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 _____	12/22/2011

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey started on December 19, 2011 and completed on December 22, 2011 the sample included five (5) residents for complete review, sixteen (16) residents for focused review, and three (3) closed records for review.	F 000	**Tag # 309** 1. ***It is the practice of this facility to monitor B/P's on non-fistula arms.*** For resident # 15, staff working with this resident were reminded to not take B/P's on fistula arm. The care plan was updated to include not only the site of the fistula but also the caution that no B/P's are to be taken on this arm. 2. ***Identifying other residents:*** There are 5 other residents who also have fistula's. The staff was educated and the careplans were checked and updated as needed to include no B/P's to be taken on fistula arm. 3. ***Measure put in place to prevent re-occurrence:*** RA's were educated not to take B/P's on fistula arms. Nurses were educated on proper data entry in the EMR related to site of B/P measurement, careplanning this information and of educating RA's related to risk of taking B/P's on fistula arm. 4. ***Monitoring:*** A quality audit was developed to interview staff on their knowledge regarding not taking B/P's on fistula arms. This QA audit will be completed by the Direct Care Specialists and Nurse Managers on a random number of RA's and nurses monthly for the first 3 months and then quarterly until substantial compliance is achieved. A quality audit tool was developed that will check B/P data entry in the EMR	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy and procedure, and staff interview, the facility failed to provide the necessary care and services for 1 of 1 sampled resident (Resident #15) currently with a dialysis fistula and receiving hemodialysis. Staff failed to monitor the resident's blood pressure on the non-fistula arm. Failure to monitor the blood pressure on the non-fistula arm placed Resident #15 at risk of injury to the fistula. Findings include: Review of the facility's policy and procedure, "Dialysis Care", reviewed 01/11, stated ". . . 9. Care of Shunts/Fistulas: . . . Blood draws, blood pressure checks should not be done on the arm with the fistula or shunt."	F 309		

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

[signature] | CEO | 1/5/2012

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 309	Continued From page 1 Review of Resident #15's medical record occurred on December 22, 2011. Current diagnosis include End Stage Renal Disease. The resident attended hemodialysis three times a week. Resident #15's blood pressure summary, dated 10/14/11 to 12/7/11, showed 13 blood pressures assessed on the resident's left arm with the hemodialysis fistula. The resident's care plan stated "Fistula to L [left] arm". The care plan failed to address blood pressure monitoring for this resident. The MAR (medication administration record), and vital sign record failed to indicate that Resident #15 Had a fistula in his/her left arm. During an interview with a CNA (certified nursing assistant) (#4), on 12/22/11 at 10:50 a.m., she reported the nurses assess Resident #15's blood pressure. In a interview with the Unit Manager (#5), she reported "typically nurses know if there's a fistula; they are trained".	F 309	weekly for one month and then monthly for those residents with fistula's to assure entry is done correctly. This will be completed by the Clinical Nurse Specialist and Nurse Managers. 5. The facility will have corrective actions implemented and be in substantial compliance by January 25th, 2012.	
F 371 SS=B	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:	F 371		

