DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 _____	11/29/2012

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 November 26, 2012 and completed on November 29, 2012 the sample included 5 residents for complete review, 21 residents for focused review, and 3 closed records for review. The sample included 6 additional residents to verify specific concerns during the survey.	F 000	**Tag #315:** 1. It is the practice of this facility to ensure that perineal care is given following acceptable standards of practice. The Resident Assistant who was observed to have done the inappropriate pericare was interviewed regarding the observation made and she was educated again on proper technique for pericare. She will be observed on technique upon her return from a medical leave. 2. The facility acknowledges that residents who have incontinence could be at risk if Certified Nursing Assistants would perform pericare inappropriately. 3. All CNA's in the "Resident Assistant" position will be re-educated at on Inservice on proper pericare technique and the importance of proper technique in the prevention of UTI's. on Dec. 19th per T.C. with Betty Vetter, DON 4. The QA audit tool for pericare technique will be completed for all Resident Assistants. A staff Licensed nurse will do at least one observation for each resident assistant. Nurses and the Direct Care Specialists will also conduct random observations. These additional random observations will be done monthly and then quarterly to assure substantial compliance is maintained. This Quality audit observation on pericare is currently	on 12/31/12 LM/pc
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of professional reference, and staff interview, the facility failed to provide perineal care in a manner consistent with practices to prevent urinary tract infections (UTIs) for 1 of 1 resident (Resident #10) observed receiving inappropriate perineal care. Failure to provide perineal care according to acceptable standards of practice placed Resident #10 at risk of developing a UTI. Findings include:	F 315		

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

Michael Reis | President/CEO | 12/18/12

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

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F 315	Continued From page 1 Kozier & Erbs, "Fundamentals of Nursing Concepts, Process, and Practice," Ninth Edition, page 675, states "Chain of Infection . . . . Human Body Area Reservoirs: . . . Urinary tract. . . . Common Infectious Microorganisms: . . . Escherichia coli enterococci (E-coli) . . . Portals of Exit: anus; feces. . . ." Page 765 states ". . . Providing Perineal-Genital Care. . . . For Female Clients. . . . wipe from the pubis to the rectum. . . . Wipe from area of least contamination (the pubis) to the greatest (the rectum). . . ." Record review for Resident #10 occurred on November 27-29, 2012. Medical diagnoses included chronic renal disease and diabetes. The current Minimum Data Set (MDS), dated 09/01/12, identified moderate cognitive impairment, frequent urinary incontinence, and extensive assistance with personal hygiene. The current comprehensive care plan identified a goal of "free from UTIs" through prevention of dehydration and encouraging fluids. Observation on 11/27/12 at 8:50 a.m. identified a certified nursing assistant (#5) assisted Resident #10 with her morning cares. Observation showed the resident's brief wet with urine. When performing perineal care, the CNA (#5) washed the resident from back to front several times. Each time the CNA washed the resident, observation showed visible stool on the washcloth. Although the cloth showed visible stool, the CNA failed to cleanse the perianal area. The CNA later confirmed the washcloth showed visible stool.	F 315	done prior to each Resident Assistant's evaluation and this practice will continue. 5. The facility will have corrective actions implemented and be in substantial compliance by January 3, 2013	

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F 315	Continued From page 2 During an interview on the morning of 11/29/12, an administrative nurse/quality assurance staff member (#6) acknowledged the above technique placed Resident #10 at risk of developing a UTI.	F 315	**Tag # 371:** 1. It is the practice of this facility to provide food using sanitary conditions. The dish machine was checked to ensure it was working properly and maintaining temperatures to sanitize the dishes.	
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY 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, policy and procedure review, review of a dietary task list, review of dietary logs, review of maintenance reports, and staff interview, the facility failed ensure safe and proper sanitizing of dishware in 1 of 1 kitchen. The facility failed to properly monitor the dish washing log and provide maintenance as needed to the dishwasher in the main kitchen to ensure sanitation of dishes. This practice placed residents at risk for foodborne illness. Findings include: Review of the facility dietary policy titled "Protocol and Procedure" occurred on 11/28/12. This policy, dated January 2009, stated, " . . . Dishwasher temperatures of water in wash and	F 371	2. There is only the one commercial dish machine in the building. 3. Dietary staff was educated on the importance of regularly checking the dish machine temps and on reporting any discrepancy with acceptable temp ranges so timely corrective action is completed. The temp log was revised and includes the proper temp ranges on the form. 4. The revised Dish machine Log for monitoring the dish machine temps includes a section for signed review by the dietary manager on weekdays to assure compliance with monitoring. The log will be reviewed weekly for 3 months to assure compliance. Then monthly for 3 months and then quarterly once compliance is achieved. The dietary manager will complete the reviews. 5. The facility will have corrective actions implemented and be in substantial compliance by January 3, 2013.	Education Dec 5, 6, 7, 8, 9th per T.C. with Betty Volk, DON 12/31/12 LM

