STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355054	A. BUILDING _____ B. WING _____	11/04/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHWEST HEALTHCARE SERVS	802 2ND ST NW BOWMAN, ND 58623

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F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey, started on 11/02/14 and completed on 11/04/14, the sample included 2 residents for complete review, 7 residents for focused review, and 1 closed record for review.	F 000		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement.	F 278	1) The 3 residents most recent MDS was modified to reflect "no" under H0200 section C of the MDS on 11/24/2014 2) All other resident's most recent MDS's were reviewed for accuracy on 11/19/2014. There were four other residents with inaccurate coding on the MDS regarding toileting. Those records were also modified by 11/24/2014. 3) New paper form for documentation will be initiated. Documentation of toileting schedule will be removed from Point of Care task list. This will be completed by 12/1/2014. Staff was educated on 11/13/2014 and 11/19/2014 on the changes in documentation regarding toileting schedule. 4) MDS's will be assessed by DON/MDS Coordinator prior to MDS being exported to determine accuracy of the MDS related to toileting schedule and resident's care plan for 4 quarters.	12/1/2014

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Becky Hansen — TITLE: Administrator — (X6) DATE: 11/25/14

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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This REQUIREMENT is not met as evidenced by:
Based on observation, record review, and review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual (Version 3.0), the facility failed to ensure the Minimum Data Sets (MDSs) accurately reflected the residents' status for 3 of 3 sampled residents (Resident #2, #4, and #8) coded on a toileting program. Failure to accurately code the MDSs limited the facility's ability to develop and implement individualized care plans consistent with the residents' needs and functional status.

Findings include:

The Long-Term Care Facility RAI User's Manual, October 2011, page 2-1 stated, ". . . The RAI process is the basis for the accurate assessment of each nursing home resident . . ." Page H-6 stated, ". . . Toileting (or trial toileting) programs refer to a specific approach that is organized, planned, documented, monitored, and evaluated that is consistent with the nursing home's policies and procedures and current standards of practice. . . ."

- Review of Resident #4's medical record occurred on all days of survey. A Quarterly MDS, dated 10/04/14, identified the resident required supervision for toileting, limited assistance of one person for personal hygiene, frequently incontinent of urine, and on a urinary toileting program. Resident #4's care plan, dated 04/13/13, stated, "[Resident #4] is incontinent of urine at times. He has a history of Bladder Outlet Obstruction and a history of Prostate Cancer." Approaches to the problem included, "[Resident #4] toilets himself. Staff to ensure ICP

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[incontinent products] are available at all times. Staff to assist and remind [Resident #4] to void at least every 2-3 hrs [hours]."

Observations during the survey showed Certified Nursing Assistants (CNAs) (#3 and #4) approached the resident on 11/02/14 at 2:30 p.m. and 4:22 p.m. and on 11/03/14 at 7:55 a.m. and asked if he needed to use the bathroom. All three times the resident stated he did not have to use the bathroom at that time and the staff members (#3 and #4) left the area without toileting the resident.

Review of documentation for the above times identified the resident's refusals on 11/02/14, but indicated staff toileted Resident #4 on 11/03/14 at 7:45 a.m. The documentation of 11/03/14 conflicts with the observation of the resident refusing to use the bathroom.

On the afternoon of 11/03/14, an MDS nurse (#2) provided information showing Resident #4's individualized toileting times were 5:00 a.m., 7:45 a.m., 10:45 a.m., 12:00 p.m., 2:30 p.m., 4:30 p.m., 5:00 p.m., 8:00 p.m., and 9:45 p.m. These times do not match the care plan which identified staff should "remind the resident to void at least every 2-3 hours."

Review of toileting records during the assessment period for the 10/04/14 MDS showed staff may chart residents' toileting in four different areas. Review of the documentation in all four areas showed conflicting information regarding when staff toileted Resident #4.

- Review of Resident #2's medical record occurred on all days of survey. A Significant

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Change MDS, dated 10/02/14, identified the resident required extensive assistance for toileting, extensive assistance of one person for personal hygiene, frequently incontinent of urine, and on a urinary toileting program. Resident #2's care plan, dated 06/12/14, stated, "[Resident #2] has bladder incontinence. She does have a history of UTI's [Urinary Tract Infections]." Approaches to the problem included, "CNA to assist [Resident #2] with toileting per schedule and prn [as needed]. See tasks for times." The "Tasks" stated, "Toilet [Resident #2] per toileting program/care plan. The task schedule identified specific times of 4:30 a.m, 6:30 a.m., 8:30 a.m., 10:45 a.m., 12:30 p.m., 2:45 p.m., 4:30 p.m., 6:45 p.m., 8 p.m., and 10:15 p.m.

Review of toileting records during the assessment period for the 10/02/14 MDS showed staff may chart residents' toileting in four different areas. Review of the documentation in all four areas showed conflicting information regarding when staff toileted Resident #2. The documentation showed staff did not consistently toilet Resident #2 at the times identified on her toileting schedule.

