STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355069	A. BUILDING _____ B. WING _____	02/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVENTIDE HEARTLAND	**620 14TH AVE NE DEVILS LAKE, ND 58301**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey, started on 02/13/17 and completed on 02/16/17, the sample included 4 residents for complete review, 9 residents for focused review, and 3 closed records for review. The sample included 4 additional residents to verify specific concerns during the survey.	F 000		
F 157 SS=D	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (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)	F 157		3/23/17

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

Electronically Signed | 03/17/2017

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F 157	Continued From page 1 (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 (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). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to timely notify the physician and family member of a significant change in condition for 1 of 13 sampled residents (Resident #3). Failure to notify the physician and family member of the resident's syncope/loss of consciousness episode does not allow the physician and family member to be fully informed of the resident's status and provide input and/or changes to Resident #3's treatment plan. Findings include: Review of Resident #3's medical record occurred on all days of survey. Diagnoses included heart disease, respiratory failure, and chronic obstructive pulmonary disease. The current care	F 157	1. Family of resident #13 has been made aware of syncope episodes, resident's physician has also been notified. 2. All residents with a significant change in health status have the potential to be affected. 3. For all residents with a significant change in condition, family and physician will be notified at the time of the change. The significant change in condition will be reviewed daily at IDT (Interdisciplinary Team) Meeting including monitoring for any change in status reported to the nurse. Education for all nurses and CNA's will be completed by 03/23/17.	

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F 157	Continued From page 2 plan stated, "Focus: ADL [activities of daily living]/MOBILITY DEFICITS . . . Has noted episodes of syncope after bathing on more than one occasion and also in her room. . . . Interventions: BATHING . . . Resident requests to be dressed in room after whirlpool. . . ." Review of the nursing progress notes showed the following: * 07/26/16 at 10:30 a.m.: "Resident was in the whirlpool. CNA [Certified Nursing Assistant] called for help resident was unresponsive sitting in tub chair. Three assist and hoyer used to get her off. She was placed in bed. She remained there all day. Her vitals were within normal limits. She got up out of bed for supper and ate and was responding appropriately to staff. She said she remembers what happened but couldn't communicate. Resident has done this before during bathes." The record lacked evidence staff notified the physician and family member of Resident #3's syncope episode. * 11/02/16 at 1:03 p.m.: "After residents bath she had a syncopal episode. She became unresponsive and pale. It lasted approximately 15 minutes. She was assisted by 4 staff and hoyer lift into bed. She started to talk and come around once she was in bed. Her vital signs were within normal limits when assessed. She occasionally does this after taking a bath." The record lacked evidence staff notified the physician and family member of Resident #3's syncope episode. * 01/24/17 at 11:00 a.m.: "Writer was called to tub room. Resident had syncope episode while sitting on tub chair. Resident was transfer by assist of three staff and hoyer lift into wheelchair. During that time resident was not responding and	F 157	4. Auditing of residents with change in health status requiring notification of family and/or physician will be monitored and completed as follows: 3 times per week for 1 month, 8 times per month for 2 months and 4 times per month for 3 months, and prn. The DON/designee will be responsible to monitor and report audits at scheduled QA meetings.	

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F 157	Continued From page 3	F 157		

flaccid [limp]. Resident was taken to room. Then transferred with hoyer lift and assisted of three into bed. Once into bed resident began responding again. Resident was alert to name and place. Resident did not remember what had happened. Resident stated she felt the tub room was just too warm. Resident stated she just felt tired and denied any pain. Vital signs: [blood pressure] [B/P] 107/64, [pulse] [P] 82, [temperature] [T] 97.2, [oxygen saturations] [O2] 94% RA [room air], [respirations] [R] 18." The record lacked evidence staff notified the physician of Resident #3's syncope episode.

* 02/03/17 at 9:41 a.m.: "Res [resident] did have episode in bathroom of decreased level of consciousness. This has occurred before, usually during tub baths. CNA's did transfer res to recliner to recover. Res did come to and respond after approx [approximately] 1 minute. Vitals were as follows: [B/P] 98/60 P-78 R-16 T-97.2 O2-94% RA. Once res had recovered she stated she felt better and was feeling well enough to eat breakfast." The record lacked evidence staff notified the physician and family member of Resident #3's syncope episode.

