STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355059	A. BUILDING _____ B. WING _____	10/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSOURI SLOPE LUTH CARE CTR	2425 HILLVIEW AVE BISMARCK, ND 58501

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F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey, started on 10/03/16 and completed on 10/06/16, the sample included 5 residents for complete review, 22 residents for focused review, and 3 closed records for review. The sample included 4 additional residents to verify specific concerns during the survey.	F 000		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, facility policy review, and staff interview, the facility failed to assess the safety of self-administration of medication (SAM) for 3 of 3 supplemental residents (Residents #31, #32, & #33) observed with unattended medications in each resident's room. Failure to determine whether SAM is a safe practice has the potential to result in a medication error and/or harm to a resident. Findings include: Review of the facility policy titled "Self Administration of Medications" occurred on 10/05/16. This policy, dated 2016, stated, " . . . self-administer of meds (medications) will be assessed. The determination will be documented in the resident's record. The attending physician will be consulted and an order obtained. . . ."	F 176	1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident 31, 32, and 33 were assessed for safety of self-administration of medications. It has been documented in medical record and a physician order is present. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice? Assessment will be completed, assessment will be documented in medical record, and a physician order will be obtained on all residents	11/10/16

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

Electronically Signed | 11/03/2016

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F 176	Continued From page 1 Observation during the initial tour on the morning of 10/03/16 showed the following: *Resident #33 - room contained one polysporin tube (skin infection), one neosporin tube (skin infection), and one nasal spray bottle (moisturizing). *Resident #32 - room contained one 2% miconazole nitrate tube (antifungal ointment). *Resident #31 - room contained one bottle of 12% Ammonium Lactate Cream 12% (anti-itch for the skin) and one nasal spray. During an interview on 10/05/16 at 10:46 a.m., when a nurse manager (#20) was asked whether Resident #31, #32, and #33 could self-administer the above observed medications, the nurse stated SAM assessments had not been completed for Resident #31, #32, and #33. Failure to assess a resident's ability to self-administer medications, obtain a physician's order, and care plan for SAM, increases the risk of a medication error.	F 176	self-administering medications. 3. What measures will be put into place or systematic changes made to ensure that the deficient practice will not recur? Family education has been added to the Hilltopper Newsletter that is sent to all families to reinforce the need to bring all items, including medications, to the nurses station upon arrival to the facility to be checked in. Hilltopper Newsletter will be mailed to all families on November 21, 2016. Staff re-education has taken place in Mentor (10/19/16), CNA (10/13/2016), Medication Assistant (10/25/2016), Nurse (11/09/2016), and HIA (Health Information Assistant) (10/19/16) meetings. All new admissions, resident and family, are given education on bringing any item to the nurses station upon arrival to the facility. Unit Directors will review self-administration of medications and family bringing in any medications at resident care conferences. A User Defined Assessment (UDA) will be developed to assure appropriate assessment of self-administration of medications. 4. How will the facility monitor its performance to make sure that solutions are sustained? A QAPI will be completed weekly (November 11, November 18, November 25, and December 2), if compliance is shown then monthly x 3 (January 6,	

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F 176	Continued From page 2	F 176	February 3, March 3 in 2017) and then quarterly x 3. This monitor will be completed by Unit Directors and monitored by Director of Resident Services. QAPI will include if medications were found in a resident's room, if medications were found if an assessment for safety of self-administration was completed on resident, and if a physician order was present for self-administration. All monitors started on November 4 2016 and will be compiled by Director of Resident services on dates indicated.	
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to implement policies regarding abuse/neglect for 1 of 1 sampled resident (Resident #2) identified with a hematoma of unknown origin. Failure to implement the facility's written abuse prevention policies and procedures and ensure a thorough investigation of injuries of unknown origin placed this resident and all other residents at risk for abuse and mistreatment. Findings include:	F 226	1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Injury of unknown origin found on resident 2 was investigated. No suspicion of abuse or neglect was found. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice?	11/10/16

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F 226	Continued From page 3 Review of the facility policy titled "Prohibition of Abuse, Neglect, or Misappropriation of Property" occurred on 10/05/16. This policy, revised on July 2016, stated, " . . . Reporting: Any alleged incident of mistreatment or suspicious injury of known or unknown origin of a resident will be reported to the appropriate supervisor, then recorded and reported immediately to the Director of Resident services. . . All incidents of injury are reported, investigated and documented on the Accident Report . . ." Review of Resident #2's medical record occurred on all days of survey. Diagnoses include dementia. The annual Minimum Data Set, dated 03/14/16, identified extensive assistance of two staff members for bed mobility, transfers, toileting, and personal hygiene. The current care plan stated, "Problem: . . . self deficit and limited physical mobility." The care card identified a Hoyer lift for transfers and wheelchair for mobility. Resident #2's progress notes identified the following: * 04/19/16 at 9:17 p.m.: "Open hematoma left forearm 3.5 cm [centimeters] x [by] 3 cm. Telfa applied and wrapped with kling. Also bruise top of left hand." * 04 /21/16 at 3:36 p.m.: "Weekly treatment charting: open hematoma L [left] arm, dry dark red scab, large amount of bruising, no redness or drainage noted." * 05/11/16 at 07:52 p.m.: "Open hematoma L forearm healed." During an interview on 10/06/16 at 12:45 p.m., a nurse manager (#4) stated with any skin injury,	F 226	All resident injuries will be investigated by Unit Director. 3. What measures will be put into place or systematic changes made to ensure that the deficient practice will not recur? Staff re-education has taken place in Mentor (10/19/16), CNA(10/13/16), Medication Assistant(10/25/16), and Nurse(11/09/16) meetings. Unit Directors will review the 24 hour shift summary each morning to assure all injuries have been investigated. 4. How will the facility monitor its performance to make sure that solutions are sustained? A QAPI will be completed weekly (November 11, November 18, November 25, and December 2), if compliance is shown then monthly x 3 (January 6, February 3, March 3 in 2017) and then quarterly x 3. This monitor will be completed by Unit Directors and monitored by Director of Resident Services. QAPI will include if injuries from review of daily 24 hour shift summary was investigated. All monitors started on November 4 2016 and will be compiled by Director of Resident services on dates indicated.	

