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AUG 26 2011
Division of Health Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355024	A. BUILDING _____ B. WING _____	07/21/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES	1315 S UNIVERSITY DR FARGO, ND 58103

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F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey started on 07/18/11 and completed on 07/21/11 the sample included five residents for complete review, 13 residents for focused review, and three closed records for review. The sample included four additional residents to verify specific concerns during the survey.	F 000	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the Facility has taken or will take actions set forth in the following Plan of Correction. The Plan of Correction constitutes the Facility's allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date indicated.	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.	F 225	**F225** It is the practice of this facility to immediately report injuries of unknown origin to the administrator for investigation. 1. An investigation was completed for resident #11's bruise of unknown origin. No abuse was substantiated. 2. Skin sheets were reviewed for bruises and documentation for identification of source of the bruise was audited. 3. Nurses were re-educated on reporting guidelines for injuries of unknown origin by the Administrative Director of Nursing Services (ADNS) or designee by 9/1/2011.	9/1/2011

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 8/25/11

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 225	Continued From page 1 The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy and procedure, and staff interview, the facility staff failed to ensure reporting of an incident of potential resident abuse for 1 of 1 sampled resident (Resident #11) with an injury of unknown origin. Failure to report incidents of potential resident abuse placed all facility residents at risk of abuse. Findings include: Review of the facility's policy "Abuse, Neglect and Misappropriation of Patient Property Prevention" occurred on the afternoon of 07/21/11. This policy, dated 04/21/06, stated, "The center must ensure that all alleged violations involving mistreatment, neglect or abuse, including injuries of unknown source . . . are reported immediately to the administrator of the center . . . immediately means as soon as possible, but ought not exceed 24 hours after discovery of the incident, in the absence of a shorter time frame requirement. . . ." Review of Resident #11's medical record	F 225	4. Skin sheets were audited weekly for the first four weeks for bruises and documentation for identification of the source of the bruise or reporting of the injury immediately if the origin is unknown. Audit tools will be reviewed by the Quality Assurance Performance Improvement (QAPI) committee for continued at the direction of the QAPI committee. 5. Completion date is 9/1/2011	

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F 225	Continued From page 2 occurred on July 19-21, 2011. The resident's diagnoses included cerebral vascular disease, hemiplegic lower extremities, muscle weakness, and anemia. The quarterly Minimum Data Set (MDS), dated 05/22/11, identified Resident #11 required extensive assistance of one to two with transfers, dressing, toilet use, personal hygiene, and bathing. Resident #11's record identified a nurse's note, dated 07/17/11 at 7:00 a.m., which stated, "Resident noted to have 6 cm [centimeter] x [by] 8 cm deep purple bruise on [right] inner thigh. Pt [patient] states it hurts when touched. Skin sheet completed. Will continue to monitor pt." During an interview on 07/20/11 at 10:45 a.m. and 07/21/11 at 1:30 p.m., an administrative nurse (#1) stated on the morning of 07/20/11 (three days after facility staff noted the bruise), a social services designee (#2) read the above nurse's note in the chart, reported the injury of unknown origin, and administrative staff members began an investigation of the incident. The administrative nurse (#1) verified the staff member (#3) who noted the bruise, failed to report the injury as per facility policy. The administrative nurse (#1) stated, regarding injuries of unknown origin, facility staff members should "contact the physician immediately and start an investigation."	F 225		
F 248 SS=E	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	F 248	**F248** It is the practice of this facility to provide an ongoing program of activities designed to meet the physical, mental and psychosocial well-being of each resident.	9/1/2011

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F 248	Continued From page 3 of each resident. This REQUIREMENT is not met as evidenced by: Based on on observation, record review, facility policy review, and staff interview, the facility failed to provide an ongoing, meaningful activity program to meet physical, mental, and psychosocial needs for 8 of 10 sampled residents (Resident #5, #7, #8, #9, #13, #14, #15, and #16) who require staff assistance to attend activities. Activities are a valuable component of residents' lives and vital to achieve their highest level of well-being. Failure to provide meaningful activities designed to reflect each resident's interests and lifestyle has the potential to negatively impact a resident's sense of self-worth and belonging. Findings include: Review of the facility's activities policies occurred on 07/21/11. The facility policy titled "ONE-TO-ONE PROGRAMMING," dated 01/07/05, stated, ". . . Care plans reflect frequency and types of services provided. . . . The activity director is responsible for scheduling specific days and providers for residents requiring a one-to-one visit. . . . Results of the one-to-one visit are documented at the conclusion of the visit and are reflective of the resident's response(s) to the activity provided. . . ." The facility policy titled "ACTIVITY, RECREATION DOCUMENTATION," dated 01/07/05, stated, ". . . RESIDENT EVALUATION . . . The activity evaluation form is completed annually and, or with a significant change of	F 248	1. An annual Activity/Recreation evaluation was completed for resident #5. Resident #5's care plan has been updated to reflect the frequency and types of services provided for One-to-One programming. Residents #5, #7 and #14 are being offered to attend activities of interest based on the Activity/Recreation evaluation and accurately documented. Resident's #9 and #15 care plan was revised to reflect current interests. They are being offered to attend activities of interest and accurately documented. The individual independent activities for resident #8 will be documented on the Daily Activity form. Residents #13 and #16 are no longer in the facility. 2. Residents who require staff assistance to attend activities could be affected. 3. Activity staff will be re-educated on One-to-One visit guidelines, correct activity documentation, accurate evaluation and provisions of opportunities for participation by the Activity Director or designee by 9/1/2011 Activity/Recreation evaluations will be completed annually in conjunction with annual MDSs to ensure completion timely.	

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F 248	Continued From page 4 condition. . . ." - During an interview on 07/20/11 at 10:30 a.m., an activity aide (#4) stated, "Socializing includes one-on-one time with the residents. It's the time we spend greeting the residents and/or asking them if we can do anything for them." The activity aide confirmed "socializing" takes a couple of minutes. - Review of Resident #5's medical record occurred on July 19-21, 2011. Diagnoses included dementia with behavioral disturbance. The resident's current Minimum Data Set (MDS), dated 07/13/11, identified short term memory problems and total dependence on one person for locomotion. An "Activity/Recreation Evaluation," dated January 2010, listed the following activities as some of Resident #5's current interests: *Animals/Pets *Bible Study *Church *Current Events *Entertainment *Games *Newspaper *Radio *Special Events *Television Review of Resident #5's medical record showed staff failed to complete an "Activity/Recreation Evaluation" annually in January 2011. Resident #5's current care plan, revised 04/25/11, stated, ". . . Enjoys bingo, special events, catholic mass with room/activity room as preferred	F 248	4. An audit of documentation will be completed weekly for four weeks by the Activity Director or designee. Audits will be submitted to the QAPI committee for continued compliance. Additional audits will be conducted as directed by the QAPI committee. 5. Completion date is 9/1/2011	