* 02/03/17 at 8:35 p.m.: "Writer was called in to residents room where she was found to be on the toilet and was noted to be having another syncopy [sic] episode with decrease level of consciousness as resident was unable to respond appropriately. Resident was pivot transfer with assist of writer and two other staff members as resident was unable to hold onto the pal lift. Once in bed resident was able to respond appropriately to writer and stated she was weak and tired. Vital were as follows: T: 99.8 (did previously have scheduled Tylenol) P 92, R 18, BP 90/55, O2 93." The record lacked evidence

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F 157	Continued From page 4 staff notified the physician and family member of Resident #3's syncope episode. The record showed staff initially informed the physician two days after the fifth syncope episode. During an interview on 02/14/17 at 5:40 p.m., an administrative nurse (#2) confirmed staff failed to follow-up on Resident #3's syncope episodes in a timely manner. The record lacked evidence nursing staff notified the family on five of six occasions of syncope/loss of consciousness.	F 157		
F 250 SS=E	483.40(d) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE (d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview, staff interview, group interview, and review of facility policy, the facility failed to assess, develop, and implement effective interventions for for 1 of 1 sampled residents (Resident #12) who displayed sexual behaviors towards at least five female residents (Residents #10, #13, #17, #18, and #19). Failure to assess the behaviors and respond appropriately affected five female residents and placed other residents at risk for potential harm. Findings include:	F 250	1. Changes to care plan for resident #12 were implemented on 2/16/17 to include that resident is not to be seated near other female residents. Rounds are to be completed every 30 minutes. Residents #10, 13, 17, and 18 impacted by behavior have been assessed and changes to care plans have been implemented. Resident 19 is deceased. All staff were educated on 2-16-17 as they came in for their shift. 2. All female residents with cognitive impairment have the potential to be affected.	3/23/17

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F 250	Continued From page 5 Review of the facility policy titled "Behavior Monitoring" occurred on 02/16/17. This policy, revised May 2013, stated, ". . . All resident care personnel will document behavior as it occurs in Point of Care (POC) or a progress note. Information to be completed includes: date, shift, number of occurrences, response to approaches utilized and the specifics of the behavioral incident. Specifics include factual, concise comments and direct resident quotations. . . . An individualized care plan will be initiated on any resident that has exhibited behaviors. This will be revised as needed with input from interdisciplinary team. . . ." - Resident #12's medical record was reviewed on all days of survey. Medical diagnoses included Alzheimer's disease and mood disorders. The annual Minimum Data Set (MDS), dated 03/20/16, identified severe cognitive impairment. The current care plan stated, ". . . Focus . . . MOOD/DEPRESSION: . . . Hx [history] of resident attempting to be affectionate with staff and residents. (May try to kiss them or put his arm around them and will say 'I love you'. Makes sexual advances and touches inappropriately to other resident's and staff at times. . . . Focus . . . BEHAVIOR/REJECTION OF CARE: . . . Resident has a history of making sexual advances towards staff (trying to pull CNA [Certified Nurse Aide] into his bed, asking her to join him) and residents. . . . Interventions . . . Encourage appropriate displays of affection (eg [example] shaking hands, quick hugs) . . . If another male resident enters [name of resident] room, redirect the resident and explain to [name of resident] that this was a friend coming to visit him. . . . Praise use of appropriate behavior. . . . Remove resident from	F 250	3. The Interdisciplinary Team will continue to review behavioral progress notes during IDT meeting, care plans to be updated, and interventions to be implemented as appropriate. Education of all staff is to be completed by 3/23/17. 4. Auditing of potential concerns identified, interventions identified, documentation, and care plans will be completed as follows: 3 times/week for 1 month, 8 times/month for 2 months, 4 times/month for 3 months and prn. The DON/designee will be responsible to monitor and report audits at scheduled QA meetings.	