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F 226	Continued From page 4 including bruises, an accident report is completed and then sent to the Unit Manager for follow up. The nurse (#4) was unable to provide an incident report for the resident's hematoma identified on 04/19/16. The facility failed to investigate/determine how Resident #2 sustained the hematoma on 4/19/16 which required medical treatment.	F 226		
F 241 SS=D	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 and staff interview, the facility failed to provide care for 3 of 23 residents (Resident #10, #11, and #12) in a manner and environment that maintained, enhanced, and respected each resident's dignity and individuality. Failure to knock on doors and wait for a reply before entering a resident's room to ensure privacy during cares did not promote the resident's dignity or enhance their quality of life. Findings include: Observations showed the following on 10/04/16: * 9:35 a.m., two CNAs (#5 and #6) assisted Resident #12 to the bathroom. A nurse (#18) knocked and entered the room without announcing herself while Resident #12 sat on the toilet with her pants pulled down to her ankles	F 241	1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Staff caring for residents 10, 11, and 12 were re-educated on knocking, resident privacy, resident dignity, and ensuring resident quality of life. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice? All staff will knock first and then wait for a response prior to entering a resident room or resident care area.	11/10/16

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F 241	Continued From page 5 and the bathroom door open. * 9:55 a.m., a CNA (#14) assisted Resident #12 during a whirlpool bath in the tub room with the curtain closed. A nurse (#16) pulled back the curtain and then said "knock knock," she had entered the tub room before announcing herself. Resident #12 sat in the whirlpool bath tub with no clothing on. * 10:00 a.m., a CNA (#5) assisted Resident #11 with personal cares. A CNA (#9) knocked and entered the room without announcing herself. * 11:10 a.m., a CNA (#14) assisted Resident #10 during a whirlpool bath in the tub room with the curtain closed. A CMA (certified medication aide) (#15) opened the curtain and entered the tub room without knocking/announcing herself to administer Resident #10's medications. Resident #10 sat in the whirlpool bath tub with no clothing on. * 11:20 a.m., a CNA (#14) assisted Resident #10 during a whirlpool bath in the tub room with the curtain closed. An unidentified CNA pulled the curtain back and entered the tub room without knocking/announcing herself. Resident #10 sat in the whirlpool bath tub with no clothing on. * 12:00 p.m., a CNA (#17) entered Resident #11's room without knocking/announcing herself. * 12:45 p.m., a staff nurse (#16) knocked and entered Resident #10's room without announcing herself. Resident #10 sat in the motorized wheelchair in her room. During an interview on 10/05/16 at 3:45 p.m., a nurse manager (#7) confirmed she would expect facility staff to knock first then wait for a response prior to entering resident's rooms.	F 241	3. What measures will be put into place or systematic changes made to ensure that the deficient practice will not recur? All staff will be re-educated on resident dignity and respect of individuality. Re-education was covered at Mentor (10/19/16), CNA(10/13/16), Medication Assistant(10/25/16), and Nurse(11/09/16) meetings. 4. How will the facility monitor its performance to make sure that solutions are sustained? A QAPI will be completed weekly (November 11, November 18, November 25, and December 2), if compliance is shown then monthly x 3 (January 6, February 3, March 3 in 2017) and then quarterly x 3. This monitor will be completed by Unit Directors and monitored by Director of Resident Services. QAPI will include if staff knock on door before entering room and if staff waited for a response before entering room. All monitors started on November 4 2016 and will be compiled by Director of Resident services on dates indicated.	
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP	F 280		11/10/16

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F 280	Continued From page 6 The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to review and revise the comprehensive care plans for 5 of 27 sampled residents (#1, #2, #3, #11 and #20). Failure to review and revise resident's care plans limited staff's ability to communicate the care needs of each resident and ensure continuity of care for each resident. Findings include: Review of the facility policy titled "Care Plan Policy and Procedure" occurred on 10/06/16.	F 280	1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident 1, 2, 3, 11, and 20 have had their comprehensive care plans reviewed and revised. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice?	

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F 280	Continued From page 7 This policy dated, July 2013, stated, " . . . provides a written plan of care for each resident that is current and therapeutically effective. . . . To define problems, needs and/or areas of concern of residents. . . . remain consistent with the attending physician's plan of medical care . . . The plan of care is evaluated on a regular basis. Acute conditions should be evaluated daily and resolved when no longer applicable. . . ." - Resident #11's medical record, reviewed all days of survey identified diagnoses including history of falls, fracture of the hip and arm, dementia, impaired gait/balance, and weakness. The resident's significant change Minimum Data Set (MDS), dated 09/03/16, identified severely impaired cognition, locomotion and walking did not occur, and extensive assist of two or more persons for bed mobility. Resident #11's current care plan, dated 05/03/13, stated, "Focus [Resident name] is at risk for falls r/t [related to] Deconditioning . . . (Recent fall with hip fracture 8-26-16) . . . Interventions . . . Ensure that resident is wearing appropriate footwear when ambulating or mobilizing in w/c [wheelchair] . . ." Observation of to Resident #11 revealed the following: *On 10/03/16 from 4:30 p.m. to 6:00 p.m., resident in bed. *On 10/04/16 from 7:45 a.m. to 3:00 p.m., resident in bed. *On 10/0516 from 7:45 a.m. to 5:00 p.m., resident in bed. During an interview on the afternoon of 10/05/16,	F 280	All residents will have their comprehensive care plan reviewed and revised monthly with mini-monthly assessment, significant changes, re-admission, quarterly, and annually. Comprehensive care plans will be updated as needed if resident care necessitates a change in that comprehensive care plan. 3. What measures will be put into place or systematic changes made to ensure that the deficient practice will not recur? Re-education will be given at Nurses meeting (11/09/16) on comprehensive care plan review and revision including when review and revision must be completed. A task will be added to the eTAR monthly to assure nurses review and revise Care Card and Care Plan. 4. How will the facility monitor its performance to make sure that solutions are sustained? A QAPI will be completed weekly (November 11, November 18, November 25, and December 2), if compliance is shown then monthly x 3 (January 6, February 3, March 3 in 2017) and then quarterly x 3. This monitor will be completed by Unit Directors and monitored by Director of Resident Services. QAPI will include if Care Card present for each shift, if Care Card up to date, if Care Card is neat, organized, and easy to follow, if there documentation that	

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F 280	Continued From page 8 a nurse manager (# 7) verified Resident #11 has been on bed rest since she fractured her left hip in August 2016. Failure of the facility to revise/update Resident #11's care plan to reflect her current mobility status has the potential for the resident to experience increase in pain and/or injury related to facility staff's lack of direction on proper mobility status. - Review of Resident #1's medical record occurred on all days of survey. Diagnoses included a stage 3 pressure ulcer to left heel, type 2 diabetes mellitus, and peripheral vascular disease. The Quarterly MDS, dated 08/02/16, identified walking in the room or corridor did not occur. The resident's progress notes identified the following: * 05/27/16 at 03:39 p.m., "walk to dine program discontinued related to heel ulcers". * 08/09/16 at 10:41 a.m. " . . . PT [Physical Therapy], to do leg strengthening exercises, no weight bearing." * 09/01/16 at 01:26 p.m., "Resident is currently working with PT on standing tolerance, goal to progress to ambulation once ulcer L [left] heel is healed . . . " Observations throughout the survey identified the staff transferred the resident using a Hoyer lift and assist of two, used the wheelchair for all locomotion, and transferred the resident in bed to check and change related to urinary incontinence.	F 280	Care Card was reviewed and revised at most recent appropriate time frame per policy, if Care Plan is present, if the Care Plan up to date (Has it been reviewed and revised per policy?), and if there is documentation that Care Plan was reviewed and revised at most recent appropriate time frame per policy. All monitors started on November 4 2016 and will be compiled by Director of Resident services on dates indicated.	