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F 248	Continued From page 5 settings. Day Enrichment, music. Added - 1:1's for socialization and pain diversion, being in bed. . . . Interventions . . . Provide 1:1 activity visits of potential interest (i.e. discussions of family, sister, likes/dislikes, reminiscing) . . ." The care plan failed to identify a specific schedule/frequency or type of activities provided for one-to-one visits. During an interview on 07/19/11 at 8:40 a.m., an activities staff member (#5) stated Resident #5 sometimes attends Daily Enrichment Group, which is held Monday through Thursday at 10:00 a.m. Activities during the enrichment group include reading the paper, singing, listening to music, hand exercises, and reminiscing. The enrichment group usually lasts 15 to 20 minutes. Observations of Resident #5 occurred throughout the survey and included the following: *07/19/11 at 9:05 a.m.: sitting in her wheelchair in her room. The radio was on, as well as the TV with the volume muted. *07/19/11 at 10:12 a.m.: Certified nursing assistants (CNAs) entered the room to assist with personal cares. Upon completion of cares, the resident remained in her room until 11:40 a.m. when a CNA brought her to dinner. *07/19/11 at 12:45 p.m.: sitting in her wheelchair in her room. No TV or radio on. *07/19/11 at 2:13 p.m.: asleep in bed. A CNA reported she assisted the resident to lie down after lunch. Observations throughout the afternoon until 5:20 p.m. showed the resident asleep in bed. At 5:20 p.m., two CNAs assisted Resident #5 out of bed and brought her to the dining room. *07/20/11 at 9:15 a.m.: Two CNAs assisted Resident #5 to lie down after breakfast.	F 248		

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F 248	Continued From page 6 Observation showed no TV or radio on, and Resident #5 remained in bed until lunch time (around 11:45 a.m.). *07/20/11 at 12:45 p.m.: sitting in her wheelchair in her room. At 1:25 p.m., two CNAs assisted the resident to lie down. Observations throughout the afternoon until 4:30 p.m. showed the resident asleep in bed with the TV on. *07/21/11 at 8:55 a.m.: asleep in her wheelchair in her room, no TV or radio on. At 9:28 a.m., the resident received communion in her room. From 9:56 a.m. until lunch time, Resident #5 remained in her room. At 12:37 p.m. and 1:32 p.m., observation showed Resident #5 sitting in her room without the TV or radio on. Facility staff failed to offer Resident #5 the opportunity to attend daily enrichment group (which staff identified as an activity Resident #5 sometimes attends), Bible study, Catholic Mass, Rosary, and pet visits (identified as some of Resident #5's activities of interest according to the activity evaluation). Review of the facility's activity calendar revealed these events occurred during the survey; however, observation showed staff failed to offer Resident #5 the opportunity to attend. Facility staff provided a copy of Resident #5's July activity log on 07/20/11 at 12:30 p.m. For the date of July 20, staff documented television: "passive participation," music/singing: "listened," and current events/reminiscing: "passive participation;" however, observation showed these activities did not occur at that time. Staff documented spiritual/religious activities: "active participation" on July 19, and the activity	F 248		

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F 248	Continued From page 7 calendar showed Bible study at 10:30 a.m. and Catholic Mass at 2:00 p.m. However, observation showed Resident #5 in her room or in bed asleep during those times. Staff failed to record participation in or refusal of any other activities during the month of July, although review of the July activity calendar revealed activities scheduled that are consistent with Resident #5's current interests (such as church services, Bible study, bingo, pet visits, games, and special entertainment). Review of Resident #5's daily activity participation logs from the months of April 2011 through July 20, 2011 revealed the following regarding one-to-one visits from facility staff: *April 2011: five one-to-one visits. *May 2011: seven one-to-one visits. *June 2011: eight one-to-one visits. During the month of June, staff failed to document results of/resident's response to the visit. *July 2011: eight one-to-one visits. During an interview on 07/21/11 at 11:15 a.m., an activities staff member (#5) stated one-to-one visits "aren't scheduled," and staff catch up with residents "whenever." This conflicts with the facility's policy regarding one-to-one activity visits, which states one-to-one visits are scheduled for specific days and are to be reflected on resident care plans. The staff member also stated she would re-educate the staff on the importance of accurate documentation. - Review of Resident #7's medical record occurred on July 19-21, 2011. Diagnoses included cerebrovascular disease. Resident #7's	F 248		

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F 248	Continued From page 8 admission MDS, dated 06/09/11, identified a Brief Interview for Mental Status (BIMS) score of seven (indicating severe cognitive impairment). An "Activity/Recreation Evaluation," dated June 2011, listed the following activities as some of Resident #7's current interests: *Animals/Pets *Bible study *Bingo *Church *Current Events *Radio Resident #7's current care plan, revised on 06/08/11, stated, ". . . Enjoys activities such as church services and socializing . . . Uses large print for bingo. Enjoys discussing farming issues/topics. . . ." Observations of Resident #7 occurred throughout the survey and included the following: *07/19/11 at 9:04 a.m.: A CNA assisted the resident with personal cares and then to lie down in bed. At 12:30 p.m., a nursing staff member brought the resident to the dining room for lunch. *07/19/11 at 2:10 p.m.: asleep in bed. *07/20/11 at 9:15 a.m.: asleep in bed. Observation showed the resident remained in bed until approximately 11:45 a.m. when he went to the dining room for lunch. *07/20/11 at 2:15 p.m.: A CNA stated she assisted Resident #7 to lie down after lunch. Observation showed he remained in bed until approximately 4:45 p.m. when a CNA assisted him from his bed to the wheelchair. *07/21/11 at 7:38 a.m., 9:50 a.m., 11:15 a.m., and 12:45 p.m.: asleep in bed	F 248		

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F 248	Continued From page 9 Facility staff provided a copy of Resident #7's July activity logs on 07/20/11 at 12:30 p.m. Staff documented television: "independent" and "therapy" as activities on July 20; however, observation showed these activities did not occur at that time. Review of Resident #7's daily activity participation logs for the months of June 2011 through July 20, 2011 revealed the following: *June 2011: Independent with "current events/reminiscing," "socializing," and "visiting" documented daily; and "therapy" documented five days a week. *July 2011: Independent with "current events/reminiscing" and "socializing" documented daily, independent with "television" documented on 11 days, and "therapy" documented five days a week. Staff did not record participation in or refusal of any other activities during the months of June and July, although review of the these activity calendars revealed activities scheduled that are consistent with Resident #7's current interests (such as church services, Bible study, bingo, and pet visits). In an interview on 07/20/11 at 4:00 p.m., a therapy staff member (#20) stated they discharged Resident #7 from physical therapy on July 7 and occupational therapy on July 11. Although Resident #7 no longer attended therapy, staff continued to chart "therapy" as an activity from July 12-20. - Review of Resident #15's medical record	F 248		

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F 248	Continued From page 10 occurred on July 20-21, 2011. Diagnoses included Parkinson's disease. The resident's current MDS, dated 07/11/11, identified short and long term memory impairment, severely impaired daily decision making skills, and extensive assistance from one person needed for locomotion. An "Activity/Recreation Evaluation," dated June 2011, listed the following activities as some of Resident #15's current interests: *Animals/Pets *Church *Current Events *Music *Television Resident #15's current care plan, revised 06/24/11, stated, ". . . Enjoys activities such as watching television, attendance at church events and listening to a wide variety of music, Day Enrichment, with room as preferred setting. . . ." Facility staff provided a list of residents who attend the Day Enrichment program. The list included Resident #15. Observation on 07/21/11 at 8:45 a.m. showed Resident #15 lying in bed. The resident remained in bed until approximately 11:40 a.m. when staff assisted her to the dining room for lunch. Observation showed staff failed to offer Resident #15 the opportunity to attend the Day Enrichment program. Review of Resident #15's daily activity participation logs for the month of July 2011 revealed the following:	F 248		

