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JUL 14 2014
Division of Health Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355053	A. BUILDING _____ B. WING _____	06/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KNIFE RIVER CARE CENTER	118 22ND ST NE BEULAH, ND 58523

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F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey started on 06/02/14 and completed on 06/05/14, the sample included 4 residents for complete review, 10 residents for focused review, and 3 closed records for review. The sample included 9 additional residents to verify specific concerns during the survey.	F 000		
F 244 SS=D	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, review of monthly resident council meeting minutes, resident and staff interview, and policy and procedure review, the facility failed to act upon a grievance expressed by residents from 1 of 3 neighborhoods (Harvest Lane); specifically concerns about the timeliness of the food service during evening meals in the Harvest Lane dining room of the facility. Failure to act upon the grievance of the residents resulted in residents continuing to be dissatisfied. Findings include: Review of the facility's "Scheduled Meal Service" occurred on the morning of 06/05/14. This policy, dated 06/28/12, stated, "Meal service shall be scheduled at regular times to assure that each	F 244	**Plan of Correction F244** 1. Nursing and Dietary Services were immediately in-serviced on our practice guideline for serving resident meals. 2. The facility has determined that all residents have the potential to be affected. 3. All nursing and dietary staff has been in-serviced on the facility's "Meal service" policy and practice guidelines. In-service training included observation of individuals performing the procedure. A "Validation Checklist" was completed for each individual observed to determine if the individual was performing the procedure in accordance with our practice guidelines. Findings were reviewed with	delete ~~07/11/14~~ T.C. 7/16/14 2 DON dl.

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

Britt Anderson | ADMINISTRATOR | 07-18-14

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 244	Continued From page 1 resident receives at least three meals per day . . . 1. The following meal times have been established by our facility: Breakfast 7:30 to 9:00 AM, Lunch 11:30 - 12:30 PM, and Supper 5:30 to 6:30 PM . . . . Water and other beverages are available prior to meal service and should be served when the resident arrives in the dining area." Review of the facility's Resident Council Minutes from March-May 2014 occurred on the morning of 06/04/14. The Resident Council Minutes, March 2014, identified ". . . Dietary: . . Resident stated evening service is not acceptable." No follow-up to the concern is identified in the meeting minutes. - Observation of the supper meal in the Harvest Lane dining room on 06/02/14 at 5:30 p.m. showed the dining room doors remained closed. When the doors opened minutes later, the residents began to enter the room and sit at the tables. At 5:50 p.m., there has been no beverage service and no meal order sheets collected. During a group meeting on 06/03/14 at 1:00 p.m., seven of the nine residents (Resident A, B, C, D, E, F, G) in attendance stated the meal service at supper the previous evening was very slow and disorganized. The residents further stated there was no food served to anyone until after 6:00 p.m. and this is unacceptable. - Observation of the supper meal in the Harvest Lane dining room on 06/03/14 at 5:30 p.m. showed the dining room doors open and a certified nursing assistant (CNA) setting glasses on the table. Residents began arriving and filling out their meal order sheets. A resident submitted	F 244	each individual observed. Corrective action was provided as needed. 4. The Dietary Manager (DM) , or designee, will complete audits of staff offering/serving meals weekly x (4) weeks, monthly for (3) months, quarterly (1) year. Random verification checklists will be completed to ensure that mealtimes in accordance with our policy and practice guidelines. Audit records and validation checklists will be reviewed by QAPI until such time consistent substantial compliance has been achieved as determined by the committee. Audit results will be shared with the Resident/Food Group Council for comment and suggestions. Corrective action completion Date: June 11, 2014.	

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F 244	Continued From page 2 her meal order sheet at 5:35 p.m. and did not receive her meal until 6:00 p.m., 25 minutes later. At 5:38 p.m., a resident submitted her meal order sheet and did not receive her meal until 6:02 p.m., 24 minutes later. At 5:38 p.m., three residents at the same table submitted their meal order sheets and did not receive their meals until 6:03 p.m., 25 minutes later. - Observation on 06/03/14 of the supper meal service in the Harvest Lane dining room identified a dietary staff member (#5): * Arrive in the kitchenette and placed the meal items in the steamer at 5:35 p.m. * Prepared a special order egg for a resident in the Fruit Blossom Household dining area * Started serving the supper meal from the steam table at 5:50 p.m. to the Fruit Blossom Household first and then the Golden Grain Household dining room During an interview, on 06/04/14 at 4:10 p.m., a dietary staff member (#5) verified: * Staff arrive to the unit kitchenette from the kitchen with the supper meal by about 5:30 p.m. * The special order egg is a regular supper item and is fixed first before the supper meal service begins * Supper is then served to the rest of that dining room before serving the other household dining area During an interview on 06/04/14 at 4:15 p.m., a supervisory staff member (#6) confirmed dietary staff should be in the kitchenettes and ready to serve the supper meal at 5:30 p.m.	F 244		
F 246 SS=G	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES	F 246		

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F 246	Continued From page 3	F 246		

A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.