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F 250	Continued From page 6 others if upset in the Dining room." Resident #12's progress notes stated the following: * 03/26/16 at 9:20 a.m.: "Staff observed resident sitting in wheelchair by birds. Resident was sitting next to another resident [Resident #13]. Resident had his hand resting on [Resident #13's] upper thigh near groin. [Resident #13] was sleeping at the time. Staff did intervene and brought resident to his room." * 04/08/16 at 10:07 a.m.: "A daughter and son attended Care Conference. . . . Nursing discussed falls and behaviors." * 07/10/16 at 11:00 a.m.: "A visitor reported that resident was grabbing at a female residents abdominal area she was giggling and pushing his hand away. This occurred in the activity room. . . . Resident was removed from area and brought to his room. Monitor resident around other female residents." * 07/10/16 at 2:26 p.m.: ". . . Writer informed on call nurse of residents behavior. She told nurse to chart in moods, leave email for stoical services, and update family. Writer called son, no answer. . . ." * 07/10/16 at 4:15 p.m.: ". . . Resident holding resident [Resident #17] hand by public sitting area by birdcage and rubbing her stomach. This resident removed from public sitting area to area by dining room." * 07/10/16 at 6:02 p.m.:". . . Resident holding resident [Resident #19] hand and other hand was in her lap. This resident removed from situation and brought back to his room." * 07/10/16 at 9:25 p.m.: "Daughter here to speak with writer. Informed her of residents behaviors today. Daughter questioning if he had any med	F 250		

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changes. Informed daughter of decrease in Lexapro."
* 07/15/16 at 2:28 p.m.: "Resident has been redirected away from several female residents today. He has not touched anyone inappropriately today or had any physical alterations."
* 07/16/16 at 1:28 p.m.: "Please make note of any and all physical, sexual and aggressive verbal behaviors on shift. every shift for behaviors until 07/20/16 [11:59 p.m.] We will closely monitor for one week related to increased behaviors. . . ."
07/30/16 at 3:16 p.m.: "Resident did have behaviors this shift. [Resident #12] was sitting by the birds next to [Resident #13]. Staff approached and [Resident #12's] hand was on [Resident #13] thigh moving up and down. Staff moved [Resident #12] away stating that was inappropriate. [Resident #12] kept going back to [Resident #13] and told staff that it didn't matter how many times they moved him, he would keep coming back. [Resident #12] was then directed to his room . . ."
* 07/30/16 at 4:25 p.m.: " Spoke to son [name of son] regarding resident having behaviors. Son expressed that resident having behaviors seems to be an issue after resident has had a antipsychotic medication change. Son expressed that it maybe beneficial for resident to go back to previous medication dosage. Advised son that I would document his concerns, and that it maybe [sic] best to call on Monday and speak with management. Son stated that he would talk to resident's daughter about this as well."
* 07/31/16 at 1:39 p.m.: ". . . Resident was in dining room after lunch, he was approached by staff as he was with various residents that are

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F 250	Continued From page 8 confused. Staff overheard him talking to the woman so stopped to redirect resident. . . . Staff intervened before anything could happen. . . . No changes in plan of care at this time." * 08/01/16 at 2:01 p.m.: "Writer sent fax to [name of physician assistant] per family request re: recent sexual behaviors to increase Lexapro back to 20 mg [milligrams] daily." * 08/02/16 at 9:36 a.m.: "Orders received to increase Lexapro to 20 mg. Resident rarely takes his medications." * 08/03/16 at 3:16 p.m.: ". . . This afternoon he was in room [Resident #18's room number]. Her family was also in there at the time. He was removed from the room." * 08/05/16 at 3:18 p.m.: "Fax sent to PMD [primary medical doctor] asking to discontinue Aricept related to side effect of hypersexuality." * 08/08/16 at 1:18 p.m.: "Order received to discontinue aricept." *08/31/16 at 3:58 p.m.: "PSYCH ROUNDS: [name of physician assistant] here to see resident this afternoon, no changes ordered at this time. Lexapro decreased on 7/7/16 and due to increase in sexual behaviors was increased again to current dose on 8/2/16. [name of physician assistant] and writer discussed that this med change was tried in the past as well without success. . . ." * 09/27/16 at 4:59 p.m.: ". . . Writer called [name of resident's daughter], let her know about a resident to resident that occurred on 09/26/16 involving touching a female resident in inappropriate places." The 09/26/16 incident was not documented. * 09/28/16 at 2:22 p.m.: ". . . discussed his recent behaviors of advances towards female residents. Educated family on interventions that are being	F 250		

