STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355079	A. BUILDING _____ B. WING _____	01/15/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLA MARIA	3102 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 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey started on January 12, 2009 and completed on January 15, 2009 the sample included 5 residents for complete review, 16 residents for focused review, and 3 closed records for review.	F 000		
F 311 SS=D	483.25(a)(2) ACTIVITIES OF DAILY LIVING A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to assess, develop and implement appropriate interventions to assist 1 of 7 sample residents (Resident #4) observed during meal service, and identified by the facility as requiring assistance with eating, to attain/maintain the ability to eat as independently as possible. Failure to assess Resident #4's eating ability as changes occur places the resident at risk for poor/inadequate meal intake, weight loss, and a decrease in function in eating abilities. Findings include: - Review of the medical record for Resident #4, on January 13-15, 2009, showed the facility admitted the resident in November 2008. Diagnoses include paralysis agitans, depressive disorder and dementia. The initial Minimum Data Set, dated 11/26/08, identified Resident #4 as independent with eating after setup help from facility staff.	F 311		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Michael Reif — TITLE: President / CEO — (X6) DATE: 1/30/09

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 311	Continued From page 1 Review of the facility meal times, provided during the entrance conference identified the facility uses a five-meal-a-day plan. Meal times are as follows: AM Snack 7 a.m. to 8:30 a.m.; Breakfast 9:45 a.m. to 11 a.m.; Coffee 1 p.m. to 2 p.m.; Dinner 3:45 p.m. to 5:30 p.m.; and Night Cap 7:00 p.m. Observation during the dinner meal on 01/13/09, began at 4:14 p.m. Resident #4 sat at an independent table using regular silverware. The meal served by the facility consisted of a chicken patty, Yukon potatoes (a style of chopped potato), Capri blend vegetables, whole wheat bread, and vanilla pudding with blueberry topping. Beverages included: 2% milk, water, a supplement, and juice. To set up the meal, staff cut the chicken patty into pieces, but did not remove the slice of bread from its wrapper. Eating independently, Resident #4 consumed less than half the meal, drank all the supplement, ½ of the juice and water, and sips of milk. Staff offered Resident #4 another choice, the resident replied she would drink some coffee. Staff gave Resident #4 some coffee and encouraged her to drink her milk. With each time staff encouraged Resident #4 to drink her milk, the resident drank some milk, but did not drink the milk without staff encouragement. Observation during the AM Snack served in Resident #4's room on 01/14/09, at 8:40 a.m., showed a Certified Nursing Assistant (CNA) (#5) assisted her to eat a slice of toast with peanut butter and jelly by holding the plate of toast in front of the resident. Resident #4 ate independently after taking the toast from the plate.	F 311	**Tag # F0311 Activities of Daily Living** 1. It is the practice at this facility to give appropriate treatment and services to maintain or improve the resident's ability to eat as independently as possible. For Resident #4, the resident was moved to an assist table in the dining room on January 15th. 2. Licensed nursing staff conducted observation of meals for all other resident's identified by nurse managers to have the potential to be at risk for requiring more assistance in the dining room. 3. A "resident change in eating" form was developed as a communication tool for dietary and direct care staff to use to report concerns observed in the dining room to the licensed nurse. Inservice education was conducted with the Dietary and licensed staff on use of the tool, on observations that should be reported and expectations of how to set-up a meal for a resident. 4. A quality audit tool was developed to do observations of meals for residents at independent setting tables in the dining room. These will be done bi-weekly for one month, then monthly for one quarter and then quarterly as needed. The QA audit will be randomly assigned to licensed nurses, the dietary manager or dieticians and COTA of the facility. 5. The facility will be in substantial compliance with this deficiency by 2-18-09.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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VILLA MARIA	3102 S UNIVERSITY DR FARGO, ND 58103

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F 311	Continued From page 2	F 311		

