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
	355050	A. BUILDING _____ B. WING _____	05/08/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE MANOR CARE CENTER	1116 9TH AVE LANGDON, ND 58249

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F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey started on May 5, 2014 and completed on May 8, 2014 the sample included three (3) residents for complete review, nine (9) residents for focused review, and one (1) closed record for review. The sample included one (1) additional resident to verify specific concerns during the survey.	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	F 278		

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

Connie Dickenson | Administrator | 6-10-14

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 material and false statement. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 04/04/13. Based on record review, staff interview, and review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual (Version 3.0), the facility failed to ensure the Minimum Data Sets (MDSs) accurately reflected the residents' status for 3 of 4 sampled residents (Resident #2, #5 and #11) coded on the MDS with a bowel toileting program (Resident #2, #5 and #11) and 1 of 1 sampled residents coded with delusions (Resident #5). Failure to accurately assess and code the MDS may affect the level of care provided to residents. Findings include: The Long-Term Care Facility RAI User's Manual, October 2013, pages E-1 and E-2, (Behavior), stated, "Definitions: Delusion: A fixed, false belief not shared by others that the resident holds even in the face of evidence to the contrary. . . . Steps for Assessment: . . . When a resident expresses a clearly false belief, determine if it can be readily corrected by a simple explanation of verifiable (real) facts (which may only require a simple reminder or reorientation) . . . The resident's response to the offering of a potential alternative explanation is often helpful in determining whether the false belief is held strongly enough to be considered fixed." - Review of Resident #5's medical record	F 278	1) The MDS with E0100B marked yes was 11-12-13 significant change / 5 day Medicare. Since that time subsequent MDS's 11-19-13; 2-6-14; 5-6-14 section E0100B has been marked no. 2) All MDS's marked with E0100A or E0100B have been reviewed to assure supporting documentation is present. 3) Social worker will meet with MDS Coordinator prior to the submission of any MDS where either E0100A or E0100B are indicated to review documentation for compliance as stated in the RAI Manual page E-2. A nursing in-service was held on supporting documentation for all behaviors including but not limited to delusions and illusions. 4) An audit form for sec E100 has been developed to assure supporting documentation is present if E0100A and E0100B are checked. This will be completed during the above (#3) review by the social worker and MDS Coordinator. QA will review audits completed of Sec E100 monthly for 4 months the quarterly for completion and accuracy. Results will be retained in QA office. 5)	05-12-14 05-12-14 06-12-14

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F 278	Continued From page 2 occurred on May 05-07, 2014. A significant change MDS, dated 11/12/13, identified the resident experienced delusions during the seven day assessment period. A progress note, dated 11/07/13, stated ". . . She asked multiple times for her aunt and uncle as she thought she was staying with them . . ." A progress note, dated 11/09/13, stated ". . . talking about 'The pretty lady in the white dress' . . ." Both progress notes failed to identify if the writer attempted to determine if her thoughts were delusional. The Long-Term Care Facility RAI User's Manual: version 3.0, October 2013, page H-12 stated, regarding bowel training program, "Steps for Assessment . . . Look for documentation . . . three requirements have been met: implementation of an individualized, resident-specific bowel toileting program based on an assessment of the resident's unique bowel pattern, evidence that the individualized program was communicated to staff and the resident . . .; notations of the resident's response to the toileting program and subsequent evaluations as needed . . ." - Review of Resident #5's quarterly MDS, dated 02/06/14, identified Resident #5 as frequently incontinent of bowel and bladder and on bowel and urinary toileting programs. The current care plan identified staff should toilet Resident #5 for the urinary toileting program "when she gets up, after breakfast, before and after dinner, 3 p.m., before and after supper, 8:30 p.m., and prn [as needed] . . ." The resident's	F 278	1) A modification MDS was completed on Res #2 and transmitted on 6-2-14, Res #2 is on an individualized Bowel and Bladder program. 2) All residents on a Bowel and Bladder program were assessed. Individualized bowel and bladder programs have been developed for all assessed residents except 2. A modification MDS was completed for those 2 residents and transmitted on 6-2-14. 3) Bowel and Bladder programs have been separated to address each residents bowel and bladder habits individually. In the 5-21-14 in-service the bowel programs were discussed. Each nurse was given a copy of the information discussed to include H0500 page H-11, H-12 of the RAI Manual. 4) QA will be done by the DON or ADON which will include a review of the bowel program of each resident at the time of the MDS. The DON/ADON will review with the MDS Coordinator prior to submitting the MDS that any and all bowel and bladder programs residents are currently on are being documented separately. 5)	06-12-14

