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 _____	12/05/2013

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 December 2, 2013 and completed on December 5, 2013 the sample included 5 residents for complete review, 16 residents for focused review, and 3 closed records for review.	F 000		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement.	F 278		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Michael J. Reiter	CEO	01/08/14

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 278	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual (Version 3.0), and staff interview, the facility failed to ensure the Minimum Data Set (MDS) accurately reflected the resident's status for 2 of 5 sampled residents (Resident #7 and #12) identified by the facility with a pressure ulcer. Failure to accurately complete the skin condition section of the MDS does not allow staff to develop a plan of care based on the resident's current status and needs. Findings include: The Long-Term Care Facility RAI User's Manual, October 2013, page M-38 stated, "The determination as to whether or not one should receive nutritional or hydration interventions for skin problems should be based on an individualized nutritional assessment. The interdisciplinary team should review the resident's diet and determine if the resident is taking in sufficient amounts of nutrients and fluids or are already taking supplements . . . Additional supplementation above the US Recommended Daily Intake (US RDI) has not been proven to provide any further benefits for management of skin problems including pressure ulcers. Vitamin and mineral supplementation should only be employed as an intervention for managing skin problems, including pressure ulcers, when nutritional deficiencies are confirmed or suspected through a thorough nutritional assessment . . . If it is determined that nutritional supplementation . . . is warranted, the facility should document the nutrition or hydration factors	F 278	**Tag #278:** 1. It is the practice of this facility to complete the MDS accurately following RAI user's manual guidelines. The MDS for resident #7 and #12 was corrected and resubmitted to the State and CMS on 12/16/2013. 2. The facility acknowledges that the interpretation and coding of M01200D on nutrition interventions under skin and ulcer treatments did not meet the intent of the RAI User's Manual, based on the interpretation as explained by the surveyor. A report was run from the Facility MDS software to identify current residents who had question M1200D answered as "Yes." A review of the nutritional assessment was conducted for the identified residents to assure coding was correct. For residents where the coding was not accurate, a corrected MDS was submitted. 3. The two facility dieticians and MDS nurses were educated by the surveyors on the interpretation and proper coding during survey. A meeting with the dieticians and MDS nurses was conducted on 1/7/2014 regarding guidelines for marking M1200D as a "Yes." M1200D will only be marked "Yes" if nutritional deficiencies are	

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F 278	Continued From page 2 that are influencing skin problems and/or wound healing and tailor nutritional supplement to the individual's intake, degree of under-nutrition, and relative impact of nutrition as a factor overall and obtain dietary consultation as needed . . . ." Review of the Resident #7 and #12's medical records occurred on December 02-04, 2013. - Resident #7's quarterly Minimum Data Set (MDS), with an assessment reference date of 09/21/13, identified one unhealed Stage 2 pressure ulcer and the implementation of nutrition or hydration interventions. The Quarterly Nutritional Assessment, dated 09/23/13, stated, ". . . Intakes are good, ave [average] 92% of meals served and meet his protein needs, . . . Risk Assessment . . . Comments: He currently has a Stage II open area on left buttock. This is recurring area. Dietary interventions for healing skin include: offer and encourage protein with daily goal of 1.2 gm [gram] per Kg [kilogram] BW [body weight] . . . provide Vit [vitamin] C fortified juices and give vitamin/min [mineral] suppl [supplement] as ordered . . . He currently meets his protein goal d/t [due to] good intakes . . . ." This assessment stated most of Resident #7's laboratory results are within normal limits. The above nutritional assessment identified Resident #7 reached and maintains recommended protein levels for healing of his pressure ulcer by adequate food intake and does not meet the definition of a nutrition or hydration program under Section M of the MDS. - This facility admitted Resident #12 on 09/10/13.	F 278	confirmed with the nutritional assessment. 4. A report will be completed through the MDS software for any "yes" answers to MDS question M1200D. A chart review audit will be completed to assure the MDS was coded correctly based on the nutritional assessment. This audit will be done monthly for one quarter and then quarterly until it is assured compliance is achieved. This quality audit will be conducted by the Dieticians and MDS nurses for the opposite unit than the one that they work. 5. The facility will have corrective actions implemented and be in substantial compliance by January 18, 2014.	