Observation during the breakfast meal on 1/14/09, beginning at 10:15 a.m. showed the facility served Resident #4 two pancakes with syrup, link sausage, a banana, 2% milk, prune juice, a supplement, and coffee. Resident #4 sat at an independent table using regular silverware. Facility staff had not cut the pancakes or link sausage, nor removed the peel from the banana. Observation showed Resident #4 trying to eat the pancakes and link sausage using a spoon. Resident #4 did manage to consume the link sausage, but did not eat any part of the pancakes. Resident #4 attempted to open the banana using the spoon, smashing in the top of the banana and having some of the banana peel on the spoon. At 10:33 a.m., a staff member (#6) approached Resident #4 and opened the banana peel. The resident removed the half of the banana opened from the peel and consumed that portion of banana. Resident #4 did not consume the banana left in the peel. Resident #4's coffee and milk were the closest beverages to her; staff members would walk by and encourage her to drink these beverages and she would take a drink or two each time. At 10:45 a.m. staff, clearing the table, removed the uneaten pancakes, took the supplement and juice Resident #4 did not drink and left the resident her milk and coffee, encouraging the resident to drink her milk, at which she took a drink. A short time later, the milk and coffee were also cleared from the table without Resident #4 drinking all her milk.

Observation during the dinner meal on 01/14/09 at 4:30 p.m. showed Resident #4 sitting at an independent table using regular silverware. Resident #4 ate all of the cut up meatballs but did not drink either her supplement, or juice, both of

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F 311	Continued From page 3 which were the farthest for her to reach. The meal card for Resident #4, identified the resident is to use built up silverware and knife. The meal card showed pancakes as one of the resident's likes, and that she is to receive prune juice at breakfast, cranberry juice at dinner and a supplement at both breakfast and dinner. During two of three meal observations, the resident did not consume the entire supplement served. The facility completed the following "Nutritional Assessments" for Resident #4: + Dated 11/17/08, identified Resident #4 weighed 145 pounds, with a usual weight of 180 pounds. This assessment identified the resident had not experienced a weight change in the last six months. The assessment also identified the facility planned to provide a supplement at breakfast, dinner, and HS [hour of sleep]. + Dated 11/19/08, and identified as a five-day Medicare assessment, stated: "[Resident #4] receives a regular diet with supplement, as she has no need for a therapeutic diet but does need oral supplements to meet her needs. . . She can feed herself after set[up] but does not (sic) built up utensils to aid in feeding [with] ease. . . Wt. [weight] is just below healthy range and a gradual gain of 2-3 # [pounds] / [per] mo. [month] would be acceptable. . . " + Dated 11/25/08, and identified as a 14 day Medicare assessment stated: "[Resident #4] receives a regular diet [with] supplements due to no need for a therapeutic diet but need for supplements to maintain wt. . . Feeds self after set[up], using built up utensils, . . . wts. are stable [and] on low end of a healthy range. . .needs supplements to meet [increased] needs due to tall stature. Goal is for maintenance or gradual gain. .	F 311		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355079	A. BUILDING _____ B. WING _____	01/15/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLA MARIA	3102 S UNIVERSITY DR FARGO, ND 58103

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F 311	Continued From page 4	F 311		

."

The care plan for Resident #4 included the goal of "Maintain from 140 - 155# or gain 2-3 # /month to reach goal of 150 - 160#." The approaches for eating and nutritional need included:
+ "EATS without assistance with set up."
+ "Eats meals in main dining room."
+ "Provide Regular diet with supplements, small portions, and regular textures as ordered."
+ "Feeds self in independent dining room. Observe and report changes in feeding ability, chewing, and swallowing ability."
+ "Monitor weights and meal intakes and watch for changes."
+ "Provide adaptive equipment as needed including: built up utensils."
+ "If meals refused, provide extra nourishments."

Review of Resident #4's weight record showed an admission weight of 145 pounds on 11/14/08 and a current weight on 01/12/09 of 132 pounds, a 13 pound weight loss. The facility failed to reassess Resident #4 to determine the cause of this weight loss.

During an interview, on 01/15/09 at 9:00 a.m., two dietary staff members (#6 and #8) identified residents should have adaptive equipment as care planned. They also believed there was a reason Resident #4 did not receive adaptive equipment and indicated they would provide more information. The facility provided no further information.

