STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355033	A. BUILDING _____ B. WING _____	06/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CATHERINES LIVING CENTER	1307 N 7TH ST WAHPETON, ND 58075

(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 and complaint survey started on June 3, 2013 and completed on June 6, 2013 the sample included four (4) residents for complete review, eleven (11) residents for focused review, and three (3) closed records for review. The sample included four (4) additional residents to verify specific concerns during the survey.	F 000	F 241 It is the practice of St. Catherine's Living Center per 483.15 to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.	
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide care in a manner that enhanced dignity/self-esteem for 5 of 13 sampled residents (Resident #3, #4, #7, #10, and #15) observed during personal cares. Failure to ensure dignity and respect during personal cares does not recognize the individuality of each resident or enhance the quality of life for each resident. Findings include: Review of the facility policy titled "Dignity" occurred on 06/06/13. This policy, dated July 2004, stated, "St. Catherine's Living Center promotes care for residents in a manner and environment that enhances each resident's dignity and respect in full recognition of his or her	F 241	Residents #2, #4, #7, #10 and #15 are now provided care and spoken to in a manner that maintains or enhances each resident's dignity/self-esteem . All residents that receive assistance with toileting/incontinence cares and feeding are at risk for and have the potential of being affected by not providing care and speaking to residents in a manner that maintains or enhances each resident's dignity/self-esteem . CNAs that care for residents #2, #4, #7, #10 and #15 received "just-in-time" re-education regarding adherence to professional standards of providing care and speaking to residents in a manner that maintains or enhances the dignity/self-esteem of the residents. All CNAs will be re-educated regarding adherence to professional standards of providing care and speaking to residents in a manner that maintains or enhances the dignity/self-esteem of the residents by 7/11/13.	

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

CEO - 6-28-13

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 241	Continued From page 1 individuality. Dignity means that residents are addressed, and staff carries out activities that assist the resident[s] to maintain privacy and enhance self-esteem and self-worth." - Observations revealed the following: * On 06/04/13 at 8:45 a.m., the Certified Nursing Assisstant (CNA) (#5) fed Resident #2 pureed foods and nectar thickened liquids via a spoon and/or nosey cup. Drool formed at the corners of Resident #2's mouth and chin. The CNA (#5) presented 2-3 additional bites/sips of food before wiping his face with a napkin. * On 06/04/13 at 12:30 p.m., drool formed at the corners of Resident #2's mouth and chin as the CNA (#6) fed him. Using the spoon, the CNA (#6) scraped the saliva/food from Resident #2's face, mixed it into the food remaining on his plate, and continued to feed him, or presented 2-3 additional bites/sips of food before wiping his face with a napkin. * On 06/04/13 at 3:30 p.m., as the two CNAs (#7 and #8) provided toileting cares, Resident #2 passed gas. Both CNAs (#7 and #8) laughed, and one of the two (#8) stated to the other (#7), "Everyone is doing that to you today." After completing pericares for Resident #2, the two CNAs (#7 and #8) rolled the resident onto his back. One CNA (#7) looked down, realized Resident #2 had urinated on the right side of the bed, and stated, "Watch out!" The other CNA (#8) looked down and laughed again. Review of Resident #2's medical record occurred on June 3-6, 2013. Diagnoses included Parkinson's disease, dementia, and swallow deficit. The quarterly Minimum Data Set (MDS), dated 04/25/13, identified severely impaired	F 241	All residents that require assistance with toileting/incontinence and eating will be audited regarding adherence and professional standards of providing care and speaking to residents in a manner that maintains or enhances the dignity/self-esteem of the residents by the Quality Assurance Coordinator or designee weekly X2, then monthly X2, and quarterly thereafter to assure compliance. Results of audits will be taken to the Quality Assurance Council for follow-up and revision as needed. 2	07/11/13

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F 241	Continued From page 2 cognitive skills and extensive assistance required for eating and toileting. During an interview on 06/05/13 at 2:00 p.m., Resident #2's family member stated, "[Resident #2] would be horrified if he saw himself now. He was very particular about his appearance." During an interview on 06/06/13 at 8:45 a.m., two administrative staff members (#3 and #4) agreed staff should use napkins to immediately clean the excess food from Resident #2's face, refrain from scraping any excess food with the spoon, and/or refrain from responding/reacting inappropriately while providing personal cares. - Observations revealed the following: * On 06/05/13 at 1:20 p.m., after placing a soaker pad on the bed, two CNAs (#11 and #12) tranferred Resident #15 into bed via a full-body lift. The CNAs then lowered the resident's pants [with elastic waistband] to mid-thigh level, and checked her brief. The CNAs failed to raise Resident #15's pants back to waist level before exiting the room. * On 06/05/13 at 2:50 p.m., the two CNAs (#11 and #12) entered Resident #15's room to provide cares. Resident #15's pants remained at mid-thigh level. The CNA's provided pericares, placed a new brief, and after adjusting her clothing transferred her into her wheelchair. Leaving the pants at mid-thigh level limited Resident #15's movement and her ability to maintain a comfortable position while sleeping. Review of Resident #15's medical record occurred on June 5-6, 2013. Diagnoses included Alzheimer's disease and dementia. The quarterly	F 241		3

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F 241	Continued From page 3 MDS, dated 04/01/13, identified severely impaired cognitive skills and extensive-to-total assistance required for all activities of daily living (ADLs). During an interview on 06/06/13 at 8:45 a.m., two administrative staff members (#3 and #4) agreed staff should not leave Resident #15's pants at mid-thigh level during periods of rest. - Observation on 06/04/13 at 3:28 p.m. showed two CNAs (#1 and #2) transferred Resident #4 from his wheelchair to bed. One CNA (#1) positioned the resident on his side and the other CNA (#2) removed his soiled brief and, referring to the brief, stated, "What did you do ... what's that, what's that ... big mess." During an interview on the morning of 06/06/13, two administrative staff members (#3 and #4) agreed the CNA's (#2) statements were inappropriate. - Observation on 06/04/13 at 10:10 a.m., showed a CNA (#10) toileted Resident #7. The CNA (#10) removed his brief which was soiled with stool and urine. After returning Resident #7 to his wheel chair, the CNA (#10) stood facing the resident and stated, "now I need to clean up the mess." Review of Resident #7's medical record occurred on June 4 - 6, 2013. Diagnoses included dementia with behaviors and depression. The quarterly MDS, dated 03/22/13, identified severely impaired cognitive skills, extensive assistance required for toileting, and frequently incontinent of bowel and bladder. - Observation on 06/04/13 at 2:25 p.m., showed	F 241		

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F 241	Continued From page 4 Resident #10 had been incontinent of urine. As two CNAs (#7 and #8) began providing perineal care, the resident passed gas. One of the CNAs laughed and stated, "That's what she thought of you," to the other CNA. Review of Resident #10's medical record occurred on June 4-6, 2013. Diagnoses included traumatic brain injury and hemiplegia. The quarterly MDS, dated 03/11/13, identified the resident adequately hears, sometimes understands others, and requires total assistance with toileting and personal hygiene.	F 241		
F 253 SS=B	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, and staff interview, the facility failed to provide housekeeping and maintenance services to maintain a sanitary and comfortable interior in 3 of 6 resident living areas (200, 500, and 700 wings). Failure to maintain a clean and sanitary environment does not provide a comfortable living environment for residents. Findings include: An initial tour of the facility occurred on the afternoon of 06/04/13. Observations showed the following: * Gouges in the walls and torn wallpaper - Room	F 253	F253 Gouges in walls, torn wallpaper, burned out light bulbs, dusty fans; vent covers, heat register covers, and skid strips will be repaired/ cleaned and placed on a weekly scheduled audit to assure a safe and clean environment. Staff education/training will be implemented for the identified areas of concern to assure that proper techniques/protocols will be followed to meet regulatory compliance with 100% accuracy. An Environmental checklist/audit will be completed weekly x2, then monthlyx2, and then quarterly thereafter. This will be monitored by the Plant Operations Supervisor.	

