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	355101	A. BUILDING _____ B. WING	05/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DAKOTA ALPHA	1303 27TH STREET NW MANDAN, ND 58554

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F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey started on May 6, 2013 and completed on May 08, 2013 the sample included two (2) residents for complete review, five (5) residents for focused review, and one (1) closed record for review. The sample included one (1) additional resident to verify specific concerns during the survey.	F 000		
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, record review, facility policy review, and staff interview, the facility failed to assess, monitor, develop a plan of care, and re-evaluate devices for 2 of 4 sampled residents (Resident #3 and #5 with seat belts and side rails) observed with potentially restraining devices. The facility failed to assess the functional effect of these devices for each individual resident. Failure to identify the side rails and seat belts as potential restraints resulted in their use without identification of need and the medical symptom they are required to treat. Findings include: Review of a facility admission document titled "Dakota Alpha Safety Practices Checklist"	F 221	Separate screening tools have been developed for side rail and seat belt use. Resident #3 was screened on the use of seat belts. It was found that it continues to be appropriate to use this seat belt as a positioning aid and to remind her to ask for assistance to walk and transfer. She continues able to open the seatbelt herself. It is noted in the side rail screening that Resident #3 sometimes asks for the side rail to be put in the "side rail-middle of the bed" position to be able to see the television screen more clearly as in the "up" (grab bar) position, it blocks her complete view. She has a bed alarm on her bed that would alert staff if she would be trying to exit the bed when the side rail is down.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Dwayne Hoff	Administrator	6-26-2013

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 221	Continued From page 1 occurred on 05/08/13. This document, dated 10/17/12, stated, ". . . BEDRAILS: It is the policy of Dakota Alpha to use bed rails for protection, safety, and as aids in postioning for those who need them. Bed rails are not used to restrain physical movement. Should bed rails be necessary for my personal safety or as postioning aids, Dakota Alpha is granted permission to place side rails on my bed. USE OF WHEELCHAIR SEAT BELTS: It is the policy of Dakota Alpha to use seat belts for persons in wheelchairs as a balancing and postioning aid and when traveling in the wheelchair using agency transportation. Should my condition require the use of a seat belt for upright postioning or for proper balance in an upright position, I give permission to have my wheelchair affixed with a seat belt." - Review of Resident #5's medical record occurred on all days of survey. Diagnoses included traumatic brain injury, right spastic hemiparesis, seizure disorder, and tremors. During the survey the following observations occurred: * 05/06/13 at 3:45 p.m., a certified nursing assistant (CNA) (#2) provided personal cares to Resident #5. The staff member then assisted Resident #5 to his wheelchair and fastened a seat belt around his lap. * 05/07/13 at 8:00 a.m., a CNA (#3) after assisting Resident #5 in the bathroom, assisted the resident into his wheelchair and fastened a seat belt around the resident's lap. * 05/07/13 at 9:15 a.m., a staff nurse (#4) applied a dressing as he sat in his wheelchair with the seat belt fastened. The nursing staff member stated, "[Resident #5's name] can release the	F 221	Quarterly side rail screening and wheelchair seatbelt screening reports will be checked for correct frequency by the DON and reported to the QA committee on the October, January, April, and July meetings. If substantial compliance is reached (>90%, spot checks will be done in 2:4 quarters for the next year to see that compliance continues). The initial screenings that were completed on 6/2 will be completed quarterly and upon any change in condition or any readmission after a hospital stay. Resident #5 was screened on the use of seat belts. It was found that he uses seat belts on the days that he is easily agitated as a reminder that he needs to ask for staff assistance to transfer out of his wheelchair. Resident #5 is able to open his seat belt on the day he was tested. He was also screened on the use of side rails. He prefers to have his side rails in the "up" (grab bar) or positioning aid position so he can move around in bed more easily as he has hemiparesis. Current residents who use wheelchairs have been assessed for the need to use	

