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	355059	A. BUILDING _____ B. WING _____	09/20/2018

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MISSOURI SLOPE LUTH CARE CTR	2425 HILLVIEW AVE BISMARCK, ND 58501

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F 000	INITIAL COMMENTS The standard Medicare/Medicaid recertification started on 09/17/18 and concluded on 09/20/18.	F 000		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review, review of the North Dakota Provider Manual for Preadmission Screening and Resident Review (PASARR) and Level of Care Screening Procedures for Long Term Care Services, and staff interview, the facility failed to complete a status change assessment for 1 of 3 sampled residents (Resident #228) with a new mental illness diagnosis since admission to the facility. Failure to complete a change in status assessment may result in the delivery of care and services that are	F 644	1. For Resident #228, he was rescreened when this was discovered and was level 1 approved. 2. All residents who have a new mental illness diagnosis after admission have the potential to be affected. 3. The Quality Assurance Performance Improvement (QAPI) Performance Improvement Project (PIP) that was	10/24/18

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

Electronically Signed | 10/05/2018

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F 644	Continued From page 1 inconsistent with residents' needs. Findings include: The North Dakota PASARR Provider Manual states, ". . . Change in Status Process . . . Whenever the following events occur, nursing facility staff must contact Ascend [contracted service provider for screening process] to update the Level I screen for determination of whether a first time or updated Level II evaluation must be performed. These situations suggest that a significant change in status has occurred: . . . If an individual with MI, ID, and/or RC (mental illness, intellectual disability, and conditions related to intellectual disability [referred to in regulatory language as related conditions or RC]) was not identified at the Level I screen process, and that condition later emerged or was discovered. . . ." Review of Resident #228's medical record occurred on September 17-20, 2018. The record showed an initial PASARR completed March 2016, prior to the resident's admission to the facility and identified a diagnosis of dementia and no mental illness. The record identified a new medical diagnosis of unspecified psychosis not due to a substance or known physiological condition, initiated 03/22/17. The record lacked evidence the facility completed a Level I screening/change in status assessment since this diagnosis. During an interview, on 09/19/18 at 4:33 p.m., a social service staff member (#3) confirmed Resident #228 had the new diagnosis of psychosis on 03/22/17 and did not believe the	F 644	started in May of 2018 will be completed. The PASRR Screen policy and procedure was updated to reflect process changes. Social Service Department re-education will be completed at the monthly Social Services staff meeting on October 3, 2018. Social Service staff will attend the North Dakota PASRR Updates and Resources Training in Bismarck on October 10, 2018. 4. See completion date below. 5. The Director of Social Services will be responsible to monitor the new procedure and will perform QAPI monitoring. The first monitor will be performed on October 10, 2018 and will be completed weekly for six weeks, monthly for three months, and then quarterly for three quarters. The Director of Social Services will report the results to the Vice President of Resident Services after each monitor is completed. If concerns are identified, immediate corrective action will be implemented. The Vice President of Resident Services will provide a report of the monitoring results to the QAPI committee at each scheduled meeting.	

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F 644	Continued From page 2 facility completed a PASARR Level I with the new diagnosis. During an interview on, 09/20/18 at 1:37 p.m. administrative staff members (#1 and #4) reported the facility identified the need to update PASARR screenings in May 2018 and reported the facility is working to complete the required Level I's, based on new diagnoses, to evaluate for a Level II PASARR. One staff member (#4) identified the social workers are checking new admissions to assure compliance, and evaluating current resident's as their Minimum Data Set (MDS) assessments come due. The facility completed MDS assessments for Resident #228 in June 2018, July 2018, and September 2018. The facility failed to update Resident #228's PASARR screening as a result of any of these MDSs.	F 644		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, record review, manufacturer's instruction guide, and staff interview, the facility failed to ensure 1 of 1 resident (Resident #91) utilized oxygen in a	F 695	1. For Resident #91, South East Unit staff will be retrained on oxygen safety and will remove oxygen tank from resident□s wheelchair any time resident	10/24/18