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F 280	Continued From page 9 The current care plan identified to encourage walking on a daily basis, and the care card identified to toilet every 2-3 hours and as needed. The resident's care plan failed to identify the current interventions regarding locomotion/ambulation and toileting. - Review of Resident #2's medical record occurred on all days of survey. Diagnoses included dementia, cerebral vascular accident with hemiplegia/hemiparesis, and urinary incontinence. The Significant Change MDS, dated 07/29/16, identified walking in room and corridor did not occur. Observations throughout the survey identified the staff transferred the resident using a Hoyer lift and assistance of two, used the wheelchair for locomotion and transferred the resident to the bed for check and change related to urinary incontinence. The current care plan identified to encourage walking on a daily basis. The care card identified to toilet every 2-3 hours and as needed, and wheelchair for mobility. The resident's current care plan failed to identify current interventions regarding locomotion/ambulation and toileting. - Review of Resident #3's medical record occurred on all days of the survey. Diagnoses included hemiplegia, metabolic encephalopathy and anxiety. Observations during survey identified staff placed	F 280		

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F 280	Continued From page 10 bilateral leg straps on the resident when in his wheelchair. A quarterly review for use of a physical restraint, dated 07/26/16, identified: " Resident has better positioning in wheelchair and has not had any falls from the wheelchair since postural belts have been implemented . . . resident releases both L [left] and R [right] positioners independently on command." The resident's current care plan and care card failed to identify the use of the leg straps in the wheelchair as an intervention for positioning. - Review of Resident #20's medical record occurred on October 5-6, 2016. Diagnoses included a left ear infection. Physician's orders, dated 09/28/16, stated, "Cephalexin [antibiotic] . . . two times a day for ear infection for 10 days. . . ." A progress note, dated 09/29/16 at 12:40 p.m., stated, "Culture [ear drainage] received many pseudomonas [bacteria] species noted. . . . Resident put in room at this time in contact precautions. . . ." Observation on 10/05/16 at 4:45 p.m. showed two staff members (#21 and #22) donned gloves and applied contact isolation gowns prior to providing cares. The current care plan failed to address the infection precautions in place. During an interview on 10/06/16 at 10:12 a.m. a nurse manager (#20) confirmed Resident #20 lacked a care plan for infection precautions.	F 280		
F 281	483.20(k)(3)(i) SERVICES PROVIDED MEET	F 281		11/10/16

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F 281 SS=E	Continued From page 11 PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: TIMELY INSULIN ADMINISTRATION 1. Based on observation, review of professional reference, review of facility policy, and staff interview, the facility failed to ensure administration of insulin occurred within the recommended times for 2 of 5 sampled residents (Resident #10 and #14) and for 1 supplemental resident (Resident #34) who received fast-acting insulin. Failure to provide appropriate nourishment within the specified time may result in low blood sugar levels (hypoglycemia). Findings include: "Nursing 2015 Drug Handbook," 35th edition, Wolters Kluwer, Philadelphia, page 757, stated regarding Humalog insulin, ". . . Inject subcutaneously within 15 minutes before or after a meal. . . ." and page 760 stated regarding NovoLog insulin, ". . . Give NovoLog 5 to 10 minutes before start of meal. . . ." Review of the facility policy titled "Diabetes Management" occurred on 10/05/16. This policy, dated June 2013, stated, "Policy: . . . 3. When scheduled insulin is given, snack such as juice etc. must be given if meal is not eaten within 15 minutes or less depending on resident condition and type of insulin being given . . ."	F 281	1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? For residents 10, 14, and 34 nursing staff has been educated on new short acting insulin administration process to assure nourishment is given within a timely manner. Staff caring for residents 1, 2, 4, 5, 6, 7, 10, 11, 14, 16, 17, 19, 20, 22, and 24 have been re-educated on reassessment of response to PRN (as needed) medications. Real time education was done with staff caring for resident 15 to assure understanding that resident was not to use a straw. Verified that care card/FMP (Functional Maintenance Program) and water list were up to date. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice? All diabetic residents on short acting insulin have the potential to be affected.	

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	355059	A. BUILDING _____ B. WING _____	10/06/2016

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F 281	Continued From page 12 - Review of Resident #14's medical record occurred on all days of survey. Diagnoses included type 2 diabetes mellitus. Review of Resident #14's progress note, dated 9/16/16 at 1 p.m., stated, " . . . blood sugar checked and insulin given at 1130 am. . . . room trays came at 1230 [p.m.] [one hour after the insulin administration] and resident asked to go to his bed. . . . resident was standing in the PAL [patient assist lift] lift his right knee buckled. . . . He did not fall at the time but was a near miss. Blood sugar was 76 at the time of the incident, orange juice was given, milk and watermelon. Blood sugar was 84 a half hour later . . ." Observation of medication pass on 10/03/16 at 5:22 p.m. showed a nurse (#24) administered 15 units of Humalog insulin to Resident #14. The resident received his supper tray at 5:56 p.m. (34 minutes after the insulin administration). During an interview on 10/06/16 at 9:30 a.m., a nurse manager (#20) confirmed Resident #14 should have been given a snack per facility policy with administration of insulin. - Observation of medication pass on 10/03/16 at 5:15 p.m. showed a nurse (#2) administered five units of NovoLog insulin to Resident #34. The resident received his supper tray and beverages at 5:56 p.m. (41 minutes after the insulin administration). - Review of Resident #10's medication administration record, on 10/04/16, showed a nurse administered 18 units of NovoLog insulin to	F 281	All diabetic residents who are started on short acting insulin will be managed using new process to ensure nourishment is given within a timely manner. All residents receiving PRN medications have the potential to be affected by reassessment for the effectiveness of medication. All PRN medications will have follow up completed within an appropriate time frame. Any resident speech therapy orders for no straws could have the potential to be affected. All residents with orders related to straws will be put on care card/FMP and water list. 3. What measures will be put into place or systematic changes made to ensure that the deficient practice will not recur? Nurses will call into dining room on walkie before short acting insulin is administered to assure resident□s tray is ready, assure there is staff available to assist resident if needed, and will assure a staff member is available to transport the resident to dining room. If the resident makes the decision to not go to the dining room after short acting insulin has been administered, substantial nourishment will be given on the unit within an appropriate time frame. Mealtime Assistants and CNAs have been educating on assuring diabetic residents who receive long acting insulin are assisted with nourishment in a timely manner. Will review this	