- Review of Resident #8's medical record occurred on November 3-4, 2014. An Annual MDS, dated 09/16/14, identified the resident required supervision for toileting, extensive assistance of one person for personal hygiene, occasionally incontinent of urine, and on a urinary toileting program. Resident #8's care plan, dated 03/26/14, stated, "[Resident #8] has a history of urinary incontinence. She is on a RESTORATIVE PROGRAM FOR TOILETING." Approaches to the problem included, "Staff to cue resident to toilet and assist if nec. [necessary] at the

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F 278	Continued From page 4 following times: 4:00 a.m., 5:30 a.m., 8:30 a.m., 11 a.m., 12:00 p.m., 1 p.m., 3:00 p.m., 5:00 p.m., 7:00 p.m., and 9:30 p.m." Review of toileting records during the assessment period for the 09/16/14 MDS showed staff may chart residents' toileting in four different areas. Review of the documentation in all four areas showed conflicting information regarding when staff toileted Resident #8. The documentation showed staff did not consistently toilet Resident #8 at the times identified on her toileting schedule.	F 278		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to safely secure an oxygen tank in 1 of 1 oxygen storage room. Failure to properly secure an oxygen tank placed residents, visitors, and staff at risk of injury in the event the unsecured tank falls and becomes a projectile object.	F 328	1) All tanks in the oxygen storage closet were secured on 11/5/2014. 2) No other oxygen tanks were found not secured. 3) Nursing staff were educated 11/5/2014 via written communication to check the oxygen closet daily to ensure the oxygen tanks were secured either in the oxygen rack or cart. Nursing staff were again educated at Nursing Staff meeting on 11/13/14. Daily the nurse will sign off regarding tank security and any corrections as needed. See daily QI form. 4) Nursing will monitor and record for oxygen tank security daily for 4 quarters. QI manager will report to the QI committee for the next 4 quarters, starting with 4th quarter of 2014.	11/14/2014

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F 328	Continued From page 5 Findings include: Review of the facility policy titled "Medical Gas and Oxygen Safety" occurred on 11/04/14. This policy, dated 11/2005, stated, ". . . A. Precautions for All Medical Gases - a. Cylinders shall be secured at all times . . ." An environmental tour of the facility occurred on 11/03/14 at 1:00 p.m. with three maintenance staff members (#5, #6, and #7). Observation of the oxygen storage room showed multiple oxygen tanks securely stored on a rack and one tank free-standing near the rack. The staff member (#7) confirmed staff are expected to place oxygen tanks on the secured rack.	F 328		
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, review of facility procedures, and staff interview, the facility failed to ensure food stored and served under sanitary conditions in 1 of 1 kitchen and 2 of 3 nourishment centers (Activity Room and Heritage	F 371	1) All containers which contained a scoop/ measuring utensil in the activity room and heritage wing were emptied, contents disposed of and the containers were sent to the kitchen for sanitization on 11/3/2014. 2) No additional scoops or measuring utensils were found or obtained. 3) Activity staff were verbally educated immediately on the infection control policy and written communication was given on 11/14/2014. Nursing staff were educated on 11/13/2014 and 11/19/2014. Weekly Activities staff and CNA Team Leaders will sign off and monitor effectiveness and compliance of this policy.	

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F 371	Continued From page 6 Unit). Failure to ensure beverage containers were completely dry prior to storage and to ensure no scoops were stored in food containers placed residents consuming food and beverages prepared in those areas at risk of foodborne illness. Findings include: Review of the facility procedure "Procedures for Washing Dishes" occurred on 11/04/14. The undated procedure stated, "2. Dishwasher: . . . D) The person assigned to dishwashing removes dishes from cart: . . . 8) Stack dishes neatly on table to complete air drying." A tour of the kitchen and nourishment centers occurred on 11/03/14 at 1:00 p.m. with two dietary supervisors (#8 and #9). Observation showed a tray with small coffee/tea carafes with water droplets visible inside the carafes stored in a cabinet. In the same cabinet, observation showed eight large coffee carafes stored with the lids on with visible fluid in the carafes. Observation on the kitchen counter showed the following: three plastic cups, one 8 ounce (oz.) glass and three 12 oz. glasses in stacks with visible water droplets in the glasses and cups. The staff member (#9) agreed staff should ensure the carafes and glasses/cups were completely dry prior to storage. Observation in the Activity Room and Heritage Unit nourishment centers showed scoops in containers of cappuccino mix and sugar in the Activity Room and a scoop in a container of Thick and Easy in the Heritage Unit. The staff member (#9) agreed staff should not place scoops in food containers.	F 371	4) Activity staff and CNA Team Leaders will monitor this infection control protocol weekly for four quarters. Activity Director and Director of Nursing will report findings during quarterly QA, starting with the fourth quarter in 2014. 1. All wet dishes that were found in the kitchen and activity room were rewashed and dried on 11/3/14 2. No additional wet dishes were found in any other departments. 3. Dietary staff was verbally educated 11/5/14 on the dish drying policy. Written communication given on 11/14/14. Issue readdressed at monthly dietary meeting 11/20/14. Daily the dietary staff will sign off regarding wet dishes and any corrections as needed. Dietary supervisors will do random dish inspections twice weekly and sign off when completed,starting 11/24/14. 4. Dietary staff will monitor and record dish drying protocol daily for four quarters. Dietary managers will report to QI committee for the next four quarters, starting with the fourth quarter in 2014.	11/14/2014 11/24/2014

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