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 _____	02/07/2019

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 The Standard Medicare/Medicaid recertification survey started on 02/04/19 and concluded 02/07/19.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal	F 550		3/14/19

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

Electronically Signed | 03/06/2019

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 _____	02/07/2019

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 550	Continued From page 1 from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide care for 2 of 24 sampled residents (Resident #66 and #74) in a manner and environment that maintained, enhanced, and respected each resident's dignity and individuality. Failure to provide assistance during meals (Resident #66) and with grooming (Resident #74) did not promote the residents' dignity or enhance their quality of life. Findings include: - Observations showed the following: * 02/05/19 at 10:36 a.m., Resident #66 sat at an assisted table in the dining room having brunch. The resident fed herself, using her fingers to pick up pieces of egg and sausage. The unidentified staff member sitting at the table failed to cue the resident to use the silverware provided. * 02/07/19 at 10:30 a.m., Resident #66 sat at an assisted table in the dining room having brunch. The resident fed herself, using her fingers to pick up pieces of pancakes covered in syrup. Two unidentified staff members attended to other residents at the table, but failed to cue the resident to use the silverware provided. During an interview on 2/07/19 at 5:00 p.m., an	F 550	1. It is the practice of the facility to encourage/cue residents to use their eating utensils to preserve dignity and enhance quality of life. It is also the practice of the facility to promote grooming of facial hair to preserve dignity and enhance quality of life. On 3/1/19, direct care staff caring for resident #66 were re-educated on the importance of encouraging/assisting resident to use her utensils during meals. On 2/6/19, facial hair on resident #74 was trimmed as resident allowed. 2. All residents needing assistance with dining and those who need assistance with grooming of facial hair have the potential to be affected by this deficient practice. 3. Re-education will be provided to all staff on 3/12/19 and 3/13/19 and will include the importance of encouraging/cueing residents to use their eating utensils during meals and to provide residents assistance with grooming of facial hair.	

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 _____	02/07/2019

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 550	Continued From page 2 administrative nurse (#1) stated, "Staff should assist residents with tray set-up and cue them throughout the meal." - Observations showed the following: * 02/05/19 at 8:30 a.m., Resident #74 sitting next to a table in the lounge area, with noticeable facial hair on her chin. * 02/06/19 at 12:10 p.m., Resident #74 sitting next to a table in the lounge area, with noticeable facial hair on her chin. A nurse (#2) stated, "[Resident #74] often refuses morning cares and won't let anyone assist her." During an interview on 02/06/19 at 2:40 p.m., a managerial nurse (#3) reported she reviewed Resident #74's chart and stated, "[Staff] charted on 1/13/19 that [Resident #74] refused cares. It's care-planned that she refuses personal cares. The nurse went down there this afternoon, and took care of it." The managerial nurse returned a few minutes later and added, "The RA [Resident Assistant] Point of Care Notes showed [Resident #74] refused cares on 01/28/19." She agreed, based on the length, the facial hair had been there for some time and could have been removed at other points of the day.	F 550	4. A quality audit will be conducted for residents that need cueing on assistance with eating utensils while dining and for residents that need assistance with facial hair grooming. These audits will be conducted weekly for four weeks, then monthly for three months and continued auditing will be scheduled per discretion of the Quality Assurance Committee. These audits will be conducted by the Quality and Learning Coordinator and/or designee. Audits will be reviewed by the Quality Assurance Committee monthly to ensure continued compliance. 5. The facility will be in substantial compliance by March 14, 2019.	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician.	F 657		3/14/19

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 _____	02/07/2019

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 657	Continued From page 3 (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to review and revise the care plan to reflect resident's current needs for 1 of 24 sampled resident (Resident #118). Failure to review and revise the care plan limited staff's ability to communicate care needs and ensure continuity of care for the resident. Findings include: Review of Resident #118's medical record occurred all days of survey. Diagnoses included local infection of the skin and subcutaneous tissue and surgical amputation of the toes on the right foot. A physicians order dated 01/22/19, identified a non-weight bearing status on the right foot.	F 657	1. It is the practice of the facility to review and revise the care plan to reflect the resident□s current needs to enhance continuity of care for the resident. On 2/8/19, the care plan of resident #118 was updated to reflect non-weight bearing status of the right foot. On 1/18/19, upon admission, the care plan of resident #118 did reflect contact isolation precautions related to MRSA. This was resolved from the care plan on 2/7/19. 2. All residents that have changes in their plan of care have the potential to be affected by this deficient practice. 3. On 2/13/19, re-education was provided	