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F 281	Continued From page 13 Resident #10 at 11:55 a.m. Observation showed the resident received her dinner tray at 12:45 p.m. (55 minutes after insulin administration). During an interview on the afternoon of 10/05/16, a nurse manager (#7) stated a resident should eat within 15 to 20 minutes after receiving NovoLog insulin. PRN MEDICATION FOLLOW-UP 2. Based on record review, review of facility policy and procedure, professional reference, and staff interview, the facility failed to ensure staff reassessed the response to as needed (PRN) pain medications for 15 of 22 residents (Resident #1, #2, #4, #5, #6, #7, #10, #11, #14, #16, #17, #19, #20, #22, and #24) identified with orders for PRN pain medications. Failure to timely reassess after administering a PRN pain medication limits staff's ability to assess the effectiveness of the pain medication and may result in the resident experiencing unrelieved pain. Findings include: Review of the facility policy titled "Medication - PRN Administration" occurred on 10/05/16. This policy, revised September 2016, stated, "Procedure: 1. Nurse will assess the need for prn medications before administration. 2. Document alternative interventions attempted prior to PRN medication administration. 3. Nurse will administer PRN medication and document in eMAR [electronic medication administration record] or eTAR [electronic treatment administration record]. 4. Nurse will assess	F 281	re-education with nursing staff again at meeting on 11/09/16. Nurses will be re-educated (meeting on 11/09/16) on reassessment of residents after PRN medication administration to assure an effective response in an appropriate time frame. Report in Point Click Care was updated to include medication name for easier follow up by Unit Directors. CNAs re-educated (meeting on 10/13/16) on ensuring speech therapy orders for no straws are followed. 4. How will the facility monitor its performance to make sure that solutions are sustained? A QAPI will be completed weekly (November 11, November 18, November 25, and December 2), if compliance is shown then monthly x 3 (January 6, February 3, March 3 in 2017) and then quarterly x 3. This monitor will be completed by Unit Directors and monitored by Director of Resident Services. QAPI will include if follow up was performed for effectiveness in a timely manner (less than 2 hour) after administration of PRN medication, what time insulin administration occurred, what time that resident started eating and if that time less was than 15 minutes, no straw will be monitored with assuring update and revision to Care Card/Care Plan monitor. All monitors started on	

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F 281	Continued From page 14 effectiveness of medication and perform appropriate follow-up. 5. Document follow up in eMAR or eTAR." "Nursing 2015 Drug Handbook," 35th ed., Wolters and Kluwer, Pennsylvania, page 704, stated, "hydrocodone bitartrate-acetaminophen [Norco] . . . Pharmacologic class: Opioid. . . ." Administered oral hydrocodone has a "peak" [highest level of pain relief] at "1 1/3 hour." Berman and Snyder, "Kozier & Erb's Fundamentals of Nursing: Concepts, Process, and Practice," 10th ed., Pearson Education, Inc., New Jersey, page 1109, states, ". . . Opioids relieve moderate to severe pain . . . NURSING RESPONSIBILITIES * Assess pain prior to and 60 minutes after administration. . . ." - Review of Resident #4's medical record occurred on all days of survey. Diagnoses included dementia, osteoarthritis, back pain, and collapsed vertebra. Medications included hydrocodone-acetaminophen 10-325 milligrams (mg) every 6 hours PRN for pain. Review of the eMAR and progress notes for October 2016 showed hydrocodone-acetaminophen administered once with reassessment occurring 9.5 hours later. - Review of Resident #5's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease, osteoarthritis, and rheumatoid arthritis. Medications included acetaminophen 650 mg every 4 hours PRN for fever or pain. Review of the eMAR and progress notes for August 2016 showed acetaminophen administered twice with reassessment occurring	F 281	November 4 2016 and will be compiled by Director of Resident services on dates indicated.	

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F 281	Continued From page 15 2-3 hours later. - Review of Resident #6's medical record occurred on all days of survey. Diagnoses included a fall with fracture in July 2016 and pain. PRN medications included Dilaudid 2 mg every 4 hours for pain, hydrocodone-acetaminophen 5-325 mg every 4 hours for pain, acetaminophen 650 mg every 8 hours for pain, and Tramadol 50 mg every 12 hours for pain. Review of Resident #6's eMAR and progress notes for September through October 5, 2016 showed the following: * Hydrocodone-acetaminophen administered 21 times with reassessment occurring 2-6 hours later. * Dilaudid administered six times with reassessment on four occasions occurring 2-6 hours later. * Acetaminophen administered four times with reassessment on three occasions occurring 2-10 hours later. * Tramadol administered five times with reassessment on two occasions occurring 2-3 hours later. - Review of Resident #22's medical record occurred on October 5-6, 2016. Diagnoses included dementia, arthritis, migraines, and joint pain. PRN medications included acetaminophen 650 mg every 4 hours PRN. Review of the eMAR and progress notes for September 2016 showed acetaminophen administered twice with reassessment on both occasions occurring 2-3 hours later.	F 281		

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F 281	Continued From page 16 - Review of Resident #1's medical record occurred on all days of survey. Diagnoses included stage 3 pressure ulcer to left heel, osteoarthritis, and diabetic neuropathy. PRN medications included Tylenol 650 mg every 4 hours PRN for pain and Tramadol 50 mg every 6 hours PRN for pain. Review of Resident #1's eMAR and progress notes for September 22 - October 6, 2016 showed the following: * Tylenol administered five times with reassessment occurring 3-7 hours later. * Tramadol administered twice with reassessment occurring 3-5 hours later. - Review of Resident #2's medical record occurred on all days of survey. Diagnoses included pain unspecified and pain to hip. PRN medications included Tylenol 325 mg two tablets every 6 hours PRN for fever or pain. Review of the eMAR and progress notes for September 1 - October 6, 2016 showed Tylenol administered once with reassessment occurring 3 hours later. - Review of Resident #7's medical record occurred on all days of survey. Diagnoses included left femur fracture and a pressure ulcer to both heels. PRN pain medications included hydrocodone-acetaminophen 5-325 mg every 4 hours, Tramadol 50 mg every 6 hours, and Tylenol Extra Strength 500 mg every 4 hours. Review of Resident #7's eMAR and progress	F 281		

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F 281	Continued From page 17 notes for September 22-29, 2016 showed the following: * hydrocodone-acetaminophen administered nine times with reassessment occurring 3-6 hours later. * Tramadol administered twice with reassessment occurring 2.5-4 hours later. * Tylenol administered once with reassessment occurring 2.5 hours later. - Review of Resident #10's medical record occurred on all days of survey. Diagnoses included knee, hip, and back pain, and right foot arterial/venous ulcers. PRN medications included oxycodone-acetaminophen 5-325 mg two tablets PRN for pain every 4 to 6 hours. Review of the eMAR and progress notes for September 2016 showed oxycodone-acetaminophen administered 25 times with reassessment on 14 occasions occurring 3-11 hours later. - Review of Resident #11's medical record occurred on October 3-5, 2016. Diagnoses included lower back and neck muscle strain, chronic pain, left hip fracture, and neuropathy. PRN medications included hydromorphone 2 mg every 6 hours PRN for pain. Review of the eMAR and progress notes for September 2016 showed hydromorphone administered 43 times with reassessment on 34 occasions occurring 2-10 hours later. - Review of Resident #19's medical record occurred on October 4-5, 2016. Diagnoses included low back, shoulder, knee, and genital	F 281		

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pain, and restless leg syndrome.

