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 _____	12/05/2019

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

(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 The Standard Medicare/Medicaid recertification survey started 12/02/19 and concluded 12/05/19.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph	F 580		1/9/20

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

Electronically Signed | 12/24/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 580	Continued From page 1 (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to notify the physician of a change in condition for 2 of 2 sampled residents (Resident #17 and #24) reviewed who experienced high blood sugars. Failure to notify the physician of blood sugar results above the ordered parameters may result in complications to the resident and prevent the physician from evaluating/prescribing an appropriate treatment plan. Findings include: Review of the facility policy titled "Diabetes - Clinical Protocol" occurred on 12/05/19. This policy, revised 07/17/15, stated, ". . . The Practitioner will follow up on any acute episodes associated with a significant change in blood sugars . . . The Practitioner will order desired parameters for monitoring and reporting information related to diabetes or blood sugar	F 580	1. Residents #17 and #24 will be monitored to ensure blood glucose results, less than 70 or greater than 350 unless specified otherwise per medical provider, and requires medical provider notification and follow-up documentation are done per policy 12/10/19. 2. All other residents will be monitored to ensure blood glucose results, less than 70 or greater than 350 unless specified otherwise per medical provider, and requires medical provider notification and follow-up documentation are done per policy 12/11/19. 3. Staff were educated 12/9/19 to notify medical provider regarding blood glucose results that require medical provider notification and follow-up documentation. All other staff will be educated January 8 and repeated January 9, 2020 on the notification of change standard listed	

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F 580	Continued From page 2 management. . . . The staff will identify and report complications . . . " - Review of Resident #17's medical record occurred on December 4-5, 2019. Diagnoses included type 2 diabetes. Medications included, "Lantus Solution (Insulin Glargine) Inject 32 unit subcutaneously one time a day for hyperglycemia [high blood sugars] related to TYPE 2 DIABETES MELLITUS . . ." The physician's orders also stated, "Blood sugar two times a day . . . for blood glucose monitoring accucheck BID [twice daily] every Monday and Friday. BS [blood sugar] < [less than] 70 or > [greater than] 350, call physician." Review of the 2019 Medication Administration Record (MAR) showed a blood sugar reading of "397 [milligrams per deciliter (mg/dL)]" on 06/01/19 at 19:59 p.m. Review of the medical record showed the facility failed to notify Resident #17's physician of the high blood sugar reading. - Review of Resident #24's medical record occurred on all days of survey. Diagnoses included type 2 diabetes. Medications included, "NovoLOG FlexPen Solution Pen-injector 100 UNIT/ML [milliliter] (Insulin Aspart) . . ." The physician's orders also stated, "Accuchecks before meals. . . . Inject as per sliding scale: if 0 - 50 = 0 give 1 am [sic] D50 [high sugar injection] call MD [physician] . . . 401 - 999 = 10 [units] call MD . . ." Review of the September-December 2019 MAR showed the following: * 09/16/19 at 4:30 p.m., 444 mg/dL	F 580	above. Change in Resident's Condition or Status policy was reviewed and revised 12/19/19. 4. All charts will be reviewed for elevated blood glucose levels less than 70 or greater than 350 unless specified otherwise per medical provider and documented notification to the medical provider 12/19/19. The DON or designee will monitor adherence to ensure blood glucose results, less than 70 or greater than 350 unless specified otherwise per medical provider, and requires medical provider notification and follow-up documentation are done per policy weekly x4, monthly x2 and quarterly x3 and reports will be submitted to QA Committee quarterly x4 quarters. 5. 01/09/2020	

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F 580	Continued From page 3 * 09/30/19 at 4:30 p.m., 477 mg/dL * 11/18/19 at 4:30 p.m., 402 mg/dL Review of the medical record showed the facility failed to notify Resident #24's physician of the high blood sugar readings. During an interview on 12/05/19 at 11:13 a.m., an administrative nurse (#1) confirmed facility staff should notify the physician of any blood sugar results above the ordered parameters and added, "Staff should document that they notified the physician."	F 580		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR	F 656		1/9/20