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F 253	Continued From page 5 207, 508, 511, 513, and 515 * Burned out light bulbs - Room 703, 708, and 709 * Dusty personal fans - Room 207 and 506 * No vent cover in the bathroom (open hole) - Room 207 An interview occurred on 06/04/13 at 9:30 a.m. with Resident #19. The most recent Minimum Data Set (MDS), dated 04/04/13, identified the resident as cognitively intact. Resident #19 stated her heat register and floor could use some cleaning. Observation showed the skid-strips between her bed and recliner peeled up creating a trip hazard, an accumulation of dust and debris in/on the heat register, and a part of the register loose and able to fall off. Observation on June 04-05, 2013 showed dust, dirt, and food debris on all the mechanical lifts throughout the facility. During the facility environmental tour on 06/05/13 at 4:15 p.m., two administrative maintenance staff members (#15 and #21) confirmed the gouged walls, dusty personal fans, and other items in need of housekeeping and repair. Staff member #21 stated the mechanical lifts are not cleaned unless they need maintenance repairs. Both staff members agreed the resident rooms are in need of some housekeeping.	F 253	All facility Mechanical Lifts will be placed on a detailed weekly cleaning schedule/audit. Mechanical lifts will be cleaned between resident uses by the nursing department and cleaned weekly by Plant Operations, to assure a clean and infection free environment. A Mechanical Lift checklist/audit will be completed weekly x2, then monthlyx2, and then quarterly thereafter. Results of audits will be taken to the Quality Assurance Council for follow-up and revision as needed.	07/11/13
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.	F 281	F281 It is the practice of St. Catherine's Living Center that services provided or arranged by the facility must meet professional standards of quality.	

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F 281	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on record review, professional reference review, review of facility policy, and staff interview, facility staff failed to follow professional standards for 3 of 15 sampled residents (Resident #1, #2, and #6) regarding administration of scheduled and as needed (PRN) medications, and neurological checks. Failure to ensure timely assessments and to follow physician's orders, placed the residents at risk for adverse health effects. Findings include: Kozier & Erb's "Fundamentals of Nursing Concepts, Process and Practice," 9th Edition, dated 2012, Pearson, Boston, page 864, stated, ". . . 6. Evaluate the client's response to the drug. The kinds of behavior that reflect the action or lack of action of a drug and its untoward effects (both minor and major) are as variable as the purposes of the drugs themselves. . . . In all nursing activities, nurses need to be aware of the medications that a client is taking and record their effectiveness as assessed by the client and the nurse on the client's chart. . . ." page 870, stated, ". . . EVALUATION Return to the client when the medication is expected to take effect (usually 30 minutes) to evaluate the effects of the medication on the client, Observe for desired effect . . . Note any adverse effects or side effects . . . " Review of the facility policy titled "DOCUMENTATION: PRN MEDICATION(S)" occurred on 06/06/12. This policy, dated 09/02/09, stated, ". . . PRN medications are to be administered when a resident needs the	F 281	Resident #6: Administration of PRN Milk of Magnesia (MOM) and PRN Bisacodyl Suppository now includes documentation of medications effectiveness. All residents administered PRN medications have the potential to be affected by the issue as stated above. Resident #6: PRN Risperdal correct ordered dose is now administered according to the physician's orders (for behavior problem/anxiety) including documentation of effectiveness. All residents administered PRN Risperdol have the potential to be affected by the issue as stated above. Licensed nursing staff that care for Resident #6, received "just-in-time" education regarding documentation of PRN medications effectiveness; and proper administration of correct ordered dose of Risperdal for appropriate reasons per physicians order. All licensed nursing staff will receive education regarding documentation of PRN medications effectiveness; and proper administration of correct ordered dose of Risperdal for appropriate reasons per physicians order by 7/11/13.	

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F 281	Continued From page 7 medication for symptom(s)/reason(s) indicated . . . Documentation of administered PRN medications shall include the date/time of administration, the amount administered, and the symptom(s)/reason(s) for administration. The effectiveness of the medication is to be documented when determined to provide baseline data for monitoring the signs, symptoms, or related causes and intended/actual benefit. Depending in the time of administration, the subsequent shift may record the effectiveness of the medication. . . ." Kozier and Erb's "Fundamentals of Nursing Concepts, Process, and Practice," 9th edition, dated 2012, Pearson, Boston, page 852, stated, ". . . A drug order is written on the client's chart by a primary care provider . . . The medication order is then copied by a nurse or clerk to a . . . medication administration record (MAR). . . . If your assigned client receives new medication orders, double-check the transcribed information with the primary care provider's order. . . ." "Nursing 2013 Drug Handbook," 33rd edition, Lippincott, Williams, & Wilkins, Philadelphia, pages 1151-1154, stated, ". . . Seroquel . . . Adjust-a-dose: Elderly patients: For immediate-release formula, use slow titration and regular monitoring. . . . For debilitated patients . . . consider . . . slower adjustment. . . ." Review of the facility policy titled "Neurological Observement" (sic) occurred on 06/06/13. This policy, dated 12/15/10, stated, ". . . Licensed nursing staff will perform, monitor resident neurological functioning. . . . Will be completed on falls if ordered by physician. . . ."	F 281	All residents with physician orders for PRN medications will be audited to ensure documentation of PRN medications effectiveness, and all residents with physician orders for PRN Risperdal will be audited to ensure proper administration of correct ordered dose of Risperdal for appropriate reasons per physicians order to include documentation of effectiveness by the Quality Assurance Coordinator or designee weekly x2, monthly x2 then quarterly thereafter to ensure continued compliance. Results of audits will be taken to the Quality Assurance Council for follow-up and revision as needed. Resident #1 Seroquel order was discontinued. All residents with new or changed prescription physician orders have the potential to be affected by this issue. Licensed nursing staff will be re-educated regarding verification of medications per physicians order upon receipt from pharmacy and proper transcription of medications per physician order and professional standards by 7/11/13.	07/11/13

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F 281	Continued From page 8 - Review of Resident #6's medical record occurred on all days of survey. Diagnoses included dementia with behavioral disturbances, pain, and anxiety. Review of the PRN medication administration records (MAR) from January through June 3, 2013 showed Resident #6 received Milk of Magnesia (MOM) (a medication to promote a bowel movement) on the following days: * January: 25, 29 * February: 2, 5 * March: 26 * April: 19, 23 Review of the PRN MAR showed Resident #6 received a Bisacodyl Suppository (a medication to promote a bowel movement) on 01/26/13 and 04/15/13. The facility staff failed to document if the above PRN MOM and Bisacodyl were effective for Resident #6. Review of Resident #6's physician's orders indicated "Risperdal [an antipsychotic medication] (risperidone) tablet; 0.25 mg; [milligram] amt: [amount] 1/2; oral Special Instructions; prn behavior problems/anxiety Every 12 hours -PRN" with a start date of 07/18/12. Review of the PRN MAR for Resident #6 for the months of April and May 2013 showed the following: * April 8 at 3:30 p.m., the resident received Risperdal 0.25 mg for increased behavior/anxiety, no documentation regarding effectiveness * May 27 at 8:00 p.m., Risperdal 0.25 mg "to promote rest," no documentation regarding effectiveness	F 281	All resident's current medications will be audited by the Quality Assurance Coordinator or designee to ensure receipt of correct medications from pharmacy and proper transcription of medications per physician order and professional standards. All resident's new/revised/dc'd medications will be audited by the Quality Assurance Coordinator or designee to ensure receipt of correct medications from pharmacy and proper transcription of medications per physician order and professional standards weekly x2, then monthly x2 and quarterly thereafter to assure compliance. Results of audits will be taken to the Quality Assurance Council for follow-up and revision as needed. Resident #1: Licensed nursing staff will now perform neuro checks following a fall as ordered by physician. All residents with physician's orders for neuro checks following a fall have the potential to be affected by this issue. Licensed nursing staff that care for Resident #6, received "just-in-time" re-education regarding performing neuro checks following a fall as ordered by physician .	07/11/13

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F 281	Continued From page 9 * May 29 at 8:00 p.m., Risperdal 0.125 mg "to promote rest," at 9:15 p.m., "sleeping [no] behaviors [with] HS [hour of sleep] cares. The facility staff failed to administer the PRN Risperdal according to the physician's orders (for behavior problem/anxiety) and failed to administer the ordered dose of 0.125 mg. During an interview on 06/05/13 at 2:10 p.m., an administrative nurse (#4) stated staff should be documenting if a medication was effective. - Review of Resident #2's medical record occurred on June 3-6, 2013. Diagnoses included dementia, confusion, agitation, and behaviors. A physician order, dated 02/26/13 at 10:45 a.m., stated, ". . . 2) discontinue (DC) Seroquel 25 mg [milligrams] PO [oral] BID [twice daily] PRN [as needed]." The Medication Administration Record (MAR), dated 02/01/2013-02/28/13, identified the following: * Seroquel 25 mg twice a day * Seroquel 25 mg twice a day prn, with a handwritten note stating "DC 02/26/13" A physician note, dated 03/20/13, stated, ". . . decrease Seroquel to 12.5 mg at HS [bedtime]. . . ." The Physician Communication form, dated 03/21/13, stated, ". . . SITUATION . . . [Medical Doctor] - yest. [yesterday] when you were here - you [decreased] his Seroquel to 12.5 mg at bedtime. He has not been getting any Seroquel since 02/26/13. [Physician] DC'd [discontinued]	F 281	All licensed nursing staff will receive re-education regarding performing neuro checks following a fall as ordered by physician by 7/11/13. All resident's with physicians orders for neuro checks following a fall will be audited by the Quality Assurance Coordinator or designee weekly x2, then monthly x2 and quarterly thereafter to assure compliance. Results of audits will be taken to the Quality Assurance Council for follow-up and revision as needed.	07/11/13