PRN medications included Norco 5-325 mg (hydrocodone-acetaminophen) every 4 hours PRN for pain. Review of the eMAR and progress notes for September 2016 showed Norco administered 26 times with reassessment on 18 occasions occurring 2-10.5 hours later.

- Review of Resident #16's medical record occurred on October 3-5, 2016. Diagnoses included dementia, peripheral vascular disease, and foot wound/ulcer.

PRN medications included hydrocodone-acetaminophen 5-325 mg every 4 hours PRN for pain and Tramadol 50 mg every 6 hours PRN for pain.

Resident #16's eMAR and nursing progress notes from September 1 - October 5, 2016 showed the following:
* hydrocodone/acetaminophen administered 11 times with reassessment on six occasions occurring 2-5.5 hours later.
* Tramadol administered 16 times with reassessment on 12 occasions occurring 2-7 hours later.

- Review of Resident #17's medical record occurred on October 3-5, 2016. Diagnoses included dementia, unspecified pain, and osteoarthritis.

PRN medications included Tylenol 650 mg every 4 hours PRN for pain, fever, or headache. The eMAR and nursing progress notes from September 1 - October 5, 2016 showed Tylenol

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administered twice with reassessment on both occasions occurring 3.5-4 hours later.

- Review of Resident #24's medical record occurred on October 5-6, 2016. Diagnoses included chronic pain syndrome and polyneuropathy.

PRN medications included Tramadol 50 mg every 6 hours PRN for pain. The eMAR and nursing progress notes from September 1 - October 5, 2016 showed Tramadol administered twice with reassessment on both occasions occurring 6.5-7 hours later.

- Review of Resident #14's medical record occurred on all days of survey. Diagnoses included rotator cuff (shoulder) tear and cervicalgia (neck pain).

PRN medications included Norco 5-325 mg every 6 hours PRN for pain. Review of the eMAR and progress notes for October 2016 showed Norco administered twice with reassessment occurring 3.25 hours later.

- Review of Resident #20's medical record occurred on October 5-6, 2016. Diagnoses included osteoarthritis.

PRN medications included acetaminophen 325 mg every 4 hours PRN for temperature or pain. Review of the eMAR and progress notes for September 2016 showed acetaminophen administered once with reassessment occurring 3.25 hours later.

During an interview on the afternoon of 10/05/16,

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F 281	Continued From page 20 a nurse manager (#3) stated follow-up for PRN pain medications should occur within 1-2 hours after administration. During an interview on the afternoon of 10/05/16, a nurse manager (#7) verified the documentation response time for PRN medications should occur within one hour after administration. Failure to follow-up on the effectiveness of PRN pain medications in a timely manner may lead to unresolved symptoms and unnecessary pain or discomfort. USE OF STRAWS 3. Based on observation, record review, review of facility policy/procedure, and staff interview, the facility failed to follow swallowing precautions for 1 of 7 residents (Resident #15) identified by the facility with swallowing issues. Failure to ensure a resident followed speech therapy orders for no straw use may result in aspiration (inhalation of foreign material) or pneumonia (lung infection). Findings include: Review of the facility policy titled "Physical Therapy, Occupational Therapy, and Speech Therapy" occurred on 10/06/16. This policy, revised June 2016, stated, "Provide therapeutic environment for residents to sustain functioning and/or prevent deterioration as able. . . . Speech Therapy will write FUMPs (functional maintenance programs) after therapy as needed to direct nursing staff on special resident cares that are needed. . . ."	F 281		

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F 281	Continued From page 21 Review of Resident #15's medical record occurred on all days of survey. Diagnoses included a history of dysphagia (difficulty swallowing). A speech therapy order, dated 08/26/16, stated, "No straws." Observation on 10/04/16 at 7:51 a.m., showed a certified nurse aide (CNA) (#23) handed Resident #15 a styrofoam cup of water with a straw in it. Resident #15 took a drink from the cup using the straw. Observations of Resident #15's room on October 4-6, 2016, showed a styrofoam cup with a straw at bedside. During an interview on 10/06/16 at 9:30 a.m., a nurse manager (#20) confirmed Resident #15 should not have straws.	F 281		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES 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: Based on observation, record review, and staff interview, the facility failed to ensure the safety of 1 of 1 sampled resident (Resident #10) to leave the facility campus to smoke. Failure to assess the resident's ability to safely smoke at the	F 323	1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?	11/10/16

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F 323	Continued From page 22 facility, identify how she would acquire assistance from staff (if needed) once she's left the facility, and monitor the resident when she exits the building could result in an avoidable accident. Findings include: Review of the facility policy titled "Resident Smoking Policy" occurred on 09/06/16. This policy, revised September 2013, stated " . . . Procedure: . . . Resident will be assessed for safety and ability to smoke on admission, readmission, quarterly and significant change." - Review of Resident #10's medical record occurred on all days of survey. Diagnoses included chronic obstructive pulmonary disease, asthma, chronic respiratory failure with hypoxia (lack of oxygen in the blood), anxiety, smoker, pneumonia, congestive heart failure, upper respiratory infections, and impaired mobility. The significant change Minimum Data Set (MDS), dated 07/28/16, identified intact cognition, the use of oxygen, extensive assistance of two people to transfer and toilet use, and supervision of one person for locomotion on and off the unit. Current physician's orders identified continuous oxygen every shift, ordered 04/28/16. The current care plan identified, "Focus . . . Resident has alteration in health maintenance R/T [related to] respiratory infection, Pneumonia . . . Interventions . . . Monitor/Document for mental changes . . . Focus . . . [resident name] is at risk for falls r/t deconditioning, gait/balance problems . . . Hx [history] of falls . . . Goal . . . Resident will	F 323	Smoking Assessment for resident 10 was completed in full. Updated protocol for staff to follow when resident 10 wants to leave the facility to smoke that assures the resident□s safety, her possible need for assistance, and oxygen use safety. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents who smoke have the potential to be affected. However, we do not have any other residents who smoke at this time. The same procedure will be followed if this changes in the future. 3. What measures will be put into place or systematic changes made to ensure that the deficient practice will not recur? Smoking Assessment will be completed in full on admission, readmission, significant changes, and quarterly. Protocol for resident leaving facility to smoke will be updated with any changes found on Smoking Assessment. Re-education occurred at Mentor (10/19/16), CNA(10/13/16), Medication Assistant(10/25/16), and Nurse(11/09/16) meetings. 4. How will the facility monitor its performance to make sure that solutions are sustained? A QAPI will be completed weekly (November 11, November 18, November	