This REQUIREMENT is not met as evidenced by:
Based on record review, review of facility policy, review of call light reports, and resident and staff interviews, the facility failed to provide reasonable accommodations of individual needs regarding call light response times for 1 of 1 sampled resident (Resident #5) who voiced call light concerns. Failure to answer call lights promptly resulted in avoidable psychosocial harm due to long delays in providing toileting assistance.

Findings include:

Review of the facility policy titled "CALL LIGHT, USE OF" occurred on 06/05/14. This policy, revised 2012, stated, ". . . Procedure: 1. All nursing personnel must be aware of call lights at all times. 2. Answer ALL call lights promptly whether or not you are assigned to the resident. . . . 5. Answer all call lights in a prompt, calm, courteous manner. . . ."

Review of Resident #5's medical record occurred on June 02-05, 2014 and current diagnoses included Alzheimer's Disease. The quarterly Minimum Data Set, dated 03/01/14, identified the resident with intact cognition and a Brief Interview Mental Status (BIMS) score of 14, occasionally

Plan of Correction F246

delete ~~07/11/14~~ 7/16/14 T.C, & D.A.N. dl.

1. Some staff have difficulty understanding resident; staff will be provided with a communication book with pictures of basic needs, ie toilet, food, cup to assist with better understanding of resident requests.

2. All residents are potentially at risk.

3. The Director of Nursing Services provided in-service education for all facility staff addressing policies and procedure, regulations and facility expectations of staff regarding answering call lights in a timely manner on 6/18/14. All nursing staff (nurses, CMA's and C N A's) will be educated on badge check protocol. Badge checks will be

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F 246	Continued From page 4 incontinent, and required limited assistance with transfers and extensive assistance with toileting. During the initial tour of the facility on 06/02/14 at 10:05 a.m., Resident #5 expressed concerns with staff responding to her call light. Resident #5 stated she was incontinent of urine the morning of 06/02/14 while waiting for staff to answer her call light. Review of the call light report, dated 06/02/14, identified Resident #5 initiated her call light at 6:57 a.m. and staff responded 42 minutes later. During an interview on 06/03/14 at 7:55 a.m., Resident #5 stated she was incontinent of urine on 06/02/14 at 8:00 p.m. Resident #5 stated when a staff member responded to her call light, the staff member "did not understand [what the resident needed]" and left her room. The staff member returned after 10:00 p.m. and toileted Resident #5. Review of the call light report, dated 06/02/14, identified Resident #5 initiated her call light at 8:01 p.m. and staff responded 35 minutes later. Resident #5 initiated her call light at 9:07 p.m. and staff responded 65 minutes later. During an interview on 06/05/14 at 1:30 p.m., an administrative staff member (#4) stated call lights should be answered in a timely manner. Resident #5 brought the incontinence episodes to the surveyor's attention on two separate occasions indicating a significant impact on her mental and psychosocial well-being. Based on interviews and review of the call light report, the delay in answering Resident #5's call light	F 246	task oriented in E H R three times daily. 4. Director of Nursing, or designee, will do random badge checks weekly x 1 month, monthly x3, quarterly x1 year. and call lights answered 7/16/14 timely. T.C. to DON, dl. This Plan of correction will be monitored at the monthly QAPI meeting until such time consistent substantial compliance has been met. Corrective action completion date: July 20, 2014.	

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F 246	Continued From page 5 resulted in avoidable psychosocial harm.	F 246		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, policy review, review of professional reference, and staff interview, the facility failed to provide the necessary care and services to attain effective bowel management for 2 of 9 sampled residents (Resident #5 and #7) on a scheduled bowel medication. Failure to follow the facility's bowel protocol and administer bowel medications as ordered may contribute to unnecessary constipation and discomfort. 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 right route, at the scheduled time, and to the right client. . . ."	F 309	**Plan of Correction F309** 1. On 6/5/14 Resident # 7 order clarified and now reads Senna S 2 tabs PO QD. On 7/8/14 resident # 5 order clarified to read Senna S 2 tabs PO Q HS 2. The facility has determined that all residents have the potential to be affected. All residents with bowel medication orders will be reviewed by July 15, 2014. 3. All residents with bowel medications have been reviewed to ensure orders are clear and easy to follow. An in-service education program was conducted by the Director of Nursing Services with all direct care staff addressing the importance of maintaining adequate bowel maintenance	delete ~~07/11/14~~ T.C. 7/16/14 & D.O.N. dl