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F 278	Continued From page 3 The Admission Nutritional Assessment, dated 09/19/13, stated ". . . Intakes are good, average 85% at meals and snacks. She is more than meeting her increased needs for healing skin. . . ." Resident #12's admission MDS, with an assessment reference date of 09/18/13, identified one unhealed pressure ulcer as a Stage 2 and the implementation of nutrition or hydration interventions. The Nutrition and Skin Condition Assessment, dated 09/24/13, identified Resident #12 "meets needs" for protein intake, kilocalories (Kcal) intake and fluid intake. This assessment indicated Resident #12 was not receiving oral supplements or other supplements. The comments section indicated, "[Resident #12] has a stage 2 pressure area to her left heal. She receives a regular diet with good intakes at this time. She is more than meeting her increased needs to heal skin. . . ." Resident #12's record contained no lab reports. An interview occurred with two MDS Nurses, the Dining Room Manager, and two Dietitians (Staff #13, #14, #15, #16, and #17) on 12/05/13 at 8:30 a.m. The dietitian (Staff #13) responsible for Resident #12 indicated she coded the nutrition interventions under Skin and Ulcer treatments because Resident #12 has an open area. This staff member confirmed no special interventions were in place at the time of the assessment. The dietitian (Staff #14) responsible for Resident #7 indicated she coded the nutrition interventions under Skin and Ulcer treatments because Resident #7 has an open area.	F 278		
F 280	483.20(d)(3), 483.10(k)(2) RIGHT TO	F 280		

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F 280 SS=D	Continued From page 4 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 record review, resident interview, and staff interview, the facility failed to develop a comprehensive care plan to meet the needs of 1 of 5 interviewable residents (Resident #15) regarding the resident's off-campus activities. Failure to develop and implement a care plan in accordance with the resident's desired off-campus activities did not recognize the resident's individuality and may have resulted in increased behaviors. Findings include:	F 280	**Tag # 280:** 1. It is the practice of this facility to develop a comprehensive care plan to meet the needs of interviewable residents regarding off-campus activities. For resident #15, The care plan was revised to specifically address off-campus activities. 2. The list of interviewable residents was reviewed and cross referenced with the current list of residents with behavioral needs. All interviewable residents were interviewed regarding their satisfaction with their activity plan of care, including interest in off campus activities and suggestions for added activities. 3. A meeting was held on 1/7/14 with the Case Management staff and 1/8/14 for Activity staff regarding care planning to meet resident needs for off-campus activities. Case managers will address resident desire for off-campus activities in the VM Resident Activity History. Case Managers/Activity staff was educated on importance of documenting resident refusal of offered activities as careplanned. Nurses were educated at the 1/8/14 nurses meeting on documenting and communicating with case managers when resident expresses wishes for specific activities that are not being offered.	

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F 280	Continued From page 5 During the initial tour of the facility, on 12/02/13 at 2:35 p.m., Resident #15 reported he is not allowed to leave the facility campus in his power wheelchair without an escort, including across the street to the nearby shopping center and grocery store. Review of Resident #15's medical record occurred on December 04-05, 2013. The facility admitted the resident in June 2012. Current diagnoses included adjustment disorder with depression, suicidal ideation, behaviors, and dyspnea. The resident's quarterly Minimum Data Set (MDS), dated 11/09/13, identified he usually understood and understands others, cognitively intact, moderate depression, supervision and setup help required for transfers, and ambulation did not occur. The facility identified Resident #15 as interviewable. Resident #15's Behavioral Care Area Assessment (CAA), dated 02/22/13, identified the resident refused a dietary supplement and no other behaviors. Resident #15's medical record identified a suicidal gesture on 07/30/12 when he placed a plastic bag over his head. The facility transferred the resident to an acute hospital for short term care and he received psychiatric followup which was discontinued on 08/05/12. Resident #15's nurse's notes, dated 07/25/13 at 7:22 p.m., stated "Resident was discovered to be in his electric wheelchair and across the street on the sidewalk, appearing to be going to [name] grocery store at 6:20 p.m. Alerted by Operator, who received notification from a visitor coming in to the building. Staff immediately was dispatched	F 280	4. The case management department will conduct activity interviews using the created activity satisfaction interview form on random interviewable residents monthly for 3 months and then quarterly until compliance is achieved. The Director of Resident Services will report the results of the interviews to the Quality committee at the quarterly meeting. 5. The facility will have corrective actions implemented and be in substantial compliance by January 18, 2014.	

