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 _____	10/07/2010

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 10/04/10 and completed on 10/07/10, the sample included 5 residents for complete review, 16 residents for focused review, and 3 closed records for review.	F 000	This plan of correction constitutes our written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that a deficiency exits or that one was cited correctly. This plan of correction is submitted to meet requirements established by state and federal law.	
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 by: Based on observation, record review, and staff interview, the facility failed to ensure each resident received reasonable accommodation of individual needs for 1 of 1 sampled resident (Resident #15) regarding positioning of the resident's feet while sitting in a rock and go wheelchair. Failure to accommodate proper alignment and support of the resident's feet and legs has the potential to cause pain, circulation problems, increases the resident's risk of pressure sores, and can cause further deformities of the resident's feet. Findings include: Record review for Resident #15 occurred October 06-07, 2010. The facility admitted the resident in January 2005, with diagnoses including seizure disorder and aphasia. The quarterly Minimum	F 246	F 246 1. Resident #15 was screened by therapy for proper positioning on 10/7/10. The foot pedals on the Rock and Go were adjusted, a new calf pad was placed, and the support boots are worn when she is up in her chair. 2. All residents in Rock and Go wheelchairs have the potential to be affected. 3. All staff are trained on proper body alignment (i.e. positioning) in orientation. All nursing department staff were in-serviced on proper body alignment on 10/13/10. 4. The Quality Assurance Coordinator will audit resident #15 for proper positioning in her Rock and Go weekly x1 month, monthly	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: T Hagen | TITLE: Administrator | (X6) DATE: 10-20-10

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

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F 246	Continued From page 1 Data Set (MDS), dated 07/05/10, identified Resident #15 has long and short-term memory problems, and is dependent on two staff persons for transfers. This same MDS identified Resident #15 had partial loss of voluntary movement of the legs with no limitation of range of motion, and had limited range of motion to both feet with partial loss of voluntary movement. The "Resident Profile" information available to CNAs when providing care to Resident #15 stated, ". . . Rock and go wheelchair with calf pads, staff to propel." The current care plan for Resident #15 lacked information regarding the use of the calf pad when in the rock and go wheelchair. An approach on the care plan stated "Boots to feet when in bed." During the initial tour on 10/04/10 at 10:40 a.m., observation showed Resident #15 sitting in a rock and go wheelchair with one foot dangling above the footrest of the calf pad, and the other foot had the tips of his/her toes touching the footrest of the calf pad. Observation showed Resident #15's feet to be in a pointed position, referred to as foot drop. On this same day, a random observation made at 4:05 p.m. showed Resident #15's feet to be dangling above the footrest area of the calf pad. Random observations of Resident #15 throughout 10/05/10, showed the resident sitting in his/her rock and go wheelchair with his/her feet dangling in the air above the footrests or behind a mesh device spanning the space between the footpedals. During an observation of care on 10/06/10 at 11:20 a.m., Resident #15's feet dangled behind	F 246	x3 months and quarterly thereafter. The Unit Managers will identify residents on their caseload who use a Rock and Go and they 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.	11/11/10

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F 246	Continued From page 2 the mesh of the legrests when two CNAs (certified nurse assistants) (#6 and #7) brought the resident to his/her room. The calf board was not in place. The CNAs (#6 and #7) laid Resident #15 down to rest. During an observation on 10/06/10 at 1:10 p.m., Resident #15 sat in his/her rock and go wheelchair with his/her feet dangling above the footrests. The calf board was not in place. During an observation of care on 10/06/10 at 2:35 p.m., CNAs (#8 and #9) brought Resident #15 to his/her room, his/her feet dangled behind the mesh of the legrests, and the calf board was not in place. The CNAs (#8 and #9) laid Resident #15 down, provided care, and transferred the resident back into his/her rock and go chair. The CNAs (#8 and #9) positioned the resident so that his/her feet hung in the air behind the mesh of the leg rests. The CNAs (#8 and #9) did not place the calf pad. The CNAs (#8 and #9) returned Resident #15 to the lounge leaving his/her legs/feet dangling behind the mesh of the leg rests. During an observation on 10/07/10 at 8:40 a.m., Resident #15's feet/legs were observed dangling above the footrests of the wheelchair, with the calf pad in place. An administrative nursing staff member (#4) and a therapy staff member (#5) agreed Resident #15's seating position failed to support his/her legs and feet. The administrative nursing staff member (#4) provided the therapy staff member (#5) with a pair of support boots for Resident #15. With the boots on and the calf board in place the resident's feet still dangled in the air above the footrest of the calf board. The therapy staff member (#4) adjusted the	F 246		

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F 246	Continued From page 3 wheelchair. This removed the dangling stress from Resident #15's legs. During an interview on 10/07/10 at 8:55 a.m., an administrative nursing staff member (#4) identified the boots observed in place during the final observation of Resident #15 are normally only used when the resident is in bed. This same staff member identified the facility had recently changed Resident #15's rock and go wheelchair as his/her previous one had broken. Staff member (#4) identified they had not adjusted the new wheelchair to fit Resident #15. When asked, nursing staff member (#4) could not provide documentation of communication with therapy staff concerning proper positioning for Resident #15 when in her wheelchair.	F 246		