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F 371	Continued From page 3 rinse cycle are to be monitored on regular basis and maintained at 160 [degrees] and 180 [degrees] F [Fahrenheit]. If these temperatures are not reached, maintenance will be contacted for repair." Review of the facility's "Pre-Shift Log" minutes occurred on 11/28/12. This log identified maintenance replaced a booster heater in the dishmachine on 09/25/12 and staff received education on the need to inform the dietary supervisor or maintenance if the machine failed to reach proper temperatures. The minutes identified staff received education on 10/04/12 regarding documentation of the dishmachine temperatures. Review of a facility task list posted in the kitchen identified the "Server 1" position working from 7:00 a.m. to 4:00 p.m. is to check the dishwasher temperatures daily. The dish machine log identified areas to document the temperatures daily for the wash and sanitation cycle of the dishwasher and during an interview on 11/26/12 at 1:05 p.m., a dietary supervisor (#1) identified temperature readings for the dish machine were to be written on the log. Review of the facility's dishwasher maintenance reports identified the dishwasher had been serviced or repaired on: 06/04/12, 07/11/12, 08/07/12, 09/12/12, 09/25/12, 10/24/12, and 11/19/12. Review of the dish machine temperature log occurred on 11/28/12. This log showed from July 2012 through November 27, 2012, (150 days) the facility documented 56 days of dish machine	F 371		

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F 371	Continued From page 4 temperature readings. This temperature log lacked the specific dates the temperatures were recorded. The log identified the following times when the sanitation cycle (rinse cycle) failed to reach 180 degrees F in 2012: * July- Week 5 on Tuesday and Wednesday for 2 low temperatures out of 15 monitored in July. * August- Week 1 showed Monday and Wednesday; Week 3 Sunday, Wednesday, and Friday; Week 4 Monday and Thursday; and Week 5 Monday, Tuesday, Thursday, and Friday for 13 low temperatures out of the 20 monitored in August. * September- Week 1 Wednesday and Thursday; Week 2 Monday and Tuesday; Week 3 Monday, Friday, and Saturday; Week 4 Monday; and Week 5 Friday for 9 low temperatures out of 13 monitored in September. The log identified appropriate temperatures on 09/25/12 when the machine received repairs and 3 days after the repairs the log identified a sanitation cycle reading of 130 degrees F. * October- Week 2 Monday and Week 5 Tuesday for 2 low temperatures out of 16 monitored in October. * November 1 through November 27- week 2 Monday (11/12/12) During an interview on 11/28/12 at 9:50 a.m., a dietary supervisor (#1) stated a service company conducts maintenance checks of the dish machine monthly (dates listed above). This supervisor reported staff should be writing in a daily temperature reading on the dish machine log and reporting to her if the temperatures are low. The facility has the dish machine monitored	F 371		

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F 371	Continued From page 5 monthly by a company to ensure it functions properly but failed to increase the need for inspection with the dish machine continuing to have sanitation rinse readings below 180 degrees F.	F 371	**Tag # 456:** 1. It is the practice of this facility to provide a safe environment. The lamp observed to be unsafe during survey was removed and replaced with a lamp that was safe and able to be located safely within the room while providing good lighting. 2. All resident rooms were checked for personal lamps that may have shades removed. No other lamps were found to be without shades. 3. Notice for all staff to watch for and report unsafe conditions was posted on the Employee e-board and sent to all employees via e-mail. Importance of observing and reporting unsafe conditions, especially lights was done during nurses meeting, RA inservices and at CM monthly meeting. The Director of Environmental Services created an Audit tool to use to check rooms for unsafe lamps. 4. The Director of Environmental Services will assure QA audits are conducted initially and then monthly and then quarterly to assure unsafe lamps are not in use. Himself, a member of the maintenance department or the housekeeping manager, will complete the QA audits. 5. The facility will have corrective actions implemented and be in substantial compliance by January 3, 2013.	Nursing mtg Dec 12, CNAs Dec 19 case mangrs Dec 20 T.C. Betty Vetter 12/31/12 LM/Pres
F 465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide a safe environment in 1 of 1 resident room (on Oak Lane) observed to have a table reading lamp without a protective shield or shade and the bare bulb in contact with the wall covering. This practice resulted in a burn area on the wall covering and placed all residents, staff and visitors at risk of a fire emergency and risk of injury from breakage of the bare bulb. Findings include: During the initial tour of the facility on the afternoon of 11/26/12, observation showed a table reading lamp with a very bright bulb without a protective shield or shade in a resident room on Oak Lane. The environmental tour of the facility, conducted on 11/28/12 at 4:15 p.m., with an environmental staff member (#2) and a housekeeping staff member (#3) showed the lamp remained with the	F 465		

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F 465	Continued From page 6 bare bulb. At the time of the tour the bare bulb was on and in contact with the wall of the room resulting in a burn mark on the wall. The housekeeping staff member moved the lamp/bulb away from the wall. During interview, on 11/29/12 at 10:35 a.m., the housekeeping staff member (#3) stated she changed the bulb to one that didn't put out as much heat. She also stated she left a message with the case manager regarding finding a shade/shield for the lamp. Observation of the lamp in a resident's room on Oak Lane, on 11/29/12 at 10:45 a.m., with an administrative nursing staff member (#4), showed the lamp remained without a shade or shield. Measurement of the burn mark on the wall identified the size of the mark as one inch in diameter. This nursing staff member (#4) stated if family or a resident bring in electrical items, maintenance staff examine the item. Policies and procedures regarding maintenance of electrical equipment and inspection of resident equipment were requested. No information was provided.	F 465		