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 _____	02/07/2019

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 657	Continued From page 4 Observation on all days of survey, showed Resident #118 on isolation. During an interview on 02/05/19 at 9:06 a.m., a licensed nurse (#20) stated, "[Resident # 118] had some toes removed and has MRSA [methicillin-resistant Staphylococcus aureus] on foot. . . He has been on contact precautions since he was admitted." The current care plan/care card failed to identify Resident #118's current status of contact isolation related to MRSA and the non weight bearing status. During an interview on 02/07/19 at 4:01 p.m. an administrative nurse (#1) stated she would expect a non-weight bearing status to be on a resident's care plan and care card.	F 657	to nursing staff on the importance of updating care plans with any necessary changes. Re-education will be provided to all staff on 3/12/19 and 3/13/19 and will include importance of revising the residents care plan to enhance continuity of care. 4. A quality audit will be conducted to ensure care plans are reflecting residents current needs. These audits will be conducted weekly for four weeks, then monthly for three months and continued auditing will be scheduled per discretion of the Quality Assurance Committee. These audits will be conducted by the Quality and Learning Coordinator and/or designee. Audits will be reviewed by the Quality Assurance Committee monthly to ensure continued compliance. 5. The facility will be in substantial compliance by March 14, 2019.	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. 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 staff followed professional standards of practice for 1 of 1 sampled resident (Resident	F 658	1. It is the practice of the facility to follow and practice professional standards to those residents with nephrostomy tubes. On 3/6/19, re-education was provided to	3/14/19

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 _____	02/07/2019

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 658	Continued From page 5 #114) with nephrostomy tubes (a tube placed in the kidney to drain urine). Failure to properly position Resident #114's tubing and drainage bag may result in complications related to infection. Findings include: Review of the facility's policy titled "Nephrostomy Tube Catheter Care" occurred on 02/07/19. This policy, revised December 2015, stated, ". . . Keep the nephrostomy catheter and drainage bag tubing free of twists, kinks and leaks . . . ." Review of Resident #114's medical record occurred on all days of survey. A physician's order, dated 11/17/2018 stated, ". . . Assure nephrostomy tubes are open and not closed, every shift . . ." The current care plan stated, ". . . Monitor my nephrostomy [sic] tubing placement . . . " Observation on 02/06/19 at 1:30 p.m., showed Resident #114 resting in bed on right side. Two certified nursing assistants (CNAs) (#4 and #5) repositioned the resident from the right to the left side. The resident remained on the left side with the nephrostomy tube and drainage bag positioned underneath the resident. The CNAs failed to ensure the patency of the nephrostomy tubing. During an interview on 02/07/19 at 3:30 p.m., an administrative staff (#1) stated, "I would expect staff to place the [nephrostomy drainage] bag below the bladder and on the side, not underneath where there is pressure."	F 658	direct care staff taking care of resident #114. Re-education included nephrostomy tube care and placement. 2. All residents who have a nephrostomy tube(s) have the potential to be affected by this deficient practice. 3. Re-education will be provided to all staff on 3/12/19 and 3/13/19 and will include nephrostomy tube care and placement. 4. A quality audit will be conducted for positioning of nephrostomy tube(s) for residents who have them in place. These audits will be conducted weekly for four weeks, then monthly for three months and continued auditing will be scheduled per discretion of the Quality Assurance Committee. These audits will be conducted by the Quality and Learning Coordinator and/or designees. Audits will be reviewed by the Quality Assurance Committee monthly to ensure continued compliance. 5. The facility will be in substantial compliance by March 14, 2019.	
F 677	ADL Care Provided for Dependent Residents	F 677		3/14/19

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 _____	02/07/2019

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 677 SS=D	Continued From page 6 CFR(s): 483.24(a)(2) §483.24(a)(2) 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 ensure 2 of 24 sampled residents (Resident #16 and #58) were positioned properly during meals. Failure to provide proper positioning had the potential to affect the resident's ability to feed themselves and maintain their caloric intake/nutritional status. - Review of Resident #16's medical record occurred on all days of survey. The current care plan stated, " I require staff assist with set up, enc. [encouragement] and physical assist as needed [for eating] . . . I require a specialized W/C [wheelchair] of rock-n-go . . ." Observations during all days of survey showed Resident #16 sat at the dining room table in a rock-n-go wheelchair in a reclined position (approximate 75 degrees) and his feet unable to touch the floor. The resident leaned forward in the wheelchair with arms fully extended to eat and reach his utensils, napkin, food and drink. The resident repeatedly leaned back in the wheelchair, and then leaned forward again to eat. Mealtime observations also included the following: *02/05/19 at 4:03 p.m.: Resident #16 ate his Magic Cup (high calorie) ice cream while leaning back in the reclined position. *02/05/19 at 4:05 p.m.: Resident #16 attempted	F 677	1. Corrective Action: It is the practice of the facility to provide assistance in positioning residents during meal times to promote their dining experience and maintain their caloric intake and nutritional status. It is also the practice of the facility to assist those residents who cannot perform oral care independently. On 2/8/19, re-education was provided to direct care staff on the importance of promoting proper positioning during meal time for resident #16 and #58. Re-education included the importance of having Rock N Go wheelchair in an upright/sitting position during meals. On 2/11/19, Unit Manager met with resident #85 who indicated she prefers to have her teeth brushed after breakfast. The care plan was updated with this preference. 2. All residents who utilize Rock N Go wheelchairs and all residents requiring assistance with oral cares have the potential to be affected by this deficient practice. 3. Re-education will be provided to all staff on 3/12/19 and 3/13/19 and will include importance of assisting/offering oral cares and proper positioning during	

