STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355039	A. BUILDING _____ B. WING _____	09/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRIGGS COUNTY CARE CENTER	1200 ROBERTS AVE NE COOPERSTOWN, ND 58425

(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 on 09/09/2019 and concluded on 09/11/2019.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.16), the facility failed to ensure the Minimum Data Set (MDS) reflected residents' status for 2 of 13 sampled residents (Resident #15 and #23). Failure to accurately complete Section E (Behaviors) and Section N (Medications) does not allow each resident's assessment to reflect their current status/needs, and may result in the development of an inaccurate care plan. Findings include: SECTION E: BEHAVIORS The Long-Term Care Facility RAI Manual, revised October 2018, page E-1 and E-2, stated, ". . . HALLUCINATION The perception of the presence of something that is not actually there. It may be auditory or visual or involve smells, tastes or touch. DELUSION A fixed, false belief not shared by others that the resident holds even in the face of evidence to the contrary. - Review of Resident #15's medical record	F 641	F641 Accuracy of Assessments 1. Resident #15 MDS was modifies and submitted 10/3/19 Resident #23 MDS was modified and submitted 9/12/19. 2. All residents of the Griggs County Care Center have the potential to be affected. 3. The MDS Coordinator/designee will review the assessments to ensure that they accurately reflect the residents current status. If a MDS assessment is found to be incorrect it will be modified to include the accurate information. Director of Nursing Services educated LSW, MDSC and Licensed nurses regarding the documentation and coding at in-service 9/16/19. 4. The DON or designee will perform random weekly MDS audits for consistent documentation of the resident□s assessments x 4 weeks then bi-weekly x 4 weeks and then monthly x 2. Results of	10/16/19

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

Electronically Signed | 09/29/2019

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F 641	Continued From page 1 occurred on all days of survey. The quarterly Minimum Data Set (MDS), dated 07/15/19, identified hallucinations and delusions; however, the resident's medical record lacked adequate evidence of hallucinations and delusions during the seven-day look back period. SECTION N: MEDICATIONS The Long-Term Care Facility RAI User's Manual, revised October 2018, page N-6 and N-7, stated, ". . . Steps for Assessment: 1. Review the resident's medical record for documentation that any of these medications were received by the resident during the 7-day look-back period (or since admission/entry or reentry if less than 7 days)." - Review of Resident #23's medical record occurred on all days of survey. A significant change MDS, dated 07/22/19, identified an anticoagulant used on six days of the seven day look back period; however, the resident's medical record lacked evidence of anticoagulant use during that time.	F 641	the audits will be reviewed at the facility QI Committee meetings until such time it is determined that substantial compliance is maintained. Any problems with the Quality Assurance checks will be reported immediately to the appropriate supervisors so that correction/education can be performed, if needed. 5. Completion date 10/16/19	
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, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and resident and staff interview, the facility failed to follow professional standards of	F 658	F658 Services Provided Meet Professional Standards 1. Phytoplex skin barrier cream was	10/16/19

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F 658	Continued From page 2 practice for 1 of 1 sampled resident (Resident #44) observed with topical (skin surface) medications left in his room. Failure to ensure medications are applied as ordered may result in adverse health effects and medication errors. Findings include: Review of the facility policy titled "Medication Administration" occurred on 09/10/19. This policy stated, " SCOPE: RNs [registered nurse], LPNs [licensed practical nurse], CMAs[certified medication assistant]. PURPOSE: Medications are administered as prescribed, in accordance with nursing standards of practice. . . . PROCEDURE: . . . 2. Medications are administered at the time they are prepared. . . ." Review of Resident #44's medical record occurred on all days of survey. A physician's order, dated 09/05/19, stated, "Phytoplex with zinc [skin barrier cream]: apply topically to tip of penis at catheter site for redness & [and] irritation BID [twice daily] x [times] 7 days . . ." The medical record lacked evidence of Resident #44's ability to self administer medications. Observation on 09/09/19 at 11:16 a.m. showed an unidentified cream in three small plastic medication cups in Resident #44's room. When asked about the cream, the resident stated, "I have a yeast infection or something" and stated he applied the cream himself, "When my mind remembers." Observation on 09/10/19 at 8:59 a.m. showed a licensed nurse (#2) in Resident #44's room and identified the cream in a medication cup located	F 658	immediately removed from resident #44□s room. All licensed nurses educated and policy reviewed. 2. All resident of the Griggs County Care center have the potential to be affected. 3. On 9/16/19 Director of Nursing Services provided in-service education to Nursing staff regarding Medication administration. 4. The DON or designee will monitor 4 rooms per week x 1 month then 4 rooms every 2 weeks x 1 month and then monthly x 2 months. Results of the audits will be reviewed at the facility QI Committee meetings until such time it is determined that substantial compliance is maintained. Any problems with the Quality Assurance checks will be reported immediately to the appropriate supervisors so that correction/education can be performed, if needed. 5. Completion date 10/16/19	