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F 281	Continued From page 10 his PRN Seroquel on 02/26/13 [and] the Pharmacy DC'd the BID dose also, so it was not DC'd on his orders in computer when you saw it. He has not been getting it since 02/26/13 [and] someone here DC'd it on his med [medication] sheet. The CNA's [Certified Nursing Assistants] say his behaviors have not changed or worsened since the Seroquel hasn't been given. Can we just go ahead [and] DC the BID dose [and] not bother [decreasing] it, because he has been without [it] since 02/26/13. Pharmacy apoligyes [sic] for the error. . . . Orders DC Seroquel. . . ." The February MAR showed staff administered Resident #2's scheduled Seroquel from February 1-28, 2013. The 03/01/2013-03/31/13 MAR identified the following: * Seroquel 25 mg twice a day, with a handwritten note stating "Dcd 03/21/13" * Seroquel 25 mg twice a day prn, with a handwritten note stating "DC 02/26/13" The MAR showed staff failed to administer the scheduled Seroquel from March 1-21, 2013. An incident report, dated 03/25/13, stated, ". . . Description of incident . . . Seroquel was ordered BID [and] had PRN BID order also. When [Physician] was here - he DC'd the PRN BID dose - pharmacy didn't have a record of the PRN dose - [and] they DC'd the Seroquel BID instead [and] so it wasn't sent since 02/26/13 some one pinked [highlighted] it out on his med sheet. When this was noted I sent a fax to [Physician] [at] clinic to inform her of this. Residents behaviors have not worsened [and] have not changed since 02/26/13, since not receiving the Seroquel BID. Have not heard response back from [Physician].	F 281		

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F 281	Continued From page 11 Enclosed DC'd fax order [signed 03/25/13] attached. . . . individual responsible for incident Multiple people. . . ." During an interview on 06/06/13 at 8:45 a.m., two administrative staff members (#3 and #4) acknowledged the medication error occurred and staff failed to follow professional standards. - Review of Resident #1's medical record occurred on June 3-6, 2013. Diagnoses included Alzheimer's disease, dementia, and history of falls. The Falls Safety Event form, dated 12/03/12, stated, ". . . DESCRIPTION: Resident was found on the floor sitting up by her bed. Did not know what happened. Stated she did hit her head. No injuries and not [sic] pain noted . . . What did the resident state they were doing just prior to fall? transfering [sic] into wheel chair. . . . Note any injury to the head, extremities, or trunk Bump. . . . Does resident exhibit any of the following as a change in mental status of new onset? Agitation, Anxiety, Confusion. . . . ORDERS General Fall: With Suspected head trauma - Neuro checks Q [every] 15 minutes x 4, then Q 1 hour x 2, then Q 2 hours x 2, then Q 4 hours x 2, then Q shift x 3. . . VITALS [Neurochecks] . . . 12/03/12 at 10:18 p.m., 12/04/12 at 5:58 a.m., 9:21 a.m., and 4:26 p.m., 12/05/12 at 5:11 a.m. and 12:59 p.m., 12/06/12 at 5:28 a.m. and 9:45 a.m. . . ." The Falls Safety Event form showed staff failed to perform neuro checks as ordered by Resident #1's physician. During an interview on 06/06/13 at 8:45 a.m., two administrative staff members (#3 and #4) agreed	F 281		

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F 281	Continued From page 12 staff should perform neuro checks as per physician's orders.	F 281	F312 It is the policy of St. Catherine's Living Center that residents who are unable to carry out activities of daily living receive the necessary services to maintain good nutrition, grooming, personal and oral hygiene. Resident's #2 and #12 are now be provided perineal care that includes cleansing of the penis, scrotum and groin per recognized standards and protocols. All male residents who require assistance with provision of perineal care per care plan have the potential to be affected by this practice. CNAs that care for Resident's #2 and #12 received "just-in-time" re-education on adhering to the performance of perineal care for male residents that includes cleansing of the penis, scrotum and groin per recognized standards and protocols. CNAs will be re-education on adhering to the performance of perineal care for male residents that includes cleansing of the penis, scrotum and groin per recognized standards and protocols by 7/11/13.	
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS 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, review of facility policy, and staff interview, the facility failed to perform complete perineal cares following urinary incontinence for 2 of 13 sampled residents (Resident #2 and #12) observed during personal cares. Failure to perform complete cleansing could result in the residents experiencing skin breakdown. Findings include: Review of the facility policy "Perineal Care" occurred on 06/06/13. The policy, dated December 2002, stated, ". . . 30. MALE . . . b. Wash penis, scrotum, and perineal area, front to back. Use clean area of cloth for each stoke. . . ." - Review of Resident #2's medical record occurred on June 3-6, 2013. The quarterly Minimum Data Set (MDS), dated 04/25/13, identified severely impaired cognitive skills and extensive assistance required for toileting. Observation during the initial tour on 06/03/13 at	F 312		

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F 312	Continued From page 13 2:10 p.m., showed Resident #2 sleeping in bed. Two unidentified CNAs entered the resident's room to provide cares. The CNAs donned gloves, lowered the resident's pants, and checked his brief. Observation showed the resident incontinent of urine. The CNAs removed his soiled brief and placed a new one. The CNAs failed to cleanse the resident's penis, scrotum, and groin area before applying the clean brief. On 06/05/13 at 10:50 a.m., after donning gloves, two CNAs (#11 and #12) transferred Resident #2 into bed. The two CNAs then lowered his pants and checked his brief. Observation showed the resident incontinent of urine. The CNAs removed his soiled brief and placed a new one. The CNAs failed to cleanse the resident's penis, scrotum, and groin area before applying the clean brief. - Review of Resident #12's medical record occurred on June 5-6, 2013. The quarterly MDS, dated 05/24/13, identified intact cognitive skills and extensive assistance required for toileting. Observation on 06/05/13 at 1:35 p.m., showed two CNAs (#11 and #12) assisting Resident #12 with toileting cares. The two CNAs (#11 and #12) lowered the resident onto the toilet using the stand lift. As the resident sat on the toilet, one of the CNAs (#11) removed his soiled brief. After the resident voided, the two CNAs (#11 and #12) donned gloves, raised the resident, and placed a new brief. The CNAs failed to cleanse the resident's penis, scrotum, and groin area before applying the clean brief. During an interview on 06/06/13 at 8:45 a.m., two administrative staff members (#3 and #4) stated	F 312	All male residents identified to require provision of perineal care per care plan will be audited by the Quality Assurance Coordinator or designee to ensure provision of appropriate perineal care per recognized standards and protocols. weekly x2, then monthly x2 and quarterly thereafter to assure compliance. Results of audits will be taken to the Quality Assurance Council for follow-up and revision as needed.	07/11/13

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F 312	Continued From page 14 they expect staff to cleanse the penis, scrotum, and groin when performing perineal cares for male residents. Failure to perform complete cleansing of the perineal area could result unpleasant odors and/or skin breakdown for the residents.	F 312	F318 It is the practice of St. Catherine's Living Center to ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and /or prevent further decrease in range of motion.	
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy and procedure review, and staff interview, the facility failed to ensure that a resident with limited range of motion received appropriate treatment and services to prevent further decline in range of motion for 1 of 1 resident with a hand mitt (Resident #10). Failure to prevent loss of range of motion may result in further painful contracture of muscles and joints. Findings include: Review of facility policies occurred on the morning of 06/06/13. The policies stated the following: *"Range of Motion," dated 03/01/03, stated, "The facility is responsible for ensuring that residents	F 318	Resident #10's order for removal of mitt and exercise of the hand has been clarified and currently states, "every 2 hours remove the mitt for 10 minutes and exercise the hand. The CNAs Daily Assignment Sheet been changed to state the above. Practices identified have been corrected for resident #10. All residents with restraints have the potential to be affected by this issue. Education on providing ROM per physicians order for residents with restraints has been provided for nursing staff that provides care for resident #10, and will be provided for all nursing staff by 7/11/13 to ensure that residents with limited range of motion receive appropriate treatment and services to increase range of motion and /or prevent further decrease in range of motion.	