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put in place. Staff will be bringing him to his wing after meals instead of in front aviary or activity room. This will provide some space between most of the residents that may be affected. . . ."
* 09/28/16 at 3:24 p.m.: "Resident to be placed at new wing nurses station after meals to avoid being left unattended with female residents."
* 11/03/16 at 12:18 p.m.: "PSYCH ROUNDS: [name of physician assistant] here to see resident this morning, no changes ordered at this time. We did discuss that resident has no behaviors documented since the end of August. . . ." One inappropriate sexual behavior occurred since the end of August.
* 11/19/16 at 10:41 p.m.: ". . . Res [resident] found in room [Resident #18's room number] this shift after he was escorted to his room to go to bed for the night. Res was sitting on the recliner in room [Resident #18's room number] when he was located by staff. . . ."
* 01/05/17 at 11:32 a.m.: ". . . participated in the activities this AM, however he was taken out after making an inappropriate sexual comment towards a female resident. I brought resident to the RT [restorative therapy] gym to do his therapy."
* 01/05/17 at 2:01 p.m.: "PSYCH ROUNDS: [name of physician assistant] here to see resident this morning, no changes ordered at this time. Discussed that resident does refuse cares at times and has a noted episode of wanting to fight another resident, he was easily redirected. . . ." The facility failed to discuss the inappropriate sexual behaviors that occurred since the last psychiatric visit.
* 01/25/17 at 12:54 p.m.: ". . . Resident was in chapel et [and] was discovered by activities aide with hand on another resident under a blanket. . .

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." This resident is identified as Resident #10.

Review of Resident #12's progress notes from March 2016 through January 2017 showed six incidents of sexually inappropriate behaviors with the CNAs.

Resident #12 displayed inappropriate sexual behaviors towards Residents #10,#13, #17, #18, and #19.

- Review of Resident #10's medical record occurred on all days of survey. Medical diagnoses included profound intellectual disabilities. The significant change MDS, dated 06/26/16, identified severely impaired cognition with short and long term memory problems.

- Review of Resident #13's medical record was reviewed on February 15-16, 2017. Medical diagnoses included dementia. Resident #13's quarterly MDS, dated 11/12/16, identified severely impaired cognition.

- Review of Resident #17's medical record occurred on February 15-16, 2017. Medical diagnoses included dementia. The quarterly MDS, dated 01/13/17, identified short and long-term memory problems.

Resident #17's progress notes stated the following:
* 07/11/16 at 5:47 p.m.: "Message left for son to call back regarding resident to resident in activity room yesterday."
* 07/12/16 at 8:29 a.m.: "Writer received a call from resident's son . . . Updated on . . . a resident-to- resident incident with [Resident #12]

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F 250	Continued From page 11 on Sunday. . . ." - Review of Resident #18's medical record occurred on February 15-16, 2017. The quarterly MDS, dated 01/27/17, identified severely impaired cognition. - Review of Resident #19's medical record occurred on February 15-16, 2017. The quarterly MDS, dated 01/05/17, identified severely impaired cognition. - Review of Resident #7's medical record occurred on all days of survey. A progress note dated 09/15/16 at 3:40 p.m. stated, ". . . Family was concerned about another resident advancing on females that are not able to communicate their needs. Staff assured the family that we will watch for all residents that could be affected by this resident. . . ." During a group interview, on 02/14/17 at 10:30 a.m., comments included: * Resident A stated Resident (#12) reached into Resident #13's shirt and fondled her breasts in front of the bird cage display while she waited for her medications. Resident A stated she didn't tell anyone and heard some of the nurses working that day talking about it, so they were aware that something happened. The resident stated she is scared of this resident and that he swore at residents and used dirty language. * Resident B stated Resident (#12) has a pretty bad temper and is verbally abusive to staff and other residents. During an interview on 02/16/17 at 9:50 a.m., Resident B stated Resident #12 likes to look into	F 250		

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(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 250	Continued From page 12 female resident rooms, stands in the doorway, and stares at them. Resident B stated women are afraid of him, and he swears at other residents and staff out in the hallways. Resident B stated the staff just let it go and say "you're not suppose to talk like that and walk away." During an interview on the afternoon of 02/16/17, an administrative staff member (#15) confirmed the facility failed to assess, develop, and implement effective interventions for Resident #12's sexually inappropriate behaviors.	F 250		
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money	F 278		3/23/17

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	355069	A. BUILDING _____ B. WING _____	02/16/2017

