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 _____	10/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey started on October 26, 2015 and completed on October 29, 2015, the sample included 5 residents for complete review, 27 residents for focused review, and 3 closed records for review. The sample included 2 additional residents to verify specific concerns during the survey.	F 000		
F 221	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to assess, care plan, and develop interventions for the use of a restraint for 3 of 5 sampled residents (Resident #4, #6, and #19) observed with a seat belt or velfoam (velcro) belt while in an electric wheelchair. Failure to complete the necessary assessment, care plan for the use, and include directions for staff prior to the placement of a seat belt or velfoam belt placed the resident at risk for injury. Findings include: Review of facility policy titled "Restraints" occurred on 10/29/15. This policy, dated August 2013, stated, ". . . The resident will be assessed by nursing staff for the least restrictive	F 221	1. What corrective action will be accomplished for those residents affected by the deficient practice; For residents 4, 6, and 19; an restraint assessment was completed and the use of safety belts were care planned. 2. How will you identify other residents having the potential to be affected by the same deficient practice; All residents who have an electric wheelchair that come equipped with a safety belt will have an assessment completed. 3. How the deficiency will be corrected;	12/3/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/19/2015

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 221	Continued From page 1 alternatives . . . request OT [occupational therapy] consult to evaluate and determine the least restrictive enabling device that will provide the most functional means for the resident to maintain safe mobility, comfortable seating and good posture. . . . Nursing will obtain a physician's order, and determine the following: a) The Medical necessity for use of a particular restraining device; b) The purpose for the device . . . c) When the device is to be used . . . Nursing will obtain a consent form from the resident if the resident is capable of making medical decisions. . . ." - Review of Resident #4's medical record occurred on all days of survey. Resident #4's daily care card states, ". . . Postural supports & Wheelchair Cushions: . . . Velfoam [velcro belt] wrap above knees in power wheelchair. . . . Ambulatory Device/Mobility: Electric wheelchair . . ." The current care plan failed to address the use of a velfoam belt and seat belt while resident is seated in an electric wheelchair. Observation on 10/26/15 at 3:30 p.m. showed Resident #4 in his room seated in his wheelchair. A fastened velfoam belt was around the residents thighs and a fastened seat belt was around his waist. Observation on 10/27/15 at 8:25 a.m. showed two CNAs (#8 & #9) transferred Resident #4 from the bed to his electric wheelchair with a mechanical stand lift. After Resident #4 was seated in his electric wheelchair, the CNA (#9) fastened the seat belt around Resident #4's waist and applied the velfoam belt around the resident's thighs.	F 221	Aegis therapy currently evaluates resident's safety with electric wheelchair. The use of safety belts will be added to the evaluation form, documented and care planned. If the belt is used the resident will be evaluated quarterly by nursing that they are capable of releasing belt when asked. The policy and procedure was updated. CNAs and nurses will be educated on the policy change. 4. How the facility plans to monitor its performance; QAPI will monitor the use of safety belts on electric wheelchairs monthly x 2 then quarterly and will be monitored by the Director of Resident Services	

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F 221	Continued From page 2 Observation on 10/27/15 at 4:21 p.m. showed two CNAs (#10 & #11) transferred Resident #4 from the bed to his electric wheelchair with a mechanical stand lift. After Resident #4 was seated in his electric wheelchair, the CNA (#11) fastened the seat belt around Resident #4's waist. During an interview on 10/27/15 at 1:30 p.m., an administrative nurse (#6) stated she was unaware Resident #4 was using a seat belt. She stated she "never did an assessment for the use of a restraint as she was unaware staff were fastening a seat belt on Resident #4 when he was in the electric wheelchair." - Review of Resident #6's medical record occurred on all days of survey. Resident #6's daily care card states, ". . . Ambulatory Device/Mobility: Independent power wheelchair. Nonskid under wheelchair cushion. . . ." The current care plan states, ". . . Resident has an electric w/c [wheelchair] for locomotion. It came with a seat belt. The resident has been using the w/c for quite some time. I noticed him applying the seat belt the other day. I told him 'I did not know you used a seat belt'. 'He said yes, it came with one so I always use it.' . . . Goal . . . He wants to continue to use the seat belt, opened and closed per resident. . . ." The daily care card failed to address the Resident's use of the electric wheelchair seatbelt, and the current care plan fails to implement interventions or staff direction on the use of the seat belt. Observation on 10/26/15 at 3:42 p.m. showed Resident #6 seated in his electric wheelchair in	F 221		

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F 221	Continued From page 3	F 221		

the lounge. A seat belt was fastened around Resident #6's waist.