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F 371	Continued From page 2 Based on observation, staff interview, and review of facility policy and procedure, the facility failed to ensure staff wore a hair net which fully covered their hair on 4 of 4 days of survey (December 19-22, 2011). Failure of staff to ensure all hair is contained in a hair net/cap placed all residents, staff, and visitors who consumed foods prepared in the facility at risk of finding hair in their food. Findings include: Review of the facility policy titled "Sanitation/Personal Hygiene" occurred on 12/22/11. This policy, dated December 2011 stated, "Procedure: . . . Always wear a hair net/cap; making sure all hair is covered in net/cap. . ." Observation during initial tour of the kitchen on 12/19/11 at 1:15 p.m. showed administrative dietary staff (#6) and dietary staff (#7) with all hair not contained in a hair net/cap. Observation during the following times of dietary tray line showed staff with uncovered hair on bangs and sides: - 12/20/11 at 9:50 a.m.: dietary staff (#7) with hair not contained in a hair net/cap - 12/21/11 at 10:25 a.m.: dietary staff (#7, and #8) with hair not contained in a hair net/cap. - 12/21/11 at 4:10 p.m.: dietary staff (#7, and #9) with hair not contained in a hair net/cap. - 12/22/11 at 10:15 a.m.: dietary staff (#7) with hair not contained in a hair net/cap. During kitchen tour on 12/21/11 at 2:50 p.m., observation showed dietary staff (#6, #7, #9, and #10) with hair not contained in a hair net/cap.	F 371	**Tag # 371 Dietary Sanitation** 1. ***It is the practice of this facility to prepare and serve food under sanitary conditions.*** Dietary staff was informed of need to wear hairnets properly by a poster on their bulletin bard on 12-23-11. 2. Only dietary staff working in the kitchen are affected by this deficiency 3. ***Measures put in place:*** The current ND Health Department website was checked for the standard of practice and the policy was adjusted to match this information. Dietary staff will be inserviced on 1-12-12 regarding the policy, plan of correction and audits to be conducted. 4. ***Monitoring:*** A quality audit tool was developed to monitor proper hairnet usage. This auditing will be done by the Dietary Manager, Dieticians and head cooks daily for one month, then weekly and quarterly until substantial compliance is achieved. 5. The facility will have corrective actions implemented and be in substantial compliance by January 25, 2012.	

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F 371	Continued From page 3 During an interview on 12/22/11 at 9:30 a.m., an administrative dietary staff (#6) reported her expectation of staff wearing hairnets was "that they have them on."	F 371		
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 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.	F 441		

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F 441	Continued From page 4 (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, record review, review of facility policy, and staff interview, the facility failed to follow proper infection control procedures for 1 of 2 sampled residents (Resident #7) observed during dressing changes. Failure to follow infection control procedures related to glove usage and hand hygiene has the potential for contamination and the spread of infection to other residents. Findings include: Review of the facility policies titled "Dressing Change: Nonsterile" and "Hand Hygiene" occurred on 12/21/11. The policy, "Dressing Change: Nonsterile," dated December 2011, stated, "PROCEDURE: . . . 4. Establish clean field for dressing change. Do not place containers or tubes directly on surfaces that may be contaminated. . . . 11. Discard dressing and gloves in trash bag. 11. Remove gloves and perform hand hygiene. . . ." The policy, "Hand Hygiene," dated November 2009, stated, "Procedure: 1) Hand hygiene is to be performed: . . . e. After contact with . . . wound dressings. . . ." Review of Resident #7's medical record occurred December 19-22, 2011. Resident #7's Treatment	F 441	**Tag # 441: Dressing Change** 1. ***It is the practice of this facility to follow proper infection control procedures related to glove use and hand hygiene with non-sterile dressing changes.*** For Resident #7, the nurse was educated and policy was reviewed with her. 2. ***Identify other residents:*** There are 4 other residents currently with non-sterile dressing changes. The policy was sent out to all nurses via e-mail for review. 3. ***Measures put in place:*** Nurses were re-trained on proper infection control for non-sterile dressing changes following facility policy at the Nurse's Meeting on Jan 11th. 4. ***Monitoring:*** The current QA tool on dressing changes will be used to observe all nurses on dressing change technique. This will be completed by the Nurse Managers or designated nurses. The audit will be done initially on all nurses and then on a random sample monthly and then quarterly until compliance is achieved. 5. The facility will have corrective actions implemented and be in substantial compliance by January 25th, 2012.	

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F 441	Continued From page 5 Administration Record stated, "Allevyn drsg [dressing] to [left] heel pressure ulcer [change] [every] three days." Observation on 12/20/11 at 8:40 a.m. showed a nursing staff member (#1) entered Resident #7's room to complete the resident's dressing change. The staff member opened the package for the Allevyn dressing, placed the packaging directly on the floor near Resident #7's wheelchair, and placed the dressing supplies on the open package. The staff member then removed the soiled Allevyn dressing from the resident's left heel. Observation showed this dressing contained drainage from the open ulcer. The staff member failed to remove her gloves and sanitize her hands before cleansing and applying a clean Allevyn dressing to the resident's left heel. During an interview on 12/22/11 at 10:15 a.m., two administrative nursing staff members (#2 and #3) confirmed, per policy, after removing the soiled dressing and before applying a clean dressing, staff should change gloves and complete hand hygiene.	F 441		