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F 318	Continued From page 15 reach and maintain their highest level of range of motion (ROM) and preventing avoidable decline of range of motion. Range of motion is defined as the extent of movement of a joint. . . . Each resident with a limited range of motion receives appropriate treatment and services to increase range of motion and to prevent further decrease in range of motion. . . . A clinical condition is considered to make a reduction in ROM unavoidable only if adequate assessment, appropriate care planning, and preventative care was provided and resulted in limitation in ROM or muscle atrophy." *"Physical Restraint Application," dated October 2010, stated, "Step in Procedure . . . Remove the restraint every 2 hours for at least 10 minutes and change the resident's position. Exercise the resident . . . Documentation The following information should be recorded in the resident's medical record: . . . Each time the device is released for resident exercise, toileting, and position change. . . ." *"Rehabilitation/Restorative Nursing Care Program," stated, "Rehabilitation/restorative care is under the direction of nursing. . . .The following criteria must be met for the program: . . .Measurable objectives and interventions must be documented in the care plan and medical record. Periodic evaluation by a licensed nurse must be present in the medical record. . . . Rehabilitation/restorative interventions: Passive range of motion. Movement of a part of the body around a fixed point or joint by the nursing staff. . . . Process: . . . If decline is noted, the interdisciplinary team makes a referral to therapy to assess/recommend. . . ."	F 318	All residents with restraints will be audited for compliance with physician orders for ROM, to ensure residents with limited range of motion receive appropriate treatment and services to increase range of motion and /or prevent further decrease in range of motion by the Quality Assurance Coordinator or designee weekly x2, monthly x2 then quarterly thereafter to ensure continued compliance. Results of audits will be taken to the Quality Assurance Council for follow-up and revision as needed.	07/11/13

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F 318	Continued From page 16 *"Therapy Screens" stated, ". . . Screening does not include any testing, measuring, actual performance of activities such as transfers by the clinician since this is considered skilled evaluation and requires a physician order . . . The following areas should be reviewed when completing a screen: 1. Matrix or other electronic health record, including progress notes and assessments/observation completed in last 30 days. . . . Also highly recommend observing residents in room or common area, especially when screening for positioning or contractures on more dependent or non- verbal residents. . . ." - Review of Resident #10's medical record occurred on June 4-6, 2013. Diagnoses included hemiplegia, traumatic brain injury, and contracture of hand joint. The current quarterly MDS, dated 03/11/13, identified a limb restraint and bilateral upper extremity functional limitation in range of motion. A physician order, dated 12/12/12, stated, "May wear mitt to Rt [right] hand for safety to prevent pulling tube [gastric feeding tube] out and putting fingers down throat. Special Instructions: Q [every] 2 hours mitt has to be removed and exercised for 10 minutes. . . ." Resident #10's current plan of care, dated 03/14/12, stated the following: "PROBLEM . . . Restraint: Resident to wear hand mitt to right hand at all times . . . GOAL . . . Resident will have no further episodes of gaging [sic] self, pulling tube out, rubbing skin raw but will have no discomfort related to mitt APPROACH . . . Remove mitt every 2 hours and	F 318		

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F 318	Continued From page 17 exercise hand for 10 minutes. . . ." Review of the "Daily Assignment Sheet" on the morning of 06/05/13 failed to address the physician's order or plan of care regarding removing Resident #10's right hand mitt and exercising her hand. Observation of cares showed CNAs failed to remove Resident #10's right hand mitt and/or exercise her hand for ten minutes: *06/04/13, 10:00 a.m. - CNAs (#6 and #16) - removed resident's mitt for cleansing only. One CNA stated the resident's right hand "starting to get more contracted." During an interview on the morning of 06/06/13, a CNA (#16) confirmed CNAs should notify a nurse of "any type of change." *06/04/13, 12:00 p.m. - CNAs (#6 and #16) - no removal of mitt *06/04/13, 2:25 p.m. - CNAs (#7 and #8) - no removal of mitt *06/04/13, 4:40 p.m. - CNAs (#6 and #8) - no removal of mitt *06/05/13, 8:20 a.m. - CNAs (#11 and #12) - no removal of mitt During an interview on 06/05/13 at 10:30 a.m., a CNA (#12) stated she cleansed Resident #10's right hand. The CNA stated the resident's right hand is really contracted so if the resident is tired or agitated it is hard to cleanse her hand. The CNA stated Resident #10 receives restorative therapy (stretching of her hand), by the restorative aide every morning at approximately 6:30 a.m. The CNA stated they take cues from the restorative aide for exercises and no ROM therapy is completed by CNAs.	F 318		

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F 318	Continued From page 18 During an interview on 06/06/13 at 7:45 a.m., a CNA (#12) demonstrated opening and closing/stretching exercise to be completed for passive range of motion (PROM). This CNA stated she had been unaware before today of the need to provide PROM to Resident #10's right hand every two hours. The CNA stated during the cleansing of the resident's hand she would spread the resident's hand for a "couple seconds." Review of CNA documentation, "Point of Care History," identified six entries by non-restorative CNAs for 15 minutes of PROM between 05/01/13 and 06/05/13. Review of the "Rehabilitation Screen" form, dated 06/05/13, completed by a Certified Occupational Therapy Assistant (COTA) (#19) stated, "No functional changes." During an interview on 06/06/13 at 1:30 p.m., the COTA (#19) stated Resident #10 had been screened with no change and did not require therapy. The staff member (#19) also confirmed she had not observed Resident #10 receiving PROM from the restorative aide while completing Resident #10's screen. During an interview on the 06/05/13 at 5:20 p.m., an administrative nurse (#4) confirmed the physician's order for removal of Resident #10's restraint every two hours and ROM/exercise to her hand should be included on the group sheet (Daily Assignment Sheet) and followed/completed by CNAs.	F 318		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323		

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F 323	Continued From page 19 The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 07/19/12. Based on observation, record review, review of facility policy, review of manufacturers recommendations, and staff interviews, the facility failed to provide adequate supervision and assistive devices for 4 of 11 sampled residents (Resident #1, #2, #12, and #13) observed during a transfer. Failure of the staff to ensure proper use of assistive devices (gaitbelts, stand lifts, and full-body lifts) has the potential to cause residents unnecessary pain and places them at risk for possible accident and/or injury. Findings include: Review of the facility policy titled "Transfer Belt Use" occurred on 06/06/13. This policy, dated 08/01/11, stated, "The purpose of a transfer belt (gait) is to provide support to residents who may be unsteady on their feet. The belt will protect the resident should they become weak or lose their balance when ambulating or transferring. . . ." Review of the "Manual/Electric Portable Patient Lift Owner's Operator Manual" occurred on	F 323	F323 It is the practice of St. Catherine's Living Center to ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Resident #1 now receives proper use of assistive devices related to the use of gait belts during transfers. Resident #~~2~~ now receives proper use of assistive devices related the use of the Hoyer lift during transfers. Changed per Kim DON via phone call on 7/11/13 KBeechie Resident #12 now receives proper use of assistive devices related the use of the Pal lift during transfers including locking brakes prior to lowering resident to wheelchair. ~~Resident #9 expired on 6-26-13.~~ Resident #13 has been discharged. per phone call with Kim DON on 7/11/13 KBeechie All residents who have been identified per residents care plans to require use of assistive devices related the use of gait belts/Hoyer-Pal lifts for transfers including locking brakes prior to lowering residents to wheelchairs have the potential to be affected by this issue.	