During an interview, on 01/15/09 at 9:40 a.m., an administrative nursing staff member (#7) identified Resident #4 may benefit from consistent cueing at meals.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 323 SS=D	483.25(h) ACCIDENTS AND SUPERVISION The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy and procedure, record review, and staff interview, the facility failed to maintain an environment as free of accident hazards as possible for 1 of 3 sampled residents (Resident # 7) observed during transfers utilizing a mechanical stand up lift. Failure to ensure facility staff assessed the resident for changing status (weight bearing, cognitive abilities/capabilities, strength of extremeties/hand grasp) placed this resident at risk for injury and/or falls during transfers. Findings include: Facility policy, reviewed on 01/15/09, titled "Mechanical Lifts," revised 01/09, stated "Policy: Resident's at . . . will be transferred in the safest, easiest manner possible . . . A standing lift is available for resident [sic] that require more than one person to assist with a transfer and is used for residents able to bear weight. Procedure: 1. The nurse will determine the need for . . . standing lift use for transfers and document on the care plan . . . 4. A standing lift transfer may be done with only one caregiver present . . . 7. Follow operating instructions for the lift used."	F 323	**Tag # F0323 Accidents and Supervision** 1. It is the practice at this facility to maintain an environment as free of accident hazards as possible during transfers utilizing a mechanical stand up lift. For Resident #7, The nurse manager consulted with therapy who observed the mechanical lift transfer of the resident and felt this remains the appropriate, safe lift technique to use for this resident's transfers. 2. Licensed nursing staff conducted observation of all resident's being transferred by standing lift to assure the transfer was safe. 3. An audit was done on the number and size of slings available for use with each mechanical standing lift. A process was implemented for assigning storage locations for mechanical lift slings. Direct care staff was inserviced on proper application of slings, using the correct size sling and reporting any change in ability to transfer to the nurse. 4. A quality audit tool was developed to do random observations of standing lift transfers. This audit will be completed monthly for one quarter by the licensed nursing staff and the direct care specialist RA's and then randomly as needed based on findings. 5. The facility will be in substantial compliance with this Deficiency by 2-18-09	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355079	A. BUILDING _____ B. WING _____	01/15/2009

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VILLA MARIA	3102 S UNIVERSITY DR FARGO, ND 58103

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F 323	Continued From page 6	F 323		

The Sara 3000 (stand up lift) operating instruction manual, undated, provided by the facility on 01/15/09, stated, " . . . Encourage the patient to lean forward slightly to enable the sling to be placed around his/her lower back . . . Position the sling around the patient's back so that the bottom of the sling lies horizontally about two inches above the patient's waistline . . . If possible, the patient should then hold on to the Patient Support grips with one or both hands. The patient is then ready to be lifted . . . If the patient is able to contribute to the standing procedure, this may be beneficial to patient confidence and muscular exercise . . . Patients who can only hold on with one hand, i.e. those who have suffered a 'stroke' may still be lifted with the Sara 3000 . . . Caution: Only use this or other methods after a satisfactory professional assessment has been carried out on the individual patient."

- Observation on 01/13/09 at 3:45 p.m., identified staff members (#1 and #2) positioned the stand up lift (Sara 3000) sling around Resident #7's upper back. A staff member (#1) commented to Resident #7 that the sling was "large" for the resident and "could wrap around her twice." The staff members (#1 and #2) attached the sling to the lift, raised Resident #7 off of the bed, and transferred her to the bedside commode. The sling slid upward into Resident #7's axilla region upon standing, forcing all of the resident's body weight to be suspended and the resident's arms/elbows positioned at a 90 degree angle from her upper body. At 4:10 p.m., a staff member (#2) raised Resident #7 off of the bedside commode to complete pericares. While suspended in the sling, Resident #7 showed the inability to bear weight on her bilateral legs. A staff member (#2) provided verbal cuing to

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	355079	A. BUILDING _____ B. WING _____	01/15/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLA MARIA	3102 S UNIVERSITY DR FARGO, ND 58103

