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 _____ FEB 4 2011	01/20/2011

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 AGTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey started on 01/18/11 and completed on 01/20/11 the sample included five residents for complete review, 16 residents for focused review, and three closed records for review.	F 000	**Tag # 280: Right to participate planning care-Revise Care Plan** 1. It is the practice of this facility to maintain the resident plan of care as current as possible. The care plan was reviewed and updated by the interdisciplinary team for residents # 3,4,12 and 16.	
F 280 SS=B	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview, and resident interview, the facility failed to update the plan of care for 4 of 21 sampled residents (Resident #3, #4, #12, and #16) with current information. Failure to update the	F 280	2. A list of residents using TED/ACE compression hose, have dentures, who use a specialized wheelchair and who are on Psychotropic medications was obtained using our electronic software. The plan of care for these residents was reviewed and updated by the nursing staff to assure accuracy. 3. A monthly care plan review process was developed, educated to all staff and implemented. Each resident's plan of care will be reviewed together by the nurse and CNA monthly to assure accuracy. A stamp was developed and implemented to assist nurses to remember to update the plan of care with all order changes. Nurses and unit clerks were educated on the order change process that includes using the new stamp. 4. A QA audit tool was developed to monitor the monthly review of care plans by the nurse and CNA, the use of the stamp and the updating of care plans with new orders. The nurses and Unit managers will be conducting these audits.	

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

President/ CEO | 2/3/11

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.

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 _____	01/20/2011

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 280	Continued From page 1 careplan has the potential for the residents to receive inappropriate and inconsistent care. *Findings* include: - Review of Resident #4's medical record occurred on January 19-20, 2011. Diagnoses included mood disorder, anxiety, renal failure, and pruritic (itching) disorder. Resident #4's careplan listed, "Focus: . . . requires assistance for DRESSING . . . Interventions: Staff to assist with putting TEDs [compression stockings] or ACE wraps [elastic bandages] on in AM [morning] off in HS [bedtime] daily . . ." and "Focus: [Name of resident] is on medication r/t [related to] depression . . . Interventions: . . . To monitor side effects of Cymbalta . . . to monitor for side effects of Xanax . . . " Review of the physician's orders showed the Cymbalta discontinued on 11/03/10 and the Xanax discontinued on 12/22/10. During an interview on 01/20/11 at 11:50 a.m., a nurse manager (#2) agreed the facility staff failed to update Resident #4's careplan regarding the discontinued medications, Cymbalta and Xanax. Observations on January 19-20, 2011 failed to show Resident #4 wearing TED stockings or ACE wraps. During an interview on 01/19/11 at 4:57 p.m., Resident #4 indicated she wore TED hose for a long time, but her legs improved and the swelling disappeared. She indicated she quit wearing them at least a month ago. The surveyor made the determination Resident #4 was reliable, based on her answers to interview questions. During an interview on 01/20/11 at 12:10 p.m., a	F 280	The audits will be done on a random sample of residents monthly for 3 months and then quarterly until compliance is achieved. 5. The facility will have corrective actions implemented and be in substantial compliance by February 24, 2011.	

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 _____	01/20/2011

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 280	Continued From page 2 licensed nurse (#1) stated Resident #4 wore TED stockings last week, but doesn't always like to wear them as they make her legs itch. The facility staff failed to update Resident #4's careplan to reflect current use of TED stockings and the discontinuation of Cymbalta and Xanax. - Review of Resident #3's medical record occurred on January 19-20, 2011. Diagnoses included dementia and dysphagia. Resident #3's careplan listed, "Focus: . . . potential for Care deficit pertaining to the teeth . . . Interventions: res. [resident] has upper and lower dentures. . . ." Progress notes, dated 10/11/10, stated, "Lower dentures missing, unable to find." Progress notes, dated 10/20/10 at 11:00 a.m., stated, "[Family member name] does not wish to have [name of resident]'s dentures replaced as he is on pureed diet and they fit poorly before and does not want to have him go to the dentist. . . ." During an interview on 01/20/11 at 11:50 a.m., a nurse manager (#2) agreed the facility staff failed to update Resident #3's careplan regarding the absence of the lower denture. - Review of Resident #16's medical record occurred on 01/20/11. Medical diagnoses included dementia and anxiety. Resident #16's care plan stated, "Focus: Required assistance for Mobility . . . Interventions . . . wheelchair with staff assist. Up in wheelchair per therapy recommendations with foot board . . ." An occupational therapy note, dated 09/24/10, stated, "Trialed Rock-n-Go w/c [wheelchair]. Res [resident] posture improved. Res able to rock self when she gets anxious. Res smiled as she rocked . . ."	F 280		