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F 323	Continued From page 20 06/06/13. The manual stated, ". . . 2. When the patient is lifted from the bed (with the patient's head supported by the sling and/or an assistant), he/she will be raised to a sitting position. . . ." Review of the "Volaro Stand Lift Owner's Operator Manual" occurred on 06/06/13. The manual stated, ". . . Once the Butterfly Sling is applied, lock the brakes on the wheel chair. . . . Assist the person's feet onto the foot board. . . . The shin rest has a built-in safety support strap. The strap helps those who need the added security and support. This will keep their shins and feet securely in place. . . . If the person is unable to hold onto the handle grips, then take the remaining material hanging from the "J" hooks and place the last (distal) loop back in the "J" hook to form a large loop of fabric. Then direct the person's hand through the fabric, until it's safely supported. . . . With the VOLARO Stand, the person being transferred does need some body strength. . . . If you find that the person you are lifting is either less ambulatory than you originally thought . . . use the . . . Full Body Lift . . ." - Review of Resident #1's medical record occurred on June 3-6, 2013. Diagnoses included Alzheimer's disease, dementia, and history of falls. The significant change Minimum Data Set (MDS), dated 04/04/13, identified severely impaired cognitive skills and extensive assistance required for transfers. Resident #1's current care plan stated, "Problem: ADL [Activities of daily living] FUNCTION: . . . Approach: . . . Transfer: 1 assist, PAL [stand] lift PRN if having increased pain or fatigue . . .	F 323	CNAs involved with the immediate care of Resident #1, #6, and #12, received "just in time" re-training regarding providing safe transfer through utilization of gait belts and Hoyer-Pal lifts including locking brakes prior to lowering residents to wheelchairs per established protocols and residents plan of care. CNAs that transfer residents through the use of gait belts and Hoyer-Pal lifts will be re-educated regarding providing safe transfer through utilization of gait belts, Hoyer-Pal lifts and wheelchair brakes per established protocols and residents plan of care by 7/11/13 All residents who have been identified per resident care plans to require use of assistive devices related to the use of gait belts/ Hoyer-Pal lifts for transfers including locking brakes prior to lowering residents to wheelchairs will be audited for appropriate use of gait belts/ Hoyer-Pal lifts and wheelchair brakes to ensure provision of safe resident transfers by the Quality Assurance Coordinator or designee for adherence to established protocols weekly x2, then monthly x2 and quarterly thereafter to ensure compliance. Results of audits will be taken to the Quality Assurance Council for follow-up and revision as needed.	07/11/13

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F 323	Continued From page 21 Locomotion: 1 assist . . ." The CNA care sheet further stated, "Ambulation: 1 assist w [with]/FWW [front wheeled walker] [and] gait belt as allows. . . ." Observation on 06/04/13 at 9:40 a.m. showed a certified nurse assistant (CNA) (#6) transported Resident #1 into the bathroom. After locking the breaks on her wheelchair, the CNA cued Resident #1 to stand, lowered her clothing as she held onto the grab bars, and cued her to sit. After Resident #1 voided, the CNA (#6) cued her to stand [holding the bars], provided pericares, adjusted her clothing, and cued her to sit in her wheelchair. The CNA (#6) transported Resident #1 to her bed, locked the breaks on her wheelchair, cued her to stand, and pivoted her onto the bed. The CNA (#6) stated, "The care plan says one assist" and "The CNA sheet says independent, one assist prn [as needed]." The CNA failed to apply a gait belt prior to transferring Resident #6 onto the toilet and/or bed. During an interview on 06/06/13 at 8:45 a.m., two administrative staff members (#3 and #4) stated they expect staff to apply/attempt to apply a gait belt around Resident #1's waist. - Review of Resident #2's medical record occurred on June 3-6, 2013. Diagnoses included Parkinson's disease, dementia, agitation, behaviors, and history of falls. The quarterly Minimum Data Set (MDS), dated 04/25/13, identified severely impaired cognitive skills and extensive assistance required for transfers. Resident #2's current care plan stated, "Problem: ADL Function: . . . Approach: . . . Transfer: Hoyer	F 323		

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	355033	A. BUILDING _____ B. WING _____	06/06/2013

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F 323	Continued From page 22 lift with assist of 2 . . ." Observation showed the following: * During the initial tour on 06/03/13 at 2:10 p.m., two unidentified CNAs transferred Resident #2 into his wheelchair using a full-body lift. As the CNA's raised the sling/lift, Resident #2's head fell back, unsupported throughout the transfer. * On 06/04/13 at 3:30 p.m. two CNAs (#7 and #8) transferred Resident #2 into his wheelchair using a full-body lift. As the CNA's raised the sling/lift, Resident #2's head fell back, unsupported throughout the transfer. As one CNA (#7) lowered the sling/lift, the other (#8) guided the resident into the wheelchair. The CNAs failed to support Resident #2's head while transferring him into his wheelchair. During an interview on 06/06/13 at 8:45 a.m., two administrative staff members (#3 and #4) stated they expect staff to support Resident #2's head during a full-body lift transfer. - Review of Resident #12's medical record occurred on June 5-6, 2013. Diagnoses included cerbrovascular accident (CVA) with right-sided hemiplegia and behaviors. The quarterly Minimum Data Set (MDS), dated 05/24/13, identified intact cognitive skills and extensive assistance required for transfers. Resident #12's current care plan stated, "Problem: ADL FUNCTION: . . . Approach: . . . Transfer: Pal Lift with one or two assist . . ." Observations showed the following: * On 06/05/13 at 1:35 p.m., two CNAs (#11 and #12) transferred Resident #12 into the bathroom	F 323		

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F 323	Continued From page 23 using the stand lift. The CNAs placed the resident's feet on the foot board, the sling harness behind his back/around his torso, and assisted the resident to hold onto the handle grips before raising the lift. The CNAs failed to place support strap around Resident #2's shins. * On 06/05/13 at 3:05 p.m., two CNAs (#17 and #18) transferred Resident #12 into his wheelchair using the stand lift. The CNAs cued/assisted the resident to lift his feet onto the foot board. Resident #2's feet were placed on the left half of the board with his right foot turned inward. The CNA's placed the sling harness and assisted the resident to hold onto the handle grips before raising the lift. The CNAs failed to adjust Resident #12's feet on the foot board before raising the lift. * On 06/05/13 at 4:30 p.m., a CNA (#5) transferred Resident #12 into the bathroom using the stand lift. The CNA placed the resident's feet on the foot board, the support strap around his shins, and the harness behind his back/around his torso before raising the lift. The CNA (#6) cued Resident #12 to hold onto the left handle grip, leaving his right arm to hang at his side. The resident failed to bear weight and was in a seated position as he hung from the harness. As the harness straps pulled upward into Resident #12's axillae (armpits), his right shoulder raised to ear level. As the CNA lowered Resident #12 into his wheelchair, the wheelchair rolled backwards 3-6 inches. The CNA failed to support his right arm during the transfer and failed to lock the brakes prior to lowering the resident into the wheelchair. During an interview on 06/06/13 at 8:45 a.m., two administrative staff members (#3 and #4) stated they expect staff to place Resident #12's feet on the foot board, use the shin support strap, and	F 323		

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F 323	Continued From page 24 support his right arm during a transfer. They also stated they expect the breaks on Resident #12's wheelchair to be locked prior to transfer. - Review of Resident #13's medical record occurred on June 05-06, 2013. Diagnoses included dementia, left eye blindness, and right hemiparesis. The current care plan identified Resident #13 required a sit-to-stand lift or full body mechanical lift for transfers. On 06/05/13 at 1:45 p.m., a CNA (#9) utilized a sit-to-stand lift and transferred Resident #13 to the bathroom. The lift had two lipped areas on the platform for foot placement. Observation showed the resident lifted his left foot out of the lipped area numerous times and placed the ball of his foot directly on the lip. The CNA (#9) lifted Resident #13 to an upright position and moved him towards the bathroom. The surveyor pointed out the resident's foot placement on the platform and the CNA stopped the transfer and placed his foot correctly on the platform. After toileting, the CNA (#9) utilized the lift and transferred Resident #13 to his bed. Observation again showed the resident's left foot placed incorrectly on the platform.	F 323		
F 327 SS=E	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE	F 327	F327 Hydration It is the practice of St. Catherine's Living Center to provide each resident with sufficient fluid intake to maintain proper hydration and health.	25

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F 327	Continued From page 25 SURVEY COMPLETED ON 07/19/12. Based on observation, record review, policy review, and staff interview, the facility failed to provide sufficient fluids to maintain adequate hydration to 5 of 9 sampled residents (Resident #2, #4, #12, #13, and #14) who required assistance with eating. Failure to offer fluids during cares may result in inadequate hydration for all residents. Findings include: Review of the facility policy titled "Hydration Program" occurred on 06/06/13. This policy, dated 2012, stated, ". . . Staff will offer and encourage appropriate fluids per physician order/resident care plan as part of daily interaction with the resident, unless fluids are restricted, a minimum of 2x [times] per shift to include the following: . . . water is provided at bedside daily . . . The following will be in place as reminders to staff to offer fluids: Drops of water pictures will be placed in resident bathroom/rooms . . . " - During the initial tour of the facility on 06/04/13 at 2:10 p.m., observation showed two unopened containers of thickened water on Resident #13's bedside table. Review of Resident #13's medical record occurred on June 05-06, 2013. Diagnoses included dementia, left eye blindness, and right sided hemiparesis. A physician's order, dated 05/30/13, stated, ". . . trial NECTAR thickened liquids." Resident #13's admission MDS, dated 04/22/13, identified severely impaired cognition	F 327	Residents #2, #4, #12, #13, and #14 are offered fluids during cares per individual care plans to maintain the resident's hydration status. All residents who require provision of assistance with eating requiring assistance with receipt of fluids throughout the day to maintain proper hydration per care plan have the potential to be affected by this issue. CNAs that care for resident's # 2, #4, #12, #13, and #14 received "just in time" re-education regarding offering of fluids during cares per individual care plans to maintain the resident's hydration status. All CNAs will receive re-education regarding offering of fluids during cares per individual care plans to maintain the resident's hydration status. Educated on 7/10/13 per Kim, DON on 7/11/13 @ 2:55pm via phone call KBeechie Residents identified to require provision of assistance with eating requiring assistance with receipt of fluids throughout the day to maintain proper hydration per care plan will be audited by the Quality Assurance Coordinator or designee to ensure compliance weekly x2, then monthly x2 and quarterly thereafter to assure compliance.	