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 _____	02/07/2019

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 677	Continued From page 7 to lean over the table/plate and bring food to his mouth. Observation showed food fall to his lap. *02/06/19 at 4:02 p.m.: A certified nursing assistant (CNA) (#21) placed Resident's #16's wheelchair approximately two feet from the dining table. Observation showed the resident held a napkin under his fork as he brought food to his mouth. He later dropped the fork onto the floor and stopped eating. The resident asked staff for a new fork four times. The resident attempted to pull himself closer to the table multiple times but failed. The CNA (#21) obtained a clean fork for Resident #16. Another CNA (#22) pushed the resident closer to the table, and the resident began to eat. During an interview on 02/07/19 at 3:25 p.m., an administrative nurse (#1) stated the rock-n-go wheelchair should have been locked in an upright position prior to eating and agreed Resident #16's wheelchair should have been placed closer to the table. Based on observation, record review, review of the facility's policy, and staff interview, the facility failed to assist with activities of daily living for 1 of 24 sampled resident's (#85) who required staff assistance for oral cares. Failure to provide assistance to residents who cannot perform the task independently may result in an increased risk of oral infections and decreased self-esteem. Review of the facility policy titled "STANDARDS OF CARE" occurred on 02/07/19. This policy, dated October 2012, stated, ". . . Each of the following is part of the routine care provided by caregivers, unless otherwise directed. Each item is based on the abilities of the resident to	F 677	meals for residents in Rock N Go wheelchairs. 4. Quality audits will be conducted for proper positioning during meals for residents utilizing a Rock N Go wheelchair and for oral cares being completed/offered to residents needing assistance. These audits will be conducted weekly for four weeks, then monthly for three months and continued auditing will be scheduled per discretion of the Quality Assurance Committee. These audits will be conducted by the Quality and Learning Coordinator and/or designees. Audits will be reviewed by the Quality Assurance Committee monthly to ensure continued compliance. 5. The facility will be in substantial compliance by March 14, 2019.	

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 _____	02/07/2019

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 677	Continued From page 8 participate in their care and needs based on physical and mental limitations. . . . Daily Morning Care Standards: . . . Provide oral cares . . . Daily Evening Care Standards: . . . provide oral cares . . ." Review of Resident #85's medical record occurred on all days of survey. A quarterly Minimum Data Set dated 01/05/19, identified total assistance of 1 to 2 persons required for all ADLs [activities of daily living]. The current care plan stated, ". . . I have ADL deficits related to end stage MS [multiple sclerosis] . . . ORAL CARE: I require physical assistance with mouth care . . ." Observation on 02/05/19 at 2:09 p.m. showed Resident #85's oral secretions pasty and teeth full of debris. Observation during morning cares on 02/07/19 at 8:54 a.m. showed facility staff failed to provide oral cares.	F 677		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, record review, and staff interview, the facility	F 679	1. It is the practice of the facility to implement an individualized Activity	3/14/19

