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 _____	10/11/2012

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 10/08/12 and completed on 10/11/12, the sample included five (5) residents for complete review, 22 residents for focused review, and three (3) closed records for review. The sample included one (1) additional resident to verify specific concerns during the survey.	F 000		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to provide the necessary care and services to manage behavioral symptoms for 2 of 14 sampled residents (Resident #8 and #12) identified by the facility with behaviors and who received an as needed (PRN) psychotropic medication. Failure to identify target behaviors, assess the reason/causative factor(s) for behaviors, and establish accurate on-going monitoring of the behaviors has the potential for these residents not to obtain their highest practicable physical, mental, and psychosocial well-being. Findings include:	F 309	F309 **How corrective action will be accomplished for those residents affected by the deficient practice:** Resident #8 was started on behavior mapping on Oct. 15, 2012 for seven days. Adjustments were made to resident's plan of care for staff to try. Behaviors have improved since medication adjustments were made on Oct. 4,2012 and only needing prn Haldol two days since that time. Resident # 12 was started on behavior mapping on Oct. 15, 2012 for seven days. On Oct. 15 she was also admitted to hospice and expired on Oct. 31, 2012.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: President/CEO — (X6) DATE: 11-5-12

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 309	Continued From page 1 Review of the facility policy titled "PRN Medication Administration" occurred on 10/11/12. This undated policy stated, ". . . Procedure: 1. Nurse will assess the need for prn medications before administration. 2. Document alternative interventions tried prior to medication administration. 3. Nurse will assess effectiveness of medication and do appropriate follow-up. 4. Document all in the nursing progress notes." - Review of Resident #8's medical record occurred on all days of survey. Diagnoses included dementia and anxiety. The most recent Minimum Data Set (MDS), completed on 07/27/12, identified Resident #10 with severely impaired cognition, and the resident had behaviors, rejection of care, or wandering. Resident #8's current care plan, dated 09/02/12, stated, ". . . Focus: [Resident's name] has mood problem r/t [related to] Dementia, Anxiety, and Depression. She is a very worrisome person and can be difficult to get her to redirect her focus at times . . . Interventions . . . Administer medications as ordered. Monitor/document for side effects and effectiveness. . . . Encourage [Resident's name] to express feelings . . . Monitor/Document/Report to Nurse/MD [medical doctor] s/sx [signs and symptoms] of depression: . . . Monitor/Record mood to determine if problems seem to be related to external causes, i.e. [such as] medications, treatments, concern over diagnosis . . . Encourage and provide opportunities for exercise, physical activity . . ." Resident #8's physician ordered a consult with a psychiatrist on 09/13/12. The resident was seen	F 309	**How will the facility identify other residents having the potential to be affected by the same deficient practice;** All residents who have been identified as having behavior problems and a prn psychotropic medication may be affected by the deficient practice. **What measures we have put in place or systemic changes we have made to ensure that the deficient practice does not recur:** A phone message was put out for all nurses on Oct. 15, 2012 for nurses to document on any non-pharmacologic interventions they have tried as well as the effectiveness/ineffectiveness of the interventions and medication if given. A nurse meeting was held on October 23, 2012. Nurses were given an in-service by St. Alexius Hospice on interventions for the resident with Delirium. Nurses were again instructed on use of non-pharmacologic interventions and effectiveness/ineffectiveness of interventions and medications.	

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F 309	Continued From page 2 by a psychiatrist on 10/04/12 and the progress note stated, ". . . confused, paranoid, delusional, attn [attention] seeking . . . Med [medication] side effects. . . legs agitated since Risperdal and Haldol [an antipsychotic medication] . . .". The psychiatrist increased the Zoloft [antidepressant medication] and kept the current doses of Risperdal and Haldol. Review of medication orders showed the following medications ordered since July 2012: * Zoloft 50 milligrams (mg) ordered on 02/08/12, increased to 75 mg on 07/12/12, and increased to 100 mg on 10/04/12 * Lorazepam 0.25 mg daily at 6:00 p.m., ordered from 07/24/12 through 09/05/12 and Lorazepam 0.25 mg PRN ordered from 01/31/12 through 09/05/12 * Risperdal 0.25 mg in the morning ordered on 09/10/12 and increased to 0.5 mg on 09/19/12 * Risperdal 0.25 mg at 3:00 p.m. ordered 09/05/12, increased to 0.5 mg on 09/10/12, and to 0.75 mg on 09/19/12 * Risperdal 0.5 mg at 8:00 p.m. ordered on 09/13/12 * Exelon patch [an Alzheimer's medication], 4.6 mg/day on 08/29/12, and discontinued on 09/13/12 due to increased anxiety * as needed Haldol 0.25 mg ordered on 09/06/12, increased to 0.5 mg on 09/10/12, and to 1.0 mg on 09/19/12 Review of Resident #8's prn medication administration records (MARs) showed the following PRN doses of Lorazepam and Haldol received from 07/01/12 through 10/10/12: * July- Lorazepam administered 10 times with 3 doses documented as ineffective	F 309	Our Behavior Management Plan was updated and is kept in the Nursing Policy and Procedure Manual kept at the nurse's station for their reference. Bi-monthly Behavior Meetings will resume on all units in January 2013. Currently those meeting have been occurring on WestView (Dementia Unit) only. **Monitoring we have put in place to ensure deficient practices will not recur;** A CQI was conducted the week of Oct. 29, 2012 and will be completed monthly x 3 then quarterly. The compliance will be monitored by the Unit Directors and Director of Resident Services.	~~11/15/20~~ 11/15/12 Per Carlotta DON on 11/15/12 @ 1:30pm KB