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F 656	Continued From page 4 recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to develop a comprehensive care plan for 2 of 2 sampled residents (Resident #21 and #30) reviewed for anticoagulant use. Care planning drives the type of care and services a resident receives and failure to develop a care plan that includes the care and services to be provided to the resident may negatively impact the resident's quality of care/quality of life. Findings include: Review of the facility policy titled "CARE PLANNING" occurred on 12/05/19. This undated policy stated, "POLICY: Southwest Healthcare Services shall provide an individualized, interdisciplinary plan of care for all residents . . . Procedure: The plan of care shall be	F 656	1. Residents #21 and #30 care plans were revised to reflect the signs/symptoms of an adverse reaction secondary to an anti-coagulant drug use 12/16/19. 2. All other residents receiving anti-coagulant drug care plans were reviewed and revised 12/16/19. 3. Staff were educated in the Care Planning process on 12/9/19 regarding anticoagulant medication side effect monitoring. All other staff will be educated January 8 and repeated January 9, 2020 on the Care Planning standard listed above. Care Plan policy was reviewed and revised 12/19/19. 4. The MDS manager, DON or designee will monitor adherence to the Care	

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F 656	Continued From page 5 individualized based upon the diagnosis and resident assessment. . . . Care plans shall be reviewed and updated on an ongoing basis, with revisions reflecting the reassessment of needs of the resident. . . ." - Review of Resident #21's medical record occured on 12/05/19, and identified a diagnoses of Atrial fibrillation. A quarterly Minimum Data Set (MDS), dated 10/24/19, stated, Anticoagulant for 7 days. A physcian order included, " . . . Eliquis Tablet 5 MG [milligram] (Apixaban) [blood thinner] Give 5 mg by mouth two times a day . . ." The care plan failed to reflect the signs/symptoms of an adverse reaction secondary to anti-coagulant drug use. - Review of Resident #30's medical record occurred on all days of survey and identified a diagnosis of long term and current use of anticoagulants. The current physician orders included the medication warfarin (coumadin). The care plan failed to reflect the signs/symptoms of an adverse reaction secondary to anticoagulant drug use. During an interview on 12/05/19 at 8:09 a.m., an administrative nurse (#1) agreed the care plan should include interventions related to Resident #30's use of an anticoagulant medication.	F 656	Planning standard weekly x4, monthly x2 and quarterly x3 and all reports will be submitted to QA Committee quarterly x4 quarters. 5. 01/09/2020	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan,	F 658		1/9/20

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F 658	Continued From page 6 must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: PHYSICIAN ORDERS 1. Based on record review, review of facility policy and staff interview, the facility failed to provide a current physician order for lab tests for 1 of 1 resident (Resident #17) with diabetes mellitus. Failure to obtain a current order may result in an adverse reaction and ineffective management of a resident's condition. Findings include: Review of the facility's policy titled "Diabetes - Clinical Protocol" occurred on 12/05/19. This policy, revised October 2010, stated, ". . . The practitioner will order appropriate lab tests (for example, . . . hemoglobin A1c [HbA1c] (blood sugar test) and adjust treatments based on these results . . ." Review of Resident #17 medical record occured on December 4-5, 2019. The current care plan stated, " . . . Blood sugars will be stable by next review with a Hgb A1C < 7. . . ." During an interview on 12/04/19 at 4:02 p.m., an administrative staff member (#1) provided a copy of Resident #17's A1C lab report dated 07/17/2018. The administrative staff member (#1) stated the lab work was missed, the physician failed to reorder Resident #17's hemoglobin A1C. INSULIN ADMINISTRATION	F 658	1. Professional standards of care was not met in the following areas: A. Routine A1c labs for those on (diabetic agent) a. Res #17 received order per medical provider for A1C every 3 months 12/19/19. B. Proper use and delivery of insulin using an insulin pen per manufacturer instructions a. Res #24 was observed receiving insulin by nurse via insulin pen according to manufacturer instructions 12/12/19. C. Delivery of medication on an empty stomach a. Res #16 was observed to receive Levothyroxine on an empty stomach on 12/15/19. 2. A. All other residents requiring A1C lab work were reviewed and orders received for A1C every 3 months 12/15/19. B. All other residents who receive insulin via an insulin pen were observed for proper nurse technique per manufacturer instructions by 12/27/19. C. All other residents who have orders for Levothyroxine were observed to receive med on an empty stomach by 12/14/19. 3. Staff involved in the non-compliance of the professional standards were educated on 12/6/19. All other staff will be educated January 8 and repeated	

