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 _____	01/13/2011

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 January 10, 2011 and completed on January 13, 2011, the sample included five (5) residents for complete review, twenty-two (22) residents for focused review, and three (3) closed records for review. The sample included eight (8) additional residents to verify specific concerns during the survey.	F 000	F225 **How corrective action will be accomplished for those residents affected by the deficient practice:** Resident # 19 is unable to recall how her 5th metatarsal was fractured. Resident has a diagnosis of Alzheimers/Dementia. The nurse completing the physician's orders was reinstructed on incidents of unknown origin and the necessity of completing an incident report and investigating the incident. Nurse verbalizes understanding of MSLCC policy. **How will the facility identify other residents having the potential to be affected by the same deficient practice;** All residents in the facility who need assistance with cares have the potential to receive an injury of unknown origin and be a victim of abuse or neglect. **What measures we have put in place or systemic changes we have made to ensure that the deficient practice does not recur:** Nurses will be in-serviced on February 10, 2011 on MSLCC policy of completing an Incident Report when they become aware of an injury of unknown origin and investigating for possible abuse and reporting as stated in the MSLCC abuse policy. **Monitoring we have put in place to ensure deficient practices will not recur;** A CQI will be completed by the Unit Directors monthly for 3 months then quarterly x 3. CQI will be monitored by the Director of Resident Services.	2-17-11
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.	F 225		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Robert Thompson MSLCC | TITLE: President/CEO | (X6) DATE: 2-3-11

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 225	Continued From page 1 The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, review of policy and procedure, and staff interview, the facility failed to ensure all investigations of injuries were reported to the administrator or his designated representative, for 1 of 6 sampled residents with injuries of unknown origin (Resident #19). Failure to investigate and report this incident did not allow the facility to determine causative factors of this incident, implement corrective action, and placed facility residents at risk for potential injury. Findings include: Review of the facility's policy and procedure, Prohibition of Abuse, Neglect, or Misappropriation of Property, occurred on 01/13/11. This document, revised 09/21/10, stated "POLICY, MSLCC [Missouri Slope Lutheran Care Center] supports the residents' right to be free of abuse, neglect . . . IV. INVESTIGATION/DOCUMENTATION, All incidents of injury are reported, investigated and documented on the Accident Report. . . . The Incident Report will serve as the notice to the Administrator, Director of Social Services and Director of Human Resources in cases of non-serious injury to the resident . . .	F 225		

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F 225	Continued From page 2 PROCEDURES . . . I. INCIDENTS OF ALLEGATIONS OF ABUSE, NEGLECT , MISAPPROPRIATION OF PROPERTY INVOLVING RESIDENTS A. REPORTING, 1. The reporter immediately reports the incident to the nurse in charge of the resident's care. B. RECORDING OF INCIDENT 1. Any report of abuse, neglect or misappropriation of property must be documented on blue Incident Report and investigated. 2. Any occurrences of injury to a resident will be documented on a white Accident Report by the reporter of the incident and/or charge nurse. If abuse or neglect is suspected at any point in the review process a blue Incident Report will be completed. 3. Charge Nurse/Immediate Supervisor investigates and documents all details of investigation on the blue Incident Report form. 4. All white Accident Reports will be routed to: Unit Director, Director of Resident Services and Director of Staff Development for review to assure identification of abuse or neglect. . . . E. INVESTIGATION 1. The Charge Nurse/Unit Director/Dept. [Department] Director immediately conducts the investigation by interviewing all persons having information about the situation such as staff, residents, visitors, family members, and reviewing any pertinent documentation. . F. INCIDENT RECORDS 1. Completed Incident/Investigation Reports will be filed in the Staff Development Office. ."	F 225		