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F 309	Continued From page 6 Review of the facility policy titled "Bowel Protocol" occurred on 06/04/14. This undated protocol stated, "1. No BM [bowel movement] for 2 days - ONE intervention will be implemented and recorded on BM roster. 2. No BM for 3 days - TWO interventions will be implemented and recorded on the BM roster. 3. If after the 3rd day, the resident has not had results, the Nurse will then perform a nursing assessment, review prior interventions and decide whether or not to provide further interventions such as physician ordered medication, laxative, or enema." During an interview on the morning of 06/04/14 when asked about the Bowel Protocol, an administrative nurse (#12) stated an example of one intervention would be a fruit ball or prune juice, recorded under natural laxatives on the BM roster, or a medication. Staff try to use a natural laxative first. - Review of Resident #5's medical record occurred on June 02-05, 2014. Resident #5's current physician orders identified the following: * Senna S two tablets at bedtime if no bowel movement * Milk of magnesia (MOM) 30 ml (milliliters) and prune juice mid-day each day, if no bowel movement after Senna S During an interview on 06/04/14 at 1:30 p.m., an administrative staff member (#4) stated if Senna S was administered the night before and Resident #5 had a bowel movement by 11:00 a.m. facility staff would not administer MOM and prune juice. If Senna S was not administered the night before, facility staff would not administer MOM and prune juice and would administer Senna S if Resident #5 did not have a bowel	F 309	and the importance of timely documentation. Licensed staff will be in-serviced on the importance of easy to read orders and the necessity to clarify any difficult to follow orders immediately on July 15, 2014. 4. The Director of Nursing Services, or designee, will conduct random audit of bowel orders/bowel protocol being followed weekly x4, monthly x3, quarterly x 1 year. This plan of correction will be monitored at the monthly QAPI meeting until such time consistent substantial compliance has been met. Corrective action completion date: July 20, 2014	

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movement by 8:00 p.m.

Review of Resident #5's bowel roster, and April, May, and June 2014 medication administration records (MARs) showed facility staff administered the following:
* MOM and prune juice administered 14 times when Senna S was not administered the night before
* MOM and prune juice administered 15 times when Resident #5 already had a bowel movement
* MOM and prune juice not administered three times when the resident did not have a bowel movement
* Senna S administered 25 times when Resident #5 already had a bowel movement
* Senna S not administered four times when the resident did not have a bowel movement

Review of Resident #5's medical record identified facility staff failed to follow the physician orders 61 times from April 1, 2014 to June 3, 2014. Failure to carry out physician orders as prescribed has the potential to result in a negative resident outcome.

- Review of Resident #7's medical record occurred on all days of survey. Diagnoses included constipation and Alzheimer's disease. Medications included:
* 04/27/11 - "Milk of Magnesia: 30 ml po prn [as needed]"
* 12/19/13 - "Senna S: 2 tabs [tablets] po [orally] daily if no BM the preceding 3 days"
* 03/27/14 - "Dulcolax: 10 mg [milligrams] suppository prn if no BM > [greater than] 3 days. Check for impaction first and manually disimpact it B/4 [before] giving supp."

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F 309	Continued From page 8 Review of Resident #7's Bowel and Bladder Flowsheets, BM Records, and MARs, dated 04/01/14 - 06/03/14 revealed the following: * On 26 of 30 times staff administered Senna S, they failed to follow the physician's order, as the resident had a BM in the preceding 3 days. * On four occasions staff failed to follow the portion of the Bowel Protocol requiring two interventions when a resident had "no BM for 3 days." Staff failed to administer Milk of Magnesia on these occasions when Senna S was not indicated. During an interview on 06/04/14 at 8:15 a.m., an administrative nurse (#12) stated Resident #7's Senna S order was difficult to follow leading to errors in administration. Failure to follow the physician's Senna S order and the facility bowel protocol has the potential to result in a negative outcome for Resident #7.	F 309		
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	F 329	**Plan of Correction F329** 1. #1 – A "special requirement" tab was placed in our Electronic Health Record (E H R) to assure that nursing staff will be providing non-pharmacological interventions prior to administering psychotropic medications #2 – All resident's currently prescribed psychotropic medications were reviewed and Gradual Dose Reduction (GDR) forms completed for physician review.	delete ~~07/11/14~~ T.C. 7/16/14 & D.O.N. 22

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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:
NON-PHARMACOLOGICAL INTERVENTIONS

1. Based on record review, review of policies/procedures, and staff interview, the facility failed to identify and implement non-pharmacological interventions for 1 of 3 sampled residents (Residents #6) before administering as needed (PRN) anti-anxiety medications. Failure to implement non-pharmacological interventions before administering a PRN anti-anxiety medication may result in administering an unnecessary medication.