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F 280	Continued From page 6 to supervise and return this resident. Nurse immediately called son of this incident. . . ." Resident #15's current care plan, undated, stated the following: *"Focus, I have ADL [Activities of Daily Living] self care performance deficits . . . Interventions, LOCOMOTION: . . . I also utilize an electric scooter throughout the facility . . ."; *"Focus, I have a hx [history] of behavior problems that include verbally, socially and sexually inappropriate statements, swearing at staff, rejection of care, refusal of taking meds [medications], related to: Anger, frustration . . . hx of attempting to leave facility. Goals, I will not leave facility unattended through the review date. . . . Interventions . . . I swear in day to day conversation. . . ."; *"Focus, I have a mood problem . . . hx of suicidal comments . . . Loss of independence . . . Interventions . . . Encourage me to express feelings of anger and concerns as necessary. . . ."; *"Focus, I will do activities of my choice with staff assist as needed. . . . Interventions . . . I have my own scooter and like to go outside as the weather permits. I should tell the receptionist when I go out and will try to stay on the sidewalk and not use the parking lot. . . ." Resident #15's care plan identified swearing negatively as a behavior and positively as a means of expressing his anger and frustration. This limited the resident's ability to express himself in a manner to which he is accustomed, increasing his frustration. During interviews, on December 03-04, 2013, Resident #15 reported he would like to take trips	F 280		

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F 280	Continued From page 7 to the nearby shopping center in his power wheelchair. He reported facility staff did not offer one-to-one escort and he did not like to go in a group. During interview, on 12/05/13 at 10:40 a.m., a social services staff member (#3) and an activities management staff member (#2) reported Resident #15's family member takes him out frequently when weather permits; Resident #15's behaviors are much improved from previously; the facility did not offer one-to-one outings for the resident; and, confirmed the care plan failed to identify one-to-one outings to the shopping center or grocery store. Resident #15's care plan is contradictory regarding his swearing as a behavior and as a means of expressing his frustration. The facility identified going outside and the resident identified going to the nearby shopping center and grocery store independently or with one-to-one escort are important to him. Failure to develop and implement a care plan addressing outings with facility staff as a means to reduce his anger and frustration may have contributed to Resident #15's behaviors.	F 280		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control	F 441		

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F 441	Continued From page 8 Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy and procedure, family interview, and staff interview, the facility failed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of disease and infection regarding 1 of 1 plugged sink in a resident room. Continued use of the plugged sink for hand washing by facility staff,	F 441	**Tag # 441:** 1. It is the practice of this facility to provide a safe, sanitary and comfortable environment. The sink, counter and floor in resident #4 and #5 room was sanitized immediately upon being informed by the surveyor on 12/4/13. 2. The Director of Environmental Services was notified immediately of the need for communication to assure sanitation when a sink is plugged and worked on by either facility maintenance staff or a contract plumber. The Director of Environmental Services reports no other rooms had been identified with a plugged sink problem since 12/5/2013. 3. A policy on maintenance repair safety was created to delineate accountability of repair work. A meeting was held with the Director of Environmental Services and the maintenance staff to review the policy and accountabilities. This policy was also reviewed at the nurses meeting on 12/19/2013 with the licensed nurses to assure they understood their role in accountability for a safe and sanitary environment with maintenance repairs. A log was created to track repairs for plugged sinks. This will be maintained by Maintenance staff.	