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F 695	Continued From page 3 safe manner while smoking. Failure to remove the resident's oxygen tank before going outside to smoke may result in accidents, including burns and/or injuries. Findings include: Review of the facility policy titled "Resident Smoking" occurred on 09/19/18. This policy, dated January 2018, stated, ". . . If resident is on oxygen, staff will remove oxygen prior to resident leaving the unit to go smoke. (Always store oxygen tank in a holder.) Replace oxygen when resident arrives back on unit. . . ." Review of the DeVilbiss iFill Oxygen Cylinder Instruction Guide, 2015 DeVilbiss Healthcare LLC, page 5, stated, ". . . WARNING: HIGH PRESSURE OXIDIZING GAS VIGOROUSLY ACCELERATES COMBUSTION . . . DANGER-NO SMOKING. . . ." Observation on 09/18/18 at 5:15 p.m. showed Resident #91 reported to an unidentified certified nurse aide (CNA) the resident was going out to smoke. The CNA turned off the mini oxygen (02) tank, removed the nasal cannula, and placed it in the 02 tank pocket on the back of the resident's wheelchair. The CNA failed to remove the 02 tank from the resident's wheelchair and place it in a holder in the resident's room. Review of Resident #91's medical record occurred on all days of survey. The current care plan stated, "Staff will remove the 02 tank from her W/C [wheelchair] when she comes to the nurse desk . . . Staff will reapply the 02 to her w/c when she returns from smoking. . . ." The	F 695	indicates that she plans to go outside to smoke. 2. Any resident who smokes and uses oxygen has the potential to be affected. 3. Re-education on oxygen safety will be completed at the Nurse/Medication Assistant/CNA meeting on September 27, 2018. South East Unit staff will have additional re-education at unit standups on resident #91□s needs and the smoking care plan/agreement that should be followed. Facility wide October Safety Newsletter will contain oxygen safety education. 4. See completion date below. 5. The South East Unit Director will be responsible to monitor compliance with the smoking care plan/agreement and will perform QAPI monitoring. The first monitor will be performed on October 10, 2018 and will be completed weekly for six weeks, monthly for three months, and then quarterly for three quarters. The South East Unit Director will report the results to the Vice President of Resident Services after each monitor is completed. If concerns are identified, immediate corrective action will be implemented. The Vice President of Resident Services will provide a report of the monitoring results to the QAPI committee at each scheduled meeting.	

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F 695	Continued From page 4 resident's Expectation Agreement for smoking, dated 08/23/18, stated, "Have staff remove your oxygen tank before you go outside. . . ." During interviews on the morning of 09/19/18 with two staff nurses (#2 and #5) and in the afternoon with a nurse manager (#1), they agreed staff should remove the resident's 02 tank and place it in her room in a holder whenever the resident goes out to smoke.	F 695		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must	F 725		10/24/18

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F 725	Continued From page 5 designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, resident, group and family interviews, and review of facility policy, the facility failed to ensure sufficient staff available to promptly respond to residents' call lights for 9 of 9 sampled residents (Resident A, B, C, D, E, F, G, H, and I), 6 of 9 residents attending the group interview (Resident J, K, L, M, N, and O) and 2 of 4 family interviews (Family P and Q) who had concerns regarding call light response time. Failure to promptly respond to resident calls for assistance may result in residents experiencing falls and/or incontinence. Findings include: Review of the facility policy titled "Call Lights" occurred on 09/20/18. This policy, revised September 2016, stated, "Prompt answering of resident call lights is a responsibility of each employee . . . " RESIDENT INTERVIEWS During an interview on 09/17/18 at 10:15 a.m., Resident C identified the following: * Frequently waited longer than 30 minutes before staff answered call lights. No certain time of the day when call lights not answered promptly * Staff stated to the resident they (staff) were working short * Have been incontinent of bowel movement (BM) 3 times in just the last 2 weeks. Each time I was sitting in my wheelchair waiting for staff to answer my call light	F 725	1. For Residents A, B, C, D, E, F, G, H, I, J, K, L, M, N, and O and family P and Q, we are unable to follow up individually, as we do not have a resident and family name list to refer to. For rooms 147 and 149, residents were assisted at the time of finding and staff on that unit, South East (SE), were verbally re-educated on the spot by the Unit Director. 2. All residents have the potential to be affected by prolonged call light response times. 3. Re-education on prompt call light response will occur at the Nurse/Medication Assistant/CNA meeting on September 27, 2018. Our second unit, SE, will go-live with RTLS (Real Time Location System) on October 22, 2018. RTLS will enable the SE unit residents (in addition to the North Central unit residents where RTLS went live first) to alert staff that they need assistance from anywhere in the facility. RTLS alerts can go directly to the iPads the CNAs carry and also allow staff to see how long call lights have been on, enabling them to prioritize calls, preventing residents who have had their call light on the longest from being the last light answered. RTLS will go live facility wide after SE has successfully implemented the new system. Until the North East, South	