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F 658	Continued From page 3 on the window ledge as Phytoplex. During an interview on 09/10/19 at 2:21 p.m., an administrative staff member (#5) confirmed Resident #44 does not self administer medications/creams and on 09/11/19 at 10:16 a.m., stated a nurse needed to apply the Phytoplex because it contains zinc.	F 658		
F 689 SS=E	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 and staff interview, the facility failed to maintain safe water temperatures at hand washing sinks in the resident bathrooms in 3 of 4 resident units (North, West, and South). Failure to ensure safe water temperatures may result in injuries/burns to the residents and staff. Findings include: Observations on 09/09/19 from 10:50 a.m. to 12:09 p.m. showed the following water temperatures at the hand washing sinks in the resident bathrooms: - North Unit: * Room 113 - 137 degrees Fahrenheit (F) * Room 119 - 141.3 degrees F * Room 121 - 141.6 degrees F	F 689	F689 Free of Accident/Hazards/Supervision/Devices 1. Griggs County Care Center Environmental Services monitored and documented water temperatures at random locations and upon investigation determined the mixing valve was faulty and was immediately replaced 9/10/19. 2. All residents of the Griggs County Care Center have the potential to be affected. 3. The facility will take hot water temps in 4 random rooms, once in the morning and once in the afternoon to identify potential problems. All staff were	10/16/19

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F 689	Continued From page 4 * Room 122 - 138.2 degrees F - West Unit: * Room 123 - 146.9 degrees F * Room 126 - 136.4 degrees F - South Unit: * Room 132 - 132.8 degrees F * Room 133 - 126.8 degrees F * Room 134 - 139.8 degrees F On 09/09/19 at 12:15 p.m., after informing an administrative staff member (#9) and an administrative staff nurse (#8) of the hot water temperatures, both stated they were aware of problems with the water temperatures measuring too cold and had been working with the environmental services staff to rectify this concern. The administrative staff member (#9) stated she would inform the environmental service staff (#10) immediately. During an interview on the afternoon of 09/09/19 at approximately 4:30 p.m., the environmental staff member (#10) stated he turned down the temperature on the water boiler system and completed temperature checks in random rooms. The temperatures measured under 110 degrees F during these checks.	F 689	provided education on 9/16/19 at in-service. 4. Environmental services will monitor hot water temps in 4 random rooms daily once in the morning and once in the afternoon for 1 month, then 3 times a week for 1 month , then 2 times weekly times 1 month. Staff are to notify Director of Environmental services immediately if water temperatures are above 109 degrees for further investigation/ monitoring . All documentation will be turned into the safety officer and stored in the education room. Results of the audits will be reviewed at the facility QI Committee meetings until such time it is determined that substantial compliance is maintained. Any problems with the Quality Assurance checks will be reported immediately to the appropriate supervisors so that correction/repairs can be performed, if needed. 5. Completion date 10/16/2019	
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,	F 695		10/16/19