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F 658	Continued From page 7 2. Based on observation, review of facility policy, review of professional reference, and staff interview, the facility failed to follow professional standards of practice for 1 of 2 sampled residents (Resident #24) observed during insulin preparation and administration. Failure to properly prime an insulin pen and administer insulin may result in the resident receiving an inaccurate amount of insulin. Findings include: The manufacturers instructions for the NOVOLOG® FlexPen®, found at www.nov-pi.com/novolog.pdf, stated, ". . . Keep the needle in the skin for at least 6 seconds. . . . This will make sure that the full dose has been given. . . ." Review of the facility policy titled "Insulin Pen Policy" occurred on 12/05/19. This undated policy, stated, ". . . 10. Prime needle before each injection. a. Turn the dose knob to 2 units b. Hold pen with needle pointing up and gently tap to move any air bubbles to the top. c. Depress the Dose Knob until it stops and hold for 5 seconds . . . 11. Select your dose by turning the dose knob to the number of units you need to inject. . . . 12. Chose injection site . . . 14. Insert the needle perpendicular to the injection site. 15. Depress dose knob all the way in until the counter shows "0" and then slowly count to 5, or what the manufacturer recommends. . . ." - Observation on 12/04/19 at 11:14 a.m. showed a licensed nurse (#8) primed Resident #24's insulin pen holding the pen in a horizontal position. The nurse (#8) administered Resident	F 658	January 9, 2020 on the above professional standards listed above. The following policies were reviewed and revised: A. Diabetes □ Clinical Protocol 12/19/19 B. Medication Administration 12/18/19 C. Medication Administration/Use of Insulin Pen 12/23/19. 4. The DON or designee will monitor adherence to the Professional standard of care as listed above weekly x4, monthly x2 and quarterly x3 and all reports will be submitted to QA Committee quarterly x4 quarters. 5. 01/09/2020	

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F 658	Continued From page 8	F 658		

24's insulin and removed the needle from the skin after 1 second.

During an interview on 12/05/19 at 08:09 a.m., an administrative nurse (#1) agreed staff should prime the insulin pen in an upright position and hold the needle in the skin for at least 6 seconds.

MEDICATION ADMINISTRATION

3. Based on observation, record review, review of professional reference, and staff interview, the facility failed to follow professional standards of practice for 1 of 2 sampled residents (Resident #16) observed receiving oral medications. Failure to administer medications as recommended may affect the absorption and efficacy of the medication.

Findings include:

Wolters Kluwer "Nursing 2017 Drug Handbook," 37th ed., pages 875-876 states, "Levothyroxine sodium . . . ADMINISTRATION P.O. [by mouth] . . . Give drug at same time each day on an empty stomach, preferably 1/2 to 1 hour before breakfast . . . INTERACTIONS . . . Antacids, calcium carbonate . . . May impair levothryoxine absorption. Separate doses by 4 to 5 hours. . . ."

Review of Resident #16's medical record occurred on all days of survey. The current physician's orders showed Resident #16 takes levothyroxine, calcium carbonate, and a liquid antacid. The resident's electronic medical record indicated these medications to be administered at 8:00 a.m.