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F 278	Continued From page 3 care plan for bowel toileting stated "Alteration in elimination related to . . . incontinence of bowel . . . Toilet as scheduled and prn." The "as scheduled" referred to the urinary program toileting schedule. The facility failed to assess and develop an individualized bowel toileting program for this resident. - Review of Resident #2's medical record occurred on all days of survey and included diagnoses of constipation and dementia. The resident's quarterly MDS, dated 04/08/14, identified Resident #2 on a bowel toileting plan and frequently incontinent of bowel. Resident #2's current care plan stated, ". . . Alteration in elimination . . . has incontinence of bowel and bladder . . . Toilet per schedule and upon request per 1-2 staff . . . Info: Toilet times 1AM, 5:30AM, 8AM, 10:30AM, 12PM, 2PM, 3:30PM, 5PM, 7PM, 9PM, and PRN . . . " - Review of Resident #11's medical record occurred on 05/08/14 and included diagnoses of constipation and dementia. The resident's quarterly MDS, dated 02/25/14, identified Resident #11 on a bowel toileting program and continent of bowel. A significant change MDS, dated 09/27/13, identified the resident not on a bowel toileting program and continent of bowel. Resident #11's current care plan stated, ". . . Alteration in elimination . . . resident has occasional incontinence of stool . . . Info: she is on a toilet schedule . . . " The resident's care plan identified a urinary toileting plan as "toilet when she gets up, 9:30am. 11am, 12pm, 1:30pm, 3:00pm, 5pm, 6pm, 8pm, 9:30pm and prn".	F 278		

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F 278	Continued From page 4 During an interview on the morning of 05/08/14, a nursing staff member (#1) reported the bowel toileting plans for Resident #2, #5, and #11 are the same as the resident's urinary toileting plan. The facility failed to implement individualized, resident-specific bowel toileting programs, apart from the resident's urinary toileting plan and based on an assessment of Resident #2, #5, and #11's unique bowel pattern.	F 278		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of professional reference, and staff interview, the facility failed to follow professional standards of practice for 1 of 1 sampled resident (Resident #6) observed receiving a physician prescribed medication/treatment. Failure to carry out physician orders as prescribed has the potential to result in a negative resident outcome. Findings include: Berman and Snyder, "Kozier & Erb's Fundamentals of Nursing: Concepts, Process, and Practice," 9th ed., Pearson Education, Inc., New Jersey, pages 73-74, stated ". . . Carrying Out a Physician's Orders . . . the nurse is responsible for carrying it out. . . . Legal Protection for Nurses . . . Make sure the correct medications are given in the correct dose, by the	F 281		

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F 281	Continued From page 5 right route, at the scheduled time, and to the right client. When delegating nursing responsibilities, make sure that the person who is delegated a task understands what to do and that the person has the required knowledge and skill. . . ." Page 860 stated ". . . Administering Medications . . . Do not leave medications at the bedside . . ." Observation on 05/06/14 at 3:12 p.m., showed a medication cup labeled with the resident's name, containing Zinc Oxide cream sitting on Resident #6's bedside table. A Certified Nursing Assistant (CNA) (#3) applied the Zinc cream from the medication cup to Resident #6's buttocks and covered the area with a gauze dressing. The CNA then applied the Zinc cream to the resident's bilateral groin folds and covered the areas with an ABD (abdominal) dressing. Review of Resident #6's medical record occurred on May 05-07, 2014. Current physician's orders identified the following: * "Cleanse wound to left ankle with normal saline. Apply Zinc Oxide cream. Cover with dry dressing and tegaderm. Change every three days." * "Cleanse bottom with normal saline. Apply Mupricion ointment and cover with gauze everyday." * "Place gauze in groin folds twice a day - done by CNA." During an interview on 05/07/14 at 1:09 p.m., a nursing staff member (#7) stated the Zinc Oxide cream is to be applied to Resident #6's left ankle by a nurse, the Mupricion ointment should be applied to Resident #6's buttocks by a nurse, and only gauze should be placed in the resident's groin folds by the CNAs.	F 281	1) Physician Orders and Care Plan on Resident #6 were reviewed on 5-12-14. 2) Nurses have been educated on what constitutes a physician order verses general nursing judgment including delegation of tasks to CNA's. 3) Yearly education on nursing delegation responsibilities and physician orders, versus general nursing judgment will be part of nursing yearly in-services. 4) All nurses will complete yearly education to include nursing responsibilities, documentation, and delegation of tasks. QA will monitor all nursing personnel files yearly to assure completion of questionnaire is present in files. 5)	06-12-14