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F 327	Continued From page 26 and vision and required extensive assistance with eating. The current care plan stated, "Encourage fluids to adequate levels of hydration." Review of the nutrition assessment, dated 04/18/13, identified Resident #13's daily fluid needs as 1600 - 1900 (ml) milliliters per day. The documented fluid intake record from 04/17/13 to 05/07/13 showed Resident #13 consumed half of his daily fluids needs 13 of 17 days documented. Observation on 06/05/13 at 1:45 p.m. showed a CNA (#9) assisted Resident #13 from his wheelchair to the bathroom and then to bed. The CNA failed to offer the resident any fluids with cares. Observation showed no water in the resident's room, an unopened bottle on Ensure (a nutritional supplement), dated 06/04/13, on the bedside table, and a picture of a water drop on the bathroom door. - Review of Resident #4's medical record occurred on June 04-06, 2013. Diagnoses included Lewy body dementia (a specific form of dementia). Resident #4's quarterly Minimum Data Set (MDS), dated 04/08/13, identified long and short term memory difficulties and required extensive assistance with eating. The current care plan stated, "Nutrition: . . . Oral intakes 75-100% food/fluids at meals . . . Requires assistance from staff for oral intake . . . Approach: . . . Provide and encourage foods/fluids between meals . . ." On 06/04/13 at 9:36 a.m., 11:40 a.m., and 3:28 p.m., certified nursing assistants (CNAs) provided personal cares for Resident #4 in his room. Observation during all cares showed a large cup	F 327	Results of audits will be taken to the Quality Assurance Council for follow-up and revision as needed.	07/11/13

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F 327	Continued From page 27 of water and an unopened straw on the resident's bedside stand and a picture of a water drop on the mirror in the resident's bathroom. The CNAs failed to offer Resident #4 fluids at anytime during cares. - Review of Resident #14's medical record occurred on June 05-06, 2013. Diagnoses included dementia. The annual MDS, dated 04/10/13, identified severely impaired cognition and required extensive assistance with eating. A physician's order, dated 10/16/12, stated, ". . . NECTAR consistency liquids . . ." Resident #14's current care plan stated, "Resident at risk for dehydration . . . Approach: . . . Assist with fluids as needed. Keep fluids accessible . . ." On 06/05/13 at 1:05 p.m., a CNA (#9) assisted Resident #14 from her wheelchair to the bathroom and then to bed. Observation showed no fluids in the resident's room and a picture of a water drop on the bathroom door. The CNA (#9) failed to offer Resident #14 fluids. During an interview on the morning of 06/06/13, two administrative staff members (#3 and #4) stated facility staff are expected to offer residents fluids with cares, especially the residents identified with a water drop on their door. - Review of Resident #2's medical record occurred on June 3-6, 2013. Diagnoses included Parkinson's disease, dementia, and swallow deficit. The quarterly Minimum Data Set (MDS), dated 04/25/13, identified severely impaired cognitive skills and extensive assistance required for eating.	F 327		

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F 327	Continued From page 28 Resident #2's current care plan stated, "Problem: URINARY . . . BOWEL . . . SKIN . . . Approach: . . . Encourage fluids to adequate levels of hydration. . . . Problem: NUTRITION. . . Approach: . . . Requires assistance with oral intake for all . . . fluids. . . . Nectar thickened liquids . . ." The mini-nutritional assessment, dated 04/25/13, identified, ". . . Fluid Requirements: 2100 ml . . . Current Intake: Fair 50-75% . . ." Observations showed the following: * During the initial tour on 06/03/13 at 2:10 p.m., a picture of a water drop on Resident #2's bathroom door. * On 06/03/13 at 2:10 p.m., 06/04/13 at 7:25 a.m. and 2:25 p.m., 06/05/13 at 10:50 a.m., 1:45 p.m., and 5:45 p.m., and 06/06/13 at 7:50 a.m., two unopened containers of nectar-thick liquid on Resident #2 dresser. * 06/04/13 at 8:20 a.m., as Resident #2 lay in bed, two CNA's (#6 and #16) provided toileting and grooming cares. The CNAs failed to offer Resident #2 fluids prior to/following cares. * 06/04/13 at 3:30 p.m., two CNA's (#7 and #8) provided toileting cares and transferred Resident #2 into his wheelchair. The CNAs failed to offer Resident #2 fluids prior to cares or following the transfer. * 06/05/13 at 1:45 p.m., two CNA's (#11 and #12) transferred Resident #2 into bed and provided toileting cares. The CNAs failed to offer Resident #2 fluids prior to the transfer or following cares. - Review of Resident #12's medical record occurred on June 5-6, 2013. Diagnoses included cerbrovascular accident (CVA) with right-sided	F 327		

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F 327	Continued From page 29 hemiplegia and dysarthria. The quarterly Minimum Data Set (MDS), dated 05/24/13, identified extensive assistance required for transfers, and supervision for eating. Resident #12's current care plan stated, "Problem: NUTRITION. . . Approach: . . . NECTAR thickened liquids . . . Provide and encourage . . . fluids between meals. Offer fluids often! . . . Problem: URINARY . . . BOWEL . . . SKIN . . . Approach: . . . Encourage fluids to adequate levels of hydration. . . ." The mini-nutritional assessment, dated 05/23/13, identified, ". . . Fluid Requirements: 1800-2200 ml . . . Current Intake: Fair 50-75% . . ." Observations showed the following: * During the initial tour on 06/03/13 at 2:10 p.m., a picture of a water drop on Resident #2's bathroom door. * On 06/03/13 at 2:10 p.m., 06/05/13 at 1:45 p.m., 4:30 p.m., and 5:45 p.m., and 06/06/13 at 7:50 a.m., two unopened containers of nectar-thick liquids on the left side and one behind Resident #12's TV. * 06/05/13 at 1:35 p.m., two CNAs (#11 and #12) provided toileting cares and transferred Resident #12 into bed. The CNAs failed to offer Resident #12 fluids prior to cares or following the transfer. * 06/05/13 at 4:30 p.m., a CNA (#5) provided toileting cares and transferred Resident #12 into his wheelchair. The CNA failed to offer Resident #12 fluids prior to cares or following the transfer. During an interview on 06/06/13 at 8:45 a.m., two administrative staff members (#3 and #4) agreed staff should offer fluids to the residents during	F 327		30

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F 327	Continued From page 30 cares. Failure to offer fluids could result in residents not meeting their fluid/nutritional needs.	F 327	F329 It is the practice of St. Catherine's Living Center that each resident's drug regimen must be free from unnecessary drugs to include any drug when used in excessive dose (including duplicate therapy); and/or without adequate indications for its use. Resident #6: PRN Risperdal ordered dose is now administered according to the physician's orders (for behavior problem/anxiety) including documentation of effectiveness. All residents administered PRN Risperdal have the potential to be affected by this issue Licensed nursing staff that care for Resident #6, received "just-in-time" education regarding proper administration of ordered dose of PRN Risperdal for appropriate reasons per physicians order to include documentation of effectiveness. All licensed nursing staff will receive education regarding proper administration of ordered dose of PRN Risperdal for appropriate reasons per physicians order to include documentation of effectiveness by 7/11/13.	
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review, review of professional reference, and staff interview, the facility failed to ensure a drug regimen free from unnecessary	F 329		