Findings include:

Review of Resident #6's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease, dementia, and anxiety. The quarterly Minimum Data Set (MDS), dated 05/11/14, identified severely impaired decision making skills, constant disorganized thinking, and a fall with injury. The Resident Centered Care Plan, revised 06/03/14, stated, "Sometimes reality

2. The facility has determined that all residents receiving psychotropic medications have the potential to be affected.

3. #1 – All licensed Nursing staff will be educated regarding the "special requirement" tab in Electronic Medication Administration Record (EMAR) at the Nurse Meeting on 7/15/2014. There will also be a power point "Antipsychotics and Beyond: What you need to know" presented at the Nurse meeting on 7/15/2014. Knife River Care Center's PRN Psychotropic Protocol will be reviewed at the Nurse Meeting on 7/15/2014.
#2 – All Licensed Nursing staff will be in-serviced regarding the facility policy for Guidelines for Psychoactive Medication Monitoring at the Nurse Meeting on 7/15/2014. "Antipsychotic Medicines for People with Dementia" information will be provided at

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F 329	Continued From page 10 becomes 'blurred' for me . . . thoughts can be very real and frightening to me and once I get my mind set, it can be difficult to redirect me. Sometimes letting me talk to [family] helps. . . ." Review of Resident #6's medication administration record (MAR) for March, April, and May of 2014 identified Ativan tablet 0.25 milligram (mg) by mouth every 4 hours as needed (PRN) for agitation. The MAR and nursing progress notes indicated nursing staff administered PRN Ativan without identifying specific non-pharmacological interventions attempted: * 8 of 11 times in March 2014 * 3 of 10 times in April 2014 * 6 of 10 times in May 2014 During an interview, on 06/05/14 at 10:45 a.m., a nurse manager (#2) indicated nurses use their discretion for implementing non-pharmacological interventions before giving PRN Ativan. Nurses then document those interventions along with the behaviors surrounding the agitation in the nursing progress notes. Review of the nursing progress notes did not consistently identify documentation of interventions utilized prior to administration of PRN Ativan. Gradual Dose Reduction (GDR) 2. Based on record review, policy review, review of professional reference, and staff interview, the facility failed to ensure 1 of 2 sampled residents (Resident #13) with physician orders for antianxiety and hypnotic medications received GDR unless clinically contraindicated. Failure to attempt a reduction in the dose of Resident #13's Ativan (an antianxiety medication) and Ambien (a hypnotic medication) may lead to the use of	F 329	the Nurse Meeting on 7/15/2014. Nursing Management will present Psychopharmacological Drugs and Gradual Dose Reduction Schedule information provided by "Skilled Care Pharmacy 2009" to the Licensed Nursing staff on 7/15/2014. 4. #1 – The Director of Nursing Services (DNS), or designee, will complete random weekly audits for four (4) weeks, then Monthly for three (3) months, and then quarterly for one year of the E H R / Nurses Notes to assure Licensed Nursing Personnel are documenting non-pharmacologic interventions prior to administering psychoactive medications. #2- The Director of Nursing Services (DNS), or designee, will complete random weekly audits for four (4) weeks, then Monthly for three (3) months, and then quarterly for one year of GDRs completed on resident's who receive psychoactive medication.	

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(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
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unnecessary medications and possible adverse reactions.

Findings include:

Review of the facility policy titled "Guidelines for Psychoactive Medication Monitoring - Review for Gradual Dose Reduction (GDR)" occurred on 06/05/14. This undated policy stated, "Objective: To evaluate each residents drug regimen for unnecessary use, when any drug is used: 1] in excessive dose, 2] for excessive duration . . . Procedure: . . . For Hypnotic/Sedative Drugs: When a sedative/hypnotic is used beyond the routine manufacturer's recommendations for duration of use, an attempt to taper should be attempted quarterly unless clinically contraindicated. . . . For Anxiolytics [antianxiety medication]: . . . After the first year, a tapering should be attempted annually, unless clinically contraindicated. . . ."

"Nursing 2013 Drug Handbook," 33rd edition, Lippincott, Williams & Wilkins, Pennsylvania, page 1421 states regarding Ambien, "Indications & Dosages: Short-term management of insomnia . . . Nursing Considerations: . . . Use drug only for short-term management of insomnia, usually 7 to 10 days. . . ."