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F 323	Continued From page 23 be free of falls . . . Interventions . . . Resident needs a safe environment . . ." The DAILY CARE CARD (CARE PLAN), dated 9/13/2016, identified, " . . . Transfer: assist of 1 . . . Ambulation Device/Mobility: Electric wheelchair . . ." A smoking assessment, dated 07/25/16, stated, " . . . Dexterity . . . Does have [sic] resident have dexterity problem? Yes . . . Resident is safe to smoke unsupervised at this time . . . [response left blank] . . ." The facility failed to complete this assessment. The Smoking Area information sheet, dated 6/17/16, identified, " . . . She can go independently as long as she is independent with her electric wheelchair. If she is using oxygen (not currently using), she is to ask staff to remove the oxygen tank from her electric wheelchair before leaving the unit. She is to take her cell phone with her . . ." Observation on 10/04/16 at 7:50 a.m., showed Resident #10 laying in bed. The resident stated, "I'm just not up to par this morning. I usually get myself up, but not sure if I'll be able to do that today since my hands are shaking so bad." Resident #10's hands were visibly shaking. Observations on 10/04/16 showed the following: * at 12:00 p.m., Resident #10 seated in her electric wheel chair with her coat on in her room with a pack of cigarettes and lighter. The portable oxygen tank remained on the back of her wheelchair. * at 12:05 p.m., Resident #10 exited the building	F 323	25, and December 2), if compliance is shown then monthly x 3 (January 6, February 3, March 3 in 2017) and then quarterly x 3. This monitor will be completed by Unit Directors and monitored by Director of Resident Services. QAPI will include if Smoking Assessment was completed on admission, readmission, significant change, and quarterly per policy, if Smoking Assessment was completed in full, if is resident safe to smoke unsupervised at this time, if cigarettes and lighter are stored in medication room, if oxygen tank was removed from scooter before resident left facility to smoke, if resident had cell phone when resident left the facility, and if smoking safety was care planned. All monitors started on November 4 2016 and will be compiled by Director of Resident services on dates indicated.	

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	355059	A. BUILDING _____ B. WING _____	10/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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utilizing her electric wheel chair and parked her electric wheelchair across the parking lot. The portable oxygen tank remained on the back of her wheelchair.

During an interview on 10/04/15 at 12:10 p.m., when asked how the facility is aware of when she goes out of the building to smoke, Resident #10 stated, "they don't know when I go out here, I usually just go." When asked if she had difficulty getting back to or in the building how would she contact someone for help, Resident #10 stated she usually brings her cell phone with her, but she didn't remember it this time and she must be getting more forgetful. Resident #10 stated, "I can't believe I have to sit out in the cold in my electric wheelchair without any shelter while I smoke, doesn't make much sense." Resident #10 was observed to be visibly short of breath.

Observation on 10/05/16 at 11:00 a.m., showed Resident #10 seated in her electric wheelchair in her room. Resident #10's hands were visibly shaking. Resident #10 stated, "I have had these tremors in my hands for about six months now and I don't know what is causing it. It's even difficult to write with a pen, I keep dropping it. I feel so miserable right now, I'm sure I still have pneumonia."

During an interview on the afternoon of 10/05/16, a nurse manager (#7) stated a smoking assessment should be completed quarterly and the resident is to notify staff she is going outside to smoke so the staff can remove the oxygen tank from her wheelchair. The nurse (#7) stated there is a camera to monitor the door where the resident exits the building, but was not aware of

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F 323	Continued From page 25 any staff monitoring the camera. The facility failed to assess if Resident #10 could safely smoke in the designated smoking area (across the parking lot) and ensure Resident #10 was monitored appropriately when she exited the building, and/or identify/care plan how Resident #10 would acquire assistance from staff (if needed) once she exited the facility to smoke.	F 323		
F 329 SS=E	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.	F 329		11/10/16

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F 329	Continued From page 26 This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to ensure a medication regimen free from unnecessary drugs for 5 of 9 sampled residents (Resident #6, #10, #16, #17, and #18) who received as needed (PRN) anti-anxiety medications. Failure to determine the necessity of a medication, attempt non-pharmacological interventions prior to administration, follow-up in a timely manner to assess effectiveness, and simultaneously administering a PRN pain medication placed residents at risk of receiving unnecessary medications and suffering adverse consequences related to their use. Findings include: Review of the facility policy titled "Medication - PRN Administration" occurred on 10/05/16. This policy, revised September 2016, stated, "Procedure: 1. Nurse will assess the need for prn medications before administration. 2. Document alternative interventions attempted prior to PRN medication administration. 3. Nurse will administer PRN medication and document in eMAR [electronic medication administration record] or eTAR [electronic treatment administration record]. 4. Nurse will assess effectiveness of medication and perform appropriate follow-up. 5. Document follow up in eMAR or eTAR." Review of the facility policy titled "Behaviors Protocol" occurred on 10/06/16. This policy, revised June 2016, stated, ". . . A. Assess for causes of behavioral symptoms, i.e. [for	F 329	1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Staff caring for residents 6, 10, 16, 17, and 18 have been educated on the use of nonpharmacological intervention use prior to PRN antipsychotic medication administration, timely follow-up for effectiveness of antipsychotic medication administration, and simultaneous administration of PRN medications. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents have the potential to receive unnecessary medications. 3. What measures will be put into place or systematic changes made to ensure that the deficient practice will not recur? Re-education has been done at unit stand up meetings. Re-education will be done at Nurse Meeting (11/09/16) on always attempting nonpharmacological interventions prior to PRN antipsychotic medication administration, follow up in a timely manner for effectiveness after PRN antipsychotic medication administration, and simultaneous administration of PRN medications.	

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F 329	Continued From page 27 example] pain, environmental, physical, infection, medication, etc [etcetera]. B. Perform appropriate interventions and document in PCC [Point Click Care]. . . . E. Provide diversional activity for wandering, agitation, and aggression. . . ." - Review of Resident #6's medical record occurred on all days of survey. Diagnoses included a fall with fracture in July 2016, pain, and anxiety. PRN medications included Ativan 0.5 milligrams (mg) every 6 hours for anxiety, hydrocodone-acetaminophen 5-325 mg every 4 hours for pain, and Tramadol 50 mg every 12 hours for pain. Resident #6's current care plan stated, ". . . pain . . . Administer analgesic as per orders & monitor for relief obtained. . . . psychotropic medication R/T [related to] Anxiety Disorder, Insomnia . . . Monitor/document for side effects and effectiveness. . . ." Resident #6's eMAR, behavior assessments, and nursing progress notes for August and September 2016 showed staff administered PRN Ativan 27 times: * 20 times without a behavior assessment or non-pharmacological interventions attempted * 18 times without effectiveness assessed in a timely manner. * six times administered simultaneously with a PRN pain medication (four times with hydrocodone-acetaminophen and twice with Tramadol) - Review of Resident #16's medical record occurred on October 3-5, 2016. Diagnoses included dementia with behavioral disturbance,	F 329	4. How will the facility monitor its performance to make sure that solutions are sustained? A QAPI will be completed weekly (November 11, November 18, November 25, and December 2), if compliance is shown then monthly x 3 (January 6, February 3, March 3 in 2017) and then quarterly x 3. This monitor will be completed by Unit Directors and monitored by Director of Resident Services. QAPI will include if nonpharmacological interventions were attempted and documented before PRN medication administration, if reason for PRN medication administration was documented, if UDA was completed, if PRN medications were administered simultaneously and if so, was simultaneous administration appropriate. All monitors started on November 4 2016 and will be compiled by Director of Resident services on dates indicated.	