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F 225	Continued From page 3 - Review of Resident #19's medical record occurred on January 12-13, 2011. The facility admitted the resident in 04/10. The resident's current diagnoses included glaucoma and history of fracture of the left fifth metatarsal. The resident's current quarterly MDS, dated 09/30/10, identified short term memory problems, no long term memory problems, falls, and fractures other than hip fractures in the past 180 days. The admission MDS, dated 04/07/10, identified limited assistance of one person for walking in room, in corridor, on, and off her living unit. The resident's Resident Assessment Protocols (RAPS) and Nurse's Notes identified falls on 04/30/10, 08/15/10, and 12/03/10. The Nurse's Notes did not include complaints of foot pain by Resident #19. Resident #19's Nurse's Notes identified an appointment with a podiatrist, on 06/08/10, regarding trimming of callouses on her feet. The podiatrist's visit note identified tenderness in the left foot and x-rays showed a fracture of the fifth metatarsal. Resident #19 returned to the facility in a soft brace and used a walker for approximately one month. Resident #19 experienced a fracture without an associated fall or other injury. Resident #19's medical record lacked information the facility staff investigated the origin of the fracture, including the possibility of abuse. During interviews, on 01/13/11 at 10:00 a.m., a social work staff member (#13) and a supervisory nursing staff member (#14) reported they recalled completing the Incident Report after identification of Resident #19's fracture but lacked any	F 225		

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F 225	Continued From page 4 documentation of the report. These staff members reported no record of the Incident Report in the facility's monitoring system. It is unknown what happened to the Incident Report as reported by staff members (#13) and (#14). The facility did not provide a record of an investigation regarding this fracture. Failure to investigate Resident #19's fracture and report it to the administrator and other responsible parties, as identified in the facility's policy and procedure, did not allow the facility staff to determine any causative factors for this incident; determine if corrective action was appropriate; implement any appropriate corrective action; track and trend this incident to determine any pattern or frequency; and, determine the possibility of abuse. This failure placed Resident #19 at continued risk and all facility residents at risk of potential injury or abuse.	F 225		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, review of policy and procedure, and staff interview, the facility staff failed to provide care for 5 of 27 sampled residents (Resident #5, #8, #9, #17, and #21) and 7 supplemental residents (Resident #31, #32, #33, #34, #35, #36, and #37) in a manner and in an environment that maintained or enhanced each resident's dignity and respect in full	F 241	**F241** **How corrective action will be accomplished for those residents affected by the deficient practice;** Dietary supervisors and charge nurses were informed of deficient practice with feeding and to give reinstruction to CNAs who are scraping residents faces while assisting them to eat. Charge nurses and dieticians supervise in the dining rooms during meals. Resident #5 resides in a private room and asks that bathroom door does not be closed, but has agreed to allow door to corridor be closed while she is in the bathroom.	

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F 241	Continued From page 5 recognition of their individuality regarding scraping of food material from residents' faces, returning the food to the dish, and continuing to feed the residents (Resident #8, #31, #32, #33, #34, #35, and #36) during 3 of 6 meal observations; failed to close the resident room and bathroom doors to allow privacy during toileting (Resident #5); failed to provide privacy during administration of insulin injections (Resident #21 and #37); failed to provide privacy during bathing (Resident #9); and, failed to wait for permission to enter a resident's room during cares after knocking (Resident #17). These facility practices failed to enhance the residents' dignity, self esteem, or self worth and failed to recognize their individuality. Findings include: Review of the policy and procedure, CNA (Certified Nursing Assistant Routine Care for Residents), occurred on 01/13/11. This document, revised 08/06, stated "Each of the following is part of the routine care provided by the Nursing Assistants, unless otherwise directed. . . . Basic Nursing Care Procedures: . . . 4. Treat each resident with dignity and respect always. 5. Knock and identify yourself upon entering the room. Give resident time to respond. 6. Provide privacy during all care. . . . Feeding . . . E. . . . Do not re-feed drooled food. . . . " - Observation during the breakfast meal on 01/11/11 at 8:55 a.m., showed a CNA staff member (#9) assisting Resident #8 with the meal. The staff member fed the resident hot cereal with	F 241	Nurse who did not provide privacy for residents with insulin injections was given reinstruction. Staff who are knocking and failing to wait for permission before entering will be addressed when it is noticed by mentor CNAs, charge nurses and nurse managers. **How will the facility identify other residents having the potential to be affected by the same deficient practice;** All residents in the facility have the right to privacy especially when cares are being provided to them. **What measures we have put into place or systemic changes we made to ensure that the deficient practice will not recur:** Staff were in-serviced at the unit behavior meetings on January 18,19,21,27 and 28. Mentor CNAs were in-serviced on January 26, 2011 and informed to reinstruct staff as they become aware of issues of dignity or privacy. CNA staff will be in-serviced at the meeting on February 3, 2011. **Monitoring we have put into place to ensure practice does not recur:** A CQI will be completed monthly x 3 months then quarterly for residents dignity with assisted feeding. This CQI will be completed by dietary supervisors, and charge nurses who currently supervise during meal time. A CQI will be completed monthly x 3 months then quarterly on nurses providing privacy when checking blood sugars and giving insulin. This CQI will be completed by Nurse Managers and the Director of Resident Services. A CQI will be completed monthly x 3 then quarterly for resident privacy. This CQI will be completed by Mentor CNAs. **All CQIs will be monitored by the Director of Resident Services**	2-17-11