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F 725	Continued From page 6 During an interview on 09/17/18 at 12:10 p.m., Resident A identified the following: * Frequently waited for staff over 20 minutes and once waited for 1 1/2 hours before call light answered * Incontinent a few times recently due to call lights not answered promptly * Staff have stated to the resident they (staff) were "working short" * Not enough staff, especially at night During an interview on 09/17/18 at 2:19 p.m., Resident H identified the following: * Waited up to an hour for my call light to be answered and have wet myself while waiting * They are short of help * Evenings are the worst During an interview on 09/17/18 at 2:20 p.m., Resident E stated, "They are sometimes short staffed. Sometimes takes awhile for answering call lights mostly at night. The longest wait was two hours." During an interview on 09/17/18 at 2:20 p.m., Resident B identified the following: * Night staff (after 8 p.m.) do not answer call lights promptly * Frequently waited 20-30 minutes before call light answered * Some of the night staff were not very friendly. Staff do their job but frequently do not talk to the resident and seemed like staff do not care During an interview on 09/17/18 at 4:41 p.m. Resident I identified the following: * Sometimes it takes 30 minutes to answer my call light	F 725	Central, West, and West View units go live with RTLS, the Unit Directors, Charge Nurses, and Health Information Assistants (unit clerks) will increase their observations of the call light monitors in those nurses stations. If a call light is observed to be on for an extended amount of time (greater than 10 minutes) when viewing the monitor at the nurses station, the Unit Director, Charge Nurse, or Health Information Assistant will notify the CNAs to advise them to make that call light a priority when a CNA is available to prevent prolonged call light wait times. The Vice President of Resident Services will attend the next Resident Council meeting on October 17, 2018 to discuss the call light issues that were noted during survey, if call light times are getting better, and if there are any further issues that need to be addressed. Evening shift differential will be increased from $1.00 per hour to $3.00 per hour on October 21, 2018 to increase recruitment and retention of evening shift staff to assure adequate staffing patterns and prevent open shifts. To additionally create a positive impact recruitment and prevent open shifts, a career fair will be held on October 5, 2018 at MSLCC, the open position advertisements will remain in place, and the Employment Coordinator has several recruitment events scheduled this fall. 4. See completion date below. 5. The Unit Directors, Charge Nurses,	

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F 725	Continued From page 7 * At night time it takes the longest During an interview on 09/17/18 at 4:50 p.m., Resident F stated, "They are short staffed mostly on the evening shift and weekends." The resident stated she soiled herself this morning waiting 50 minutes for staff to answer her call light and her husband had to get her to the bathroom. Resident F stated, "the average wait is 20 minutes." During an interview on 09/18/18 at 9:00 a.m., Resident D identified the following: * Frequently waited at least 30 minutes or longer for staff to answer call lights. No certain time of the day when call lights not answered promptly * Staff frequently in such a rush. Staff bring resident back to room after meals and leave right away before resident can tell them what he/she needs During an interview on 09/18/18 at 9:37 p.m., Resident G stated, "They are short staffed at night. I've had to wait up to an hour, mostly after 6:00 p.m., almost every day". RESIDENT COUNCIL During a group interview on 09/18/18 at 1:00 p.m. when asked about response to call lights in a timely manner, residents (identified by the facility as interviewable) responded as follows: * Resident J - waits a long time, does not time them, has on occasion wet his/her pants while waiting * Resident K - waited up to 45 minutes * Resident L - waited up to 30 minutes on the weekend * Resident M - waited up to one and half hours	F 725	CNA Mentors, and Health Information Assistants will be responsible to monitor compliance with timely response to call lights. The Vice President of Resident Services will compile QAPI monitoring. The first monitor will be performed on October 10, 2018 and will be completed weekly for six weeks, monthly for three months, and then quarterly for three quarters. If concerns are identified, immediate corrective action will be implemented. The Vice President of Resident Services will provide a report of the monitoring results to the QAPI committee at each scheduled meeting.	