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anxiety disorder, and peripheral vascular disease. PRN medications included Ativan 0.5 mg every 8 hours for sleep and agitation, hydrocodone-acetaminophen 5-325 mg every 4 hours for pain, and Tramadol 50 mg every 6 hours for pain.

Resident #16's current care plan stated, ". . . behavior problem r/t sexual comment toward staff, aggressive, and wanders. . . . Document behavior and potential causes. . . . Refer to Behavior Approaches . . ."

Resident #16's eMAR, Behavior assessments, and nursing progress notes from August 26 - October 3, 2016 showed staff administered PRN Ativan on 27 occasions:
* nine times without a behavior assessment
* four times without any description of the behavior and 4 times listed the behavior as "anxiety" or "agitation"
* eight times without evidence staff tried non-pharmacological interventions prior to administering Ativan
* six times without effectiveness assessed in a timely manner
* nine times administered simultaneously with a PRN pain medication (4 times with hydrocodone-acetaminophen and 5 times with Tramadol)

- Review of Resident #17's medical record occurred on October 3-5, 2016. Diagnoses included dementia with behavioral disturbance, anxiety disorder, unspecified pain, restlessness and agitation. PRN medications included Ativan 0.5 mg every 4 hours for anxiety and Tylenol 650 mg every 4 hours for pain, fever, or headache.

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F 329	Continued From page 29 Resident #17's current care plan stated, ". . . verbal behaviors of yelling, threatening and using abusive language . . . Analyze key times, places, circumstances, triggers, and what de-escalates behavior and document. . . . Assess and anticipate [resident's name] needs: food, thirst, toileting needs, comfort level, body positioning, pain . . . Intervene before agitation escalates; Guide away from source of distress; Engage calmly in conversation; If response is aggressive, staff to walk calmly away, and approach later. . . . physical behaviors of hitting [includes interventions similar to above] . . . resistive to cares . . . [includes multiple non-pharmacological interventions]." Resident #17's eMAR, Behavior assessments, and nursing progress notes from September 2 - October 3, 2016 showed staff administered PRN Ativan on 17 occasions: * four times without a behavior assessment * four times without a description of the behavior * five times without evidence staff tried non-pharmacological interventions prior to administering Ativan * five times without effectiveness assessed in a timely manner * once administered simultaneously with PRN Tylenol - Review of Resident #18's medical record occurred on October 3-5, 2016. Diagnoses included dementia with behavioral disturbance, anxiety disorder, restlessness and agitation. PRN medication included Klonopin 0.5 mg every 6 hours for anxiety.	F 329		

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F 329	Continued From page 30 Resident #18's current care plan stated, ". . . behavior problem r/t dx [diagnosis] of Dementia, combative, resistive to cares, wandering (exit-seeking), and verbal abuse (threatening staff). . . . Assess for pain/discomfort/toileting needs. . . . Monitor behavior episodes and attempt to determine underlying cause. . . . Document behavior and potential causes. . . . Refer to Behavior Approaches . . . [includes multiple non-pharmacological interventions]." Resident #18's eMAR, Behavior assessments, and nursing progress notes from August 1 - October 3, 2016 showed staff administered PRN Klonopin on three occasions: * twice without evidence staff tried non-pharmacological interventions prior to administering Klonopin * twice without effectiveness assessed in a timely manner During an interview on the afternoon of 10/05/16, two nurse managers (#3 and #4) stated a behavior assessment including non-pharmacological interventions should have been completed before administering a PRN antianxiety medication. Both agreed follow-up should have been completed in a timely manner and administering a pain medication at the same time as an antianxiety medication could increase the possibility of an unnecessary drug. During an interview on 10/06/16, a nurse manager (#19) stated staff should follow-up within an hour of administering a PRN medication and should be documenting non-pharmacological interventions used prior to administering the medication.	F 329		

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F 329	Continued From page 31 - Review of Resident #10's medical record occurred on all days of survey. Diagnoses included pain and anxiety. PRN medications included Ativan 0.5 mg twice daily for anxiety, Ambien 2.5 mg every evening for insomnia, Baclofen 10 mg every 12 hours for muscle spasms, oxycodone-acetaminophen 5-325 two tablets every 4-6 hours for pain. Resident #10's current care plan stated, ". . . has acute pain . . . Administer analgesic as per orders & monitor for relief obtained. . . . uses psychotropic medications R/T Anxiety Disorder, Depression, Insomnia . . . Administer medications as ordered . . . Monitor/document for side effects and effectiveness. . . ." Resident #10's eMAR, Behavior assessments, and nursing progress notes from September 1 - October 5, 2016 showed staff administered PRN Ativan on nine occasions: * seven times without a behavior assessment and non-pharmacological interventions attempted * four times without effectiveness assessed in a timely manner * twice administered simultaneously with both PRN oxycodone-acetaminophen and Ambien * eight times administered simultaneously with both PRN oxycodone-acetaminophen and Baclofen	F 329		
F 431 SS=F	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an	F 431		11/10/16

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F 431	Continued From page 32 accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. 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. 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. The facility must provide 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, review of temperature logs, and staff interview, the facility failed to store medications in 1 of 6 medication refrigerators (North Central) within manufacturers' recommended temperatures. Failure to store medications correctly may decrease the efficacy	F 431	1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? No residents were affected by this	

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F 431	Continued From page 33 of the medications. Findings include: A tour of the medication room occurred on 10/05/16 at 11:00 a.m. with a nurse (#1). The medication refrigerator contained one vial of tuberculin purified protein which stated to store at 35 to 46 degrees Fahrenheit (F), one vial of NovoLog insulin which stated to store at 36 to 46 degrees F, a box of Brovana inhaler vials which stated to store at 36 to 46 F, and a bottle of Neomycin & Polymyxin B Sulfates and Dexathasone opthalmic suspension (eye drops) which stated to store at 46 to 80 degrees F. Review of the medication room refrigerator temperature logs for May - October 05, 2016 identified 70 days of recorded temperatures below 36 degrees with readings as low as 26 degrees F. The temperature log identified the following, "Instructions: Night Nurse will check and record temperature nightly. The normal range is 35-46 degrees Fahrenheit . . ." During the tour of the medication room, the nurse (#1) confirmed staff failed to keep the refrigerator at the temperature appropriate for the medications contained in the refrigerator.	F 431	deficiency. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice? Any resident who has a medication that needs to be refrigerated could be affected. 3. What measures will be put into place or systematic changes made to ensure that the deficient practice will not recur? New medication fridge was purchased and installed while survey team was on site (10/05/16). A new medication fridge temperature log was created to include initials of staff recording temperature, if out of range what action they took, maintenance initials, when maintenance check issue, and what maintenance was performed. Re-education will take place a Nurse Meeting (11/09/16). 4. How will the facility monitor its performance to make sure that solutions are sustained? Medication fridge temperature log will be monitored daily by Charge Nurse on each unit. Unit Director will monitor log weekly (November 11, November 18, November 25, and December 2), if compliance is shown then monthly. Each failure in compliance with this log will be followed up on an individual basis with specific staff member involved. This monitor will	