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F 241	Continued From page 6 a spoon, scraped food from around the resident's mouth, returned it to the bowl, and continued to feed the resident cereal from the bowl. - Observation of meal service in the Fireside Dining Room identified the following incidents of CNA staff members scraping food material from residents' faces, returning the food to the dish, and continuing to feed the residents from the dish: *01/11/011, 8:00 a.m. - CNA (#10) feeding Resident #31. - CNA (#9) feeding Resident #32. *01/11/11, 11:45 a.m. - CNA (#9) feeding Resident #33. - CNA (#10) feeding Resident #34. *01/12/11, 12:00 noon - CNA (#9) feeding Resident #35. - Observation on 01/12/11 at noon, showed CNA (#1) feeding Resident #36, scraping the resident's mouth after each bite, dipping the spoon with the scrapings into the bowl of food, and re-feeding the resident food scraped from her mouth. - Observation of Resident #9 receiving a tub bath with assistance from CNA (#11) on 01/12/11 at 10:38 a.m., showed the privacy curtains partially drawn. An unidentified licensed nursing staff member (#12), knocked, identified him/herself, was granted permission to enter, and entered to use the toilet room in the bathing area. After using the toilet, the staff member (#12) washed their hands at the sink in the bathing area, and left the bathing area. Resident #9 could be seen by the staff member (#12). During interviews on 01/13/11 at 1:30 p.m. a social work staff member (#13) and a supervisory	F 241		

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F 241	Continued From page 7 nursing staff member (#14) agreed scraping food material from residents' faces and re-feeding to residents is not an acceptable practice. These staff members also reported facility staff should have used the toilet room designated for staff when Resident #9 used the bathing area. - Observation on 01/10/11 at 4:40 p.m. showed a nursing staff member (#5) checked Resident #21's blood glucose in the west activity room within visual view of other staff, family members, and other residents in the adjacent lounge area. At 4:50 p.m. the staff member (#5) checked Resident #37's blood glucose and administered insulin in the resident's abdomen in the same west activity room within view of other staff, family members, and residents in the adjacent lounge area. During an interview on 01/13/11 at 9:10 a.m., an administrative staff member (#8) stated she expected nursing staff to check resident's blood glucose and administer insulin in a private area without other people around. - Observation on 01/11/11 at 8:45 a.m. showed two CNAs (#6 and #7) assisted Resident #5 with toileting. On 01/11/11 at 12:20 p.m. observation showed a CNA (#6) assisted Resident #5 with toileting. During both observations the staff members failed to close both the resident's bathroom door and the door opening to the corridor. When both doors remained open during toileting, the resident was visible from the corridor. Resident #5 resided in a private room. During an interview on 01/12/11 at 10:45 a.m., an administrative staff member (#8) stated she expected staff to close the door to the corridor	F 241		