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F 248	Continued From page 11 *Independent with "current events/reminiscing," "television," and "socializing" documented daily *Independent with "visitors" documented on three days *Active in "spiritual/religious activities" documented on five days, "music" on one day, "reading/writing" on one day, and "social programs" on two days *Refused "cards/games" documented on one day *Sleeping during "sensory stimulation" documented on one day Staff failed to record participation in or refusal of any other activities during the month of July, although review of the July activity calendar revealed activities scheduled that are consistent with Resident #15's current interests (such as church services, pet visits, and music). - Review of Resident #8's medical record occurred on July 19-21, 2011. The facility originally admitted the resident in March 2005 and readmitted the resident in May 2011 after a hospital stay. Current diagnoses included depression. The resident's admission MDS, dated 05/09/11 identified short term memory problems and no long term memory problems. A significant change MDS, dated 03/05/11, identified the resident was moderately cognitively impaired. Resident #8's current care plan, dated 04/01/11, stated "Focus . . . Enjoys reading personal newspaper, visiting with family, church . . . 1:1's for sensory stimulation, discussions. . . . Goals . . . Will involve self in independnent [sic] activities of choice and attend group activities as chooses, Resident will participate in 1:1 interaction with staff. Interventions, Offer schedule of activities for	F 248		

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F 248	Continued From page 12 resident to select choices . . . Provide 1:1 activity visits of potential interest . . ." Resident #8's One-To-One and Daily Activity Documentation identified the following: *April 2011 - One-To-One - two days. Daily Activity - independent activities daily and refused exercise three times and religious activities one time. *May 2011 - One-To-One - eight days. Daily Activity - independent activities daily and refused special events one time. *June 2011 - One-To-One - eight days. Daily Activity - independent activities daily, received hair care one time, and refused resident council one time. *Through July 20, 2011 - One-To-One - eight days. Daily Activity - independent activities daily, refused music one time, and refused religious activities two times. Resident #8's One-To-One Activity Comments included the following: *05/14/11 - "[Resident #8] was awake and looking at a mag [magazine]/book from church. I spoke to her and she responded. We also looked at pictures together. She said thank you for the visit." The Documentation for this visit identified auditory stimulation, tactile stimulation, visual stimulation, and independent reading/writing. *06/04/11 - "Visited [Resident #8] in her room. She had good eye contact & [and] we talked about the sunny day outside. She was moving around, didn't verbalize much." The Documentation for this visit identified auditory stimulation, socializing/conversing, tactile stimulation, and visual stimulation.	F 248		

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	355024	A. BUILDING _____ B. WING _____	07/21/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 248	Continued From page 13 The facility's documented Activity Comments identified passive activities for Resident #8 and failed to show the independent activity participation identified on the Daily Activity form. - Review of Resident #9's medical record occurred on July 19-21, 2011. The facility admitted the resident in May 2011. Current diagnoses included dementia and depression. The resident's significant change MDS, dated 07/05/11, identified short term memory problems, no long term memory problems, and moderately impaired daily decision making. Resident #9's current care plan, dated 06/08/11, stated "Focus, Enjoys group and independent activities [such] as church services, socializes with others, bingo, watching tv-current events . . . Wife visits daily. Seen 1:1's for stimulation and socialization . . . Interventions . . . Offer schedule of activities for resident to select choices, provide 1:1 activity visits of potential interest . . ." Resident #9's One-To-One and Daily Activity Documentation identified the following: *June 2011 - One-To-One - eight days. Daily Activity - wife visited daily, independent activities daily, entertainment two times, bingo one time, music two times, and religious activities four times. *July 01-20, 2011 - One-To-One - eight days. Daily Activity - wife visited daily, independent activities daily, cards one time, current events one time, educational two times, music two times, and religious activities four times. "In Therapy" is identified five times each week on the Daily Activity Documentation for the months of June through July.	F 248		

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F 248	Continued From page 14 Resident #9's One-To-One Activity Comments included the following: *05/28/11 - "Visited [with] resident, touched his hand (did pull back). Attempted to get up. Was directed to stay and not to get up. We (I talked) about the weather to him. He appeared slightly nervous." *06/05/11 - "Visited [Resident #9] in his room, he asked me what he was doing here & appeared lost and not in the right state of mind. No eye contact but did vocalize fine." The Documentation for these visits identified auditory stimulation, socializing/conversing, tactile stimulation, and visual stimulation. The facility's documented Activity Comments identified passive activities for Resident #9 and failed to show the independent activity participation identified on the Daily Activity form. - Review of Resident #16's medical record occurred on July 20-21, 2011. The facility admitted the resident in February 2011. Current diagnoses included dementia. The resident's current quarterly MDS, dated 05/28/11, identified short term memory problems and no long term memory problems. Resident #16's current care plan, dated 02/20/11, stated "Focus . . . Prefers not to attend group activities . . . Goals, Will engage in 1:1 activities such as discussing picture books of birds, flowers, church communion . . . Interventions . . . Offer schedule of activities . . . Provide 1:1 activities . . ." Resident #16's One-To-One and Daily Activity	F 248		

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F 248	Continued From page 15 Documentation identified the following: *April 2011 - One-To-One - six days. Daily Activity - independent activities daily and therapy services. *June 2011 - One-To-One - seven days. Daily Activity - independent activities daily and therapy services. *Through July 20, 2011 - One-To-One - six days. Daily Activity - independent activities daily. Resident #16's One-To-One Activity Comments included the following: *06/10/11 - Visited [Resident #16]. She appeared tired & didn't verbalize @ [at] all. She smiled a couple times & had some eye contact, otherwise not very sociable." The Documentation for this visit identified auditory stimulation, music, socializing/conversing, and tactile stimulation. The facility's documented Activity Comments identified passive activities for Resident #16 and failed to show the independent activity participation identified on the Daily Activity form. The facility staff also identified therapy services as an activity. - Review of Resident #13's medical record occurred on July 19-21, 2011. Her diagnoses included depression and sleep disorder. An "Activity/Recreation Evaluation", dated 07/19/11, listed the following activities as some of Resident #13's current interests: * Animals/Pets * Children * Current Events * Entertainment	F 248		

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F 248	Continued From page 16 * Games * Music * Special Events Observations of Resident #13 occurred throughout the survey and included the following: * 07/20/11 at 10:30 a.m.: sitting in her wheelchair around the dining room table with three other female residents. An activity aide (#4) read to the group. No radio on in the background. Review of Resident 13's daily activity participation logs for the month of July 2011 revealed the following: * Active participation in "current events" on 07/20/11. * Active participation in "educational/intellectual" activities on 07/20/11. * Active participation in "music/singing" on 07/20/11. * Active participation in "sensory stimulation" on 07/20/11. * Active participation in "social programs" on 07/20/11. * Active participation/Independent in "socializing" documented daily. * Independent in "visitors" documented almost daily. * Active participation in "women's group" on 07/20/11. During interviews on July 20, 2011 at 1:15 p.m. and July 21, 2011 at 9:15 a.m., a management staff member (#5) stated, "One activity may include numerous items [on the Daily Activity/Recreation Participation Documentation form]. On Resident #13's form, Current Events/Reminiscing and Educational/Intellectual	F 248		