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 _____	02/07/2019

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 679	Continued From page 9 failed to provide individualized, meaningful activities for 1 of 1 sampled resident (Resident #73) dependent on staff for activity participation. Failure to implement an individualized program to meet the needs and interests of a dependent resident from another country(Resident #73) may have negatively affected her overall well-being. Findings include: Review of the facility policy titled "Activity Program" occurred on 2/7/19. This policy, dated September 2018, stated, ". . . [Facility] shall have an activity program . . . appropriate to the needs and interests of each resident . . ." Review of Resident #73's medical record occurred on all days of survey. Diagnoses included major depressive and mood disorders. The current care plan stated, "I will observe activities of my choice . . . I enjoy time outdoors when the weather is nice, daycare visits, 1:1s from Bosnian speaking staff. My areas of possible preferred activities are: observing others in parlor, watching the fish, listening to music in my apartment with staff assist [and] family visits [and] phone calls, daycare/baby visits. My religious preference is: Muslim, I am not active at this time. Spiritual visits. . . . I need assistance/escort to activity functions. . . ." Observations showed the following: * All days of survey, staff failed to post an activity calendar in Resident #73's room. * 02/04/19 at 3:36 p.m., Resident #73 lay in bed, in silence. * 02/05/19 at 2:02 p.m., Resident #73 lay in bed,	F 679	program to meet the needs and interests of dependent residents from another country. A CD player/radio was provided for resident #73 for her to enjoy her music. On 2/13/19, an activity log was created for staff to document 1:1 visits. On 3/6/19, an individual activity calendar was created and provided to resident #73. On 3/6/19, a Bosnian interpreter met with resident #73 and her activity interests were reviewed and updated. 2. All non-English speaking, dependent residents have the potential to be affected by this deficient practice. 3. On 3/1/19, re-education was provided to the Care Managers by the Director of Resident Services regarding the importance of reviewing and implementation of the individualized activity program to meet the needs and interest of non-English speaking, dependent residents. Re-education will be provided to all staff on 3/12/19 and 3/13/19 and will include the importance of offering and documenting individualized activities for non-English speaking residents. 4. A quality audit will be conducted on non-English speaking, dependent residents to ensure that activities of their choice are being offered and documented. These audits will be conducted weekly for four weeks, then monthly for three months and continued auditing will be scheduled per discretion	

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 _____	02/07/2019

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 679	Continued From page 10 in silence. An unidentified certified nursing assistant (CNA) attempted to ask Resident #73 if she was experiencing any pain. The CNA spoke in English and inserted the Bosnian word for pain when attempting to communicate with her. Resident #73 gestured towards the right side of her face/neck and repeated the Bosnian word for pain. * 02/06/19 at 12:16 p.m., an unidentified CNA transported Resident #73, asleep in her wheelchair, to the front door of the facility where she sat waiting for the facility van to take her to her appointment. During an interview on 02/06/19 at 3:20 p.m., when asked for a copy of Resident #73's activity log, an activities staff member (#7) confirmed the record lacked documentation of activities staff provided to Resident #73 from November on. The activities staff member (#7) stated "[Resident #73] made it clear she does not want to go to church or large groups. She likes to sit in the parlor by the fish. [Resident #73] has music in her room. [Name of staff member] does weekly visits." Observation on 2/07/19 at 12:43 p.m. showed an activities staff member (#7) searching Resident #73's room for "the CD player she used to have in her room." Approximately 20 minutes later, Resident #73 lay in bed listening to music after the activity staff member (#7) left a second CD player on the dresser in her room. During an interview on 2/07/19 at 5:00 p.m., an administrative nurse (#1) agreed staff should be implementing an individualized activity program that meets Resident #73's needs and interests.	F 679	of the Quality Assurance Committee. These audits will be conducted by the Quality and Learning Coordinator and/or designees. Audits will be reviewed by the Quality Assurance Committee monthly to ensure continued compliance. 5. The facility will be in substantial compliance by March 14, 2019.	

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 _____	02/07/2019

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 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: 1. Based on observation, record review, review of professional reference, and staff interview, the facility failed to ensure 1 of 1 sampled resident (Resident #73) observed being assisted to drink while lying in bed received the necessary care and services to ensure her safety. Failure to properly position Resident #73 resulted in her aspirating liquids. Findings include: Swigert's "The Source for Dysphagia," 3rd ed., Pro-Ed, Inc., Texas, 2007, pages 9, 10, 125, and educational handouts, identified, ". . . Signs and Symptoms of Dysphagia . . . coughing . . . during a meal . . Some patients cough and choke when they aspirate . . . During the oral intake of . . . food and/or liquids, it is optimal for a patient to be seated at a 90 degree angle, whether in bed or in a chair. . . . Even a slightly reclined position while eating greatly increases the risk of premature loss of food over the back of the tongue. - Review of Resident #73's medical record occurred on all days of survey. Diagnoses	F 684	1. It is the practice of the facility to properly position residents to reduce the likelihood of aspirating on liquids. Also, it is the practice of the facility to assess and monitor new/existing skin conditions and provide timely intervention. On 2/11/19, a chest x-ray was obtained and reviewed by the provider and resulted in no changes to the plan of care. On 3/4/19, re-education was provided to direct care staff caring for resident #73 on the important of positioning during fluid intake. On 2/6/2019, the provider was updated on the status of resident #118□s bilateral hands and fingers. A new order was received on 2/12/19 to apply Vaseline to hands and fingers at HS and apply gloves until AM. 2. All residents requiring assistance with fluid intake and all residents with new/existing skin conditions have the potential to be affected by this deficient practice.	3/14/19