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F 241	Continued From page 8 when toileting residents. - Observation of a CNA (#16) assisting Resident #17 to transfer from the wheelchair to the bathroom with the standing lift occurred on 01/11/11 at 10:45 a.m. Observation showed another staff member (#17) knocked on the resident's door and immediately walked into the room without announcing him/herself and without waiting for the resident and/or other staff member to indicate he/she could enter the room. During interview, on 01/13/11 at 3:30 p.m., an administrative nursing staff member (#4) agreed scraping food material from residents' faces and re-feeding to residents, administering injections in view of others, failure to close the doors during toileting, staff use of the toilet in the bathing area while a resident was bathed, and failure to wait for permission to enter a room were not acceptable practices and should not have been done by facility staff.	F 241		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, review of professional literature, and staff interview, the facility failed to provide services in accordance with professional standards of quality for 1 of 2 sampled residents with an indwelling catheter (Resident #8). Failure to ensure the resident's indwelling catheter remained a closed system placed the resident at risk for urinary tract infections.	F 281	F281 **What corrective action will be accomplished for those residents affected by the deficient practice;** The catheter for Resident #8 was corrected by the charge nurse immediately when it was noticed. The resident was followed by hospice at the time of the incident and had no negative outcome or skin breakdown from the incident. Day caregiver verbalizes understanding of which port to connect tubing when hooking a new bag and demonstrates understanding. Incident may have been human error.	

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F 281	Continued From page 9 Findings include: Berman, Snyder, Kozier, and Erb, "Fundamentals of Nursing, Concepts, Process and Practice," 8th edition, Pearson - Prentice Hall, New Jersey, page 1304, states ". . . Retention catheters . . . consists of the catheter, drainage tubing, and a collecting bag for the urine. A closed system cannot be opened anywhere along the system, from catheter to collecting bag. Closed systems reduce the risk of microorganisms entering the system and infecting the urinary tract. . . .;" and, page 1309, states "PRACTICE GUIDELINES, Preventing Catheter - Associated Urinary Infections . . . Maintain a sterile closed - drainage system. Do not disconnect the catheter and drainage tubing unless absolutely necessary. . . ." Review of Resident #8's medical record occurred on January 10-13, 2011. The facility admitted the resident in 10/07. Current diagnoses included Alzheimer's disease, dementia with behaviors, benign prostatic hypertrophy, chronic urinary tract infection with indwelling catheter, and urinary retention. The resident's current Significant Change Minimum Data Set (MDS), dated 12/30/10, identified short and long term memory problems, severely impaired cognitive status, required extensive to total assistance of one or two persons for activities of daily living, and had an indwelling catheter. Resident #8's current care plan, dated 12/31/09 and updated 03/19/10, stated "Problem . . . Chronic bacturemia [sic] [bacteria in the urine], do not tx [treat], asymptomatic - only [with] prolonged c/o [complaints] . . . Approaches . . . Change the catheter monthly and p.r.n. [as needed] and	F 281	**How will the facility identify other residents having the potential to be affected by the same deficient practice;** All residents who have a urinary catheter may be at risk for this deficient practice. **What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:** CNAs will be in-serviced on catheter care on February 3, 2011 at the CNA meeting. **Monitoring we have put into place to ensure practice does not recur;** A CQI will be completed quarterly by the unit mentors. CQI will be monitored by the Director of Resident Services.	2-17-11