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F 725	Continued From page 8 * Resident N - waited up to two hours * Resident O - waited up to 30 minutes FAMILY INTERVIEWS During a family interview on the afternoon of 09/17/18, Resident I's family member stated her mother's roommate has waited up to 45 minutes to go to the bathroom. During an interview on 09/17/18 at 4:07 p.m., Resident Q's wife stated, "They are short staffed every day, every shift." OBSERVATIONS Observation on 09/17/18 at 4:40 p.m. showed Resident H's call light on. Staff did not enter the room to assist the resident until 5:05 p.m. (25 minutes later) During an observation on 9/18/18 at 5:20 p.m. the South East unit nurses' station computer identified the call light continued as activated/unanswered for 30 minutes for room 149 and 15 minutes for room 147. Observation of the two rooms, after identifying the long call light times, showed two certified nurse aides (CNAs) entered each room to provide cares. STAFF INTERVIEWS During an interview on 09/19/18 at 4:00 p.m., a nurse manager (#1) identified the following: * The CNAs are alerted to a resident's call light only by the sound of the call light and the light blinking above resident doors and the end of the hallways. * The staff have no way of knowing how long a resident's light has been on in order to answer the lights in the order activated.	F 725		

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F 725	Continued From page 9 * The computer at the nurses' station shows the time each call light has been activated until it is answered, but the time information is not saved. * If a resident has complained about long call light waits, we may have the charge nurse watch during a shift. The facility has not had many complaints of call light waits. * The last time the facility completed a quality assurance on call light response times was in 2016. During an interview on 09/20/18 at 11:30 a.m., a staff member (#6) stated no call light complaints were found in the Resident Council meeting notes for the last year. The staff member identified the issue of long call light response times was brought up during resident care conferences by family members and residents.	F 725		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide	F 761		10/24/18

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F 761	Continued From page 10 separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to ensure accurate labeling of controlled medications for 1 of 3 medication carts (South East Unit) observed during medication storage review. Failure to correctly label medications increases the risk of residents receiving an inaccurate dose and/or medication. Findings include: Review of the facility's policy titled "Medications - Dispensing, Storage, and Labeling" occurred on 09/19/18. This policy, dated November 2015, stated, ". . . Medication orders are communicated to the appropriate pharmacy on an as needed basis. 4. Medication labels are changed or altered by pharmacy only. . . . 6. All medication labels include the following information: resident's full name, Physician's name. prescription number, medication name, dose and frequency ordered. . . ." Observation on 09/19/18 at 10:15 a.m. with a staff nurse (#2) showed the medication cart on the South East Unit (Group 1) contained two medication cards for Resident #91. Both cards contained the pain medication	F 761	1. Resident #91□s inaccurately labeled medication was relabeled immediately at time of finding. After relabeling, verification was completed assuring the provider order and eMAR entry matched the medication card label. 2. All residents who have medications have the potential to be affected. 3. The Medications □ Dispensing, Storage, and Labeling policy and procedure was updated to assure pharmacy has reviewed that narcotic medication card labels match the most recent physician order when a resident, who has transferred to the hospital, returns to MSLCC. Nurses and Medication Assistants will have re-education at the Nurse/Medication Assistant/CNA meeting on September 27, 2018. 4. See completion date below. 5. The Unit Directors, Charge Nurses, and Medication Assistants will be responsible to monitor compliance to	

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MISSOURI SLOPE LUTH CARE CTR	2425 HILLVIEW AVE BISMARCK, ND 58501

(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 761	Continued From page 11 hydrocodone/APAP (Tylenol) 5 milligrams/325 mg. One card contained 22 tablets labeled to administer every 6 hours as needed (PRN), and the other card contained 4 tablets labeled to administer 3 times per day (3x/d) PRN. Review of the narcotic sign out sheet for each medication showed both cards had been used in the last month. Review of Resident #91's electronic medication administration record (eMAR) for July through September 2018 identified the order for every 6 hours was discontinued on 07/07/18 and the order for 3x/d was started on 07/07/18. Staff failed to have pharmacy relabel the discontinued medication card with the new order.	F 761	assure medication card labels match physician orders and eMAR entries and will perform QAPI monitoring. The first monitor will be performed on October 10, 2018 and will be completed weekly for six weeks, monthly for three months, and then quarterly for three quarters. The Unit Directors will report the results to the Vice President of Resident Services after each monitor is completed. If concerns are identified, immediate corrective action will be implemented. The Vice President of Resident Services will provide a report of the monitoring results to the QAPI committee at each scheduled meeting.	