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F 658	Continued From page 9 Observation on 12/04/19 at 08:01 a.m. showed a medication aide (#9) administered the levothyroxine and calcium carbonate to Resident #16 with her other scheduled 8:00 a.m. medications right before Resident #16 went to the dining room for breakfast. During an interview on 12/05/19 at 08:09 a.m., an administrative nurse (#1) agreed levothyroxine should be given on an empty stomach at least a half hour before breakfast.	F 658		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to provide adequate assistance for 2 of 2 sampled residents (Residents #12 and #24) observed during a sit-to-stand mechanical lift transfer. Failure to ensure proper use of the stand lift placed Resident #12 and #24 at risk of experiencing pain/discomfort and/or possible accidents with/without injury. Findings include: - Review of Resident #12's medical record occurred on all days of survey. The annual	F 689	1. Residents #12 and #24 who use the sit to stand lift were assessed by therapy 12/16/19 and 12/19/19 respectfully. 2. All other residents who used the stand lift were assessed to ensure proper use of the stand lift to ensure comfort and avoid injury 12/20/19. 3. Journey Sit to Stand Lift policy was reviewed and revised 12/20/19. Staff were educated in failure to provide safe transfer with the sit to stand lift were educated 12/9/19. All other staff will be educated January 8 and repeated January 9, 2020 on the Journey Sit to	1/9/20

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F 689	Continued From page 10 Minimum Data Set (MDS), dated 09/24/19, identified extensive assistance of two or more persons is required for transfers. Observations showed the following: * On 12/03/19 at 8:15 a.m., two certified nursing assistants (CNA) (#3 and #4) transferred Resident #12 from his wheelchair into a wheelchair used to weigh residents utilizing a sit-to-stand mechanical lift. The resident hung from the harness in a semi-seated position and failed to bear weight. As the harness straps pulled upward into Resident #12's axillae, his shoulders raised with his elbows extending horizontally. * On 12/03/19 at approximately 8:30 a.m., the CNAs (#3 and #4) transferred Resident #12 from the wheelchair used to weigh residents onto the bed utilizing the sit-to-stand mechanical lift. The resident hung from the harness in a seated position and failed to bear weight. As the harness straps pulled upward into Resident #12's axillae, his shoulders raised with his elbows extending horizontally. The CNAs (#3 and #4) only had to lower the lift approximately two inches before Resident #12 was seated on the edge of the bed. - Resident #24's medical record occurred on all days of survey. The annual MDS, dated 11/01/19, identified extensive assistance of two or more persons is required for transfers. Observations showed the following: * On 12/03/19 at 9:02 a.m., two CNA (#4 and #5) transferred Resident #24 from her electric wheelchair into a wheelchair used to weigh residents utilizing a sit-to-stand mechanical lift. Resident #24 stated, "Oh, ow, ow, ow, oh my	F 689	Stand Lift policy. 4. The DON or designee will monitor adherence for safe sit to stand transfers weekly x4, monthly x2 and quarterly x3. All reports will be submitted to QA Committee quarterly x4 quarters. 5. 01/09/2020	

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F 689	Continued From page 11 hand hurts, oh, ow, ow, ow" when the CNAs (#4 and #5) placed her hands on the handles of the lift. The resident hung from the harness in a semi-seated position and failed to bear weight. As the harness straps pulled upward into Resident #24's axillae, her shoulders raised with her elbows extending horizontally. * On 12/04/19 at 10:44 a.m., two CNAs (#3 and #5) transferred Resident #24 from the toilet to her electric wheelchair utilizing the sit-to-stand mechanical lift. The resident hung from the harness in a seated position and failed to bear weight. As the harness straps pulled upward into Resident #24's axillae, her shoulders raised with her elbows extending horizontally. The CNAs (#3 and #5) had to raise the lift approximately two inches before Resident #24 was able to slide into her wheelchair. During an interview on the morning of 12/05/19, an administrative nurse (#1) confirmed facility staff should ensure residents bear weight when utilizing the stand lift and should ensure the harness is not pulling upward/putting pressure on their axillae.	F 689		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or	F 692		1/9/20

