all of these instructions carefully. If you do not follow these instructions completely, you may get too much or too little insulin. . . . Hold the Pen with the needle pointing up and remove the outer needle shield. . . . Remove the inner needle shield . . . Prime every time. The Pen must be primed to a stream of insulin (not just a few drops) before each injection to make sure the Pen is ready to dose. Turn the dose knob clockwise until the number '2' is seen in the dose window. . . . Hold your Pen with the needle pointing straight up. . . . You should see a stream of insulin come out of the tip of the needle. . . ." Review of the facility policy titled "Injection - Insulin Pen" occurred on 08/22/12. This policy, dated March 2012, stated " . . . 5. Attach safety needle to insulin pen as directed by manufacturer. 6. Remove needle cap. 7. Check the flow by dialing up 2 units and dispensing it into the air. A drop of liquid should appear at the needle tip. Repeat if no liquid is noted. May attempt 3 times. Replace needle if no liquid is noted at the needle tip after third attempt. . . ." Review of the facility policy titled "Inhalers-Administering Metered Dose" occurred on 08/22/12. This policy, dated September 2011, stated "Purpose: Medications can be delivered to the airways in the high concentration. . . Procedure: . . . 10. Wait at least 60 seconds between puffs of same inhaler. . . ."	F 281	1. All nursing and TMA staff were notified regarding the policies for insulin pens, inhalers, and General Medication Administration regarding labels and the E-MAR. 2. All residents using insulin pens, inhalers requiring more than one puff and any labeled medication are affected. 3. The "Injection-Insulin Pen" policy was changed on 9/22/12 and all staff notified. The "Inhalers-Administering Metered Dose" policy was reviewed with no changes noted but all staff were notified regarding the 60 second wait time between 2 puffs of the same inhaler. All nursing staff and TMAs will be educated regarding the revised policy for insulin pens and the inhaler policy at a meeting on October 10, 2012. Emphasis will be placed on the Medication-Administration policy related to labels not matching what is written on the E-MAR. 4. The Quality Assurance Coordinator will audit Residents #8, #32, #33, #34, #35 and #36 for receiving insulin via pen in keeping with policy. She will audit Resident #31 for use of inhaler following facility policy.	

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F 281	Continued From page 17 - Observation of medication pass on 08/20/12 showed a certified medication assistant (CMA) (#5) administered insulin to Resident #32 at 9:45 a.m. The CMA held the Novolog flexpen horizontally, slightly pointing downward and primed the pen with two units of insulin. - Observation of medication pass on 08/20/12 showed a CMA (#15) administered insulin to Resident #8 at 4:50 p.m. The CMA held the Novolog flexpen horizontally and primed the pen with two units of insulin. - Observation on 08/20/12 at 4:50 p.m., showed a licensed nurse (#17) administered insulin to Resident #35. The nurse held the Novolog flexpen upright with the cap on and primed the pen with two units of insulin. - Observation on 08/20/12 at 5:10 p.m., showed a licensed nurse (#17) administered insulin to Resident #36. The nurse held the Novolog flexpen horizontally with the cap on and primed the pen with two units of insulin. - Observation of medication pass on 08/20/12 showed a licensed nursing staff member (#16) administered insulin to Resident #34 at 5:20 p.m. The nurse held the Novolog flexpen horizontally with the cap on and primed the pen with two units of insulin. - Observation of medication pass on 08/21/12 showed a CMA (#20) administered insulin to Resident #33 at 12:25 p.m. The CMA held the Novolog flexpen horizontally, slightly pointing downward and primed the pen with two units of	F 281	These audits will be conducted weekly x 1 month, monthly x 3 months and quarterly thereafter. Random audits on 4 additional diabetic residents and 4 additional residents using inhalers with two puffs will be conducted in the same manner. Random audits will also be performed comparing labels to the E-MAR 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.	~~11/22/12~~ 10-10-12

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F 281	Continued From page 18 insulin. Observation showed no insulin at the tip of the needle with priming. - Observation of medication pass on 08/20/12 showed a CMA (#5) administered Resident #31's Combivent metered dose inhaler at 8:25 a.m. Review of Resident #31's medical record identified the physician's order for the inhaler identified two puffs. The CMA administered the second puff within ten seconds of the first puff, and failed to wait the recommended 60 seconds between inhaler puffs. During an interview on 08/22/12 at 9:38 a.m., an administrative nurse (#22) stated it would not be the standard of practice to hold the insulin horizontally during priming. THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 09/28/11 2. Based on observation, record review, policy and procedure review, and staff interview, the facility failed to follow professional standards of practice for 1 of 1 supplemental resident (Resident #32) observed receiving a nasal spray medication. Failure to ensure consistency between medication labels and medication administration records has the potential to result in medication errors. Findings include: Review of the facility policy titled "Medication Administration-General" occurred on 08/22/12. This policy, dated July 2012, stated, "PURPOSE: Medications are administered as prescribed, in accordance with good nursing principles and	F 281		