Review of Resident #13's medical record occurred on June 4-5, 2014. Diagnoses included anxiety and insomnia. Medications included Ativan 0.5 milligrams (mg) every 6 hours as needed (prn), ordered 05/19/11, and Ativan 0.5 mg every 6 hours, ordered 05/31/11, and Ambien 5 mg every bedtime (HS).

The current care plan stated, ". . . I have some

Audit records will be reviewed by the QAPI Committee until such time consistent substantial compliance has been achieved as determined by the committee.

Corrective action completion date: July 20, 2014

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problems with depression and anxiety, but the doctor prescribes medications that help me feel more content and relaxed. I will ask if I think I need medication to calm myself. . . . I am often shaky and weak in the mornings and I take Ativan to help me feel less shaky and due to my anxiety. . . . Sometimes I have a hard time sleeping and I take medication every night that helps me sleep. . . . I tend to fixate on things and have frequent health and non health related complaints almost daily. . . ."

Resident #13's significant change Minimum Data Set (MDS), dated 08/15/13, and quarterly MDSs dated 11/14/13, 02/14/14, and 05/16/14, indicated intact cognition; no symptom presence of trouble falling or staying asleep, or sleeping too much; and received an antianxiety and a hypnotic medication during the assessment reference period. Lack of symptoms of insomnia during the MDS assessment periods since August 2013 renders support for possible tapering of the Ambien.

Review of Resident #13's medication administration records (MARs) showed no use of the prn Ativan from April 1 - June 5, 2014. A fax to the physician, dated 03/08/14, stated, "2 a.m. Ativan 0.5 mg po [oral] missed. No adverse reaction noted." Lack of Resident #13's use of prn Ativan for greater than two months and lack of adverse effects from missing a scheduled dose of Ativan renders support for possible tapering of the Ativan.

Review of Resident #13's record showed the physician completed a Request of Medication Review & Gradual Dose Reduction form, dated 06/12/13, for Ativan 0.5 mg every 6 hours, Ativan

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F 329	Continued From page 13 prn, and Ambien 5 mg at HS. On each form, the physician marked "This medication is not appropriate for tapering and in my professional opinion, continues to be clinically indicated." The physician failed to consider a GDR of Ambien quarterly in September 2013, December 2013, and March 2014, and failed to document on the GDR form or in Resident #13's record the reason tapering of Ativan and Ambien was clinically contraindicated. During an interview on 06/05/14 at 10:40 a.m., a nursing supervisor (#4) stated the facility evaluates a medication for GDR based on the resident's behaviors, interviews, and how staff feel the resident would do without the medication. This nurse stated she "was not aware Ambien needed quarterly review." During an interview on 06/05/14 at 11:15 a.m., a nursing supervisor (#13) stated a GDR form is completed on admission, quarterly with the MDS for one year, and then annually. With new medications or changes to current [psychoactive] medications, the GDR forms are completed quarterly again for a year. This nurse stated she was not aware of the quarterly requirement for GDR of hypnotics after the first year.	F 329		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by:	F 332	**Plan of Correction F332** 1. The charge nurse obtained a blood sugar on Resident # 6, 18, and 19 to ensure it was within ordered parameters. These blood sugars required sliding scale fast acting insulin as the physician orders had stated.	delete ~~07/11/14~~ T.C. 7/14/14 D.O.N. dl

Nurse involved was educated on 6/5/14 by DON regarding timeliness of fast-acting insulin.
T.C. 7/14/14 with D.O.N. dl.

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F 332	Continued From page 14 Based on observation, review of policies/procedures, review of manufacturer's instructions, review of professional reference, and staff interview, the facility failed to ensure a medication error rate of less than five percent during observation of medication administration for 3 of 3 sampled residents (Resident #6, #18, and #19) who received insulin. Failure to provide a meal 10-15 minutes after staff administered NovoLog or Humalog rapid-acting insulin has the potential for a hypoglycemic (low blood sugar) episode. Three errors occurred during staff administration of 33 medications, which resulted in a 9 percent error rate. Findings include: Review of the facility policy titled "Medication System Procedure" occurred on 06/05/14. This policy, revised April 2014, stated, ". . . d. Follow manufacture [sic] recommendations regarding taking medications with or without food. . . ." Review of the manufacturer's instructions for NovoLog insulin occurred on 06/05/14. The instructions stated, ". . . You should eat a meal within 5 to 10 minutes after using NovoLog to avoid low blood sugar. NovoLog is a fast-acting insulin. The effects of NovoLog start working 10 to 20 minutes after injection. . . Do not inject NovoLog if you do not plan to eat right after your injection. . . ." Lippincott, Williams & Wilkins, "Nursing 2013 Drug Handbook," 33rd ed., Wolters Kluwer Health, Philadelphia, page 733, states "Control of hyperglycemia with Humalog . . . Inject subcutaneously within 15 minutes before or after a meal. . . ."	F 332	2. All residents receiving fast-acting insulin have the potential to be affected by this practice. 3. On 7/15/2014 the Director of Nursing Services and / or designee will in-service the nurses and medication aides on preventing medication errors and on the protocol for use of fast-acting insulin. 4. Random audits of fast-acting insulin administration will be conducted weekly x4, then monthly x3, then quarterly x1 year to ensure compliance with facility guidelines. Audit results will be reviewed monthly by the QAPI committee until such time consistent substantial compliance has been achieved as determined by the committee. Corrective action completion date: July 20, 2014.	