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F 281	Continued From page 10 irrigate it as ordered. . . ." Resident #8's current physician orders included to change the catheter monthly "on the 12th" and prn; and, to irrigate the catheter weekly and prn. Resident #8's Nurse's Notes, dated 11/04/10 at 5:00 p.m., stated "Resident's catheter was improperly hooked up. Tubing was attached to wrong port. Resident's clothing was completely saturated with urine. Bag and tubing appear to be new. No record of cath [catheter] being changed." The medical record lacked any additional information regarding this incident. During interviews, on 01/13/11 at 10:00 a.m., a social work staff member (#13) and a supervisory nursing staff member (#14) reported it was unknown how the resident's catheter was improperly attached or by whom. The improper attachment of Resident #8's catheter tube resulted in his bed saturated in urine for an undetermined period of time; and resulted in the indwelling catheter system being open to potential contaminants placing the resident at increased risk of additional urinary tract infections. Resident #8's history and diagnoses of chronic urinary tract infections and bacteremia placed him at increased risk of illness. Failure to ensure Resident #8's indwelling catheter remained a closed system placed him at increased risk of additional urinary tract infections and illness. The circumstances of this incident, including when the catheter was changed, by whom, and how the tubing came to be improperly attached, were unknown to the facility staff. Lack of information regarding this incident placed	F 281		

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F 281	Continued From page 11 Resident #8 and all residents at risk of similar incidents occurring and limited the facility's ability to implement corrective action.	F 281		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of policy and procedure, and staff interview, facility staff failed to provide the necessary services to maintain good oral hygiene for 1 of 1 sampled resident care planned to receive oral care after each meal (Resident #9). Failure to provide oral care may have resulted in previous tooth decay and placed the resident at risk of additional tooth decay, tooth loss, pain, and limited oral intake. Findings include: Review of the policy and procedure, Oral Hygiene Policy, occurred on 01/13/11. This document, revised 09/06, stated "Policy: Residents will receive oral hygiene in the AM [morning], PM [afternoon/evening] and prn [as needed]. . . ." Review of the policy and procedure, CNA [Certified Nursing Assistant] Routine Care for Residents, occurred on 01/13/11. This document, revised 08/06, stated "Each of the following is part of the routine care provided by the Nursing Assistants, unless otherwise directed. . . .	F 312	F312 **What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** Resident # 9 oral cares will be monitored by the charge nurse that they are completed after meals as stated on the plan of care. **How will the facility identify other residents having the potential to be affected by the same deficient practice;** All residents who are dependent on staff for ADL cares have the potential to be affected by this deficient practice. **What measures will be put into place or systemic changes made to ensure the deficient practice rill not recur;** CNA staff will be in-serviced on February 3, 2011. **Monitoring we have put in place to ensure practice does not recur;** A CQI will be completed monthly x 3 then quarterly by the CNA mentors and charge nurses. CQI will be monitored by the Director of Resident Services.	2-17-11

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	355059	A. BUILDING _____ B. WING _____	01/13/2011

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

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F 312	Continued From page 12 Basic Nursing Care Procedures: . . . 2. Read resident care card daily. . . Oral Cares, A. Give oral hygiene AM, HS [hour of sleep] and prn. B. Assess oral membranes with oral cares and report concerns to nurse. . . ." Review of Resident #9's medical record occurred on January 10-13, 2011. The facility admitted the resident in 04/07. Current diagnoses included dementia, dysphagia, and gastroesophageal reflux disease. The resident's current Significant Change Minimum Data Set (MDS), dated 11/15/10, identified short and long term memory problems, and required extensive assistance of one person for personal hygiene. Resident #9's Outpatient Referral Form, dated 04/14/10, signed by the resident's dental care provider, stated ". . . Findings: A lot of plaque and build-up along gumline. Diagnosis: Moderate decay, gingivitis. Physician's Orders: [Resident #9] needs a lot more help brushing his teeth. Pt.'s [Patient's] gums are very red, sore & [and] swollen and it appeared as though his teeth hadn't been brushed in months!" Resident #9's current Dental Care Care Area Assessment, dated 11/19/10, stated "Triggers: because [sic] he has quite a few of his own teeth lost and broken. . . . He is provided with or assisted with oral care daily as he will allow. He had cleaning on 04/14/10 refer to the Outpatient Referral Form for more specifics. . . . Dental condition had improved a lot, but now is not as good at this time. We will proceed with the plan of care, encouraging daily cares." Review of Resident #9's Daily Care Card (Care	F 312		