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F 221	Continued From page 2 belt." * 05/07/13 at 12:05 p.m., showed Resident #5 in his bed with the top half side rails in the up position. Resident #5's most recent Minimum Data Set (MDS), dated 02/16/13, identified poor short and long term memory, severely impaired cognition, and extensive assistance of one person for bed mobility and transfer. Resident #5's "Care Plan/Individual Program Plan" lacked information regarding the use of a seatbelt or a side rail. While his "Room Care Plan" stated, ". . . Mobility & [and] Transfers Manual Wheelchair . . . Enc [encourage] to use seatbelt. He is not always cooperative with this. He can fasten and unfasten per self. . . ." An April 2013 Nursing Summary, dated 05/02/2013, stated, ". . . He has a safety belt in wheelchair. . . ." This summary lacked information regarding the function of the seat belt or the effect on Resident #5. An Occupational Therapy Quarterly Summary, dated April 2013, stated, ". . . UE [upper extremity] FUNCTION : . . . continues to have RUE [right upper extremity] limitations with decreased AROM [active range of motion] and increased flexor tone. . . holds his hand in a fisted position . . . the thumb remains tight . . . also continues to have the ataxic and tremulous movements on the left UE . . ." - Review of Resident #3's medical record occurred on all days of survey. Diagnoses included closed head injury and left third nerve	F 221	seatbelts in their wheelchairs. The interdisciplinary team has, based on each resident's assessment, determined that some residents need to use seat belts to prevent falls and, for postural instability when they propel their wheelchairs with their feet and cannot use their hands. All current residents who use side rails have been assessed for the need to use them as positioning aids. The interdisciplinary team has, based on each resident's assessment determined that one resident who is cognitively intact has made the decision to use his side rails in the "middle of the bed side rail position" due to his increased sense of security when in bed as he likes to have his bed up higher when he sleeps. This resident has a greater potential for falls as he cannot move his legs well if they start to fall out of bed. All other residents wish them to be in the "grab bar position" for ease in bed mobility except for the resident who likes to have them moved to watch television.	

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F 221	Continued From page 3 palsy. Observation on 05/06/13 at 3:05 p.m. showed Resident #3 in her bed with a half-rail raised and positioned at the center of the bed. The rail in the center position would limit the normal exiting pattern from a bed, and would inhibit a resident from exiting the middle of the bed without staff assistance to remove the rail. Observations throughout the day on 05/06/13 and 05/07/13 showed Resident #3 with a seatbelt when in her wheelchair. Resident #3's current "Care Plan/Individual Program Plan" stated, "Resident Summary: . . . I need to use a seatbelt so I remember that I need help to walk and to help my sitting balance in my wheelchair so I don't slouch when I propel it with my feet. I can open the seatbelt myself. . . . Problem/Identified Need: I am not able to walk without staff or family helping me. Most of the time I use a wheelchair with a seat belt that I can unlock. The seatbelt is a reminder that I can't walk by myself. . . ." The care plan failed to address the use of side rails. Resident #3's most recent MDS, dated 04/16/13, identified extensive assistance of one person with bed mobility and transfers. Resident #3's current "Room Care Plan" stated, "Mobility & [and] Transfers: Safety: Use a quick release seatbelt at all times when in w/c [wheelchair] due to being impulsive and having impaired balance. . . ." Resident #3's "March Nursing Summary" dated	F 221	Assessments for seat belt and side rail use will be performed upon admission, readmission after hospitalization, quarterly, and if cognitive changes occur between these parameters to address changes when they occur. Residents who use side rails and seatbelts will have these issues addressed in their care plans. Care plans are updated when needed, but at least on a quarterly basis. Assessments have been set up through our electronic documentation to be completed once per quarter.	6/7/13

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F 221	Continued From page 4 04/10/13, stated, ". . . She has a Quick release belt placed on her wheelchair for safety. . . . She is a very high fall risk. Her bed is in the low position . . ." The facility failed to implement a system process to assess and re-evaluate the use of potentially restraining devices for Resident #3 and #5.	F 221		
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	Resident #3 and Resident#7 had individual toileting times kept over a period of a month. Per understanding of "individualized toileting program", a program was developed that encouraged them to be dry by changing toileting times daily. According to the guidelines in the MDS toileting program, the program must be by specific toileting times and with these two residents, the times vary day by day. The coding, therefore, for individualized toileting program according to the MDS guidelines is in error. Neither of these residents has had a MDS since the survey, but on succeeding MDS's a toileting program for either of these individuals will not be coded unless it meets the MDS guidelines. Since we do not have RUGS as a payment source, no extra funding was given for this MDS coding on past MDS's.	

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F 278	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on record review and review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual (Version 3.0), the facility failed to complete Minimum Data Set (MDS) assessments which accurately reflected the residents' status for 2 of 2 sampled residents (Resident #3 and #7) coded on the MDS on a urinary toileting program. Failure to accurately assess and code the MDS may affect the level of care provided to residents. Findings include: The Long-Term Care Facility RAI User's Manual: version 3.0, October 2012, page H-5, stated, " . . . implementation of an individualized, resident-specific toileting program that was based on an assessment of the resident's unique voiding pattern, evidence that the individualized program was communicated to staff and the resident (as appropriate) verbally and through a care plan, flow records, and a written report, notations of the resident's response to the toileting program and subsequent evaluations as needed . . ." - Review of Resident #3's medical record occurred on all days of survey. Medical diagnoses included closed head injury, left third nerve palsy, neurogenic bladder, and incontinence. Resident #3's most recent MDS, dated 04/16/13, identified the resident as on a urinary toileting program.	F 278	(Amendment): Resident #7 had a MDS on 5/12/13 which was answered "No" to a bladder training program. Resident #3's MDS of 4/16/13 was corrected and re-submitted on 6/13/13 to reflect "No" to a bladder training program. The MDS coordinator will bring a copy of the most recent MDS for individuals on bladder programs to the QA meeting for a period of one year for review by the QA committee to address concerns with proper coding. Following the survey, the MDs coordinator, social worker, and ADON attended a basic MDS workshop the week of May 13th through May 15th to learn the specifics needed to code the toileting program specifics for our current and future residents.	6/13/13 5/15/13