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F 332	Continued From page 15 - Observation of medication pass on 06/02/14 at 5:10 p.m. showed a nurse (#1) administered two units of scheduled NovoLog to Resident #19. Observation in the dining room revealed Resident #19 drank four ounces of juice at 5:35 p.m. - Observation of medication pass on 06/02/14 at 5:15 p.m. showed a nurse (#1) administered one unit of Humalog to Resident #18. Observation in the dining room revealed staff served and Resident #18 began eating the supper meal at 5:40 p.m. - Observation of medication pass on 06/03/14 at 5:28 p.m. showed a nurse (#1) administered five units of sliding scale NovoLog to Resident #6. Observation in the dining room revealed Resident #6 drank coffee until staff served her meal at 5:52 p.m. During an interview on 06/05/14 at 2:50 p.m., a nurse (#2) stated residents should eat within five to ten minutes after receiving scheduled and/or sliding scale insulin ordered before meals.	F 332		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.	F 428	**Plan of Correction F428** 1. A review of all residents with psychotropic medications will be completed and GDR forms sent to the resident's primary care provider to review by 7/15/2014. Administrator reviewed 33-07-03.2-18 Pharmaceutical Services from the North Dakota Nursing Facilities Requirements Manual	delete ~~07/11/14~~ T.C. 7/16/14 = D.O.N. dl

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This REQUIREMENT is not met as evidenced by:
Based on record review, policy review, and staff interview, the facility's consulting pharmacist failed to report a medication irregularity regarding gradual dose reduction (GDR) to the attending physician and the director of nursing for 1 of 2 sampled residents (Resident #13) receiving a hypnotic medication. Failure to suggest a quarterly GDR of Ambien (a hypnotic medication) has the potential for the resident to receive unnecessary medication and suffer adverse reactions.

Findings include:

Review of the facility policy titled "Guidelines for Psychoactive Medication Monitoring - Review for Gradual Dose Reduction (GDR)" occurred on 06/05/14. This undated policy stated, "Objective: To evaluate each residents drug regimen for unnecessary use, when any drug is used: 1] in excessive dose, 2] for excessive duration . . . Procedure: . . . For Hypnotic/Sedative Drugs: When a sedative/hypnotic is used beyond the routine manufacturer's recommendations for duration of use, an attempt to taper should be attempted quarterly unless clinically contraindicated. . . . "

Review of Resident #13's medical record occurred on June 4-5, 2014. Diagnoses included insomnia. Medications included Ambien 5 milligrams (mg) every bedtime (HS).

Review of Resident #13's record showed the physician completed a Request of Medication

of Operations with the Consultant Pharmacist.

2. All Residents that are prescribed psychotropic medications may be affected.

   A facility procedure "Pharmaceutical Services" was revised and clearly states that a pharmacist must review each resident's drug regimen monthly. The Director of Nursing Services will review the guidelines with the staff nurses and nurse managers on 7/15/2014.

3. The DON and /or ADON will address any irregularities identified by the medication regimen review within ten days of receipt of the report. Documentation will be provided of action taken for each irregularity noted. The Director of Nursing Services (DNS), or designee, will complete random weekly audits for four (4) weeks, then Monthly for three

pharmacist will review records & recommend GDR, to be followed up on by the DON &/or ADON.
T.C. 7/16/14 ē D.O.N. dl