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F 431	Continued From page 34	F 431	be completed by Charge Nurses, Unit Directors, and then monitored by Director of Resident Services. QAPI will include date, temperature, initials of nurse checking, if out of range what action was taken, maintenance initials and date checked if indicated, and maintenance performed. All monitors started on November 4 2016 and will be compiled by Director of Resident services on dates indicated.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if	F 441		11/10/16

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F 441	Continued From page 35 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 infection control practices for 3 of 20 sampled residents (Resident #7, #12, and #20) observed during perineal care/dressing change. Failure to follow infection control practices related to proper procedure when performing perineal care, hand hygiene during perineal care, and wound dressing changes has the potential to spread infection to other residents, staff, and visitors. Findings include: Review of the facility policy titled, "PERINEAL CARE" occurred on 10/06/16. This policy, revised August 2013, stated, "Objective: To cleanse the genital and anal area of the body. To prevent infection . . . Equipment: May use . . . disposable wipes . . . Procedure: Cleanse perineal area from front to back . . . using a clean section of washcloth with each wipe down . . ."	F 441	1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident 7, 12, and 20 had no adverse outcome from this deficiency. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected by this deficiency. 3. What measures will be put into place or systematic changes made to ensure that the deficient practice will not recur? All staff re-educated on hand hygiene. CNAs and Nurses will be re-educated on perineal cares. Nurses will be re-educated on proper wound care. Will	

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	355059	A. BUILDING _____ B. WING _____	10/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSOURI SLOPE LUTH CARE CTR	2425 HILLVIEW AVE BISMARCK, ND 58501

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F 441	Continued From page 36 Review of the facility policy titled, "Dressings Clean and Sterile" occurred on 10/05/16. This policy, revised August 2012, stated, ". . . In the event of multiple wounds, each wound is considered a separate treatment. . . . 6. Remove soiled dressing and discard in plastic bag. 7. Remove gloves. Wash hands/hand sanitizer. . . . 10. Assess wound characteristics. Measure as indicated. 11. Remove and discard gloves. Wash/sanitize hands. . . ." Review of facility policy titled, "Hand Washing, Hand Sanitizer, Artificial Nails" occurred on 10/06/16. This policy, revised September 2016, stated, "Hand washing . . . most important procedure for preventing the spread of health-care associated infections. . . . Indications for hand washing: 1. When hands are visibly soiled. 2. Before and after resident care. . . ." Review of facility policy titled, "Isolation" occurred on 10/06/16. This policy, reviewed August 2016, stated, ". . . Contact precautions . . . Remove PPE (personal protective equipment) . . . and wash hands before leaving room. . . ." - Observation on 10/04/16 at 10:05 a.m. showed a licensed nurse (#10) and a certified nursing assistant (CNA) (#11) assisted Resident #7 with morning cares. The nurse (#10) removed a dressing from Resident #7's left heel pressure ulcer. Without performing hand hygiene, the nurse then removed Resident #7's right heel boot, adjusted the blanket and assessed the right heel pressure ulcer. At 10:15 a.m. a family nurse practitioner (FNP) (#12) arrived to assess Resident #7's heel and coccyx pressure ulcers. The FNP donned gloves and examined Resident	F 441	clarify wound care procedure and hand hygiene policy with FNP involved in the care of resident 7. Re-education at Mentor (10/19/16), CNA(10/13/16), Medication Assistant(10/25/16), and Nurse(11/09/16) meetings. All staff re-education has also been added on HealthStream with a completion due date of 11/30/16. 4. How will the facility monitor its performance to make sure that solutions are sustained? A QAPI will be completed weekly (November 11, November 18, November 25, and December 2), if compliance is shown then monthly x 3 (January 6, February 3, March 3 in 2017) and then quarterly x 3. This monitor will be completed by Unit Directors and monitored by Director of Resident Services. QAPI will include if staff used appropriate hand hygiene before resident contact, if staff used appropriate hand hygiene after resident contact, if in isolation, was appropriate PPE worn, if staff performed perineal cares appropriately, and if hand hygiene and glove changes were performed correctly during wound care. All monitors started on November 4 2016 and will be compiled by Director of Resident services on dates indicated.	

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F 441	Continued From page 37	F 441		

#7's coccyx area, touching the area. The FNP (#12) removed her gloves and without performing hand hygiene donned new gloves. The FNP measured the resident's open area on the left heel and using the same paper ruler measured the open area on the right heel.

After the nurse (#10) completed dressing changes, the CNA (#11) performed perineal care for Resident #7. With visible bowel movement (BM) on the washcloth, the CNA rinsed the cloth in the basin and continued with frontal perineal care. The CNA (#11) failed to remove her gloves, perform hand hygiene, and obtain a clean cloth before continuing with the resident's perineal care.

During an interview on 10/05/16 at 5:00 p.m. a nurse manager (#13) stated she expected staff to perform hand hygiene after removing a dressing and after assessing each wound. She further stated she expected staff to obtain a clean washcloth and not continue with perineal care when there is visible BM on a washcloth.

- Review of Resident #12's medical record occurred on all days of survey. Diagnoses included urinary tract infections and incontinence.

Observation on 10/04/16 at 9:35 a.m., showed two CNAs (#5 and #6) assisting Resident #12 with toileting cares. After the resident had an incontinent stool, the CNA (#5) donned gloves and provided perineal cares using a pre-soaked disposable wipe. The CNA (#5) cleansed the resident's perineum from the pubis to the rectum three times with visible stool on the wipe. The CNA (#5) failed to use a different area of the

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F 441	Continued From page 38 cleansing wipe or obtain a fresh wipe when cleansing the resident's perineum. - Review of Resident #20's medical record occurred on October 5-6, 2016. Diagnoses included a left ear infection. A progress note, dated 09/29/16 at 12:40 p.m., stated, "Culture [ear drainage] received many pseudomonas [bacteria] species noted. . . . Resident put in room at this time in contact precautions. . . ." Observation on 10/05/16 at 4:45 p.m. showed a CNA (#21) donned personal protective equipment (PPE). In the bathroom, after assisting Resident #20 with perineal cares, the CNA removed the PPE and left the room without washing his/her hands. During an interview on 10/06/16 at 9:21 a.m., a nurse manager (#20) confirmed staff need to wash hands after cares and before leaving the room.	F 441		