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F 315	Continued From page 6	F 315	1) Observations of perineal care on Resident #1 and #6 were completed daily for 7 days to assure proper procedure was followed.	5-18-14
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 facility policy, and review of professional reference, the facility failed to provide perineal care in a manner consistent with standards of practice to prevent urinary tract infections (UTIs) for 2 of 4 sampled residents (Resident #1 and #6) observed receiving inappropriate perineal care. Failure to provide perineal care according to acceptable standards of practice placed Resident #1 and Resident #6 at risk of developing a UTI. Findings include: Berman and Snyder, "Kozier & Erb's Fundamentals of Nursing: Concepts, Process, and Practice," 9th ed., Pearson Education, Inc., New Jersey, page 765, stated, ". . . Providing Perineal-Genital Care . . . For Female Clients . . . Use separate quarters of the washcloth for each stroke, and wipe from the pubis to the rectum. . . . Using separate quarters of the washcloth or new wipes prevents the transmission of	F 315	2) Mandatory CNA in-service was held to reeducate all CNA on our perineal care policy and procedures. 3) CNA's have been in serviced on perineal cares on 5-21-14. CNA's demonstrated peri care procedures on mannequins. CNA's were given a written copy of facility policy and procedures on peri cares. 4) Observation of peri cares will be performed by ADON every month for 3 months and then quarterly for 9 months and randomly thereafter. QA will collect all documentation to assure plan has been followed and results are positive. 5)	5-21-14 6-12-14

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F 315	Continued From page 7	F 315		

microorganisms from one area to the other. Wipe from the area of least contamination (the pubis) to that of greatest (the rectum). . . ."

Review of the facility policy titled "Perineal Care Policy and Procedure" occurred on 05/08/14. This undated policy stated, "Purpose/Objective: To keep the perineal area clean and to prevent infection and odor to residents with or without a catheter. . . . For female: 1. Wash perineal area from center to thighs and front to back. 2. . . . Use different area on disposable wipe or wash cloth with each wipe. . . . 5. Wash rectal area; . . . using a front to back direction. . . ."

- Review of Resident #1's medical record occurred on May 05-07, 2014. Current diagnoses included female stress incontinence. The quarterly Minimum Data Set (MDS), dated 03/10/14, identified occasional urinary incontinence and frequent bowel incontinence.

Review of nurse's notes identified Resident #1 was treated for a UTI with oral antibiotics from 04/28/14 - 05/03/14.

Observation on 05/06/14 at 1:25 p.m. showed a certified nursing assistant (CNA) (#2) provided perineal cares to Resident #1. The CNA (#2) wiped the resident's perianal area front to back with a wet wipe and then wiped the perineal area back to front with toilet paper. The CNA (#2) failed to provide proper perineal care.

- Review of Resident #6's medical record occurred on May 05-07, 2014. Diagnoses included neurogenic bladder and a history of urinary tract infection. The quarterly MDS, dated 03/24/14, identified indwelling catheter and

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F 315	Continued From page 8 always incontinent of bowel. Observation on 05/06/14 at 3:12 p.m. identified two CNAs (#3 and #4) providing perineal cares. Observation showed the resident's brief soiled with stool. One CNA (#3) appropriately wiped front to back with toilet paper and a washcloth. When the second washcloth became soiled with stool, the CNA (#3) placed the washcloth in the basin of water, removed her gloves, washed her hands, and donned new gloves. The CNA (#3) wiped Resident #6's perianal area front to back with toilet paper, removed the soiled incontinent product, and took the soiled washcloth from the water basin and wiped the perianal area. The CNA (#3) continued to rinse the soiled washcloth in the water basin and wipe the resident's perianal area two more times. The CNA (#3) removed her gloves, washed her hands, emptied the soiled water from the basin and refilled with water, donned new gloves, obtained a third washcloth and wiped the perineal area front to back. When the third washcloth became soiled with stool, the CNA (#3) placed the washcloth in the basin and reused the soiled washcloth to finish perineal cares. The CNA (#3) failed to provide proper perineal care. Observation on 05/07/14 at 12:33 p.m. identified two CNAs (#5 and #6) providing perineal cares. Observation showed the resident's brief soiled with stool. One CNA (#5) cleansed Resident #6's perianal area with a washcloth, dried the area, and placed a clean incontinent product under the resident. The CNA then cleansed the perineal area with the same washcloth she used prior that was visibly soiled with stool. The CNA (#5) failed to provide proper perineal care.	F 315		

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F 315	Continued From page 9 Failure of staff to wipe front to back and use a clean washcloth or a new wipe for each stroke during perineal cares placed Resident #1 and Resident #6 at risk of developing a UTI.	F 315		