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F 428	Continued From page 17 Review & Gradual Dose Reduction form, dated 06/12/13, for Ambien 5 mg at HS. On the form, the physician marked "This medication is not appropriate for tapering and in my professional opinion, continues to be clinically indicated." The physician failed to document on the form or in Resident #13's record the reason tapering of the medication was clinically contraindicated, and failed to consider a GDR of Ambien quarterly in September 2013, December 2013, and March 2014. Upon request on 06/05/14, a nursing administrator (#11) provided Resident #13's consulting pharmacist's drug regimen reviews related to GDR of Ambien for the past year. The only information provided, dated 02/17/14, stated, "Recommend a gradual dose reduction of Ambien 5 mg tablet to evaluate if Resident is still on the lowest possible dose. It has been at least 1 quarter since the last attempt of a gradual dose reduction. . . ." The consultant pharmacist failed to recommend a GDR quarterly since the physician declined a GDR of Resident #13's Ambien on 06/12/13.	F 428	(3) months, and then quarterly for one year. Audit results will be reviewed by the QAPI committee until such time consistent substantial compliance has been achieved as determined by the committee. Corrective action completion date: 7/20/2014	
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 -	F 441	**Plan of Correction F441** 1. NA/Employee list not provided 2. The facility has determined that all residents have the potential to be affected.	delete ~~07/11/14~~ T.C. 7/16/14 ≥ D.O.N. dl

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F 441	Continued From page 18 (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 05/09/13. HAND HYGIENE AFTER PERINEAL CARES 1. Based on observation, review of policy and procedure, and staff interview, the facility failed to follow proper infection control procedures for 2 of 7 sampled residents (Resident #1 and #2)	F 441	3. All personnel were in-serviced on the facility's policies for employee and resident hand washing on 6/18/14. All licensed staff and Certified Medication Aides will be in-serviced on infection control procedures related to medication passes on July 15, 2014. 4. The Director of Nursing Services (DNS), or designee, will complete random Validation Checklists of personnel and the timing and technique of hand washing procedure. To ensure personnel are performing the procedure in accordance with our facility's Practice Guideline, random monitors will be done weekly x4, monthly x3, quarterly x 1 year. This plan of correction will be monitored at the monthly QAPI meeting until such time consistent substantial compliance has been met. Corrective action completion date: July 20, 2014. will also monitor staff post resident perineal cares & handhygiene. T.C. 7/16/14 c D.O.N. dl.	

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observed during perineal cares. Failure to perform hand hygiene after perineal cares increases the potential for the spread of infections to other residents.

Findings include:

Review of the facility policy titled "RESIDENT HANDWASHING PROCEDURE" occurred on 06/05/14. This policy, revised 06/07/13, stated, ". . . When to Wash Hands (at a minimum) . . . Before and after using the toilet . . . After contact with any body fluids . . . After contact with peri area . . ."

Review of the facility policy titled "RESIDENT USE OF ALCOHOL-BASED HAND RUB (Hand Sanitizer)" occurred on 06/05/14. This policy, revised 06/07/13, stated, ". . . Procedure: . . . 5. Always wash hands with soap and water after blood or body fluid exposure. . . ."

Review of the facility policy titled "EMPLOYEE HANDWASHING PROCEDURE" occurred on 06/05/14. This policy, revised 06/07/13, stated, ". . . When to Wash Hands (at a minimum) . . . Before and after each resident contact, After touching a resident or handling his or her belongings, Whenever hands are visibly soiled, After contact with any body fluids, After handling any contaminated items (linens, soiled briefs, garbage, etc.) . . ."

- Observation on 06/02/14 at 4:37 p.m. showed a certified nursing assistant (CNA) (#8) assisted Resident #1 with toileting. Resident #1 was continent of urine and performed self perineal cares. The CNA (#8) finished cares and assisted the resident into bed. The CNA (#8) failed to offer

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Resident #1 hand hygiene after contact with her perineal area.

Observation on 06/03/14 at 3:41 p.m. showed a CNA (#9) assisted Resident #1 with toileting. The resident was incontinent of urine and performed self perineal cares. The CNA (#9) finished cares and brought the resident to the lounge. The CNA (#9) failed to offer Resident #1 hand hygiene after contact with her perineal area.

During an interview on 06/05/14 at 1:30 p.m., an administrative staff member (#4) stated staff members should offer handwashing to the residents.

- On 06/03/14 at 8:13 a.m., observation showed a CNA (#10) assisted Resident #2 to stand from the toilet, washed the resident's perineal area, removed her gloves, applied a new brief, and adjusted the resident's pants. The CNA then assisted Resident #2 to ambulate to her wheelchair, applied jewelry and perfume, brushed and combed the resident's hair, placed a chair alarm and foot pedals on the wheelchair, and wheeled her to the dining room. The CNA failed to perform hand hygiene after performing pericares and prior to completing other tasks, and prior to leaving the room.

During an interview on 06/05/14 at 1:20 p.m., an administrative nurse (#11) agreed staff members should wash their hands after completing pericares and removing gloves.