Observation on 10/26/15 at 5:39 p.m. showed Resident #6 seated in his electric wheelchair at the dining room table. A seat belt was fastened around Resident #6's waist.

Observation on 10/27/15 at 8:45 a.m. showed a staff nurse (#2) applied cream to Resident #6's bilateral knees in a treatment room. Resident #6 was seated in his electric wheechair with a seat belt fastened around his waist.

Observation on 10/28/15 at 7:45 a.m. showed Resident #6 seated in his electric wheelchair at the dining room table. A seat belt was fastened around his waist.

During an interview on 10/27/15 at 1:30 p.m., an administrative nurse (#6) stated there was no restraint assessment done on Resident #6.

- Review of Resident #19's medical record occurred on all days of survey. Resident #19's daily care card and current care plan failed to identify the use of a velfoam belt.

Observation on 10/26/15 at 9:00 a.m. showed Resident #19 self propelling herself in her room while seated in an electric wheelchair. A velfoam belt was fastened around the resident's thighs.

Observation on 10/29/15 at 8:55 a.m. showed Resident #19 in the lounge seated in her electric wheelchair. A velfoam belt was fastened around the resident's thighs.

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F 221	Continued From page 4 During an interview on 10/29/15 at 9:45 a.m., an administrative nurse (#6) stated she was unaware Resident #19 was using a velfoam and it was not on the resident's care card. She stated there was no assessment done for the use of the velfoam belt. The facility failed to assess, care plan, and provide direction for the use of seat belts and velfoam belts to ensure the residents' safety.	F 221		
F 281	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of professional reference, review of facility policy, and staff interview, the facility failed to follow professional standards of practice regarding medication administration for 2 of 2 supplemental residents (Resident #31 and #32) observed during medication pass. Failure to ensure accurate transcription of medication orders may result in medication errors and adverse drug reactions. Findings include: The Geriatric Medication Handbook, 7th ed., American Society of Consultant Pharmacists, page 148, stated, ". . . Steps of Medication Administration . . . Medication administration record (MAR) verified with medication label information . . ."	F 281	1. What corrective action will be accomplished for those residents affected by the deficient practice; For residents #31 and #32 the medication cassettes were checked to the physician order and the eMAR was changed to match the order and med cassette. 2. How will you identify other residents having the potential to be affected by the same deficient practice; Although the mentioned residents did not result in a medication error all residents have that receive medication have the potential to have a medication error. 3. How the deficiency will be corrected;	12/3/15

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F 281	Continued From page 5 Review of the facility policy titled "Medication Administration" occurred on 10/29/15. This policy, revised March 2013, stated, ". . . If an order is incomplete or unclear, the nurse will contact the Health Care Provider and obtain clarification. . . . Proper steps for identification of medication and identification of resident must be carried out each time medications are administered. . . . 2. Right medication 3. Right dosage . . . 5. Right time . . ." - Review of Resident #31's medical record occurred on 10/26/15. The current physician's orders for ibuprofen, as well as the October MAR, stated, "Give 200 mg [milligrams] by mouth two times a day for pain Take 2 tablets by mouth twice a day." Observation of medication pass occurred on 10/26/15 at 4:18 p.m. A certified medication aide (CMA) (#7) administered two 200 mg ibuprofen tablets to Resident #31, for a total of 400 mg. The medication label identified, "Take 2 tablets (400 mg) BID [twice per day]." The staff member failed to seek clarification regarding the discrepancy between the physician order, the MAR, and the medication label. - Review of Resident #32's medical record occurred on 10/26/15. The current physician's orders, as well as the October MAR, identified, "Combivent Aerosol 18-103 mcg/act [micrograms per actuation] (Ipratropium-Albuterol) [a bronchodilator] 1 inhalation inhale orally four times a day" and "Simethicone [used to relieve gas pain] Tablet Give 80 mg by mouth four times a day."	F 281	All residents med cards were reviewed and compared to the eMAR by a nurse. Nurses and CMAs were educated to read and compare med cassettes to the eMAR. Nurses and Unit Clerks were educated to carefully select the right medication in the computer when inputting orders into the computer. 4.How does the facility plan to monitor its performance to ensure solutions are permanent; A QAPI will be completed monthly x 2 and quarterly and will be monitored by the Unit Director and Director of Resident Services.	