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F 692	Continued From page 12 desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and resident and staff interviews, the facility staff failed to offer fluids to 3 of 15 sampled residents (Resident #2, #12, and #34) who required staff assistance for fluid intake and/or are at risk for dehydration. Failure to provide assistance with fluid intake may result in dehydration, constipation, and urinary tract infections (UTIs). Findings include: Review of the facility policy titled "Hydration/Dehydration" occurred on 12/05/19. This undated policy stated, ". . . Dehydration occurs when a resident does not have adequate fluid in the body. . . . Continue to encourage fluids unless not indicated by physician. . . . " - Review of Resident #2's medical record occurred on all days of survey. The current care plan stated, " . . . [Resident #2's] dx [diagnosis] of dementia places her at moderate risk for malnutrition. . . ."	F 692	1. Residents #2, #12, #34 were observed to receive fluids after cares 12/18/19. 2. All other residents were will be observed for receiving fluids after cares by 1/9/19. 3. Staff were educated in not providing fluids after cares on 12/9/19. All other staff will be educated January 8 and repeated January 9, 2020 on the hydration policy. Nutrition and Hydration policy was reviewed and revised 12/20/19. 4. The DON or designee will monitor adherence to adequate hydration weekly x4, monthly x2 and quarterly x3. All reports will be submitted to QA Committee quarterly x4 quarters. 5. 01/09/2020	

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F 692	Continued From page 13	F 692		

Observation on 12/03/19 at 1:30 p.m. showed a certified nursing assistant (CNA) (#3) provided cares and transferred Resident #2 into a recliner. The staff member failed to offer Resident #2 fluids after cares.

- Review of Resident #12's medical record occurred on all days of survey. The current care plan stated, " . . . [Resident #12] has high fluid needs. Fluid assessment reveals he is slightly short of getting adequate fluids. Staff to offer him increased fluids. . . ."

Observations showed the following:
* 12/02/19 at 2:25 p.m., Resident #12 sat in his wheelchair in his room. No water mug or glass present in room. When asked if he had any readily available liquids, Resident #12 pointed to the sink and stated, "If I need a drink, I can drink outa there."
* 12/03/19 at approximately 11:00 a.m., showed two CNAs (#3 and #5) provided cares and transferred Resident #12 into his wheelchair. The staff members failed to offer Resident #12 fluids after cares.

- Review of Resident #34's medical record occurred on all days of survey. The current care plan stated, " . . . [Resident #34] is considered high risk for malnutrition . . . [Resident #34] is at risk for dehydration due to diuretic use. . . . Offer adequate fluids throughout the day. Assess for S/S [signs/symptoms] of dehydration and report to Dr. [physician]. . . ."

Observation on 12/02/19 at 2:15 p.m. showed a CNA (#10) provided cares and transferred Resident #34 into her electric wheelchair. The

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F 692	Continued From page 14 staff member failed to offer Resident #34 fluids after cares. During an interview on the morning of 12/05/19, an administrative nurse (#1) confirmed facility staff should offer fluids when providing cares.	F 692		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and review of facility policy, the facility failed to provide necessary care and services for 2 of 3 sampled residents (Resident #1 and #32) who received oxygen. Failure to provide oxygen as ordered may complicate a resident's respiratory status. Finding include: Review of the facility policy titled, "Oxygen Concentrator" occurred on 12/05/19. This policy, dated March 2018, stated, ". . . Obtain an order from the resident's Practitioner on amount of oxygen resident is to receive and how often. . . . Adjust flow rate of oxygen per Practioner's orders. . . . Record in the TAR [treatment administration record] liter flow, time Oxygen used and O2 [oxygen] sats [saturation] with or	F 695	1. Residents #1 and #32 involved in not receiving the oxygen flow delivery rate as ordered for provider were assessed 12/11/19 to ensure the proper flow rate was being delivered. 2. All other residents who receive oxygen were assessed to ensure the proper flow rate was being delivered 12/11/19. 3. Oxygen policy was reviewed and revised 12/18/19. Staff were educated in failure to provide proper oxygen flow rate as ordered per provider were educated 12/9/19. All other staff will be educated January 8 and repeated January 9, 2020 on the oxygen flow rate per order standard listed above. 4. The QA manager, DON or designee	1/9/20