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 _____	01/20/2011

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 280	Continued From page 3 During an interview on 01/20/11 at 12:05 p.m., an administrative nurse (#7) stated staff have utilized the Rock-n-Go wheelchair since 09/24/10 and Resident #16 has adjusted well to its use. Failure to revise Resident #16's plan of care to reflect the implementation of the Rock-n-Go wheelchair on 09/24/10 has the potential for the resident to be placed in the wrong type of wheelchair adversely affecting her posture and her level of anxiety. - Review of Resident #12's medical record occurred January 18-20, 2011. The resident's diagnoses included dementia with behavioral disturbances and osteoarthrosis. Resident #12's care plan stated, "Focus: Requires assistance for Mobility . . . Interventions . . . Mobility - Dependent in w/c. Focus: Risk for falls . . . Interventions . . . Ensure proper fall prevention device is in place: bed/chair alarm/ WC cushion for seating/ scoot guard bottom of WC cushion . . ." Documentation showed physical therapy approved the trial of a Rock-n-Go wheelchair on 11/16/10. Resident #12's care plan failed to identify the use of the specialized wheelchair for the resident. Observations on all days of survey, January 18-20, 2011, showed Resident #12 seated in a Rock-n-Go wheelchair. During an interview on 01/20/11 at 10:10 a.m., an administrative nursing staff member (#6) identified the Rock-n-Go chair as a service the facility can provide to residents who are restless, explaining, the chair will rock and is more relaxing for the residents. At 1:40 p.m., the nursing staff member (#6) agreed specialized equipment used	F 280		

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 _____	01/20/2011

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 280	Continued From page 4 for a resident should be included in their care plan.	F 280	**Tag #323: Free of Accident Hazard/Supervision/Devices**	
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. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to provide necessary assistive devices (e.g. foot pedals, wheelchair brakes) for 2 of 10 sampled residents (Resident #9 and #11) and 1 random resident observed to be transferred by staff. Failure to utilize these assistive devices may result in falls and/or injury to residents. Findings include: - Review of Resident #9's medical record occurred on January 19-20, 2011. Diagnoses included hemiplegia, myalgia, and tremors. Observation on 01/19/11 at 11:18 a.m. showed a certified nursing assistant (CNA) (#3) propelled Resident #9 in his wheelchair from the dining room to the therapy room. Resident #9's left foot bounced along the surface of the floor, and the resident did not lift his left foot. The CNA failed to apply a foot pedal to Resident #9's wheelchair, although observation showed a foot pedal located	F 323	1. It is the practice of this facility to ensure the resident environment is as free of accident hazards as possible. For resident # 9, #11 and the random resident (as indicated by the surveyor) the RA's were educated on safe practice technique. 2. The RN Unit Managers developed lists of those residents who need to ambulate in front of their w/c. Either the careplan was reviewed/revised to indicate the resident requires the assist of 2 with ambulation or the resident is able to stand while brakes are applied or a one-hand wheelchair lock brake was purchased and installed on the resident's wheelchair. The RN Unit Manager also completed a review with the staff nurses and developed a list of those residents who have it careplanned to not use foot pedals. For these residents, a sticker to indicate no footpedal use was placed on the wheelchair. 3. All staff was educated on safe technique with wheelchair locking and resident ambulation. All staff was also educated on the standard of use of footpedals when pushing a resident and what the sticker means. Stickers were developed to indicate which residents do not use foot	

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 _____	01/20/2011

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 323	Continued From page 5 in a pouch on the back of the wheelchair. - Review of Resident #11's medical record occurred on January 18-20, 2011. Resident #11's medical diagnoses included Alzheimer's dementia and osteoarthritis. Observation on 01/19/11 at 1:49 p.m. showed Resident #11 ambulating with a walker and a CNA (#4). The CNA held onto the resident's gaitbelt with one hand and pulled the resident's wheelchair along with the other hand. After ambulating approximately 20 feet, the resident sat down in his wheelchair. The CNA held on to the wheelchair's left arm rest, but failed to lock the brakes. As Resident #11 sat, the wheelchair moved a few inches away from the resident. - A random observation on 01/19/11 at 3:30 p.m. showed a resident ambulating with a walker and an unidentified CNA. The CNA held onto the resident's gaitbelt with one hand and pulled the resident's wheelchair along with the other hand. After ambulating down the hallway, the resident sat down in her wheelchair. The CNA held on to the wheelchair's left arm rest, but failed to lock the brakes. As the resident sat, the wheelchair moved a few inches away from the resident. During an interview on 01/20/11 at 11:40 a.m., a supervisory nursing staff member (#5) agreed the above transfers were unsafe and stated she would re-educate staff members on transferring residents safely.	F 323	pedals as this would be the exception to the standard. 4. A QA audit tool was developed to monitor ambulation technique with those residents walking in front of the wheelchair with assist. This QA will be completed by staff nurses weekly for one month, then quarterly until substantial compliance is obtained. A QA audit tool was developed to interview staff for understanding of wheelchair pedal use for safety and the meaning of stickers to identify those who do not use pedals. This QA audit will be completed by the Direct Care Specialists and nurse managers on a random number of all staff monthly for the first 3 months and then quarterly until substantial compliance is achieved. 5. The facility will have corrective actions implemented and be in substantial compliance by February 24, 2011.	