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F 248	Continued From page 17 were checked off because the Activity Aide (#4) read a newspaper and/or magazine article to the residents. Music/Singing were checked off because the radio was on in the background during some part of the session. Sensory Stimulation was checked because the music provided [a form of] auditory stimulation. Social Programs and Women's Group were checked because the residents came to the 'Ladies Coffee' activity. Yes, all of these items took place at 10:30 a.m." The staff member (#5) confirmed the statements made by the activity aide (#4) on 07/20/11. Resident #13's participation in the activity program consisted of less than two minutes of interaction with activity staff July 15-19, 2011, and 'Ladies Coffee' on the morning of July 20, 2011. The facility failed to provide stimulating and engaging activities to Resident #13. An individualized activity program could potentially decrease the residents' depression; and improve the residents' quality of life. - Review of Resident #14's medical record occurred on July 20-21, 2011. Diagnoses included depression, anxiety, and macular degeneration. The resident's quarterly MDS, dated 06/07/11, identified moderately impaired cognition and moderate depression. The "Interview for Daily Preferences" section on the significant change MDS, dated 03/16/11, identified snacks, reading materials, animals, groups, and outside, as very important activities for Resident #14. Resident #14's "Activity/Recreation Evaluation," dated 03/10/11, stated, "[resident name] spends	F 248		

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F 248	Continued From page 18 time out of room. She socialized with staff & others. She comes out of her room for meals. She attends Day Enrichment, Church, Red hatters and initiates conversation. Continue with plan. An "Activity/Recreation Progress Note," dated 06/14/11, stated, ". . . She enjoys group activities and independent activities . . . enjoys holding a dolly. It appears she finds comfort holding the doll & no longer asks for cigarettes. She enjoys spending time in & out of her room. She is alert with confusion. She enjoys going outside weather permitting and enjoys socializing about nature. She attends bingo, games, crafts, current events, educational/intellectual, entertainment, exercise, music programs, off sites [outings], pet visits, reading-passive, sensory, coffee shops, special & themed [sic], church, trivia, Red Hats. For more goals, details and interventions see ICP [individualized care plan]." Resident #14's current care plan stated, "Enjoys group and independent activities such as watching TV, pet visits, animals, arts/crafts, bingo, books (mysteries), children, church services. Day enrichment, current events, magazines, movies, sitting outside weather permitting . . . Enjoys sitting and watching activity in hallway by nurses station and the TV lounges . . ." An observation on 07/20/11 at 4:00 p.m. showed Resident #14 seated in the TV lounge and stated loudly, "I want a beer, get me a beer, come on, come on!" At 4:15 p.m., observation showed a CNA (#21) feeding Resident #14 ice cream in the hall outside her room.	F 248		

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F 248	Continued From page 19 Observations of Resident #14 on 07/21/11 showed the following: * 7:30 a.m. - seated in her wheelchair outside her room and holding a doll * 9:00 a.m. - in the dining room eating breakfast * 9:15 a.m. - seated in her wheelchair outside her room * 9:25 a.m. to 10:15 a.m. - in bed and awake * 10:25 a.m. to 12:00 p.m. - in bed with her eyes closed Daily Enrichment occurred at 10:00 a.m. The activity staff member (#4) stated Resident #14 refused to attend the activity which conflicted with this surveyor's observation of the Resident not asked to attend. General observations throughout the survey showed Resident #14 seated in her wheelchair outside her room holding a doll except for the above noted observations. Facility staff failed to provide meaningful activities for Resident #14 as stated on her care plan, MDS, and Activity/Recreation Evaluation.	F 248		
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy	F 309	**F309** It is the practice of this facility to provide the necessary care and services for each resident to attain their highest practicable physical, mental and psychosocial well being. 1. A neurological examination was conducted on residents #3, #5, #6, #7, #8, #9, #10 and #11. 2. Resident's who have had un-witnessed falls with suspected head injury within the past 14 days were reviewed for completion of the neurological flow sheet. If incomplete a neurological examination was conducted.	9/1/2011

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F 309	Continued From page 20 and procedure, and staff interview, the facility failed to ensure completion of neurological evaluations following falls with a known or suspected head injury for 8 of 10 sampled residents (Resident #3, #5, #6, #7, #8, #9, #10, and #11). Failure of facility staff to assess the neurological staus of the residents after falls, limited the staff's ability to identify changes in the residents' level of consciousness and placed the residents at risk of complications. Findings include: Review of the facility policy and procedure "Neurological: Neurological Evaluation" occurred on 07/21/11. This document, dated March 2010, stated "PURPOSE: A neurological evaluation is used to establish a baseline neurological status upon which subsequent evaluations may be compared and changes in neurological status may be determined. USE: Following a witnessed fall (when a patient has hit his/her head) Following an un-witnessed fall (when a head injury may be suspected) Following a patient event which results in a known or suspected head injury (i.e. [in example]: hemorrhagic stroke) . . . PROCEDURE: 1. Initiate and document a baseline neurological evaluation as indicated on the Neurological Evaluation Flow Sheet. . . . 4. After the completion of the initial neurological evaluation with vital signs, continue evaluations every 30-minutes x [times] 4, then every 1-hour x 4, then every 8-hours x 9 (for the next 72 hours) . . ."	F 309	3. Licensed staff were re-educated on the correct completion of the neurological flow sheet by the ADNS or designee by 9/1/2011. Falls will be reviewed in the morning Eagle Room meeting for correct completion of the neurological flow sheet following a fall with suspected head injury. 4. Two random audits per week for four weeks will be conducted on falls if available for correct completion of the neurological flow sheet. Audits will be submitted to the QAPI committee for continued compliance. Additional audits will be conducted as directed by the QAPI committee. 5. Completion date is 9/1/2011.	

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F 309	Continued From page 21 Review of the facility form "Neurological Evaluation Flow Sheet" occurred on July 19-21, 2011. This form, dated March 2010, stated "DIRECTIONS: Complete neurological evaluation with vital signs initially, then every 30 minutes x 4, then every 8 hours x 9 (72 hours). . . ." The form included columns for dates and times of evaluations and evaluation criteria of level of consciousness, orientation, pupils, motor movement evaluation, communication/language, unusual/new observations, and vital signs. - Review of Resident #8's medical record occurred on July 19-21, 2011. The facility originally admitted the resident in March 2005 and readmitted the resident in May 2011 after a hospital stay due to a urinary tract infection. The resident's significant change Minimum Data Set (MDS), dated 03/05/11, identified the resident experienced falls in the previous six months in the facility. Resident #8's current care plan, dated 03/11/08, stated "Focus, At risk for falls . . . Interventions . . . Monitor for and report . . . change in mental status . . . or neurological status for at least 72 hours after a fall. . . ." Resident #8's Nurse's Notes identified the following: *11/19/10, 10:45 a.m. - ". . . fell out of her w/c [wheelchair]. Patient has large open area to forehead, and actively bleeding." *11/19/10, 11:00 a.m. - ". . . send to walk-in [clinic] for possible sutures." *11/21/10, 2:30 a.m. - ". . . Denies h/a [headache], nausea, dizziness or pain [with] neuro's [neurological checks] (flow sheet) WNL	F 309		