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F 278	Continued From page 13 penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.14), and staff interview, the facility failed to ensure accuracy of the coding of the Minimum Data Set (MDS) for 3 of 13 sampled residents (Resident #2, #3, and #8). Failure to accurately complete Section E (Hallucinations) (Resident #2), Section H (Bladder and Bowel) (Resident #3), and Section K (Swallowing/Nutritional Status) (Resident #8) does not allow each assessment to reflect the resident's current status/needs and has the potential to affect the accurate development of a comprehensive care plan and the care provided to the residents. Findings include: HALLUCINATIONS The Long-Term Care Facility RAI User's Manual (Version 1.14), October 2016, pages E-2 - E-3 stated, ". . . E0100: Potential Indicators of Psychosis . . . Coding Instructions . . . Code based on behaviors observed and/or thoughts expressed in the last 7 days rather than the	F 278	1. Assessments for residents #2, 3, and 8 have been modified to reflect current status and resubmitted. 2. All residents with a change in status have the potential to be affected. 3. All MDS assessments completed will be reviewed for accuracy weekly prior to submission. All staff completing MDS sections will be educated on proper coding of the MDS Assessment from nursing documentation prior to 3-23-17. 4. The DON/Nurse Managers will be responsible to monitor and audit as follows: All MDS assessments for 1 month, 8 MDS assessments/month for 2 months, and prn. The DON/designee will be responsible to monitor and report audits at scheduled QA meetings.	

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presence of a medical diagnosis. Check all that apply. *Check E0100A, hallucinations: if hallucinations were present in the last 7 days. A hallucination is the perception of the presence of something that is not actually there. It may be auditory or visual or involve smells, tastes or touch. . . ."

- Resident #2's medical record, reviewed on all days of survey, identified a diagnosis of psychotic disorder with delusions. A quarterly MDS, dated 11/30/16, identified the resident experienced hallucinations during the seven day assessment period. Record review failed to identify Resident #2 had hallucinations during the assessment period.

During an interview on 02/15/17 at 12:15 p.m. an MDS nurse (#3) confirmed Resident #2's record lacked evidence the resident had hallucinations during the seven day assessment period for the quarterly MDS, dated 11/30/16.

BLADDER AND BOWEL

The Long-Term Care Facility RAI User's Manual (Version 1.14), October 2016, pages H-1 stated, "SECTION H: BLADDER AND BOWEL . . . H0100: Appliances . . . Coding Instructions . . . H0100C, ostomy (including urostomy, ileostomy, and colostomy) . . ." Page H-10 - H-11 stated, ". . . H0400: Bowel Continence . . . Coding Instructions . . . Code 3, always incontinent: if during the 7-day look-back period, the resident was incontinent of bowel for all bowel movements and had no continent bowel movements. Code 9, not rated: if during the 7-day look-back period the resident had an

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ostomy or did not have a bowel movement for the entire 7 days. . . ."

- Review of Resident #3's medical record occurred on all days of survey. The current care plan stated, "Focus: TOILETING/CONTINENCE/ELIMINATION . . . has illeostomy to R) [right] abd. [abdomen] . . . Interventions: Empty illeostomy bag every shift and prn [as needed]. . . ." The quarterly MDS, dated 11/18/16, identified an ostomy and always incontinent of bowel.

During an interview on 02/15/17 at 11:30 a.m., an MDS nurse (#3) confirmed Resident #3's bowel incontinence should have been coded as 'not rated'.

SWALLOWING/NUTRITIONAL STATUS

The Long-Term Care Facility RAI User's Manual, (Version 1.14), October 2016, page K-2 stated, "K0100: Swallowing/Nutritional Status . . . Coding Instructions Check all that apply. K0100C, coughing or choking during meals or when swallowing medications. The resident may cough or gag, turn red, have more labored breathing, or have difficulty speaking when eating, drinking, or taking medications. The resident may frequently complain of food or medications 'going down the wrong way.' . . . Coding Tips . . . Code even if the symptom occurred only once in the 7-day look-back period. . . ."

- Review of Resident #8's, medical record occurred on all days of survey. The annual MDS, dated 09/16/16, identified no signs and symptoms of possible swallow disorder.