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F 281	Continued From page 19 practices . . . PROCEDURE: . . . 6. Prior to administration, the medication and dosage schedule on the resident's E-MAR [electronic medication administration record] is compared with the medication label. If the label and E-MAR are different, the physician's orders are checked for the correct dosage schedule. . . ." Observation during medication pass on 08/20/12 at 9:41 a.m. showed a CMA (#5) administered a corticosteroidal nasal spray, fluticasone, one spray in each nostril to Resident #32. The E-MAR identified the dosage of the fluticasone as one spray to each nostril twice daily. The label on the bottle of fluticasone nasal spray, dated 08/02/12, identified the dosage as two sprays to each nostril twice daily. Review of Resident #32's medical record identified a physician's order, dated 03/09/11 (16 months prior), for the fluticasone nasal spray one spray twice daily. During an interview on 08/21/12 at 3:36 p.m., an administrative nurse (#21) confirmed the label of the nasal spray medication did not match the E-MAR/physician order and was unable to provide documentation to clarify the the E-MAR and the medication label discrepancy.	F 281		
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.	F 323		

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F 323	Continued From page 20 This REQUIREMENT is not met as evidenced by: 1. Based on observation, record review, and staff interview, the facility failed to utilize an assistive device to ensure a safe transfer for 1 of 3 sampled residents (Resident #7) requiring a pivot disk for transfers. Failure to transfer a resident with the required assistive devices may result in the resident experiencing pain or an injury. Findings include: Review of Resident #7's medical record occurred on August 20-22, 2012. The resident's diagnoses included debility, osteoarthrosis, and muscle weakness. The quarterly Minimum Data Set (MDS), dated 07/30/12, stated extensive assistance of two or more persons with transfers and lower extremity impairment of functional range of motion on both sides. Resident #7's "Pro Rehab Nursing Referral for Therapy Screen," dated 07/21/12, stated, "Currently uses 2 [person] [with] pivot disc when transfers, her feet always turn inward and overlap. She is very unsteady and staff usually end up bearing all of her weight [with] transfers. The occupational therapist's response on the screen, dated 07/27/12, stated, "Educated a.m. [and] p.m. staff [on] transfer using pivot disc. . . ." Resident #7's current plan of care, dated 05/01/12, stated, "Problem . . . Alteration in Mobility . . . Approach . . . Assist of 1-2 to transfer using pivot disk. . . ." Observation on 08/20/12 at 8:25 a.m. in the	F 323	1. Staff caring for Resident #7 were re-educated re: use of the pivot disc for transfers as per care plan. Resident #19 had a wanderguard applied. The care plan was updated and staff on 5th Ave re-educated on Fall Prevention policy and communication of all significant events. Resident #19 discharged to home on 8/27/12. 2. All residents at risk for falls and/or elopement on admission and all residents using a pivot disc have the potential to be affected. 3. Pivot discs will be placed in each bathing area for accessability. All staff will be re-educated at a meeting on October 10, 2012 regarding the Fall Prevention Policy, Elopement Risk, and communication/follow-up of significant events. 4. The Quality Assurance Coordinator will audit Resident #7 for use of pivot disc weekly x 1 month, monthly x 3 months and quarterly thereafter. Random audits will be done on any other current residents or new admissions using a pivot disc in the same manner. She will audit residents with a "fall leaf" to	

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F 323	Continued From page 21 bathing room, showed two certified nurse aides CNAs (#1 and #2) transferring Resident #7 from her wheelchair to a toilet and from the toilet to the bathing chair. The CNAs failed to utilize a pivot disk during these transfers. When the CNAs transferred the resident to the bathing chair, the resident expressed discomfort stating "Oh, that's sharp [pain in foot]." Observation on 08/20/12 at 9:00 a.m. showed two CNAs (#1 and #2) transferring Resident #7 from the bathing chair to her wheelchair without a pivot disk. During the transfer, the resident stated, "I wish I could turn my foot." Observation on 08/20/12 at 11:40 a.m., showed two CNAs (#2 and #3) transferring Resident #7 from her wheelchair to a bathroom toilet without a pivot disk. During the transfer the resident stated, "I can't stand much longer, Oh." During an interview on 08/22/12 at 8:30 a.m., an administrative nursing staff member (#4) stated it is her expectation facility staff use a pivot disk with all of Resident #7's transfers. 2. Based on observation, record review, review of facility policy and procedure, and staff interview, the facility failed to provide adequate supervision and implement necessary safety precautions for 1 of 1 sampled resident (Resident #19) with a history of falls, who was cognitively impaired, and who was left unattended outside of the building. Failure to ensure supervision of the cognitively impaired resident outside the building and failure to investigate, develop, and implement preventive measures placed all cognitively impaired residents at risk of wandering and residents with	F 323	assure policy is being followed regarding visual checks weekly x 1 month, monthly x 3 months and quarterly thereafter. Audits will also be done on all new admissions deemed not at risk for elopement 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 meeting. 5. See "Completion Date" column	11/22/12 10-10-12 HS