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 _____	02/07/2019

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 684	Continued From page 12 included pneumonitis due to inhalation of food and vomit. The current physician's orders stated, "As Tolerated diet: Mechanical Soft texture, Nectar consistency, Okay for pleasure feedings per family and resident request. Primary source of nutrition is G-tube feeding, for Nutrition." The current care plan stated, "I have nutritional prob. [problems] . . . related to: Dx [diagnosis] . . . adult FTT [failure to thrive] w/hx [with history] of asp. [aspiration] pneumonia . . . Provide tube feeding to meet nutr [nutritional] needs . . . Will provide . . . NTL [nectar thickened liquids] for pleasure feedings as requested . . . I have extensive assist [and] supervision with pleasure feedings . . . Monitor/document/report tube feeding complications: Aspiration . . . I have respiratory concerns possible pneumonia r/t [related to] symptoms of cough . . . SOB [shortness of breath] . . . Elevate the head of bed for comfort [and] lung expansion. . . ." Observation on the afternoon of 02/06/19 showed two certified nursing assistants (CNAs) (#17 and #18) transferred Resident #73 into bed with a full body lift and provide toileting cares. One of the CNAs (#17) then raised the head of the bed to an approximate 70 degree angle. Resident #73's head was tilted upward (as though she was looking at the ceiling) and her body leaned heavily to the right (with her hips on the left side of the bed and her head on the right side of the bed). The CNA (#17) gave Resident #73 a drink of water from a glass. Resident #73 immediately aspirated the water, began coughing, turned pink, and appeared to have difficulty catching her breath. The CNA (#17) asked her if she needed a nurse. Resident #73	F 684	3. Re-education will be provided to all staff on 3/12/19 and 3/13/19 and will include the importance of ensuring proper positioning during fluid intake as well as the importance of timely assessment and intervention of new/existing skin conditions. 4. A quality audit will be conducted for proper positioning of residents requiring assistance during fluid intake and for the timely assessment and intervention of residents with new/existing skin conditions. These audits will be conducted weekly for four weeks, then monthly for three months and continued auditing will be scheduled per discretion of the Quality Assurance Committee. These audits will be conducted by the Quality and Learning Coordinator and/or designees. Audits will be reviewed by the Quality Assurance Committee monthly to ensure continued compliance. 5. The facility will be in substantial compliance by March 14, 2019.	

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 _____	02/07/2019

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 684	Continued From page 13	F 684		

did not respond, but continued coughing an additional eighteen times before settling down. The CNA (#17) told Resident #73 she would inform the nurse of her coughing episode prior to exiting the room.

During an interview on 02/07/19 at 3:15 p.m., when asked questions pertaining to positioning, a managerial nurse (#3) reported, "We would expect [Resident #73] to be sitting just like any other person, sitting up-right."

During an interview on 02/07/19 at 5:00 p.m., an administrative nurse (#1) agreed residents should be seated upright (as close to 90 degrees as possible) prior to offering them liquids.

2. Based on observation, record review, review of the facility's policy, and resident and staff interview, the facility failed to provide necessary care and services to attain the highest practicable physical well-being for 1 of 24 sampled residents (Resident #118) requiring assessment and monitoring of skin conditions. Failure to assess and address new/existing skin conditions and provide timely and appropriate interventions may contribute to further skin breakdown, increased risk for infection, and pain/discomfort.

Findings include:

Review of the facility's policy titled "Skin Integrity Policy" occurred on 02/07/19. This policy, revised September 2016, stated, "Residents will receive appropriate assessment and care to prevent skin breakdown. . . . Do a visual head to toe skin assessment on admission, then weekly and as