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F 278	Continued From page 6 Resident #3's current "Care Plan/Individual Program Plan" stated, ". . . Problem/Identified Need: I do not always have control of my bladder and bowels and sometimes I can tell staff if I need to use the bathroom. I sometimes don't void when I sit on the toilet and 5 minutes later I am wet and don't know I have gone to the bathroom. Goal: I will be dry when I am able to tell the staff I have to use the restroom and will have staff change my pullup on a scheduled basis when I am not able to tell them. Approach/Personnel Involved: . . . Staff has me try to void about every 2 hours and before every meal which is my usual pattern. . . ." Resident #3's "Room Care Plan" stated, "Toileting & [and] PeriCares: . . . should be taken to the bathroom upon rising, after meals, before bedtime & PRN [as needed]. She usual (sic) knows if she needs to go, and if she is very anxious taking her helps. My needs (sic) prompts on how to sit on the toilet. . . . Is incontinent of B&B [bowel and bladder] occasionally. . . ." Resident #3's "March Nursing Summary" dated 04/10/13, stated, ". . . is more incontinent of bladder usual 2-3 x [times] per day. . . Her incontinence of bladder seems to be increasing. She does not tell us when she has to void, even sitting at the meal voiding as she sits at the table. She wears attends at all times d/t [due to] increased incontinence. . . ." - Review of Resident #7's medical record occurred on 05/05/13 included diagnoses of traumatic brain injury and left hemiparesis.	F 278		

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F 278	Continued From page 7 Resident #7's most recent MDS, dated 02/10/13, identified the resident as on a urinary toileting program. Resident #7's current "Care Plan/Individual Program Plan" stated, ". . . I am able to wait longer intervals (two hours or more) to urinate most of the time. . . " Resident #7's current "Room Care Plan" stated, "Toileting & [and] PeriCare . . . is encouraged to wait 2 hours between toileting times . . . 2 hr [hour] bathroom reminder . . ." The facility failed to implement individualized, resident-specific toileting programs, periodically evaluate the effectiveness of these specific toileting times, and make revisions to the program, if needed, based on an assessment of Resident #3 and #7's unique voiding pattern.	F 278		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that -- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating	F 322	The nurse who did not check the placement of the feeding tube prior to the medication and bolus feeding of resident #4 was reminded of the Dakota Alpha policy for tube feedings by the ADON on 5/9/13. All other nurses were reminded to check placement of the tube through a note of the deficiencies in the report book. The ADON will be having a review of the total procedure involving tube feedings during her nurse's meeting that will be held on 6/17/13. Nurse's that are not able to attend this meeting must "sign off" on	

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F 322	Continued From page 8 skills. This REQUIREMENT is not met as evidenced by: Based on observation, facility policy review, and staff interview, the facility failed to provide the appropriate treatment and services (checking for placement) for 1 supplemental resident (Resident #9) with a feeding tube. Failure to check for correct placement of the tube prior to administration of medications and feedings may result in harm to the resident. Findings include: Review of the facility policy titled "Medication Administration Via Enteral Tubes" occurred on May 9, 2013. This policy, dated 2005, stated ". . . Equipment and Supplies: 1. Medication to be administered 2. 60 ml [milliliter] syringe . . . 8. Stethoscope . . . Procedures: . . . 8. Check for proper tube placement. . . . " Observation of a staff nurse (#4) administering medications and a bolus feeding via a feeding tube occurred on 05/07/13 at 9:50 a.m. The nurse (#4) failed to check placement of the feeding tube prior to administering medications and a bolus feeding. During interview on the afternoon of 05/09/13, an administrative nursing staff member (#1) confirmed staff should check placement of the	F 322	the meeting minutes so they are kept up to date on the information. The ADON will "spot check" nurse's performing tube feedings on resident's two times per week each full week of June, 2013. By June 30th, 8 checks will be done. If spot checks result in no errors, the ADON will reduce the number of "spot checks" to one per month for the following six months (through December 2013). At the end of December, if no errors have been found, the checks will be discontinued. If errors are found, the number of checks will be increased and re-education will be done with the nurses repeating the errors. The ADON will report the error rate to the Q.A. committee on a quarterly basis for the remainder of the year or until compliance is reached.	6/17/13

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F 322	Continued From page 9 feeding tube prior to administering medications and feedings.	F 322		