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F 695	Continued From page 5 and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility staff failed to provide the necessary care and services for 2 of 2 sampled residents (Resident #23 and Resident #287) with orders for continuous oxygen. Failure to provide oxygen as ordered has potential for residents to experience complications related to inadequate oxygen saturation levels. Findings include: - Review of Resident #23's medical record occurred on all days of survey. Diagnoses included pulmonary fibrosis and generalized anxiety disorder. Current physician's orders identified continuous oxygen at two liters/minute per nasal cannula. Observation on 09/09/19 at 11:44 a.m. showed Resident #23 in bed with oxygen via nasal cannula at two liters per minute. The resident stated she needs to wear oxygen all the time due to shortness of breath. Observation on 09/10/19 at 11:20 a.m. showed a certified nursing assistant (CNA) (#11) assisted Resident #23 with morning cares. The resident sat on the commode without oxygen in place. The CNA stated Resident #23 wears oxygen continously and she "has a hard time breathing." Observation showed Resident #23 was short of breath, grunting, and breathing heavily. The CNA assisted the resident with dressing and grooming. A second CNA (#12) entered the room and assisted with a gait belt/pivot transfer to the	F 695	F695 Respiratory/Tracheostomy Care and Suctioning 1. CNA□s caring for resident # 23 and #287 on 9/9/19 and 9/10/19 were provided education on continuous oxygen during ADL□s. This education was provided immediately upon surveyor notifying DON of these occurrences the afternoon of 9/11/19. 2. All residents at the Griggs County Care Center dependent on oxygen have the potential to be affected. 3. On 9/16/19 Director of Nursing Services provided in-service training to all direct care staff addressing the significance of continuous oxygen and SOB. Policies reviewed. 4. The DON or designee will monitor 6 residents per week x 1 month then 4 residents every 2 weeks x 1 month and then monthly x 2 months. . Results of the audits will be reviewed at the facility QI Committee meetings until such time it is determined that substantial compliance is maintained. Any problems with the Quality Assurance checks will be reported immediately to the appropriate supervisors so that correction/education can be performed, if needed. 5. Completion date 10/16/19	

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F 695	Continued From page 6 wheelchair. The CNA (#12) stated Resident #23's portable oxygen tank (located on the back of her wheelchair) was empty and placed the nasal cannula on Resident #23. The CNA (#12) then transported the resident to the oxygen storage area to replace the tank. - Review of Resident #287's medical record occurred on all days of survey. Diagnoses include chronic obstructive pulmonary disease (COPD), heart failure, unspecified, and dependence on supplemental oxygen (O2). A physician's order dated 08/28/19 stated "oxygen two liters per nasal cannula continuous." The resident's care plan stated, "Resident has shortness of breath related to [R/T] COPD . . . administer oxygen at [sic] as ordered." Observation of morning cares on 09/10/19 at 8:42 a.m., showed a CNA (#7) removed Resident #287's O2, enabling the resident to wash her face. The CNA (#7) assisted Resident #287 with the remaining morning cares. At 9:04 a.m. (22 minutes later), the CNA (#7) re-applied Resident #287's O2 and transported her to the dining room. During an interview on 09/11/19 at 2:30 p.m., an administrative nurse (#8) stated, "They should have made sure her oxygen was on her the whole time."	F 695		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain	F 755		10/16/19

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F 755	Continued From page 7 them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide a system of accountability for controlled medications in 1 of 1 medication room. Failure to provide a system to adequately receive and dispense controlled medications resulted in Resident #29 receiving a lower dose of medication than ordered and has the potential to	F 755	F755 Pharmacy Services/Procedures/Pharmacist /Records 1. Med Error reviewed and investigated. Resident #29 has had no adverse effects. Controlled medications counted 7/11/19. No other discrepancies found.	

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F 755	Continued From page 8 result in drug diversion. Findings include: Review of the facility policy titled "Narcotic Controls" occured on 09/11/19. This policy, dated 10/16/2007, stated ". . . Purpose: To ensure adequate control over and storage of narcotic medications in a secure environment . . . Procedure: 1. Nurses receive narcotics and immediately log the narcotic on the Narcotic Log kept in the locked cabinet [left side] in the Narcotic Cupboard in the Nursing Home Med Room. This log must contain the date the drug was received, and the nurses' names that received the drug. Narcotic count sheets will also be started at the time the medication is logged in to the facility. The nurse initiating the count sheet will ensure that the name of the medication is written on the count sheet, and will ensure that the appropriate number of tabs is written on the form to initiate the count. 2. Narcotics are to be kept in the cupboard until they are put into use at which time they will be signed out on the log by two nurses or a nurse and a CMA. The log book will be kept at the nurse's station." Review of the narcotic storage cabinet occurred on 09/11/19 at 11:35 a.m. with a staff nurse (#2), and a certified medication assistant (CMA) (#3). The cabinet contained several 30-day supply medication punch cards, including a total of nine cards of varying medications and dosages for Resident #29. Review of one Tramadol, a narcotic pain medication, as needed (PRN) card for Resident #29, dated 04/04/19, showed it contained 25 half tablets of 50 milligram (mg) tablets available with five tablets punched	F 755	2. All residents of the Griggs County Care Center have the potential to be affected. 3. On 9/16/19 the DON provided RN, LPN and CMA□s in-service education on controlled medication storage system. Policy Revised. DON and Consulting Pharmacist also spoke to Pharmacist at Cooperstown Drug. GCCC is currently in process with Cooperstown Drug Pharmacy to reduce the amount of controlled substance medications on hand within the facility and have revised the policy how controlled substances are checked in/out. Two staff (RN/LPN/CMA) will count controlled substances at the end of each shift to verify contents are accurate. 4. DON or designee will inspect controlled substance cabinet to confirm accuracy 4 times per week x one month then twice weekly x one month and then weekly x 1 month. Results of the audits will be reviewed at the facility QI Committee meetings until such time it is determined that substantial compliance is maintained. Any problems with the Quality Assurance checks will be reported immediately to the appropriate supervisors so that correction/education can be performed, if needed. 5. Completion date 10/16/19	