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F 312	Continued From page 13 Plan), attached to a clipboard in the resident's bathroom, occurred on January 11-13, 2011. This document, dated 08/02/10 and revised on 01/05/11, stated "General, Teeth: own - brush w/ [with] assist [assistance] after meals . . . Days . . . Personal Hygiene: Assist x [times] 1 - assist w/ brushing teeth after meals . . . PM's . . . Personal Hygiene: Assist x 1 - assist w/ brushing teeth after meals . . ." Observation of Resident #9 after meals identified the following: *01/11/11, 12:30 p.m. - The resident completed his meal and returned to the nurse's station lounge on his unit. 12:50 p.m. - CNA (#9) and (#15) transferred the resident to his bed, performed perineal cares, offered him water, which he accepted, positioned him on his right side, and left the room. The facility staff failed to provide or attempt to provide oral cares for Resident #9. *01/12/11, 8:25 a.m. -The resident completed his meal and returned to the nurse's station lounge on his unit. 9:00 a.m. - The resident remained in the lounge until going to therapy at this time. 10:15 a.m. - The resident returned from therapy and returned to the nurse's station lounge. 10:30 a.m. - The resident received a tub bath and shave by CNA (#11) and did not receive oral cares. 10:57 a.m. - CNA (#9) and (#15) returned the resident to his room after the tub bath, transferred him to his bed, dressed the resident, transferred him to the wheelchair, provided him with soda at his request, and returned him to the lounge. The facility staff failed to provide or attempt to provide oral cares for Resident #9. *01/12/11, 1:00 p.m. - CNA (#9) and (#15)	F 312		

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F 312	Continued From page 14 returned the resident from the nurse's station lounge to his room, transferred him to his bed, performed perineal cares, provided soda at his request, and left the room. The facility staff failed to provide or attempt to provide oral cares for Resident #9. The surveyor requested the facility staff to inform the surveyor if they provided resident cares not observed by the surveyor. The facility staff did not report any oral cares provided. During interviews on 01/13/11 at 1:30 p.m. with a social work staff member (#13) and a supervisory nursing staff member (#14) and at 3:30 p.m. with an administrative nursing staff member (#4), these staff members reported their expectation is that facility staff would attempt to provide oral cares for Resident #9 after every meal, as identified on his care card/care plan.	F 312		
F 431 SS=D	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 instructions, and the expiration date when applicable. In accordance with State and Federal laws, the	F 431	F431 **What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** No specific residents were harmed by this practice. **How will the facility identify other residents having the potential to be affected by the same deficient practice;** All residents who may need the medications from the emergency medication boxes or may need biologicals from the crash cart may be affected by the deficient practice.	

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F 431	Continued From page 15 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 facility policy, and review of professional reference, the facility failed to store and maintain drugs and biologicals according to facility policy and current professional principles for 1 of 2 emergency medication boxes (located on the North East unit) and 1 of 1 medical crash cart (located on the North Central unit). Storage and use of medications beyond the recommended expiration date has the potential to affect the efficacy and/or potency of the medication. Findings include: The Centers for Medicare and Medicaid Services (CMS) has outlined the standards of practice regarding the labeling and storage of drugs and biologicals. . . . Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and	F 431	**What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;** The Supply person who had signed the form that she had checked expiration dates was given corrective action. The items on the crash cart were reviewed to make sure those were still needed on the cart as well as the form updated to make it easier to understand and follow. Pharmacy had developed a form for the pharmacy technician to follow when she is restocking and will now be checking for expiration dates monthly. **Monitoring we have put in place to ensure practice does not recur;** A CQI will be completed quarterly by the Director of Environmental Services on the expiration dates on the biologicals on the crash cart. A CQI will be completed quarterly by the pharmacist on the expiration dates on the medications in the emergency med boxes.	2-17-11