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F 309	Continued From page 22 [within normal limits]. . . ." Resident #8's medical record lacked evidence facility staff monitored the resident's neurological status after the fall on 11/19/10 as identified in the resident's care plan, the facility's policy and procedure, or completion of the neurological evaluation as identified in the Nurse's Notes. Following interview, on 07/21/11 at 9:30 a.m., to discuss the lack of a neurological evaluation for Resident #8, an administrative nurse (#13) and a supervisory nurse (#1) did not provide any additional information. - Review of Resident #9's medical record occurred on July 19-21, 2011. The facility admitted the resident in May 2011. Current diagnoses included dementia and subdural hematoma with burr holes to relieve cranial pressure prior to admission. The resident's admission MDS, dated 05/23/11, and significant change MDS, dated 07/05/11, identified short term memory problems, no long term memory problems, and falls in the past six months. Resident #9's current care plan, dated 05/26/11, stated "Focus, Cognitive loss as evidenced by stm [short term memory] loss related to Subdural Hematoma and Dementia . . . Interventions . . . Observe for and report changes in cognitive status. . . .;" and, dated 07/12/11, "Focus, Neurological deficiencies related to: Head injury, subdural hematoma with continued slow bleed. Goals, To detect and intervene with early or worsening neuro [neurological] problems. Interventions . . . Neurological system evaluation as needed. Report changes to physician as	F 309		

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F 309	Continued From page 23 needed. Observe for and report any decline in physical or mental abilities. . . ." Resident #9's Nurse's Notes identified the following falls and the corresponding Neurological Evaluation Flow Sheets: *05/16/11, 11:00 p.m. - "Resident found sitting on floor next to bed . . . Denies hitting head or neck. . . ." The Flow Sheet identified the facility staff completed the every eight hour evaluations as "AM" [morning] 05/17/11, "NOC" [night] 05/18/11, and "NOC" 05/19/11. The facility staff failed to complete the every eight hour evaluations x nine and failed to identify the time of completion to ensure an eight hour period between evaluations. *05/24/11, 10:30 p.m. - The staff found on floor beside bed. The Flow Sheet identified the facility staff completed the eight hour evaluations at 8:30 p.m. on 05/25/11, "NOC" 05/26/11, 9:00 a.m. on 05/26/11, and identified "AM", "PM" [evening], "NOC", "D" [days], or "P" [evenings] through 05/29/11. The facility staff failed to complete the evaluations every eight hours and failed to identify the time of the evaluations to ensure an eight hour period between evaluations. *06/27/11, 4:15 a.m. - The staff found the resident on the floor at side of bed, rolled out of bed. The Flow Sheet identified the facility staff completed an initial evaluation and then every fifteen minutes x three. The facility staff failed to complete additional evaluations. *06/27/11, 8:30 p.m. - "Resident was observed falling out of wheelchair onto head. . . . Has abrasion to right forehead." *06/27/11, 9:15 p.m. - "Resident transferred to [acute care facility] ER [emergency room] . . ." *06/28/11, 5:45 p.m. - "Resident returned from [acute care facility] . . ." The medical record	F 309		

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F 309	Continued From page 24 included results of a repeat computerized tomography (CT) scan of Resident #9's head, completed while hospitalized on June 27-28, 2011, which showed possible recurrent subdural bleeding. The record also showed the resident's family declined to pursue additional surgical procedure. The medical record lacked evidence of neurological evaluations after Resident #9's return from the acute care facility to monitor for possible increased subdural bleeding. *07/05/11, 3:30 a.m. - "Pt. [Patient] rolled out of bed onto floor mat . . ." The Flow Sheet identified the facility staff completed the initial vital signs, evaluations every 15 minutes x three, every 30 minutes x three, and identified "AM", "PM", "NOC", or "DAYS from the morning of 07/05/11 through the night of 07/09/11. The facility staff failed to complete the neurological evaluations per facility policy. The facility staff failed to complete the Neurological Evaluation Flow Sheets as directed for Resident #9's falls and failed to assess the neurological status following the fall and possible increased bleeding on 06/28/11. These failures placed Resident #9 at risk of unidentified neurological changes. - Review of Resident #6's medical record occurred on July 19-21, 2011. Diagnoses included depression, anxiety, and muscle weakness. The "Nurse's Notes" identified the following: * 02/19/11, 9:05 a.m. - "During ambul. [ambulation] [with] CNA [certified nursing assistant] back from breakfast - triped [sic] in doorway - eased to floor . . ." * 02/19/11, 2:30 p.m. - "When resident up for	F 309		

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F 309	Continued From page 25 lunch - noted 3.5 x [by] 3.5 cm [centimeter] bump/bruise on L [left] temple - 'I slid against the door when I fell - didn't hit on floor!' . . ." * 02/20/11, 10:20 p.m. - "Spoke [with] daughter [name] regarding pt condition. Daughter was concern [sic] because pt [patient] was not responding like usual. Only answered 'uh huh' and 'I don't know.' . . . [daughter stated] This is the first time I have seen her act this way . . ." * 02/21/11, 8:00 a.m. - ". . . pt unable to state first or last name . . ." * 02/21/11, 11:00 a.m. - "During report, notified that pt fell in her room on 02/19/11 et [and] hit the L side of head. Pt A&O [alert and orientated] x 3 [after] fall per daughter . . . Upon assessment today, pt alert but disorientated x 3. Pt couldn't follow simple commands . . . received orders to send pt to . . . ER . . ." Resident #6 returned from the hospital on 02/25/11 with a diagnosis of pneumonia. A Neurological Evaluation Flow Sheet, dated 02/19/11 at 9:30 a.m., indicated staff initiated neurological checks at that time. The next evaluations documented on the Flow Sheet were on 02/19/11 at 12:55 p.m., 1:30 p.m., 5:00 p.m., 10:00 p.m., 3:00 a.m., and the day and night shift on 02/21/11 night shift. Staff failed to complete neurological checks for Resident #6 as per facility policy. Failure of facility staff to evaluate the neurological status of Resident #6 may have resulted in delayed treatment for a head injury. - Review of Resident #10's medical record occurred on July 19-21, 2011. Review of the Neurological Evaluation Flow Sheets identified	F 309		

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	355024	A. BUILDING _____ B. WING _____	07/21/2011

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F 309	Continued From page 26 facility staff failed to complete these assessments at the time intervals per the Flow Sheet instructions following Resident #10's unwitnessed falls on 05/23/11, 06/03/11, 06/15/11 , and 07/06/11. Following the fall on 06/03/11, Resident #10 indicated he did hit the left side of his head. - Review of Resident #3's medical record occurred on July 19-21, 2011. The medical record included Neurological Evaluation Flow Sheets following an unwitnessed fall on 03/10/11 indicating facility staff suspected the resident experienced a head injury. Review of the Neurological Evaluation Flow Sheets identified facility staff failed to complete these assessments at the time intervals per Flow Sheet instructions. - Review of Resident #11's medical record occurred on July 19-21, 2011. The medical record included Neurological Evaluation Flow Sheets following an unwitnessed fall on 10/06/10 indicating facility staff suspected the resident experienced a head injury. Review of the Neurological Evaluation Flow Sheets identified facility staff failed to complete these assessments at the time intervals per Flow Sheet instructions. - Review of Resident #5's medical record occurred on July 19-21, 2011. Diagnoses included dementia. The "interdisciplinary progress notes" identified a fall on 12/14/10 at 5:20 a.m. The note stated, ". . . Res. [resident] found on floor mat next to bed. . . . Assisted off floor [with] lift [and] assist of 2. [No] apparent injuries noted. . . ." A Neurological Evaluation Flow Sheet, indicating facility staff suspected the resident experienced a	F 309		