BARE HAND CONTACT WITH MEDICATIONS

2. Based on observation and staff interview, the facility failed to follow proper infection control

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F 441	Continued From page 21 procedures for 1 of 2 Certified Medication Aides (CMAs) (#7) observed during medication administration pass. Failure to follow infection control procedures related to handling medications increases the potential for the spread of infections to other residents. Findings include: Observation on 06/03/14 during the 5:00 p.m. medication administration pass showed a CMA (#7) prepared Resident #1's medications. The CMA (#7) placed a Calcium Citrate tablet in a pill splitter, positioned the medication with her bare hand, cut the medication, and then placed the medication into the medication cup. The CMA (#7) opened the medication cart drawer and placed a Multivitamin with Minerals tablet in a pill splitter, positioned the medication with her bare hand, cut the medication, and placed the medication into the medication cup. The CMA (#7) administered the medications with a spoon and touched one medication with her left index finger to push the medication onto the spoon. The CMA (#7) failed to wear gloves when coming in direct contact with the resident's medication. During an interview on 06/05/14 at 1:30 p.m., an administrative staff member (#4) stated staff members should not touch medications with their bare hands.	F 441		
F 463 SS=B	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' stations must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities.	F 463	**Plan of Correction F463** 1. Resident #4 had her call badge returned to her the morning of 06/03/14. She had her cell phone, a call light in her	~~07/11/14~~ T.C. delete 7/16/14 per D.O.N. dl

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This REQUIREMENT is not met as evidenced by:
Based on observation, record review, and resident and staff interview, the facility failed to maintain a functioning call system for 1 of 14 residents (Resident #4) from approximately 06/02/14 to 06/03/14. Failure to have a functional call system may lead to falls, accidents, and injuries.

Findings include:

Review of Resident #4's medical record occurred on all days of survey. Diagnoses included coronary artery disease and congestive heart failure. The quarterly Minimum Data Set, dated 05/05/14, indicated Resident #4 was cognitively intact and ambulated independently with a four-wheeled walker. The June 2014 physician orders identified oxygen at 2-4 liters per minute via nasal cannula to keep saturation greater than 92%. Nursing notes verified the facility sent the resident to the emergency room per ambulance on 04/28/14 due to chest pain and shortness of breath.

Observation during initial tour, on 06/02/14 at 10:30 a.m., identified Resident #4 did not have a call button device clipped to her shirt. The resident verified the call button must have been missing since she had gotten dressed earlier that morning. The resident indicated her call button missing at least three other times during the last year. A certified nursing assistant (CNA) (#3) was informed of the missing call button, searched the resident's room, and was unable to locate the missing call button.

bathroom, and a bell to alert staff to her needs.

2. The facility has determined that all residents have the potential to be affected.

3. An in-service education program was conducted by the Director of Nursing Services with all staff on June 18, 2014 and the Call Light, use of Policy was reviewed. Badge checks have been set up in E H R to be done three times daily.

4. The Director of Nursing Services, or designee, will conduct a random audit of E H R badge checks to ensure call lights are available at all times to residents weekly x4, monthly x3, and quarterly x1 year. This plan of correction will be monitored at the monthly QAPI meeting until such time consistent substantial compliance has been met. Corrective action completion date: July 20, 2014.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355053	A. BUILDING _____ B. WING _____	06/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KNIFE RIVER CARE CENTER	118 22ND ST NE BEULAH, ND 58523

(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 463	Continued From page 23	F 463		

During an interview on 06/02/14 at 3:15 p.m., with Resident #4 who was seated in her recliner, she complained of "not feeling well today" and "short of breath" when up walking in her room. She indicated staff had told her to use the bathroom call cord or ring the bell located on a bedside desk to summon help while the call button was missing. Observation identified neither device was located near the resident's recliner.

During an interview on 06/02/14 at 5:00 p.m., a CNA (#3) stated the resident was not feeling well and requested a room tray for dinner. The CNA verified an event report was completed for the missing call button, and the resident should be issued a replacement.

During an interview on 06/03/14 at 9:15 a.m., Resident #4 indicated staff had found the call button in the laundry that morning.

During interviews on 06/04/14 at 10:30 a.m. and on 06/05/14 at 11:20 a.m., a nurse manager (#4) verified:
* A CNA completed an Incident Report on 06/02/14 at 11:00 a.m. for Resident #4's missing call button
* Staff documented the call button missing for all three shifts on 06/02/14 on the Resident Badge Check form
* Laundry staff found the call button on 06/03/14 at approximately 7:00 a.m. in the laundry room
* The ward clerk or information technologist should have activated a replacement call button "soon" after the event report
* Staff can replace and activate a new call button within 12 hours of a button reported missing
* The resident would have a bathroom call cord,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 463	Continued From page 24 bell, or phone to use until the call button was found or replaced	F 463		