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F 323	Continued From page 7 encourage Resident #7 to use her legs during the transfer. Observation on 01/13/09 at 5:25 p.m., identified a staff member (#2) placed the sling around Resident #7's lower back and transferred the resident from her wheelchair to bed utilizing a different mechanical stand up lift (Stand-n-Weigh). During the transfer while raising Resident #7 to a standing position, the sling lifted upward into the resident's axilla region, forcing all of the resident' body weight to be suspended and her arms/elbows positioned at a 90 degree angle from her upper body. A staff member (#2) stated the facility recently purchased this Stand-n-Weigh lift and wanted to utilize this new lift on Resident #7. Observation on 01/14/09 at 9:35 a.m., identified a staff member (#3) used the stand up lift (Stand-n-Weigh), to transfer Resident #7 to the bedside commode. A staff member (#3) placed the sling around the resident's lower back. During the transfer, Resident #7 demonstrated the ability to fully bear weight on her bilateral legs and remained in a standing position throughout transfer. Resident #7 exhibited facial grimacing and upper body tension while being suspended during the transfer. Observation on 01/14/09 at 9:50 a.m., identified a staff member (#3) transferred Resident #7 to her wheelchair from the bedside commode using the stand up lift (Stand-n-Weigh). Resident #7's bilateral legs weakened while suspended during pericares. Resident #7 dropped to a low seated position while being suspended in the air due to an inability to continuously grasp the Patient Support grips (handle bars) of the mechanical lift.	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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VILLA MARIA	3102 S UNIVERSITY DR FARGO, ND 58103

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F 323	Continued From page 8	F 323		

Resident #7's shoulders extended to the Patient Support grips and remained at a 90 degree angle throughout the transfer. Resident #7 failed to maintain right hand grasp and completely let go of the Patient Support grip. The staff member (#3) assisted Resident #7 in regaining right hand grasp of the Patient Support grip by directing it with her own. The staff member (#3) lowered the resident down into the wheelchair. Resident #7 exhibited facial grimacing and upper body tension while being suspended and lowered throughout the transfer.

Review of Resident #7's medical record occurred on January 12-15, 2009 and identified the facility admitted the resident on 02/04/08. The resident's current diagnosis include cerebral vascular accident, osteoporosis, and congestive heart failure.

Resident #7's current quarterly Minimum Data Set (MDS), dated 10/29/08, identified short and long term memory problems, impaired daily decision making, extensive assistance with transfers, toilet use, and bed mobility, mode of transfer "lifted mechanically" (with a standing lift), and experienced moderate joint pain less than daily.

Resident #7's current care plan, with a print date of 09/16/08, included the following "Focus" (problem) areas and "Interventions"
". . . 1.b. Requires assistance for the physical process of TOILETING related to: Imp. mobility" and interventions of "TOILETING - One person constant supervision and phys [physical] assist for safety ie. [sic] . . . Use Mechanical lift -standing lift. "
"1c. Requires assistance for TRANSFERRING from one position to another related to: physical

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	355079	A. BUILDING _____ B. WING _____	01/15/2009

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VILLA MARIA	3102 S UNIVERSITY DR FARGO, ND 58103

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F 323	Continued From page 9 limitations" and interventions of "TRANSFERS: Provide one person/standing lift for transfers." Review of Resident #7's January 2009 progress notes, identified the resident received treatment for a respiratory infection beginning 01/01/09. Further review of Resident #7's progress notes failed to include any documentation regarding Resident #7's tolerance of mechanical stand up lift for transfers while being treated for and recovering from an acute infection. Review of the facility's 24 hour report sheet (form used by facility staff to report changes and/or potential concerns regarding residents) dated January 13-14, 2009, occurred on 01/15/09 and identified staff members (#1, #2, and #3) failed to inform the charge nurse of the resident's poor participation during the above observations. During interview on 01/14/09 at 9:30 a.m., an administrative nursing staff member (#4) stated determination of which type of mechanical transfer aide utilized by nursing staff in transferring residents is "nurse driven" and therapy (physical) may be involved to determine the appropriate type of lift. The administrative nursing staff member (#4) stated she expected resident assistants to inform the charge nurse if they have a concern with the current type of mechanical lift utilized by the resident. Failure to communicate and inform nursing staff of concerns with using a mechanical stand up lift when transferring Resident #7 prevented the facility from reviewing and revising the plan of care to minimize Resident #7's discomfort and potential for injury.	F 323		
F 371	483.35(i) SANITARY CONDITIONS	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355079	A. BUILDING _____ B. WING _____	01/15/2009