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F 309	Continued From page 27 head injury, dated 12/15/10 at 5:45 a.m., indicated staff initiated neurological checks at that time. Staff completed a second evaluation on the Flow Sheet, dated 12/15/10 with "days" [day shift] listed as the time. Except for the two entries, the Neurological Evaluation Flow Sheet remained blank. Staff failed to complete neurological checks for an unwitnessed fall as per facility policy. - Review of Resident #7's medical record occurred on July 19-21, 2011. Diagnoses included cerebrovascular disease, muscle weakness, and a history of falls. Resident #7's record identified unwitnessed falls from bed on 06/03/11, 07/01/11, and 07/07/11. Review of a Neurological Evaluation Flow Sheet, indicating facility staff suspected the resident experienced a head injury, for the fall that occurred on 06/03/11 showed staff failed to complete neurological checks for an unwitnessed fall as per policy. Staff failed to initiate a Neurological Evaluation Flow Sheet for the unwitnessed fall that occurred on 07/01/11. During an interview on 07/21/11 at 8:15 a.m., a supervisory nursing staff member (#6) stated she would expect staff to perform neurological checks after the above unwitnessed falls because "you just never know [referring to sustaining a head injury]." During an interview on 07/21/11 at 9:30 a.m., an administrative nurse (#13) reported facility staff may not monitor the resident's neurological status for the entire period identified in the facility's policy and procedure if changes in the resident's status are not identified.	F 309		

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F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to provide necessary assistance for 2 of 2 sampled residents (Resident #4 and #5) who requested fluids from staff. Failure to meet the requests of residents who cannot independently carry out their activities of daily living (such as obtaining fluids) places them at risk of dehydration. Findings include: - Review of Resident #5's medical record occurred on July 19-21, 2011. Diagnoses included dementia, chronic kidney disease, and diabetes mellitus. Resident #5's current Minimum Data Set (MDS), dated 07/13/11, identified short term memory problems, moderately impaired decision making, and extensive assistance needed from one person for eating. The current care plan, revised 07/19/11, stated, ". . . Focus . . . Risk for alteration in hydration related to diuretics . . . requires feeding assistance and encouragement/cueing [sic] at times . . . Interventions . . . Encourage and assist as needed to consume all fluids offered at and between meals. . . ."	F 312	**F312** It is the practice of this facility to provide assistance to residents who are unable to carry out activities of daily living to maintain good nutrition, grooming, personal and oral hygiene. 1. Residents #4 and #5 were reviewed for signs and symptoms of negative effects related to lack of assistance with fluid intake. 2. Residents were reviewed to determine other residents in the facility that requires staff assistance with fluid intake. 3. Re-educate the CNA staff on water pass, provision of fluids between routine water pass and offering fluids with cares. This will be provided by the ADNS or designees by 9/1/2011. 4. Three audits per week for four weeks will be conducted to verify fluids are available and assistance is provided as needed to residents who require that assistance. Audit results will be reviewed by the QAPI committee for continued compliance. Ongoing audits will be conducted as directed by the QAPI committee. 5. Completion date is 9/1/2011.	9/1/2011

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F 312	Continued From page 29 Observation of personal cares with Resident #5 occurred on 07/19/11 at 10:12 a.m. Upon completion of cares, a certified nursing assistant (CNA) (#16) asked Resident #5 if she would like some water. The resident replied, "Yes, I would." Observation showed no water pitcher/glass available in the room, and the CNA stated she would go get the resident a glass of water. Observation from 10:12 a.m. until 11:40 a.m. (when a CNA returned to bring Resident #5 to the dining room for dinner) showed staff failed to bring Resident #5 a glass of water as requested. Observation of Resident #5 on 07/19/11 from 12:45 p.m. until 2:46 p.m. showed the resident in her room without any fluids available. During an interview on 07/21/11 at 8:15 a.m., a supervisory nursing staff member (#6) stated CNAs should offer fluids frequently because Resident #5 "does not always know to ask and needs help accessing them [the fluids]." - Review of Resident #4's medical record occurred on July 19-21, 2011. The facility admitted the resident in May 2011. Current diagnoses included lower extremity weakness, diabetes, neurogenic bowel and bladder, and constipation. The resident's admission MDS, dated 05/24/11, identified the resident was cognitively intact, required extensive assistance of two or more persons for bed mobility, and supervision of one person for eating. The resident's current care plan, dated 05/17/11, stated "ADL [Activities of Daily Living] Self care deficit . . . Interventions, Assist with . . . eating as needed . . .;" and, dated 06/06/11, stated "Focus,	F 312		

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F 312	Continued From page 30 Risk for alteration in hydration . . . Interventions, Encourage and assist as needed to consume all fluids offered at and between meals. . . ." Observation on 07/19/11 at 2:45 p.m. showed Resident #4 returned to bed after toileting by certified nursing assistants (CNAs) (#14) and (#15). The resident's bedside water container was empty and the resident requested fresh tap water. The CNAs reported another staff person was bringing around fresh water and would arrive soon. At 4:50 p.m., Resident #4 reported the facility staff failed to bring her any fresh water since her request at 2:45 p.m. The resident activated her call light. At 5:00 p.m., CNA (#14) responded and obtained a container of fresh water for the resident from her bathroom sink, two and a quarter hours after Resident #4 initially requested fresh water. During interview, on 07/21/11 at 9:00 a.m., an administrative nurse (#13) and a supervisory nurse (#9) agreed facility staff should provide fresh water on request. Resident #4 is unable to access fluids independently. The resident requested fresh tap water available from her bathroom sink which the CNA provided to her more than two hours after her request. Failure to provide accessible fluids to Resident #4 when requested placed her at risk of dehydration.	F 312		
F 314 SS=D	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	F 314	**F314** It is the practice of this facility to provide necessary treatment and services to promote healing, prevent infection and prevent new ulcers from developing.	9/1/2011

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F 314	Continued From page 31 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 professional literature, and staff interview, the facility failed to assess, monitor, and treat a pressure ulcer for 1 of 4 sampled residents (Resident #2) identified with a facility aquired pressure wound/ulcer. Failure to assess, document, and follow the treatment plan as ordered by the physician may have resulted in delayed healing and avoidable pain. Findings include: The Centers for Medicare and Medicaid Services (CMS) has outlined the standards of practice regarding pressure ulcers. The standards state, "After completing a thorough evaluation . . . Many clinicians recommend evaluating skin condition . . . When assessing the ulcer itself, it is important to . . . Describe and monitor the ulcer's characteristics; Monitor the progress toward healing and for potential complications . . . Monitor dressings and treatments." The National Pressure Ulcer Advisory Panel (NPUAP) has defined a pressure ulcer as a localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of presure, or pressure in combination with	F 314	1. Resident #2's open area on her back has healed. 2. Residents with wounds were audited to be sure the dressing used was the dressing ordered. 3. Licensed nurses were re-educated on following physician orders for wound care and documentation of any newly identified skin alteration by the ADNS or designee by 9/1/2011. 4. Observations of dressings on wounds will be made three times per week for four weeks for correct wound dressing per physician order. New skin alterations will be checked in morning Eagle Room meeting for correct documentation. Observations will be reviewed by the QAPI committee for continued compliance. Additional audits will be conducted at the direction of the QAPI committee. 5. Completion date is 9/1/2011.	