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F 695	Continued From page 15 without oxygen." - Review of Resident #1's medical record occurred on all days of survey and indicated a diagnosis of obstructive sleep apnea. The current physician's orders showed, "Night time 02- 2L [liters] per N.C. [nasal cannula] at bedtime for during sleep 108 minutes less than 88%." Documentation on Resident #1's TAR, from 11/01/19 through 12/02/19, indicated the resident received oxygen at 2 liters each day at bedtime. Observations on 12/04/19 at 8:20 a.m. and 12/05/19 at 7:40 a.m. showed Resident #1 in bed wearing oxygen and the liter flow set a 1 LPM (liter per minute) on the oxygen concentrator. During an interview on 12/05/19 at 7:59 a.m., when asked to clarify Resident #1's oxygen order, a licensed nurse (#8) stated, "[Resident's name] drops below 90% at night. That's why he is on 2L per N/C. I don't know what the minutes are." During an interview on 12/05/19 at 8:09 a.m., an administrative nurse (#1) stated, Resident #1 has oxygen saturation levels below 88% for 108 minutes and "that is why they received an order for the night time oxygen. The minutes part should not have been included in the order." The administrative nurse (#1) stated, "I can see where the order could be confusing" and confirmed Resident #1's liter flow should be set at 2LPM. The facility failed to provide resident #32 oxygen at 2 LPM as ordered.	F 695	will monitor adherence to the accuracy of oxygen delivery weekly x4, monthly x2 and quarterly x3. All reports will be submitted to QA Committee quarterly x4 quarters. 5. 01/09/2020	

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F 695	Continued From page 16 - Review of Resident #32's medical record occurred on all days of survey and indicated a diagnosis of bronchitis. The current physician's orders showed, "Administer oxygen to maintain 02Sats greater than 90% every morning and at bedtime for 02Sats dropping below 90%. . ." Documentation on Resident #32's TAR, from 12/02/19 through 12/05/19, indicated the resident received oxygen at 2 liters each day. Observations of Resident #32 in her room wearing oxygen with the liter flow rate set a 1.5 LPM occurred on: * 12/02/19 at 4:47 p.m. * 12/04/19 at 8:24 a.m. * 12/05/19 at 10:01 a.m. The facility failed to provide Resident #32's oxygen as per the physician's order.	F 695		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.	F 756		1/9/20

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F 756	Continued From page 17 (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to ensure the consultant pharmacist reported drug regimen irregularities for 1 of 6 sampled residents (Resident #34) reviewed for drug regimen. Failure to report drug regimen irregularities may result in residents receiving unnecessary medications and experiencing adverse consequences related to their use. Findings include: Review of the facility policy titled "Use of Antipyschotics" occurred on 12/05/19. This	F 756	1. Resident #34 involved in the lack of documented drug regimen review/Gradual Dose Reduction was reviewed per pharmacist 12/18/19. 2. All other residents lacking documentation of a drug regimen/Gradual Dose Reduction will be reviewed per pharmacist 12/24/19. 3. Drug Review policy will be reviewed and revised 12/24/19. 4. The Pharmacist, DON or designee will monitor adherence to the drug regimen/Gradual Dose Reduction weekly x4, monthly x2 and quarterly x3. All	