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F 281	Continued From page 6 Observation of medication pass occurred on 10/26/15 at 4:25 p.m. A CMA (#7) administered Combivent and simethicone to Resident #32. The dose on the Combivent package identified 20-100 mcg/act, not 18-103 mcg/act as identified on the physician's orders/MAR. The medication label for the simethicone identified, "Take 1 tablet PO [by mouth] after meals and at bedtime." The CMA stated Resident #32 ate supper around 5:00 p.m. The physician's order/MAR failed to identify if the resident should take the simethicone after meals. The CMA failed to seek clarification regarding the discrepancy between the Combivent doses and the Simethicone administration times. During an interview on 10/28/15 at 4:50 p.m., a supervisory nurse (#6) identified Combivent is not available in that dose anymore, and the order "should have been clarified."	F 281		
F 309	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide the necessary care and services	F 309	1. How the corrective action will be accomplished for those residents found to have been affected by the deficient	12/3/15

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F 309	Continued From page 7 regarding an AV (arteriovenous) fistula or graft for 2 of 3 sampled residents (#20 and #22) receiving dialysis. Obtaining residents blood pressure readings from the arm the graft/fistula may compromise the integrity of the fistula/graft, resulting in damage and delayed dialysis treatment. Findings include: Review of the facility policy titled "Nursing Care Protocols and Resident Assessment Guidelines" occurred on 10/29/15. This policy, dated, November 2014, stated, ". . . Dialysis Care . . . Take BP [blood pressure] in opposite arm of shunt placement . . ." - Review of Resident #20's medical record occurred on October 28-29, 2015. Medical diagnoses included chronic kidney disease dependent on renal dialysis. Resident #20's orders stated, ". . . Fistula can be used starting April 20th . . . Palpate thrill of right arm fistula daily. . ." The current care plan stated ". . . needs dialysis (3 times/week) R/T [related to] Renal Failure . . . Obtain full set of vital signes daily . . ." Observation on 10/28/15 at 4:35 p.m. in Resident #20's room showed a sign above the resident's bed which stated "No lab draws or BP taken on right arm." Review of Resident #20's electronic weekly blood pressure record identified staff actually performed BP checks on the right arm 34 times from April 2015 to October 2015. - Review of Resident #22's medical record occurred on October 28-29, 2015. Medical	F 309	practice: Resident #20 is cognitively intact and oriented. When asked if staff are taking blood pressures on the right arm she stated a BP has never been taken on the right arm and that she would tell them not to, if they tried. Resident #22 is not able to verify that a BP has been taken in the left arm as she is confused. However nurses were interviewed and all are aware the resident has a shunt in her left arm and have not taken a BP in the arm. Neither of these residents have needed shunt replacement since initial placement. All indicators show that we are not taking BPs in the dialysis arm, but that we are documenting incorrectly in the medical record. Resident #20 and #22 had the correct arm to take BPs (#20 right arm and #22 left arm) added to their care card and care plan. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice; All dialysis residents who have shunt placement in the arm could be affected. 3. How the deficiency will be corrected; All nursing staff will be re-educated on the care and safety of resident with a dialysis shunt. 4. How does the facility plan to monitor its performance;	

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F 309	Continued From page 8 diagnoses included End Stage Renal Disease. Resident #22's current care plan identified ". . . Focus: . . . needs dialysis R/T [related to] Renal Failure; fistula to left arm. Dialysis 3 times a week as scheduled. . . . Interventions: . . . Do not draw blood or take BP [blood pressure] in arm with graft. . . ." Observation in Resident #22's room showed a sign above the resident's bed which stated "No blood pressures or blood draws taken from left arm." Review of Resident #22's electronic weekly blood pressure record identified staff actually performed BP checks on the left arm 12 times from February 2015 to October 2015. During an interview on 10/29/15 at 10:45 a.m., an administrative staff member (#5) stated she expected staff to not take blood pressure readings from the arm with the fistula or graft.	F 309	A QAPI will be completed monthly x 2 and quarterly. This monitoring will be completed by Unit Directors and Director of Resident Services.	
F 431	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 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	F 431		12/3/15