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F 309	Continued From page 3 * August- Lorazepam administered 17 times with 2 doses documented as ineffective * September- Lorazepam administered 7 times with 3 doses documented as ineffective; 0.25 mg Haldol administered 7 times with 3 doses documented as ineffective; 0.5 mg Haldol administered 13 times with 7 doses documented as ineffective; and 1 mg Haldol administered 11 times with 3 doses documented as ineffective (total of 38 doses of prn psychotropic medications in September) * October- 1 mg Haldol administered 5 times with 2 doses documented as ineffective Resident #8's MARs identified 70 times facility staff administered PRN psychotropic medications from 07/01/12 through 10/10/12. Review of nurses notes identified 55 times the facility staff administered PRN psychotropic medications without evidence of non-pharmacological interventions attempted prior to administration. The nurses notes identified, for 23 doses documented as ineffective on the MAR, the facility failed to identify other interventions provided by staff for 17 of the 23 doses. During an interview on 10/10/12 at 7:50 a.m., an administrative nurse (#13) stated social services and nursing staff are responsible for tracking and trending behaviors and for charting prior nonpharmacological interventions tried before giving an as needed medication. This nurse stated if a medication is ineffective staff should be calling the doctor and documenting what else was tried during this time frame. The nurse (#13) also stated staff were providing one on one with Resident #8 during this time frame where medications were being adjusted related to her	F 309		

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F 309	Continued From page 4 increase in anxiety. During an interview on 10/10/12 at 11:00 a.m., a staff nurse (#15) stated when a resident has behaviors, facility staff should try nonpharmacological interventions and document this in the medical record. The nurse (#15) and two other nurses (#16 and #17) were not able to identify a place in the MAR where interventions are consistently documented. During an interview on 10/10/12 at 4:25 p.m., an administrative nurse (#13) confirmed Resident #8's medical record lacked evidence related to staff attempting nonpharmacological interventions prior to giving as needed psychotropic medications to Resident #8. - Review of Resident #12's medical record occurred on October 08-10, 2012. Diagnoses included congestive heart failure, insomnia, delusional disorder, Alzheimer's disease, dementia, and anxiety. Physician's orders included Ativan (an antianxiety medication) 0.25 mg every four hours PRN for shortness of breath and resistance with cares. Resident #12's quarterly MDS, dated 07/31/12, identified short and long term memory problems, rejected cares one to three days during the assessment period. and required extensive assistance for all activities of daily living (ADLs) except eating, which required supervision. Resident #12's current care plan stated: "Focus: [resident name] has rejection of care and yelling out r/t [related to] Dx. [diagnosis] of Anxiety, Delusional Disorder, Dementia and	F 309		

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F 309	Continued From page 5 Alzheimer's. . . . Interventions: Encourage as much participation/interaction by [resident name] as possible during care activities. Give clear explanation of all care activities prior to an [sic] as they occur during each contact. If [resident name] resists with ADLs, reassure resident, leave and return later when safe to do so and try again. Provide consistency in care to promote comfort with ADLs. Maintain consistency in timing of ADLs, caregivers and routine, as much as possible. Focus: [resident name] has mood problem r/t Dx. of Depressive Disorder, Anxiety State, Insomnia, and Delusional Disorder, psychosis feeling tired or having little energy and poor appetite. . . . Interventions: Administer medications as ordered . . . Monitor/record mood to determine if problems seem to be related to external causes, i.e. [such as] medications, treatments, concern over diagnosis . . ." Review Resident #12's MAR showed facility staff administered PRN Ativan 18 times in September 2012. Review of the resident's progress notes showed nursing staff documented once, 09/12/12 at 9:41 a.m., that non-pharmacological interventions were tried prior to the administration of the Ativan. During an interview on 10/10/12 at 11:25 a.m., an administrative nurse (#19) stated nurses are expected to document in the nurses notes the non-pharmacological interventions attempted prior to administering Ativan. The facility failed to identify behaviors, other than yelling, displayed by Resident #12, possible triggers/causes for the behaviors symptoms, and	F 309		