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F 431	Continued From page 16 include the appropriate accessory and cautionary instructions, and the expiration date when applicable. Medication labeling identifies, at a minimum, the medication's name, . . . expiration date when applicable. Review of the facility policy titled, "Medications - Dispensing, Storage and Labeling" occurred on 01/13/11. This policy, not dated, stated, "Policy: . . . attempt to to safely provide medications to residents. Procedure: . . .8. medications are regularly inspected for expiration dates and are not used beyond the date of expiration, the medication is removed from the medication room and either returned to the pharmacy or destroyed in house under proper authority of the Pharmacist Consultant. . . ." Review of the facility policy titled, "Emergency Pharmacy service and Emergency Box" occurred on 01/13/11. This policy, not dated, stated, " . . . Procedures: . . . g. The emergency boxes are inventoried by the primary provider . . . every 30 days for completeness and expiration dates of the contents." - Observation of the North East unit emergency medication box occurred on 01/12/11 at 9:30 a.m. The emergency medication box contained medications, packaged by the pharmacy, with expiration dates as follows: * Vitamin K injectable 10 mg/ml (milligrams/milliliter] - expiration date December 1, 2010. * Teargen - expiration date November 2010. * Bacteriostatic 0.9% normal saline - expiration date December 1, 2010. * Heparin lock flush, 100 USP (United States Pharmocopeia) units/ml - expiration date	F 431		

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F 431	Continued From page 17 November 1, 2010. * Albuterol 0.5 % inhalation solution - expiration date November 2010 * Ceftriaxone 1 gram - expiration date December 2010. - Observation of the crash cart on the North Central unit, on 01/12/11 at 9:45 a.m. showed 4 bottles (250 ml each) of normal saline. Two of the bottles had an expiration date of March 2010, and the other two bottles had an expiration date of August 2010.	F 431		
F 465 SS=F	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure a safe and sanitary environment for residents, staff, and the public regarding the lack of anti-siphon backflow valves on hand held hoses in two separate locations in the facility (one in the laundry and one in the special care unit.) Failure to ensure anti-siphon backflow valves were in place created the potential for siphoning contaminated water into the potable (drinking) water system in the event of loss of water pressure causing widespread contamination of the facility and community water system. Based on review of the North Dakota Department of Health, Division of Health Facilities provider	F 465	F465 **What corrective action will be accomplished for those residents found to have been affected by the deficient practice;** No specific residents were identified to be harmed by this practice. **How the facility will identify other residents having the potential to be affected by the same deficient practice;** All residents in the facility have the potential to be affected by the potential of siphoned contaminated water into the potable water system.	

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F 465	Continued From page 18 files, this facility has not sustained correction of this issue. This requirement was found to be out of compliance during the previous survey completed on 11/01/07. Findings include: During the environmental tour, on 01/12/11 at 2:30 p.m., observation identified hand held hoses in the following locations: *Special Care Unit, Soiled Utility Room - at the utility sink and at the bedpan cleaner. *Laundry, soiled linen sorting room - at the utility sink. These hoses were long enough to potentially rest on the bottom of the respective sinks and cleaner. Observation failed to identify anti-siphon backflow valves on these hoses. A maintenance management staff member (#18) present during the tour was uncertain if the hose assemblies, which were of similar appearance, contained internal backflow devices. During interview, on 01/13/11 at 1:50 p.m., staff member (#18) reported disassembling one of the hose assemblies which confirmed the lack of an anti-siphon backflow device in the three hose assemblies.	F 465	**What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;** As of 1-20-11 anti-back flow devices have been installed on the three sinks in our 2003 additions listed in the deficiency. Nine other sinks, with similar set ups in our facility have been identified and confirmed that they have anti-back flow devices. **Monitoring the facility has put in place to ensure the deficient practice will not recur;** Anti-back flow devices have been installed and should not need any further follow up. In the future, if new sinks of this type are installed in our facility, the Director of Maintenance will ensure the anti-back flow devices are part of the installation.	2-17-11