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F 314	Continued From page 32 shear and/or friction. Review of Resident #2's medical record occurred on July 19-21, 2011. Medical diagnoses included hemiplegia, and the medication regimen included morphine sulfate (a pain medication) 30 milligrams twice a day. A physician's order, dated 05/09/11, stated, "Tegaderm Foam to sore on spine [change] every 3 days." Resident #2's current Minimum Data Set (MDS), dated 05/13/11, identified the resident required extensive assistance of two or more persons for bed mobility. Resident #2's current care plan stated, "At risk for alteration in skin integrity related to: impaired sensation secondary to (R) [right] hemiparesis, immobility, bowel incontinence, and protruding spine. Interventions: . . . Encourage and assist as needed to reposition frequently . . . Administer preventive trt. [treatment] as ordered by physician." Review of the "Skin Alteration Record," dated 07/07/11, identified a dark pink/red painful open area on Resident #2's back measuring 0.7 centimeters (cm) by 0.7 cm. On 07/13/11, the record identified a dark pink/red non-painful open area with a "scant" amount of bleeding measured 0.6 cm by 0.4 cm. Observation on 07/19/11 at 5:25 p.m. showed a licensed nurse (#8) removed the wound dressing from Resident #2's back, and stated, "This is Mepilex (a type of dressing) . . . not what's ordered." She stated Mepilex is a sticky dressing and pulls at the skin when removed. Observation now showed two open areas on the resident's	F 314		

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F 314	Continued From page 33 back. The nurse cleansed the wound and applied a Tegaderm Foam dressing, per physician's order. The application of the incorrect dressing (Mepilex) may have caused the tearing of fragile skin around a current wound upon removal (pulling) of the dressing. The nurse (#8) failed to measure and document the new open area. On the morning of 07/20/11, observation showed two licensed nurses (#18 and #19) assessed pressure ulcers of residents in the facility with known ulcers. When asked if they assessed Resident #2's open areas on her back, the nurse (#18) stated they do not "look at" her back because her wound is related to shearing. Resident #2's medical record failed to identify the new open area on the resident's back until 07/20/11 at 5:55 p.m. when a licensed nurse (#1) assessed and measured the wounds. The two open areas measured 1.3 cm by 0.5 cm, and 0.5 cm by 0.5 cm. Observation showed the area surrounding the wounds reddened. Failure of facility staff to follow the ordered plan of treatment to prevent the development of additional pressure sores (due to possible shearing), assess promptly, and document a new wound upon identification, may have caused additional pain and delayed the healing process of Resident #2's wound/ulcer.	F 314		
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	**F323** It is the practice of this facility to ensure that each resident receives adequate supervision and assistance devices to prevent accidents.	9/1/2011

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F 323	Continued From page 34 This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to implement fall prevention measures for 1 of 5 sampled residents (Resident #7) identified by the facility as experiencing falls. Failure to implement interventions (i.e. fall mats) determined by staff to be appropriate has the potential to result in avoidable injury should Resident #7 experience a fall. Findings include: Review of Resident #7's medical record occurred on July 19-21, 2011. Diagnoses included cerebrovascular disease, muscle weakness, difficulty walking, anemia, and a history of falls. Resident #7's admission MDS, dated 06/09/11, identified a Brief Interview for Mental Status (BIMS) score of seven (indicating severe cognitive impairment), extensive assistance from two people needed for transferring, and a history of falls prior to admission. Medications included Seroquel (an antipsychotic), which may cause dizziness and orthostatic hypotension; and metoprolol succinate (an antihypertensive), which may cause dizziness and hypotension. Review of nurses' notes identified Resident #7 experienced three falls in the six weeks since his admission, on 06/03/11, 07/01/11, and 07/07/11. The falls occurred when the resident fell from his bed. A nurses' note dated 07/08/11 at 4:25 p.m.	F 323	1. Resident #7 was reviewed for appropriate interventions to reduce the potential of fall related injuries. Landing strips were deemed to be a hazard to this resident and a falls off cycle was completed to document this decision. 2. The accident/incident log was reviewed for residents who had falls in the past 60 days. The fall audit tool was completed for these residents to ensure interventions are documented on the off cycle evaluation, care plan, and patient information worksheet. 3. Re-education will be provided to licensed nursing staff on Falls guidelines by ADNS or designee by 9/1/2011. Re-education will be provided to CNAs on monitoring fall interventions are in place as documented on the patient information worksheet and Kardex. This will be provided by the ADNS or designee by 9/1/2011. Falls will be reviewed in Eagle Room meetings for completion of all areas outlined in Falls guidelines. 4. Three falls per week for four weeks will be audited, if they occur, for completion and documentation of interventions on the off cycle evaluation, care plan and patient information.	

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F 323	Continued From page 35 stated, ". . . Pt [patient] alert this shift. Pt denies pain. Pt VS [vital signs] WNL [within normal limits] this shift. Floor mats placed bedside . . ." An "off-cycle falls" report, completed on 07/07/11 (after Resident #7's last fall) stated, ". . . Pt found lying on floor beside bed in room. Stated 'I just fell out I guess.' Assisted back to bed with Hoyer [full body lift] lift and 2 nurses. Denied any pain or discomfort. No medications given. Will care plan for fall mats to be placed on either side of bed." Staff failed to update Resident #7's current care plan (initiated 06/03/11) with the intervention of fall mats after his fall on 07/07/11. Observations throughout the survey showed Resident #7 frequently napping in his bed. Observation showed no fall mats present on either side of his bed or anywhere in his room. On the afternoon of 07/20/11, an unidentified CNA stated she walked by Resident #7's room and saw him attempting to get out of bed. The CNA assisted him to transfer to his wheelchair. During an interview on 07/21/11 at 8:15 a.m., a supervisory nursing staff member (#6) stated staff may have removed the fall mats for cleaning. She confirmed Resident #7 should have fall mats beside his bed.	F 323	worksheet and to ensure interventions documented are in place. Audits will be submitted to QAPI committee to ensure continued compliance. Additional audits will be completed as directed by the QAPI committee. 5. Compliance date is 9/1/2011.	
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater.	F 332	**F332** It is the practice of this facility to ensure that it is free of medication error rates of five percent or greater.	9/1/2011

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F 332	Continued From page 36 This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to ensure a medication error rate of less than five percent during observation on 2 of 3 days of medication pass (July 20-21, 2011). Failure to ensure medications are administered at the correct time and according to physician/pharmacy recommendations may decrease the efficacy of medications administered to residents. Four errors occurred during staff administration of 47 medications, which resulted in an eight percent error rate. Findings include: Review of the facility policy "Medication Administration: Medication Pass" occurred on July 21, 2011. This policy, dated March 2010, stated, ". . . Purpose: To safely and accurately prepare and administer medication according to physician order and patient needs . . . Procedure: . . . 9. Administer medication . . . in accordance with frequency prescribed by physician - within 60 minutes before or after prescribed dosing time . . ." The Nursing 2011 Drug Handbook, 31st edition, Lippincott, Williams & Wilkins, pages 934-935, stated: ". . . omeprazole [Prilosec] . . . proton pump inhibitor [used to treat gastroesophageal reflux disease or GERD] . . . ADMINISTRATION . . . Give drug 30 minutes before meals. . . ." - Observation of medication pass occurred on 07/20/11 at 8:07 a.m. A nursing staff member	F 332	1. Resident #15, #23, #24 and #25 physicians were notified of the late or missed medications and monitoring was completed as directed by the physician. Resident #15 was given the daily medication that was missed as directed by the physician. 2. Medication administration records were reviewed for patients that required medication administration on an empty stomach and for missed medication. 3. Medication times for medications to be given on an empty stomach were adjusted to ensure administration prior to the patient's scheduled dining time. Re-education will be provided to licensed nurses on Medication Administration Guidelines by the ADNS or designee by 9/1/2011. Medication skills checklists will be completed for licensed nurses by the Directors of Care Delivery or designee. 4. Audits will be conducted three times per week for four weeks for correct medication administration of medications to be given on an empty stomach. Medicine Administration Records (MARs) will be audited three times per week for four weeks for missed medications. Results of the audits will be submitted to the QAPI	