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F 323	Continued From page 22 histories of falls at risk of injury when they leave the building. Findings include: Review of the facility policy and procedure, "Fall Prevention Program," occurred on 08/22/12. This document, dated May 2011, stated "POLICY: To provide optimum safety with a minimum of restriction for the residents . . . PROCEDURE: 1. Assessment of residents is continuous and on an ongoing basis. . . . 4. Residents and/or family/guardian are educated and involved regarding safety concerns and interventions. 5. All staff are educated as to the purpose of the fall leaf magnet . . . 6. Visual checks are done each time staff is walking in a hallway on those residents with leaf magnet or every hour at minimum. . . ." Review of Resident #19's medical record occurred on August 21-22, 2012. The facility admitted the resident on August 01, 2012. Admission diagnoses included post cerebral bleeding with right side weakness. The resident's admission Minimum Data Set (MDS), dated 08/08/12, identified the resident was moderately cognitively impaired, required limited assistance of one person for transfers and walking in room and corridor, and experienced falls before admission and two falls without injuries since admission. Resident #19's Resident Progress Notes identified the following falls: *08/04/12 - Resident #19 reached for his shaver in his room, his family was present.	F 323		

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F 323	Continued From page 23 *08/06/12 - Resident #19 attempted to put on his sock independently. In both instances, the resident did not request assistance. Resident #19's Resident Progress Notes, dated 08/09/12 at 11:21 p.m., stated "Resident found outside in facility courtyard at beginning of shift. Staff outside at time was able to redirect back to room. Frequent checks by staff. Need to direct resident to room after activities. Educated resident to walk with assistance. Returned resident to room, were [sic] he proceeded to bed. Wife and daughter here at supper and evening. Noted to be self transferring. . . . Standby assist with walking. Gait steady. . . ." Resident #19's Care Area Assessments (CAAs), dated 08/08/12, identified the following: *Cognitive - short term memory loss *Activities of Daily Living (ADLs) - does not always understand safety precautions *Falls - assistance to transfer. Impulsive, will not use call light. Unaware of his limitations. Resident #19's Elopement Risk Assessment, dated 08/01/12, identified the resident was not cognitively intact and was not safe to leave the building unsupervised. This Assessment also stated "Plan Of Care . . . Falling leaf protocol, see plan of care. . . ." Resident #19's current care plan, dated 08/21/12, stated "Problem, Impaired cognition r/t [related to] CVD [cerebral vascular disease] - short term memory loss . . . Approach . . . Monitor for changes in safety awareness and notify appropriate staff. . . .:" and, dated 08/01/12,	F 323		

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F 323	Continued From page 24 "Problem, Alteration in mobility r/t limited ROM [range of motion], weakness. CVA [cerebral vascular accident] prior to admission. . . . Approach, Assist of 1 to walk with standby assist and gait belt to all meals. . . . Falling leaf protocol. . . . [dated 08/03/12] Restorative [therapy] to walk resident with standby assist up to 400 feet. . . . [dated 08/19/12] Due to altered cognition, resident will often walk in room, bathroom and hallways without assistance. Wife can walk resident in halls with gait belt and SBA [standby assistance]. . . ." Resident #19's Resident Profile, identified by a supervisory nursing staff member (#7) as a guide for certified nursing assistants (CNAs) to provide resident care, included those Approaches previously identified from the current care plan. The resident's Profile also stated, dated 08/01/12, ". . . ADL: Wheelchair locomotion: Uses w/c [wheelchair] assist to destinations as needed. . . ." Resident #19's current care plan and Resident Profile failed to to address the resident being found unattended outside the building, failed to address the resident's safety or fall prevention after being found in the facility's courtyard, the resident's use of the courtyard, or education provided to the resident's family regarding use of the courtyard. Observation on all days of survey identified a facility staff member ambulated Resident #19 to and from the dining room and to and from therapies with a gait belt around his waist. Observation identified a leaf magnet on the resident's private room door frame to alert staff to	F 323		