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F 756	Continued From page 18 undated policy stated, ". . . All medications will be reviewed monthly by the Pharmacist. . . . A gradual dose reduction [GDR] will be attempted for Antipsychotics including those used for psychiatric diagnosis. . . . After the first year, a GDR should be attempted annually. . . . A reduction will be attempted . . . unless it is contraindicated by the Practitioner. . . . Reasons for contraindication will be documented in the medical record. . . ." Review of Resident #34's medical record occurred on all days of survey. Diagnoses included bipolar disorder and depression. Current physician's orders included an 11/07/18 order for Risperdal (an antipsychotic) 0.25 milligrams (mg) daily. The monthly pharmacy reviews for 2019 showed the pharmacist failed to identify/recommend an annual GDR for Resident #34's Risperdal. During an interview on 12/05/19 at 8:30 a.m., a pharmacist (#7) reviewed her 2018-2019 documentation and stated, "I didn't recommend a GDR because [Resident #34] has had lots of psych issues in the past. If [a resident] is stable, I try not to mess with [their] medications."	F 756	reports will be submitted to QA Committee quarterly x4 quarters. 5. 01/09/2020	
F 801 SS=D	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population	F 801		1/9/20

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F 801	Continued From page 19 in accordance with the facility assessment required at §483.70(e) This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not	F 801		

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F 801	Continued From page 20 employed full-time, the facility must designate a person to serve as the director of food and nutrition services who- (i) For designations prior to November 28, 2016, meets the following requirements no later than 5 years after November 28, 2016, or no later than 1 year after November 28, 2016 for designations after November 28, 2016, is: (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is not met as evidenced by: Based on staff interview, the facility failed to ensure the dietary manager received the necessary education to obtain the required qualifications to hold the director of food and nutrition for 1 of 1 dietary manager (#2). Failure to ensure qualified staff with the appropriate competencies and skill sets to carry out the functions of the food and nutrition services has the potential to result in foodborne illness to residents, staff, and visitors.	F 801	1. Facility failed to ensure the completion of the certified dietary manager course. Dietary manager was educated on 12/9/19 the need to start this educational process and complete by 5/21/2020. 2. No other certifications are required at this time. 3. Facility will make arrangement with the registered dietician to work full-time starting January 7, 2020 until the above	

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F 801	Continued From page 21 Findings include: During a interview on 12/02/19 at 1:10 a.m., a dietary manager (#2) stated, "I have started the process of getting my CDM [certified dietary manager] and should be finished in May." She failed to provide evidence of completing the required education of a CDM, a certified food service manager, or a national certification for food service management and safety from a national certifying body. The facility failed to provide the necessary training in food and nutrition services to carry out daily operation duties.	F 801	certification is received. Dietary manager will complete 3 □ 4 lessons plus exams every month until completion. 4. The registered dietician, QA manager or designee will monitor assignment completion every month until certification obtained. All reports will be submitted to QA Committee quarterly x4 quarters. 5. 01/09/2020	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the	F 880		1/9/20

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F 880	Continued From page 22 facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which 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; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens.	F 880		

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F 880	Continued From page 23 Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and resident and staff interviews, the facility failed to follow infection control practices for 3 of 3 sampled residents (Residents #1, #12, and #32) observed with isolation supplies hanging on their doors. Failure to ensure clear signage and/or staff education regarding the specific type of Personal Protective Equipment (PPE) staff should apply when providing cares to each resident has the potential to spread infection to other residents, personnel, and visitors. Findings include: Review of the facility policy titled "Transmission-Based Precautions" occurred on 12/05/19. This policy, dated December 2018, stated, "Purpose: Transmission-Based Precautions are designed to supplement Standard Precautions in patients with documented or suspected infection/colonization of highly transmissible pathogens. . . . Isolation precaution signs are posted on the patient room door . . . to inform staff, patients and families of Transmission Based Precautions. . . . . Transmission-Based Precautions include standard precautions, and divided into three categories. 1. Contact Precautions . . . 2. Droplet Precautions . . . 3. Airborne Precautions . . ."	F 880	1. The visitor signage for residents #1, #12, #32 were reviewed and signage placed in visible location, discontinued or care planned per policy 12/18/19. Res #1: Signage per policy and care planned 2/18/19 Res #12: Isolation discontinued 12/17/19 Resident #32: Isolation discontinued 12/11/19 2. All other residents involved were reviewed and visitor signage placed in visible location, discontinued or care planned per policy 12/18/19. 3. Staff were educated in failure to clearly identify visitor signage with the type of precautions and the appropriate PPE 12/9/19. All other staff will be educated January 8 and repeated January 9, 2020 on the Infection Prevention standard listed above. The Transmission-Based policy was reviewed and revised 12/18/19. 4. The QA manager, DON or designee will monitor adherence for adherence to the Transmission-Based policy and signage weekly x4, monthly x2 and quarterly x3. All reports will be submitted to QA Committee quarterly x4 quarters. 5. 01/09/2020	