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 _____	02/07/2019

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 684	Continued From page 14 needed. . . . Implement appropriate interventions . . . For any new skin alteration . . . Document assessment findings and interventions implemented . . . Make care plan entry for identified skin risks and interventions . . . Place treatment interventions on the eTAR [electronic treatment administration record] . . . Make progress note entry . . . May utilize Skin Integrity Nurse Work tool to assist in management of resident skin integrity . . . Follow Villa Maria Skin Care Protocol when needed . . ." Review of Resident #118's medical record occurred on all days of survey. A 14 day Minimum Data Set, dated 01/22/19, identified a risk for pressure ulcers and intact cognition. A review of the resident's nursing progress notes from 01/15/19 through 02/07/19 showed only one nursing skin assessment progress note addressing the resident's fingers. This progress note, dated 02/02/19 at 1:25 p.m., stated, ". . . Resident has tan colored scabs to tips of left pinky and right ring finger, scabbing is firm and intact." During an interview on 02/05/19 at 11:34 a.m., Resident #118 showed the surveyor various areas of skin concerns to his fingers on both hands. The resident removed the Band-aids from his fingers and explained, "The one here [right index finger] has been there for about a month. The one here [right 4th finger] has been there for approximately a month." The resident specifically pointed out a black spot to the top of his right 3rd knuckle and an open area to his left pinky knuckle. The resident stated, "My son and sister have been putting Band-Aids on them. My sister has been putting antibiotic ointment on this one	F 684		

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 _____	02/07/2019

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 684	Continued From page 15 [the open area to the top left knuckle] and putting Band-Aids over it." When asked if he had asked staff to address these areas, the resident stated, "The only nurse who has addressed them was [nurse #20's name] and I was told 'All I can do [Resident #118's name] is give you a Band-Aid." During observation of Resident #118's scheduled right foot dressing change on 02/05/19, the resident told the licensed nurse (#20), "I think this needs something more [pointed to the area of the left top knuckle]. The resident also asked the nurse to clip a piece of bothersome loose skin from one of his finger tips. The nurse responded, "I think this [the left knuckle] needs more than a Band-Aid . . . I'm not sure if I want to do that [clip the loose skin]." During an interview on 02/07/19 at 4:01 p.m., an administrative nurse (#1) stated she was not aware of Resident #118's family putting ointment and Band-Aids on his fingers, and she would expect a nurse to evaluate, treat per the facility's skin protocol, document, and update the care plan if the nurse would see and/or was notified of skin issues. The medical record lacked evidence of assessment and initiation of treatment to Resident #118's fingers/knuckles.	F 684		
F 692 SS=E	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's	F 692		3/14/19

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 _____	02/07/2019

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 692	Continued From page 16 comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 04/05/18. Based on observation, record review, review of facility policy, and resident council and staff interviews, the facility failed to offer fluids to 4 of 24 sampled residents (Resident #56, #89, #106, and #114) and 3 of 3 confidential residents (Resident A, B, and C) observed during cares and requiring staff assistance for fluid intake. Failure to provide assistance with fluid intake may result in dehydration, constipation, and urinary tract infections (UTIs). Findings include: Review of the facility policy titled "Provision of Adequate Hydration Status" occurred on 02/07/19. This policy, reviewed March 2018, stated, ". . . Fluid will be provided for residents	F 692	1. It is the practice of the facility to provide and offer fluids to residents that require assistance with fluid intake and to offer fluids during cares. On 3/4/19, all direct care staff caring for residents #56, #89, #106 and #114 were re-educated on the importance of offering/encourage fluids to residents that require assistance and to offer fluids during cares. 2. All residents have the potential to be affected by this deficient practice. 3. Re-education will be provided to all staff on 3/12/19 and 3/13/19 and will include the importance of offering fluids to residents that require assistance with fluid intake and to offer fluids during cares. 4. A quality audit will be conducted to	

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 _____	02/07/2019

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 692	Continued From page 17 requiring altered consistencies with meals and snacks . . ." -During the confidential resident interviews, residents (identified by the facility as interviewable) reported the following: * 02/05/19 at 11:19 a.m., Resident A: "When I ask for water at supper, they don't bring it half the time." * 02/05/19 at 11:19 a.m., Resident B: "When I ask for water, they don't bring it at times." * 02/05/19 at 3:21 p.m., Resident C: "I sometimes have to ask for water at night." -Review of Resident #56's medical record occurred on all days of survey. The current physician's orders identified, "Fluids three times a day Offer 240 cc's [cubic centimeters] w [with]/med [medication] pass" and "Fluids two times a day Offer [and] encourage 240 cc's water as ordered." The current care plan identified, "I am at risk for dehydration or potential for unstable fluid status related to: COPD [chronic obstructive pulmonary disease] . . . constipation, and hx [history] of UTI [urinary tract infection]. Assess adequacy of fluid intakes Qtrly [quarterly] or prn [as needed] and follow up as needed. Monitor my voids and fluid intakes and report to Nsg [nursing] and/or LRD [dietitian] anything abnormal. Offer and encourage me to drink 2100 cc of fluids of choice in 24 hrs [hours]." During an interview on 02/07/19 at 1:00 p.m., a nurse (#10) reported, "[Resident #56] carries a drinking mug with her where ever she goes."	F 692	ensure residents are offered fluids between meals and snacks and during cares. The audit will be conducted by the Quality and Learning Coordinator and/or designee. This audit will be conducted weekly for four weeks, monthly for three months and continued auditing will be scheduled per discretion of the Quality Assurance Committee. Audits will be reviewed by the Quality Assurance Committee monthly to ensure continued compliance. 5. The facility will be in substantial compliance by March 14, 2019.	