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VILLA MARIA	3102 S UNIVERSITY DR FARGO, ND 58103

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F 371 SS=E	Continued From page 10	F 371		

The facility must -
(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and
(2) Store, prepare, distribute and serve food under sanitary conditions

This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, and facility policy review, the facility failed to maintain food preparation equipment in sanitary conditions for 1 of 1 main kitchen and failed to maintain food storage as directed by facility policy for 2 of 2 nutrition stations (South and North). These practices have the potential to increase the risk of foodborne illness and can affect all residents who eat food stored and prepared in these areas.

Findings include:

The facility protocol/procedure, last dated: 8/04, subject "Temperature taking; nourishment fridges" reviewed on 01/15/09, stated: "1. Temperatures of the nourishment fridges will be taken and documented by Dietary staff that will stock and rotate daily. 2. The form will be turned in to Dietary manager at the end of each month (sic) review . . . 4. If additional thermometers are needed, the dietary manager will be notified to replace . . . 9. All items are labeled and dated."

- A main tour of the kitchen and nourishment stations occurred on 01/15/09 at 8:00 a.m. with

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F 371	Continued From page 11 an administrative staff member (#6). Observation showed a Robo Coup Blixer BX3 (a blender) stored and identified by facility staff as ready for use. Inspection of the inside of the Robo Coup showed food approximately two centimeters by one centimeter and water in the bottom of the blender container. The food appeared to be a meat product versus a vegetable product. The dietary staff member removed the Robo Coup, handed it to another dietary staff member and gave instructions for cleaning. The South nutrition station observation showed the refrigerator lacked a thermometer, a violation of facility policy. The dietary staff member (#6), identified a thermometer should be in the refrigerator, but could not locate it. This same staff member identified staff should come to her and obtain a new thermometer when needed. The North nutrition station observation showed the refrigerator to be open approximately one to two inches. An attempt to close the refrigerator showed the door would not close. Items on the top shelf of the refrigerator door were two Enlive supplement juice drinks and three Thick and Easy Dairy 2% milk products, which when touched did not feel cold. The refrigerator lacked a thermometer, a violation of facility policy. The refrigerator contained an unlabeled, undated, butcher paper wrapped package of dried or roasted beef, a violation of facility policy. The dietary staff member (#6) immediately called another dietary staff member to clean out the fridge, instructing the staff member to dispose of potentially hazardous foods. Review of the "Nourishment fridge temperature" log for the months of November and December	F 371	**Tag # F0371 Sanitary Conditions** 1. It is the practice at this facility to store food and food preparation equipment under sanitary conditions. The Robocop Blixer was immediately cleaned appropriately. New thermometers were purchased for the nutrition station fridges and the door for the north nourishment center fridge was repaired. 2. All fridges that store food for consumption were checked to assure they had working thermometers in place. All food preparation equipment was checked for cleanliness and for being stored dry by the dietary manager. No equipment sanitation concerns were found. 3. New fridge temp logs were created for all facility owned resident food storage fridges. A process was created to assure temps are taken and recorded according to policy. Inservice education was conducted with staff on food preparation equipment cleaning and fridge temperature monitoring. 4. The dietary manager will conduct a quality audit of food preparation equipment cleanliness and fridge temperature logs weekly for one month, monthly for a quarter and then as needed based on findings. 5. The facility will be in substantial compliance with this Deficiency by 2-18-09	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355079	A BUILDING _____ B WING _____	01/15/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 371	Continued From page 12 2008, occurred on 01/15/09. The log showed facility staff last documented the temperature of the North Nourishment station on 11/03/08 and the South Nourishment station on 12/31/08. The South Nourishment station log also demonstrated facility staff failed to monitor temperatures for six of 30 days in November and 13 of 31 days in December. The facility did not provide documentation of temperatures taken at the North or South Nourishment stations for the month of January. Facility policy identified temperatures are to be taken daily and a new thermometer obtained if needed.	F 371		