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 _____	12/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 24 During an interview on 12/04/19 at 4:12 p.m., an administrative staff nurse (#13) stated the signage on Resident #1, #12, and #32's doors should have the visitor's isolation instructions faced to the front and the staff guidance sheet behind the visitors sheet, "to let them [staff] know what they are suppose to do [type of PPE required for staff prior to working with/entering resident rooms based on the resident's required isolation category]." - Review of Resident #1's medical record occurred on all days of survey. The current physician orders showed contact isolation due to resistant E. coli (Escherichia coli, a bacteria) in the urine. Observation on 12/02/19 at 8:18 a.m. showed Resident # 1's room door almost closed, with an isolation kit containing PPE hanging on it. Beside the isolation kit hung a guidance sheet for donning PPE. When asked what type of precautions/PPE the surveyor needed prior to entering Resident #1's room, a certified nursing assistant (CNA) (#11) stated "the resident has a germ contained in the urine" and "need to glove when providing cares." The facility failed to provide visitor isolation intructions on Resident #1's door. - Review of Resident #12's medical record occurred on all days of survey. A progress note, dated 12/02/19 at 2:43 p.m., stated, ". . . aerobic culture returned from open area on outside of penis. positive for MRSA [methicillin-resistant Staphylococcus aureus, a bacterium with	F 880		

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F 880	Continued From page 25 antibiotic resistance]. faxed results to [physician] and placed resided [sic] on isolation." The current care plan and/or care card failed to identify Resident #12 tested positive for MRSA and/or was placed on isolation. Observations for Resident #12 showed the following: * 12/02/19 at 2:25 p.m., the resident sat in his wheelchair in his room. When asked questions pertaining to the activity program, Resident #12 stated, "They told me I have to stay in my room for a couple of days." When exiting Resident #12's room, the surveyor observed an isolation kit containing PPE hanging on the door with a staff guidance sheet posted on the right side of the kit. The door had been opened at a 180 degree angle and the container/sign were not visible to staff/visitors entering the room. After exiting the room, the surveyor asked an unidentified nurse if/why Resident #12 was in isolation. The nurse stated, "He tested positive for MRSA." * 12/03/19 at 8:15 a.m., an isolation kit hung on the residents room door, with no signage present. Two CNAs (#3 and #4) entered Resident #12's room and donned gloves, gowns, and masks. When asked what types of precautions/PPE were required for visitors/the surveyor, one of the CNAs (#3) admitted she was unsure while the other CNA (#4) indicated visitors were not required to don precautions/PPE. * 12/03/19 at 10:35 a.m., an administrative nurse (#1) posted a staff guidance sheet to the left of the isolation kit on the resident's door. The facility failed to provide visitor isolation intructions on Resident #12's door.	F 880		

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F 880	Continued From page 26 - Review of Resident #32's medical record occurred on all days of survey and indicated a diagnosis of bronchitis and a care plan intervention of PPE use as indicated for upper respiratory infection. Observation of Resident #32's room, on 12/02/19 at 8:09 a.m., showed his room door closed with an isolation kit containing PPE hanging on it. Beside the isolation kit hung a guidance sheet for donning PPE; however the isolation kit covered half of this sign. When asked what type of precautions/PPE the surveyor needed prior to entering Resident #32's room, an administrative nurse (#1) stated to use a mask. The facility failed to provide visitor isolation intructions on Resident #32's door.	F 880		