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F 431	Continued From page 9 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 professional reference, and staff interview, the facility failed to ensure secure storage of controlled medications in 1 of 6 medication rooms (Southeast Unit). Failure to ensure Schedule II narcotics are stored securely may result in drug diversion or unauthorized access to these medications. Findings include: Wolters, Kluwer, Nursing 2015 Drug Handbook, Philadelphia, Pennsylvania, page 1071, stated, ". . . oxycodone hydrochloride-acetaminophen [Percocet] . . . Therapeutic class: Opioid analgesics . . . Controlled substance schedule: II	F 431	1. What corrective action will be accomplished for those resident affected by the deficient practice; No residents were affected by the deficient practice 2. How will you identify other residents having the potential to be affected; Not Applicable 3. How the deficiency will be corrected; A locked box(mail box type) was installed	

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F 431	Continued From page 10 . . ." Observation in the Southeast Unit medication room occurred on 10/28/15 at 10:56 a.m. with a staff nurse (#1). The nurse used a key to unlock the medication room. Observation showed several multi-dose packages of medication on the counter, including a package of 25 Percocet pills (not double-locked). The nurse identified the pills belonged to a new resident admitted that morning, and the pharmacist would come to repackage the medications. Failure to ensure Schedule II narcotics remain double locked may result in drug diversion or unauthorized access to these medications.	F 431	in each med room. These locked boxes will be used for Schedule II medications that need to be sent to pharmacy for re-carding or re-labeling, when pharmacy delivers meds to unit on med day or when pharmacy fills a new order. Keys will be kept by pharmacy and the unit charge nurses. Policy and procedure was updated. CMAs and Nurses will be educated on the new policy. 4. How does the facility plan to monitor its performance; A QAPI will be completed monthly x 2 and quarterly and will be monitored by the Unit Director and Director of Resident Services.	
F 441	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	F 441		12/3/15

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F 441	Continued From page 11 (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to provide a safe, sanitary environment and adhere to infection control practice for 1 of 1 sampled resident (Resident #4) with MRSA (Methicillin-resistant Staphylococcus aureus). Failure to follow infection control practices related to equipment shared with other residents has the potential to cause or spread infection (MRSA) within the facility. Findings include: Review of the facility policy titled "Isolation" occurred on 10/29/15. This policy, dated June 2013, stated, ". . . Contact Precautions . . . use	F 441	1 How corrective action will be accomplished for those residents found to have been affected by the deficient practice; Resident #4 was not affected by the deficient practice. 2. How the facility will identify other residents having the potential to be affected; All residents in the facility have the potential to be affected by the practice. 3. How the deficiency will be corrected;	

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	355059	A. BUILDING _____ B. WING _____	10/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 441	Continued From page 12 contact precautions for residents known or suspected to be infected with infectious agents that need extra control measures to prevent transmission by either direct or indirect contact with the resident or resident's environment. This includes Multi Drug Resistant Organisms such as MRSA . . . 5. Keep equipment in the resident's room and do not reuse on other residents until resident is done with isolation, such as BP [blood pressure] cuffs, stethoscopes . . . 6. . . . the supplies needed for the resident will be kept in the resident's room . . ." Review of Resident #4's medical record occurred on all days of survey. Diagnoses included peripheral vascular disease, unstageable pressure ulcers and arterial ulcers of bilateral feet and ankles, MRSA of lower extremity wound infections. Resident #4 is on contact isolation for MRSA infection of the wounds. Observation on 10/27/15 at 10:21 a.m. showed a certified nurse aide (CNA) (#3) enter Resident #4's room and removed the mechanical stand lift from the bathroom. Observation showed an egg crate cushion on the bottom foot platform used specifically for Resident #4's bilateral lower extremity wounds. The CNA wheeled the lift outside of the room and used disinfectant wipes to sanitize the metal surfaces of the mechanical stand lift. The CNA (#3) then took the stand lift with Resident #4's egg crate into another resident's room. The CNA (#3) failed to disinfect the mechanical stand lift before leaving the room and failed to leave Resident #4's egg crate in the contact isolation room. During an interview on 10/27/15 at 11:15 a.m., a	F 441	All nursing staff will be in-serviced on contact isolation protocols. 4. How does the facility plan to monitor its performance; A QAPI will be completed monthly x 2 and quarterly and will be monitored by the unit director and Director of Resident Services	

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F 441	Continued From page 13 staff nurse (#2) stated Resident #4's "egg crate should not leave the resident's room because he is on contact isolation." During an interview on 10/28/15 at 4:45 p.m., an administrative staff member (#4) stated staff are not to remove personal equipment from Resident #4's room.	F 441		