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F 755	Continued From page 9 out/missing. When asked where the missing five tablets were, the nurse (#2) stated a nurse working on 07/15/19 mistakenly removed the card dated 04/04/19 containing 30 half tablets of Tramadol instead of the card containing 30 whole tablets of Tramadol. Review of Resident #29's nacotic log sheet for the PRN Tramadol 50 mg half a tablet showed five administered between July 15-29, 2019. The resident's July PRN medication administration record (MAR) showed documentation for four of the five tablets. The MAR showed the fifth tablet administered on 07/15/19 at 12:14 p.m. instead of Resident #29's scheduled dose of Tramadol 50 mg (whole tablet). During an interview on 09/11/19 at 1:24 p.m., a nurse (#1) stated Resident #29 received Tramadol 50 mg half a tablet on 07/15/19 at 12:14 p.m. instead of the scheduled dose of Tramadol 50mg (a whole tablet) because the staff member who administered the medication removed it from the wrong card.	F 755		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals 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. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and	F 761		10/16/19

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F 761	Continued From page 10 Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) 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 and staff interview, the facility failed to securely store medications in 1 of 1 emergency medication kit (E-kit) within the medication room. Failure to securely store medications may result in unauthorized access or diversion of medications. Findings include: Observation of the E-kit occurred on 09/11/19 at 11:35 a.m., in the medication room with a certified medication aide (CMA) (#3). The facility secured the E-kit with a numbered tear away lock. The E-kit contained a blister card of oxycodone/acetaminophen 5/325 milligram (mg) tablets. It also contained extra numbered tear away locks. During an interview on 09/11/19 at 11:45 a.m., when asked about the process related to E-kit medications, a staff nurse (#4) stated,"an order is obtained and then the medication is used from	F 761	F761 Storage of Drugs and Biologicals 1. E-kit with numbered tear away tag placed into locked controlled substance cabinet. E-kit contents log placed inside e-kit per policy. 2. All resident's of Griggs County Care Center have the potential to be affected. 3. On 9/16/19 the DON provided RN, LPN and CMA□s in-service education on controlled medication storage system/E-Kit. Policy revised. Two staff (RN/LPN/CMA) will reconcile numbered tear away tag at the end of each shift. Ekit to be placed into controlled substance cabinet at all times. 4. DON or designee will inspect E-Kit tag and tag reconciliation to confirm accuracy 4 times per week x one month	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRIGGS COUNTY CARE CENTER	1200 ROBERTS AVE NE COOPERSTOWN, ND 58425

(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 761	Continued From page 11 the E-kit. If needed, the medication is re-ordered and when it is received from the pharmacy, the nurse places a new tear away lock on the E-kit and signs the log, documenting the tear away lock number with either another nurse or a CMA." The facility failed to reconcile the numbered tear away lock on the E-kit to ensure there is no unauthorized access or diversion of medications from the E-kit.	F 761	then twice weekly x one month and then weekly x 1 month. Results of the audits will be reviewed at the facility QI Committee meetings until such time it is determined that substantial compliance is maintained. Any problems with the Quality Assurance checks will be reported immediately to the appropriate supervisors so that correction/education can be performed, if needed. 5. Completion date 10/16/19	