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	355024	A. BUILDING _____ B. WING _____	07/21/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES	1315 S UNIVERSITY DR FARGO, ND 58103

(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 332	Continued From page 37 (#7) entered Resident #24's room with his morning medications. The medications included 40 milligrams (mg) Prilosec. The nurse asked, "Oh, are you done eating?" to which the resident replied, "Just about." Observation showed a small amount of oatmeal and coffee left on Resident #24's breakfast tray. The nurse administered the medications to Resident #24. Review of Resident #24's medical record showed the following medication order: "Prilosec OTC [over the counter] 20 mg tablet, take 2 tablets (40 mg) by mouth daily, 7 a.m." Resident #24's diagnoses included GERD. - Observation of medication pass occurred on 07/21/11 at 9:10 a.m. A nursing staff member (#8) dished Resident #25's morning medications from the medication cart. The nurse stated, "She [Resident #25] had a 7:30 [a.m.] Prilosec, and she already ate. I'm not going to give it [the medication]." The nurse then administered the other medications to Resident #25. Review of Resident #25's medical record showed the following medication order: "Prilosec OTC 20 mg, take 1 tablet by mouth every morning 1/2 hour before breakfast, 7:30 a.m." A physician prescribed Prilosec for an intermittent gastrointestinal bleed. - Observation of medication pass occurred on 07/20/11 at 9:35 a.m. A nursing staff member (#7) administered Cerovite Advanced Formula (a vitamin and mineral supplement) to Resident #23. The dose information stated, "Take 1 tablet by mouth every day, 8:00 a.m.", and a sticker on the medication cassette from the pharmacy stated,	F 332	committee to ensure continued compliance. Further audits will be conducted as directed by the QAPI committee. 5. Completion date is 9/1/2011.	

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F 332	Continued From page 38 "Take on an empty stomach." Observation showed the resident already ate breakfast. - Observation of medication pass occurred on 07/21/11 at 9:10 a.m. with a nursing staff member (#8). The nurse administered Diamox and Calcium with Vitamin D to Resident #15. Resident #15's 8:00 a.m. medications included Diamox, Calcium with Vitamin D, and a chewable 81 mg aspirin; however, observation showed the nurse failed to administer the aspirin. The nurse administered the aspirin to Resident #15 after a surveyor alerted her to the error at approximately 10:40 a.m. During an interview on the morning of 07/21/11, a supervisory nursing staff member (#6) agreed residents should take Prilosec on an empty stomach.	F 332		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.	F 441	**F441** It is the practice of this facility to establish and maintain an Infection Control Program designed to provide safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. 1. Resident #4 was monitored for signs or symptoms of infection upon survey identification. Nurse #12 was coached on the correct technique for clean dressing changes. CNA #11 was coached on hand washing following removal of gloves.	9/1/2011

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F 441	Continued From page 39 (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, facility staff failed to follow proper infection control procedures for 1 of 6 sampled residents (Resident #4) who required a dressing change. Failure to follow infection control procedures related to hand hygiene and dressing changes has the potential for cross contamination and the spread of infection to other residents, staff, and visitors. Findings include: Review of the facility policy titled "DRESSING CHANGE: NONSTERILE (CLEAN) AND STERILE (ASEPTIC)" occurred on 07/21/11. This	F 441	2. Residents with wounds were assessed for any signs or symptoms of infection. 3. Licensed nurses were re-educated on correct infection control use for dressing changes by the ADNS or designee by 9/1/2011. Hand hygiene education was provided to CNAs by ADNS or designee by 9/1/2011. 4. Random audits were conducted twice a week for four weeks for infection control during dressing changes. Random audits were conducted twice a week for four weeks for hand hygiene compliance. Audits were submitted to the QAPI Committee for continued compliance. Additional audits will be conducted as directed by the QAPI committee. 5. Completion date is 9/1/2011.	

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F 441	Continued From page 40 policy, dated 2009, stated, "PURPOSE: Dressing changes are performed according to physician's orders. Non-sterile (clean) dressing changes are appropriate for select wounds such as skin tears or ulcers . . . PROCEDURE: . . . 5. Perform hand hygiene . . . 8. Apply . . . gloves 9. Remove soiled dressing and discard in trash bag . . . 11. Remove . . . gloves and discard in trash bag 12. Perform hand hygiene . . . 14. Apply . . . gloves 15. Cleanse wound . . . 16. Remove gloves and perform hand hygiene 17. Apply . . . gloves 18. Apply dressings . . . 19. Remove gloves and discard 20. Perform hand hygiene . . ." Review of the facility policy titled "HAND HYGIENE" occurred on 07/21/11. This policy, dated 2009, stated, "PURPOSE: To decrease spread of infection . . . When to wash hands or use an alcohol-based hand rub: *Before applying and after removing gloves . . . *After contact with body fluids or excretions . . . *Moving from a contaminated body site to a clean body site during patient care . . ." Review of Resident #4's medical record occurred on all days of survey. Medical diagnoses included an unstageable pressure ulcer to her sacrum area related to friction and sheering. A physician's order, dated 07/15/11, stated to apply a Mepilex dressing to all areas (coccyx wound) after cleansing with soap and water and continue Aquacel dressing to the coccyx.	F 441		

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F 441	Continued From page 41 Observation on 07/19/11 at 11:40 a.m. showed two certified nursing assistants (CNAs) (#10 and #11) donned gloves, removed Resident #4's soiled brief, and placed her on a bedpan. After a few minutes, the CNA (#11) removed the bedpan, which contained urine and feces. The CNA placed the bedpan of the floor in the bathroom, removed her gloves and left the room. The CNA (#11) failed to wash her hands after she removed her gloves and before she left the room. Observation on 07/19/11 at 11:55 a.m. showed a licensed nurse (#12) donned gloves and removed a dressing from Resident #4's coccyx area. The nurse removed her gloves, applied clean gloves without sanitizing her hands, and cleansed the wound area with a saline spray and gauze. Observation showed feces on the resident's buttocks and the nurse (#12) cleansed that area with the saline spray and gauze. After cleansing, the nurse cut a piece of Aquacel (an antimicrobial dressing), placed it on the wound, and covered the wound again with a Mepilex Boarder (an antimicrobial soft silicone foam dressing). The nurse removed her gloves, washed her hands, and left the room. The nurse failed to remove her contaminated gloves, sanitize her hands, and apply clean gloves before she applied the clean dressings to Resident #4's wound. During an interview on the morning of 07/21/11, an administrative nurse (#9) agreed, facility staff failed to follow proper infection control procedures for Resident #4.	F 441		