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 _____	02/07/2019

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 692	Continued From page 18 Observations identified the following: * 02/06/19 at 1:52 p.m., a certified nursing assistant (CNA) (#8) assisted Resident #56 to the bathroom. The CNA (#8) failed to offer Resident #56 fluids following cares. Observation showed no mugs containing water in sight. * 02/07/19 at 8:51 a.m. Resident #56 sat in the lounge watching television. Observations showed no mug containing water within her reach. * 02/07/19 at 11:45 a.m. a CNA (#9) assisted Resident #56 to the bathroom. The CNA (#8) failed to offer Resident #56 fluids following cares. Observation showed no mugs containing water in sight. The January/February medication administration records (MARs) showed Resident #56's fluid intake varied between 25-100% daily. -Review of Resident #89's medical record occurred on all days of survey. The current care plan identified, "I am at risk for, dehydration or potential for unstable fluid status related to: Dementia, CHF [congestive heart failure], HTN and constipation. I am rarely able to make fluid needs known . . . Offer and encourage me to drink 2300 cc of fluids of choice in 24 hrs as tolerated. Ensure I have access to cold water or other fluids of choice whenever possible. I need assistance, encouragement and supervision with fluid intake in order to meet daily requirements." Observation identified the following: *02/05/19 at 2:34 p.m., no water/fluids available in his/her room. -Review of Resident #106's medical record occurred on all days of survey. The current care	F 692		

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 _____	02/07/2019

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 692	Continued From page 19 plan identified, "I am at risk for dehydration or potential for unstable fluid status related to: HTN, CHF, DMII [type 2], acute kidney failure , and hx of UTI . . . Offer and encourage me to drink 1700 cc's of fluids of choice in 24 hrs as tolerated. Ensure I have access to cold water and other fluids of choice whenever possible. Observations identified the following: *02/05/19 at 9:49 a.m., an unidentified CNA assisted Resident #106 to the bathroom. The CNA failed to offer Resident #106 fluids following cares. Observation showed no mugs containing water in the room. *02/06/19 at 3:20 p.m., a CNA (#4) assisted Resident #106 to the bathroom. The CNA (#4) failed to offer Resident #106 fluids following cares. Observation showed no mugs containing water in the room. -Review of Resident #114's medical record occurred on all days of survey. The current care plan identified, "I am at risk for dehydration or potential for unstable fluid status related to: DMII . . . MS [multiple sclerosis] . . . diuretic use and hx of UTI . . . Family wishes for me to have a mug of warm water available to me in my room. Offer and encourage me to drink 1700 cc's of fluids of choice in 24 hrs. Ensure I have access to warm water whenever possible. I need (assistance/encouragement/supervision) with fluid intake in order to meet daily requirements." Observations identified the following: *02/05/19 at 9:10 a.m., no water/fluids available in his/her room. *02/05/19 at 4:11 p.m., no water/fluids available in his/her room.	F 692		

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 _____	02/07/2019

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 692	Continued From page 20 *02/06/19 at 1:30 p.m., two CNA's (#5) and #(6) repositioned Resident #114 in bed. The CNAs failed to offer Resident #114 fluids following cares. Observation showed no water/fluids available in the room. During an interview on 02/07/19 at 5:00 p.m., an administrative nurse (#1) reported, "[It is a] standard of care to offer water with cares. Water should be available, especially if requested."	F 692		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and	F 880		3/14/19

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 _____	02/07/2019

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 880	Continued From page 21 procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which 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; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review.	F 880		