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F 441	Continued From page 9 release of sewer fumes and gases, and failure to sanitize the sink, counter, and floor after contact by sewer waste for more than 16 hours placed Resident #4 and #5 at risk of exposure to infectious material and noxious fumes. Findings include: Review of the facility policy and procedure, "Daily Cleaning," occurred on 12/05/13. This document, revised October 2013, stated "Policy: The environment will be cleaned, disinfected and maintained to prevent the spread of infection. . . ." Observation of facility staff providing cares for Resident #4 in her semi-private room occurred on 12/03/13 as follows: *2:15 p.m. - A certified nursing assistant (CNA) (#4) checked the resident's brief and found it to be soiled. The CNA (#4) removed her gloves and washed her hands at the in-room sink. The sink did not drain and water flowed from the sink onto the floor. - A second CNA (#5) assisted the CNA (#4) to complete Resident #4's perineal cares. The CNA (#5) removed her gloves and washed her hands at the in-room sink. Water from hand washing continued to flow onto the floor. - A maintenance department staff member (#6) entered the room, used a plunger in the sink, and water flowed onto the floor. This staff member stated he would "call a plumber." The CNA (#5) placed towels at the edge of the sink to reduce the water flowing onto the floor, placed towels on the floor to soak up water, and removed the curling iron and electric razor from the counter. A foul odor could be identified in the room *2:45 p.m. - The maintenance staff member (#6) returned to the room with a vacuum cleaner;	F 441	4. The Director of Environmental Services will review the log weekly for one month, then monthly for 3 months and then quarterly until substantial compliance is achieved to assure sanitation is occurring with plugged sink repairs. He will report the results of this log audit to the Quality Committee quarterly. 5. The facility will have corrective actions implemented and be in substantial compliance by January 18, 2014.	

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F 441	Continued From page 10 vacuumed water out of the sink; and left water and towels on the counter and on the floor. *3:00 p.m. - Resident #5 (Resident #4's roommate) ambulated into the room, accompanied by a Family Member (#1). Facility staff entered the room and removed the water and towels on the counter and from the floor. Family Member (#1) stated an odor of "sewer" in the room. *3:40 p.m. - A CNA (#7) entered the room, washed her hands at the sink which did not drain, and checked the resident's brief which was dry. The CNA (#7) again washed her hands at the sink, which did not drain, and water flowed onto the floor. The CNA (#7) placed towels on the sink counter to reduce water flowing onto the floor. At this time a maintenance staff member (#6) entered the room with an individual identified as a "plumber" and these individuals checked the sink. A CNA (#8) entered the room and the CNAs (#7) and (#8) assisted Resident #4 to transfer to a wheelchair. Observation showed the plumber dismantled the sink drain during the repair process. *4:30 p.m. - The "plumber" completed repairs on the sink. Towels remained on the counter and on the floor under the sink. The sink and counter showed visible dried material and the floor showed small pieces of material after the plumber completed the repairs. The foul odor of "sewer" remained in the room. Observation of Resident #5 (Resident #4's roommate) occurred on 12/03/13: *5:05 p.m. - Resident #5 remained in bed. A CNA (#9) encouraged the resident to get up for supper. The CNA (#9) picked up the towels from the counter and the floor, however did not clean or sanitize the sink or floor.	F 441		

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F 441	Continued From page 11 *5:10 p.m. - A licensed nurse (#10) and a CNA (#11) entered the room with Resident #5's meal tray. The resident decided to go to the dining room for the evening meal. The CNA (#11) assisted her with her shoes and ambulation to the dining room. The staff members failed to clean or sanitize the sink or floor. The foul odor of "sewer" remained in the room. Observation on 12/04/13 occurred as follows: *8:00 a.m. - The dried material remained on the sink and counter; the debris remained on the floor at the sink; and the foul odor of "sewer" remained as identified at 4:30 p.m. on 12/03/13. During observation of the residents' room, on 12/04/13 at 8:15 a.m., an administrative nursing staff member (#12) confirmed the presence of the dried material on the sink and counter and the debris on the floor. This staff member (#12) stated she expected the facility staff to find alternative methods to sanitize their hands when the sink plugged, to clean and sanitize the sink and floor after the plumber completed the repairs, and to de-odorize the "sewer" odor.	F 441		