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F 309	Continued From page 6 interventions attempted prior to the administration of Ativan.	F 309		
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 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	F 441	F441 **How corrective action will be accomplished for those residents affected by the deficient practice;** Resident #7 had been on hospice services and expired on October 18, 2012. Staff had been instructed to change oxygen tubing if it falls to the floor. Resident #10 wheelchair cushion was sent to laundry to be cleaned properly and replaced on her chair. The nurse who had put the cream on the perineal area without properly cleaning was given job coaching and re-instruction. Resident #14 was not affected by the deficient practice however all other residents could be affected that the CNA comes in contact with because of infection control.	

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F 441	Continued From page 7 infection. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and review of facility policy/procedure, the facility failed to follow standards of practice to prevent the transmission of infections for 1 of 2 sampled residents (Resident #7) in isolation, 1 of 1 sampled resident (Resident #10) with observed cares for emesis and diarrhea, 2 of 16 sampled residents (Resident #7 and #14) observed receiving perineal care. Failure to follow infection control practices has the potential to cause or spread infection in residents, staff, and visitors. Findings include: Review of the facility policy/procedure titled "Cleaning and Disinfection of Shared Lifts and Tubs" occurred on 10/11/12. This undated policy stated, ". . . 2. Hoyer/Pal Lifts are cleaned with disinfectant wipes or disinfectant spray after use in an isolation room and/or when visible soiled. . . ." Review of the facility policy/procedure titled "Oxygen Concentrators/ Oxygen Tanks" occurred on 10/11/12. This undated policy stated, " . . . 3. If cannula or mask or tubing in on the floor, it needs to be discarded and new obtained from the charge nurse. . . ." Review of the facility policy titled "Emesis Cleanup" occurred on 10/11/12. This undated policy stated, ". . . Clean surfaces with	F 441	**How will the facility identify other residents having the potential to be affected by the same deficient practice;** All residents that wear oxygen have the potential to drop oxygen tubing to the floor and are at risk for infection when the tubing is not properly cleaned or replaced before putting back on the residents face. All residents in the facility who use a pal or hoyer lift for transfer are at risk for infection if a lift is not cleaned properly after use in an isolation room. All residents and staff are at risk if proper cleaning is not done after an episode of emesis. The facility will have problems with odors if emesis episodes are not cleaned properly. All residents are at risk for skin breakdown and increased odor if pericares are not completed properly. All residents that come in contact with the CNA have increased risk of infection if staff is not using proper hand hygiene.	

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F 441	Continued From page 8 disinfectant wipes . . ." - Review of the facility policy titled "Perineal Care" occurred on 10/11/12. This policy, dated December 2006, stated, ". . . Remove soiled attend and dispose of properly . . . Cleanse perineal area from front to back (top to bottom) using a clean section of washcloth with each wipe down. . . ." Review of the facility policy titled "Hand Washing/ Hand Sanitizer. . ." occurred on 10/10/12. This policy, revised on 09/12, stated, ". . . Indications For Hand Washing: . . . 2. Before and after resident care. 3. After situations during which contamination of hands is likely, especially those involving contact with mucous membranes, blood or body fluids, secretions or excretions. . . . 7. After removing gloves. . . ." - During the initial tour, at 9:20 a.m. on 10/08/12, observation showed an unidentified staff member removed a mechanical lift from a resident's room in which the resident was in contact isolation. Without cleaning the lift, the staff member took the lift into another resident's room. - Observation throughout the day, on 10/09/12, showed a mechanical lift stored in Resident #7's room, identified by the facility as a contact isolation room. Observation on the morning of 10/09/12, showed an unidentified staff member direct an unidentified certified nurse aide (CNA) to use the lift stored in Resident #7's room. - Record review for Resident #7 occurred October 8-11, 2012. A lab report, dated 07/23/12, showed the resident as positive for Toxigenic	F 441	**What measures we have put into place or systemic changes we made to ensure that the deficient practice will not recur:** MSLCC policy was changed to read that oxygen tubing that falls to the floor must be cleaned with an alcohol wipe before putting on the residents face. The exception to this is a resident in isolation for C. Diff. the oxygen tubing needs to be replaced each time it falls to the floor. Staff was in-serviced Oct.22, for CMAs, Oct. 23, for Nurses and Oct. 30, for CNA staff. The In-service is taped for staff not in attendance. MSLCC policy was changed to read that mechanical lifts cannot be stored in an isolation room. Staff was in-serviced on new policy and reinstructed on the proper cleaning of lifts as well as any equipment used in an isolation room. Staff was in-serviced Oct. 22 for CMAs, Oct 23 for nurses and Oct. 30 for CNA staff. The policy for proper cleaning of emesis was reviewed with staff at their meetings. How to care for the soiled w/c cushion was added to the policy and reviewed with staff. Proper pericare was reviewed with the staff and encouragement for the resident to lay in bed for proper pericare after an incontinent episode was added to the policy and also reviewed.	