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 _____	02/07/2019

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 880	Continued From page 22 The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: CONTACT PRECAUTIONS Based on observation, review of the facility's policy, and review of the resident's medical record, the facility failed to follow standard infection control practices for 1 of 1 resident (#118) on contact precautions. Failure to sanitize Resident #20's wheelchair pedal after it came in contact with an infected wound has the potential to transmit infections to other residents, staff, and visitors. Findings include: Review of the facility's policy titled "Isolation Precautions" occurred on 02/07/19. This policy, revised on September 2018, stated, "POLICY: Appropriate isolation precautions will be followed according to current regulatory guidelines. . . . 2. Transmission based precaution will be used for the care of specified residents with documented or suspected infections from highly transmissible or epidemiological significant pathogens for which additional precautions beyond Standard Precautions are needed to interrupt the transmission of the pathogen . . . C. Contact Precautions: Reduce the risk of transmission by direct skin-to-skin contact or indirect contact with a contaminated intermediate object (usually inanimate). . . . 8. TRANSMISSION PRECAUTIONS should remain in effect until it is reasonable* that the resident will not transmit the infection . . . *Physician consultation or current guidelines should be used for determination.	F 880	1. It is the practice of the facility to establish and maintain an infection prevention and control program to provide a safe, sanitary and comfortable environment that helps to prevent the development and transmission of communicable diseases and infection. On 2/7/19, the Unit Manager re-educated the nurse completing the dressing change of resident #118 on sanitizing any contaminated surfaces (such as wheelchair pedals) that come in contact with the infected would. On 2/22/19, resident #58 received a wheelchair free of any missing vinyl or cracks. The lounge chairs on Friendship Lane were replaced with chairs free of any cracks. On 2/7/19, the Unit Manager re-educated the nurse administering medication to resident #90 on the importance of discarding and replacing contaminated medication. 2. All residents in contact precautions, all wheelchair cushions/backs, all lounge chairs and all residents receiving medication have the potential to be affected by this deficient practice. 3. Re-education will be provided to all staff on 3/12/19 and 3/13/19 and will include sanitation practices of equipment of those in contact precautions, importance of reporting, repairing and/or replacing damaged wheelchair	

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 _____	02/07/2019

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 880	Continued From page 23 Review of Resident #118's medical record occurred on all days of survey and identified a right foot surgical wound positive for methicillin-resistant Staphylococcus aureus (MRSA). Observation on 02/05/19 at 9:50 a.m. showed a licensed nurse (#20) performed a dressing change to Resident #118's right foot wound. The nurse (#20) removed the dressing and placed the resident's foot on the wheelchair pedal. With the resident's foot remaining on the pedal, the nurse cleansed the wound with normal saline which dripped onto the wheelchair pedal. The nurse failed to sanitize Resident #118's right wheelchair pedal after it came in contact with the infected wound. WASHABLE/CLEANABLE SURFACES Based on observation and staff interview, the facility failed to ensure wheelchairs, cushions, and lounge chairs were free from damaged surfaces on 1 of 4 units (Friendship Lane). Failure to provide resident equipment that can be effectively washed and cleaned has the potential to spread communicable diseases and placed the residents at risk for infection. Observation on Friendship Lane occurred on all days of survey and showed multiple wheelchair cushions with cracks. Resident #58's wheelchair back had several pieces of missing vinyl and cracks. The lounge chairs in the common areas showed visible cracks. During an interview on the afternoon of 02/07/19,	F 880	cushions/backs and lounge furniture and proper infection control practices during medication pass. 4. Quality audits will be conducted to ensure proper sanitation of equipment in rooms of those in contact precautions, to ensure wheelchair cushions/backs and lounge chairs are free from cracks and to ensure infection control practices are followed during medication pass. The audit will be conducted by the Quality and Learning Coordinator and/or designees. This audit will be conducted weekly for four weeks, monthly for three months and continued auditing will be scheduled per discretion of the Quality Assurance Committee. Audits will be reviewed by the Quality Assurance Committee monthly to ensure continued compliance. 5. The facility will be in substantial compliance by March 14, 2019.	

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 _____	02/07/2019

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 880	Continued From page 24 a management staff member (#23) stated, "I am aware that some work needs to be done in this area." MEDICATION PASS Based on observation, review of facility policy, and staff interview, the facility failed to follow infection control standards for 1 of 8 sampled residents (Resident #90) observed during medication pass. Failure to follow infection control standards when giving medications may result in residents receving contaminated medications. Findings include: Review of the facility policy titled "Medication Administration" occurred on 02/07/19. This policy, revised January 2019, stated, ". . . Perform hand hygiene during medication pass following infection control standards . . . if a medication is dropped . . . the medication should be discarded and a spare should be used . . ." Observation of medication pass occurred on 02/07/19 at 10:03 a.m. A staff nurse (#15) placed Resident #90's medications in a medication cup, and used a spoon to scoop up three tablets. One tablet fell on to the resident's wheelchair. The nurse (#15) used the spoon to scoop the tablet off Resident #90's wheelchair and failed to discard/replace the contaminated medication prior to administration. During an interview on 02/07/19 at 11:34 a.m., an administrative nurse (#1) stated that staff are to follow professional standards of practice.	F 880		

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 _____	02/07/2019

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