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F 329	Continued From page 31 medication for 1 of 1 sampled residents (Resident #6) who received an antipsychotic medication on an as needed (PRN) basis to promote sleep. The facility failed to follow the physician's order by administering a PRN antipsychotic without indication which resulted in Resident #6 receiving an unnecessary medication. Findings include: "Nursing 2013 Drug Handbook," 33rd edition, Lippincott, Williams, & Wilkins, Philadelphia, page 11923-1194, identified adverse reactions to Risperdal (risperidone) as somnolence, headache, insomnia, agitation, anxiety, pain, dizziness, hallucination, abnormal thinking and dreaming. "Black Box Warning Fatal cardiovascular or infectious adverse events may occur in elderly patients with dementia. Drug isn't safe or effective in these patients. . . ." Review of Resident #6's medical record occurred on all days of survey. Diagnoses included dementia with behavioral disturbances, pain, and anxiety. Review of Resident #6's physician's orders indicated "Risperdal [an antipsychotic medication] (risperidone) tablet; 0.25 mg; [milligram] amt: [amount] 1/2; oral Special Instructions; prn behavior problems/anxiety Every 12 hours -PRN" with a start date of 07/18/2012. Review of Resident #6's "Resident Progress Notes" and PRN medication administration record (MAR) stated the following: * 04/08/13 at 3:30 p.m., (the PRN MAR) the resident received Risperdal 0.25 mg for	F 329	All residents with physician orders for PRN Risperdal will be audited to ensure proper administration of ordered dose for appropriate reasons per physicians order to include documentation of effectiveness by the Quality Assurance Coordinator or designee weekly x2, monthly x2 then quarterly thereafter to ensure continued compliance. Results of audits will be taken to the Quality Assurance Council for follow-up and revision as needed.	07/11/13

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F 329	Continued From page 32 increased behavior/anxiety, no documentation regarding effectiveness. * 04/08/13 10:03 p.m., "Resident has been yelling out and hitting at staff, trying to trip staff and residents, grabbing at people as they were walking by." * 05/26/13 8:44 a.m., "Resident is up hollering most of the night, keeping other residents awake. Will attempt PRN risperdal dose in the evening to see if it helps with sleep." * 05/26/13 8:24 p.m., ". . . Was yelling out and grabbing at other residents after supper. Gave PRN Risperdal at 7:45pm and resident is resting in bed at this time. . . ." Resident #6's PRN MAR dated 05/26/12 lacked documentation this medication was given. * 05/27/13 5:44 a.m., "Res [resident] had been awake throughout this shift. . . . Res unable to redirect." * 05/27/13 at 8:00 p.m. (the PRN MAR) Risperdal 0.25 mg "to promote rest," no documentation regarding effectiveness. * 05/27/2013 10:50 p.m., "Resident continues on ABX [antibiotic treatment] for treatment of UTI. She has been leaning to her right side throughout the shift and had to be repositioned many times throughout the evening. . . ." * 05/28/13 8:49 a.m., "Resident when in wheelchair leans way over to the right side and lets right arm hang. Will not sit up. Resident was laid down. * 05/28/13 8:30 p.m., "Residents daughter, [daughter's name] called at this time . . . Explained that resident was leaning in her chair to the right side, that she was sleeping most of the day, and that AM shift reported she was lethargic. Explained to daughter, that the reason she may be very sleepy, is because she was awake on the	F 329		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CATHERINES LIVING CENTER	1307 N 7TH ST WAHPETON, ND 58075

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F 329	Continued From page 33 NOC [night] shift. . . ." * 05/29/13 at 8:00 p.m., (the PRN MAR) Risperdal 0.125 mg "to promote rest," at 9:15 p.m., "sleeping [no] behaviors [with] HS [hour of sleep] cares. * 05/29/13 8:46 p.m., "Daughter called this evening . . . Was upset that res is getting PRN risperdal at HS [hour of sleep] to aid her in sleeping during the night. States that her mother will not be druged (sic). States that she knows for a fact that her mother did not get up until 9:30 this morning and if she wan't (sic) to be up late that we are to let her. Was told that we were trying to get her back onto a normal routine with her sleep, so that she sleeps during the night reather (sic) than during the day. Res was hollering out and agitating ather (sic) res in the dining room before PRN dose was given tonight, res later was still hollering out but not as much or as loudly, Res allowed all cares including brushing of teeth which she usually refuses. Res currently sleeping at this time." * 05/30/13 3:40 p.m., "Spoke with residents daughter and she had concerns with attempting to use risperdal PRN to see if it helps for sleep. . . ." No further doses of PRN Risperdal were administered to Resident #6 after 05/30/13. The facility staff failed to administer the PRN Risperdal according to the physician's orders (for behavior problem/anxiety) and on two occassions (04/08/13 and 05/27/13) gave double to prescribed dose. During an interview on 06/05/13 at 2:10 p.m., an administrative nurse (#4) agreed that this is not a good practice.	F 329		

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F 371 SS=E	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, temperature record review, policy and procedure review, professional literature review, and staff interview, the facility failed to store foods in a safe and sanitary manner in 1 of 1 unit kitchenette (Special Care Unit) and failed to ensure proper sanitation of dishware for 1 of 2 dish machines (South Kitchen). These practices placed residents at risk for contamination of food during storage, preparation, and service which could result in a food borne illness. Findings include: The 2009 Food Code, published by the Food and Drug Administration (FDA) page 128, stated, "(A) . . . in a mechanical operation, the temperature of the fresh hot water sanitizing rinse as it enters the manifold may not be . . . less than . . . (2) For all other machines, . . . (180 [degrees] F [Fahrenheit]) . . . ." The 2009 Food Code, published by the Food and	F 371	F371 It is the practice of St. Catherine's Living Center to store, prepare, distribute and serve food under sanitary conditions. Baked potatoes used for leftovers are now unwrapped and sliced open to cool per established "Food Preparation and Leftover Handling" protocols. All residents have the potential to be affected by this issue. Dietary staff responsible for handling and storage of baked potatoes used for leftovers have been re-educated on established protocols related food preparation and leftover handling in regard to baked potatoes to ensure safe food storage. The Quality Assurance Coordinator or designee will audit for handling and storage of baked potatoes used for leftovers when baked potatoes are on menu's weekly x2, monthly x2 then quarterly thereafter to ensure safe food storage and continued compliance. Results of audits will be taken to the Quality Assurance Council for follow-up and revision as needed.	07/11/13

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F 371	Continued From page 35 Drug Administration, Public Health Reasons, page 462, stated, ". . . The surface temperature must reach at least . . . (160 [degrees] F as measured by an irreversible registering temperature measuring device to affect sanitation. . . . (180 [degrees] F for other machines . . . are based on the sanitizing rinse contact time required to achieve . . . (160 [degrees] F) utensil surface temperature." Review of the following facility's policies occurred on the afternoon of 06/05/13: *"Dishwashing Temperature Monitoring Logs," dated 08/02/06, stated, "Procedure: 1. The appropriate dishwashing temperature log is posted and in the immediate vicinity of the dishwashing area. 2. Wash and rinse temperature are observed and logged by the operator during the dishwashing. 3. The temperature of the water shall be maintained at 150-160 degrees F for the washing cycle and 180 degrees F for the rinsing and sanitizing cycle. 4. Temperatures that are below the required level will be posted to the Dietary Director/Lead Personnel/Maintenance immediately for correction of the problem before continuing procedure. . . ." *"Food Preparation and Leftover Handling," dated 08/02/06, stated, ". . . Cooling food that will be served as a leftover item . . . Food will be loosely covered until completely cooled . . ." *Food Storage Guidelines," dated 08/02/06, stated, ". . . Working containers holding dry food or ingredients that are removed from their original packages are identified with the common name of the food, unless the food is easily recognizable such as dry pasta, and dated with the appropriate open and expiration date. . . ."	F 371	The dish machine in the South kitchen dishwashing room was repaired and now maintains the final rinse cycle temperature to be at least 160F at the plate/utensil surface level. All residents have the potential to be affected by this issue. Policies and Procedures regarding monitoring and maintaining appropriate dish machine final rinse cycle temperatures to include reporting of inadequate temperatures have been reviewed and updated to ensure proper sanitation. Dietary staff utilizing dish machines have been educated regarding monitoring and maintaining appropriate final rinse cycle temperatures, including reporting of inadequate temperatures to ensure proper sanitation. Education provided 6/11/13 per Kim DON on 7/11/13 @ 2:55pm via phone call K. Beechie The Quality Assurance Coordinator or designee will audit for monitoring and maintenance of appropriate dish machine final rinse cycle temperatures, to include reporting of inadequate temperatures weekly x2, monthly x2 then quarterly thereafter to ensure proper sanitation and continued compliance. Results of audits will be taken to the Quality Assurance Council for follow-up and revision as needed.	07/11/13