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F 441	Continued From page 9 Clostridium Difficile. The facility placed the resident in contact isolation. An annual Minimum Data Set, dated 08/03/12, showed Resident #7 required extensive assistance of two or more staff members for bed mobility, transfers, and toilet use. During observation of care for Resident #7, on 10/09/12 at 11:15 a.m., the CNA (#8) transferred the oxygen tubing from the oxygen concentrator to the oxygen tank on the back of Resident #7's wheelchair. During the transfer the oxygen cannula fell to the floor. The CNA (#7) lifted the cannula off the floor by pulling up on the tubing, and placed the cannula into Resident #7's nose. During this same observation, the CNAs (#7 and #12) transferred Resident #7 using a pal mechanical lift. After the transfer, the CNAs (#7 and #12) left the lift in the the resident's room and failed to sanitize it. Facility staff who obtain the lift from the isolation room are expected to sanitize the lift prior to taking it into another resident's room. During an observation of care for Resident #7 on 10/09/12 at 2:50 p.m., two CNAs (#9 and #10) wearing gowns and gloves provided perineal care for the resident. One CNA (#9) provided frontal perineal care and the other CNA (#10) provided buttock perineal care for the resident. While providing the perineal care, the resident's nasal cannula came out of his nose. Both CNAs (#9 and #10), wearing the same gloves used for perineal care, helped Resident #7 to place the nasal cannula into his nose. During an interview on the afternoon of 10/10/12, an administrative nurse (#11) stated staff should	F 441	Job coaching and re-instruction was given to the nurse who put the cream on the resident's perineum area that was not properly cleaned. Hand washing policy was reviewed with staff at their meetings. **Monitoring we have put into place to ensure practice does not recur:** A CQI on all listed infection control issues was completed during the week of Oct. 29,2012 through staff observation and interviews. CQIs will be completed monthly x 3 months then quarterly for 1 year. The monitoring will be done by the unit managers, Director of Staff Development, and Director of Resident Services.	11-15-12

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F 441	Continued From page 10 not store lifts in isolation rooms, and staff are to clean lifts used for isolation residents immediately after use. This same staff member (#11) identified the staff failed to handle Resident #7's nasal cannula in a sanitary manner. - On 10/09/12 at 9:07 a.m., observation showed facility staff cleaning up an emesis in Resident #10's room. A CNA (#1) wiped emesis off Resident #10's wheelchair cushion with a disposable washcloth wipe. A CNA (#2) then moved the wheelchair cushion from the resident's wheelchair to her recliner. On 10/09/12 at 2:57 p.m., observation showed two CNA's (#3 and #4) provided pericares to Resident #10 after an incontinent bowel movement and applied a new brief and pants. At 3:17 p.m., the CNAs (#3 and #4) assisted the resident to lay down in bed and a nurse (#5) entered to apply a cream to the resident's perineal area. During the application, the nurse noted bowel movement in-between skin folds and some bowel movement smeared in the brief. The nurse continued to apply the cream without cleaning the area. The CNAs pulled up the resident's brief and pants, failing to clean the perineal area or change the brief. The staff members then left the room leaving the resident resting in bed. - Observation on 10/09/12 at 8:15 a.m. showed a CNA (#6) assisted Resident #14 with morning cares. As the resident lay in bed, the CNA (#6) gloved, removed Resident #14's incontinence brief, and provided perineal care. The CNA removed her gloves, applied a new brief, adjusted clothing, and left the room to retrieve the	F 441		

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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 11 mechanical lift from the hallway. CNA (#6) and an unidentified CNA transferred Resident #14 into the wheelchair. Before leaving the room CNA (#6) sanitized her hands. The CNA (#6) failed to perform hand hygiene after completing perineal care, prior to performing other tasks, and prior to leaving the room to retrieve the lift. During an interview on the afternoon of 10/10/12, an administrative nurse (#7) agreed the CNA should have performed hand hygiene after perineal care, and before leaving the room to retrieve the mechanical lift.	F 441		