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 _____	08/22/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 323	Continued From page 25 monitor the resident as part of the facility's fall program. Observation on all days of survey showed a courtyard immediately outside the resident care unit. The courtyard included a cement sidewalk, benches, grass area, and a low fence. Access to and exit from the courtyard was not restricted by a gate or lock. Resident #19's unsupervised access to the courtyard placed him at risk of falls and injuries. Immediately adjacent and accessible to residents in the courtyard was a facility entrance that accessed the therapies area and chapel, a parking area, a street, and a residential area. The therapies/chapel entrance did not require an access code but did require opening an outside door, entering a vestibule, and then pulling open another door to enter either area. During the environmental tour, on 08/22/12 at 8:00 a.m., a maintenance management staff member (#8) reported the therapies/chapel entrance is locked after 5:00 p.m. Resident #19's cognitive impairment may have limited his decision making related to traffic, attempting to enter other parts of the building, or leaving the facility grounds. Resident #19 could access the parking area, street, and residential area when left unattended. During interview, on 08/22/12 at 7:50 a.m., a supervisory nursing staff member (#7), reported the author of the Resident Progress Note, dated 08/09/12, informed her of the incident of that date on the evening of 08/21/12. Staff member (#7) reported she thought Resident #19 was found in the courtyard at the beginning of the afternoon shift, approximately 2:30 p.m. on 08/09/12. Staff	F 323		

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F 323	Continued From page 26 member (#7) reported she would search for additional information, including an incident report, investigation regarding how the resident came to be in the courtyard, and additional approaches implemented with Resident #19's family members and the facility staff. On 08/22/12 at 12:00 noon, staff member (#7) reported the facility staff failed to complete an investigation or incident report and no additional information was available. The facility staff identified Resident #19 had a history of falls prior to admission, fell after admission, was impulsive, had cognitive limitations, and continued to be at risk for falls. The facility staff were not aware of how Resident #19 got to the courtyard, how long he was there, what time facility staff discovered he was there, or if he was ambulating or using a wheelchair. Failure to complete an investigation regarding Resident #19 being found unattended in the courtyard did not provide facility staff the ability to determine the need for and implement corrective measures, educate appropriate staff or family members, and track and trend these type of incidents for the safety of other residents. Failure to monitor Resident #19's activities placed him at risk of falls, injuries related to falls, and potential exposure to traffic and the elements. Failure to develop approaches regarding this incident placed Resident #19 at risk of injury and potential recurrence of being unattended in the courtyard.	F 323		
F 499 SS=D	483.75(g) EMPLOY QUALIFIED FT/PT/CONSULT PROFESSIONALS The facility must employ on a full-time, part-time or consultant basis those professionals necessary	F 499		

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F 499	Continued From page 27 to carry out the provisions of these requirements. Professional staff must be licensed, certified, or registered in accordance with applicable State laws. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of state licensing regulations, and staff interview, the facility failed to ensure 1 of 4 medication assistants (medication assistant #5) observed during medication pass were certified to perform this task in a skilled nursing facility in accordance with applicable State laws. Failure to ensure medication assistants are certified in accordance with applicable state laws to pass medications at a skilled nursing facility may jeopardize the health and safety of the residents. Findings include: Review of North Dakota Administrative Code State Licensing Chapter 33-43-01-20 (1) a Nurse Aide Training, Competency Evaluation, and Registry, page 33 identified the following: " . . . Effective July 1, 2011 . . . .1. a. A medication assistant 1 may work in settings where the licensed nurse is not regularly scheduled, however, may not work in a nursing facility or acute care setting, including clinics. . . ." Observation of medication pass, on 08/20/2012 at 8:25 a.m., showed a medication assistant (#5) administering to residents the following: oral medications, inhaler medications, nasal sprays, and an insulin injection.	F 499	1. Medication Assistant #5 was removed from performing TMA duties immediately and has registered for class to receive her medication assistant II certification. 2. The licenses for all medication assistants working in the facility were checked for correct certification as a medication assistant II. 3. When hiring or promoting staff to a medication assistant position, verification will be made to assure the correct licensure for a medication assistant II certification is in place. The verification for correct licensure was discussed with the Staffing Coordinator and Quality Assurance Coordinator to be effective immediately. 4. The Quality Assurance Coordinator in cooperation with the Staffing Coordinator will audit any medication assistants prior to hiring to assure that they have the correct certification. Results will be immediately reported to the Director of Nursing. If concerns are identified, immediate corrective action will be taken.	

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F 499	Continued From page 28 On the afternoon of 08/21/2012, review of the list of staff, provided by the facility, failed to include the medication assistant (#5) on the list of medication assistants. Review of personnel information for the medication assistant, on the morning of 08/22/2012, identified the facility hired the staff member on 07/31/07 as a certified nurse aide and became a medication assistant I on 08/03/2009. During interview on 08/22/2012 at 9:58 a.m., an administrative nursing staff member (#6) stated she was unaware the medication assistant (#5) received a medication assistant I certification and not a medication assistant II certification as required. This administrative nursing staff member (#6) confirmed the medication assistant (#5) works one day a week administering medications to residents.	F 499	The Quality Assurance Coordinator will report the results to the Quality Assurance Committee at each scheduled meeting. 5. See "Completion Date" column.	~~11/22~~/12 10-10-12 HS