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F 371	Continued From page 36 - The initial dietary tour of the kitchen occurred on 06/03/13 at 2:00 p.m. with an administrative dietary staff member (#13). Observation of the North kitchen's walk-in cooler showed twelve baked potatoes, tightly wrapped in aluminum foil, cooling in a pan. When interviewed, the staff member (#13) stated dietary staff members were cooling the baked potatoes from the noon meal to prepare potato salad for residents. Observation during the initial dietary tour of the South kitchen's dishwashing room showed a dietary staff member (#14) removing a rack of dishes from the dish machine. An administrative dietary staff member (#13) confirmed the dish machine used hot water to sanitize dishware. Observation of the dish machine's temperature gauge showed the dish machine reached a final rinse cycle temperature of 174-178 degrees F at the manifold. This staff member (#13) passed a thermo chromatic color change strip (an irreversible registering temperature measuring device) through the dish machine. The strip showed the final rinse cycle temperature did not reach 160 degrees F at the plate/utensil surface level. The staff member (#13) passed a maximum registering thermometer through the dish machine and obtained a final rinse cycle temperature of 154 degrees at the plate/utensil surface level. Review of the "Dishmachine Temperatures" logs revealed the following final rinse cycle temperatures (less than the required 180 degrees) at the manifold per the gauge: *April - 1 entry of 175 and 1 entry 176 degrees *May - 1 entry of 170 degrees	F 371	Dry food products contained in the Special Care Unit's kitchenette cabinet are now in a sealed, labeled and dated container per established "Food Storage Guidelines" protocols. All residents have the potential to be affected by this issue. All staff responsible for placing dry food products in a sealed, labeled and dated container in the Special Care Unit kitchenette have been re-educated on established protocols related to dry food storage to ensure safe food storage practice. The Quality Assurance Coordinator or designee will audit for dry food products in a sealed, labeled and dated container in the Special Care Unit kitchenette weekly x2, monthly x2 then quarterly thereafter to ensure safe dry food storage practice and continued compliance. Results of audits will be taken to the Quality Assurance Council for follow-up and revision as needed.	07/11/13

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F 371	Continued From page 37 The log included a column with the heading, "Notify maint. [maintenance] (Time & Initials)" which facility staff failed to complete for the above temperatures at less than the required 180 degrees. Observation of the dish machine on 06/03/13 at 5:50 p.m. with an administrative maintenance staff member (#15) showed the final rinse cycle temperatures between 186 to 192 degrees at the manifold. The staff member (#15) passed a thermo chromatic color change strip through the dish machine and this strip failed to indicate the final rinse cycle temperature to be at least 160 degrees F at the plate/utensil surface level. The staff member (#15) passed a maximum registering thermometer through the dish machine and obtained a final rinse cycle temperature of 140 degrees at the plate/utensil surface level. During an interview on 06/04/13 at 7:55 a.m., an administrative maintenance staff member (#15) stated maintenance staff determined a piece of plastic approximately one inch in size had been blocking a hole in the dish machine's sprayer, preventing the flow of hot water onto the plates/utensil surfaces. An administrative staff member (#13) passed a thermo chromatic color change strip through the dish machine and the strip indicated the final rinse cycle temperatures to be at 160 degrees F at the plate/utensil surface level. Observation of the Special Care Unit's kitchenette on 06/05/13 at 2:30 p.m. showed a cabinet contained the following dry foods not labeled or dated:	F 371		

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F 371	Continued From page 38 *Container of a white granular substance *Container of a white powdery substance *Unsealed bag of graham cracker crumbs *Unsealed bag of rice chex cereal *Container of instant oatmeal During an interview on the afternoon of 06/05/13, an administrative dietary staff member (#13) stated, "Baked potatoes should be unwrapped and sliced open to cool [by dietary staff]." The staff member (#13) agreed facility staff should place dry foods in a sealed, labeled, and dated container.	F 371	F441 It is the practice of St. Catherine's Living Center to establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. SCLC has established an infection control program under which we investigate, control and prevent infections in the facility; decide what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections. Residents #1, #4, and #14 are now receiving pericare per CNAs to include appropriate hand hygiene practice. All residents who are provided pericares have a potential to be affected by this issue. CNAs that provide care for residents # 1, #4, and #14 were re-educated regarding facility hand hygiene policy to ensure the prevention/development/ transmission of disease and infection. All CNAs will receive re-education regarding facility hand hygiene policy to ensure the prevention/development/ transmission of disease and infection. Education provided 7/10/13 per KimDow on 7/11/13 Via Phone call KBeech	
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	F 441		

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F 441	Continued From page 39 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, record review, review of facility policy, and staff interview, the facility failed to follow standard infection control practices for 3 of 13 sampled residents (Resident #1, #4, and #14) observed during toileting/perineal cares. Failure to follow infection control practices related to glove usage and hand hygiene has the potential to cause or spread infection within the facility. Findings include: Review of the facility policy titled "HANDWASHING" occurred on 06/06/13. This policy, dated 2002, stated, ". . . The staff will wash hands when indicated by professional practice, according to proper procedure . . . Before [and] after assisting a resident with personal care . . . After removing gloves . . . The hands must be clean at all times in order to safeguard the health of those who are dependent	F 441	The Quality Assurance Coordinator or designee will complete hand hygiene audits for all residents who are provided pericares to ensure appropriate hand hygiene practice for the prevention/development/ transmission of disease and infection weekly x2, then monthly x2, then quarterly thereafter to assure compliance. Results of audits will be taken to the Quality Assurance Council for follow-up and revision as needed.	07/11/13

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F 441	Continued From page 40 on personal care. . . ." Review of the facility policy titled "Perineal Care" occurred on 06/06/13. This policy, dated 2002, stated, ". . . PROCEDURE: . . . 22. Apply gloves . . . 26. Place soiled brief in bag . . . 27. Remove gloves, and wash hands. 28. Apply another set of gloves to wash, rinse and dry perineal area per facility procedure . . . 33. Remove gloves and wash hands . . . POST-PROCEDURE: . . . 6. Assure resident's comfort . . . 9. Wash your hands . . ." - Review of Resident #1's medical record occurred on June 3-6, 2013. The quarterly Minimum Data Set (MDS), dated 04/04/13, identified severely impaired cognitive skills and extensive assistance required for toileting. Observation on 06/04/13 at 4:45 p.m., showed a certified nursing assistant (CNA) (#8) assisting Resident #1 with toileting cares. After the resident voided, the CNA (#8) donned gloves, assisted the resident to stand, and provided pericares. At the completion of the perineal cares, the CNA (#8) removed her gloves, assisted Resident #1 to stand-pivot into her wheelchair, combed her hair, and transported her to dinner. The CNA (#8) failed to perform any hand hygiene during this observation. - Review of Resident #4's medical record occurred on June 04-06, 2013. The quarterly Minimum Data Set (MDS), dated 04/18/13, identified the resident required extensive assistance with toilet use and personal hygiene. Observation on 06/04/13 at 3:28 p.m. showed a	F 441		41

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F 441	Continued From page 41 CNA (#1) donned gloves and provided perineal cares for Resident #4 after a bowel movement. At the completion of the perineal cares, the CNA (#1) removed her gloves, utilized a mechanical lift, with the assistance of another CNA (#2), and transferred the resident into his wheelchair. The CNA (#) assisted Resident #4 with his glasses, brushed his hair, and transported him out of the room. The CNA (#1) failed to perform any hand hygiene during this observation. - Review of Resident #14's medical record occurred on June 05-06, 2013. The quarterly MDS, dated 04/10/13, identified the resident required extensive assistance with toilet use and personal hygiene. Observation on 06/05/13 at 3:55 p.m. showed a CNA (#1) utilized a sit to stand lift and transferred Resident #14 from her bed to the toilet. The CNA donned gloves, removed the resident's wet brief and performed perineal cares, removed her gloves, and transferred her to a wheelchair. The CNA (#1) stated, "I'll go and get your snack," and exited Resident #14's room. The CNA (#1) failed to perform any hand hygiene during this observation. During an interview on 06/06/13 at 8:45 a.m., two administrative staff members (#3 and #4) agreed staff should perform proper hand hygiene after completing any toileting/perineal cares.	F 441		