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F 278	Continued From page 16 The following progress notes during the look back period identified the following: * 09/10/16: "Noted coughing spell with lunch . . ." * 09/11/16: ". . . coughing episode with supper . . ." * 09/12/16: ". . . remains on antibiotic for . . . possible aspiration pneumonia . . ." The facility failed to code Resident #8's MDS accurately to indicate the resident had signs and symptoms of a swallowing disorder.	F 278		
F 280 SS=E	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care.	F 280		3/23/17

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F 280	Continued From page 17 (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s).	F 280		

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F 280	Continued From page 18 An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE STANDARD SURVEY COMPLETED ON 02/18/16. Based on observation, facility policy, record review, and staff interview, the facility failed to review and revise the comprehensive care plans for 6 of 13 sampled residents (Resident #1, #4, #6, #8, #10, #12, and #13) and 3 supplemental residents (Resident #17, #18, and #19). Failure to review and revise the residents' care plans limits communication of resident care needs between staff and does not ensure continuity of care for each resident. Findings include: Review of the facility policy titled "CARE PLAN/COMPREHENSIVE INTERDISCIPLINARY" occurred on 02/16/17. This policy, not dated, stated, ". . . The comprehensive Care Plan will periodically be	F 280	1. Residents #1, 4, 6, 8 10, 12, 13, and 18 care plans were reviewed for accuracy and updated. Resident #19 is deceased. 2. All residents have the potential to be affected. Care plans are reviewed to ensure accuracy and updated as needed to reflect care needed. 3. Care plans are implemented on admission and reviewed and revised quarterly, annually and on every change of condition for each resident. Changes to the care plan will be communicated to the appropriate staff and implemented immediately. Staff will ensure the care plan accurately reflects the resident□s current condition. Education will be completed for staff completing care plans by 3/23/17. 4. Auditing of care plan process will be	

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F 280	Continued From page 19 reviewed and revised by the Interdisciplinary Team after each resident assessment, assessment review, or significant change in condition. . . ." - Review of Resident #4's medical record occurred on all days of survey. Diagnoses included dementia, mood disorder, and depression. A physician's order, dated 12/15/16, stated, "Discontinue Trazodone [an antidepressant]." Resident #4's current care plan stated: * "Focus . . . PSYCHOTROPIC DRUG USE: . . .interventions . . . Give antidepressant medications ordered by physician. Monitor/document side effects and effectiveness. . . ." The care plan failed to identify the most up to date information regarding Resident #4's discontinued antidepressant medication. - Review of Resident #8's medical record occurred on all days of survey. Diagnoses included dementia and dysphagia. A Speech Language Pathologist [SLP] Evaluation and Plan of Treatment, dated 12/12/16, identified the following recommendations: " . . . Supervision for oral intake = Distant supervision . . . Swallow Strategies/Positions: Reposition from slid down position prior to meals/meds [medications] . . ." Resident #8's current care plan stated: * "Focus ADL [activities of daily living]/MOBILITY DEFICITS: . . . Res [resident] with need for increased ADL help due to weakness with resident displaying sx [symptoms] of possible	F 280	completed by the DON/designee as follows: 21 care plans/week for 1 month, 27 care plans/month for 2 months, and prn. The DON/designee will be responsible to monitor and report audits at scheduled QA meetings.	

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stroke . . . with difficulty swallowing with SLP recommendations in place. . . . Interventions . . . EATING: independent after set up. . . ."

A Therapy/Nursing Communication Note, dated 01/09/17, stated, " . . . - Continue regular foods . . . and thin liquids - reposition to upright seating prior to meal . . . - choking episodes likely due to respiratory coordination: [change] of consistency will not help . . ."

The care plan failed to identify the most current recommendations made by the speech pathologist.

- Observation of cares for Resident #1 occurred on 02/14/17 at 8:35 a.m. Following cares, the Certified Nursing Assistant (CNA) (#4) stated she did not offer fluids because Resident #1 was on a fluid restriction.

Review of Resident #1's medical record, on all days of survey, identified a physician's order, dated 02/06/17, stating, "Discontinue fluid restriction." Review of Resident #1's "Bedside Kardex Report" (posted in the resident's closet for staff access) stated, "1500 ml [milliliter]/day Fluid restriction . . . CNA to see med nurse prior to giving fluids."

During an interview on 02/14/17 at 4:42 p.m. an administrative nurse (#2) confirmed the physician had discontinued Resident #1's fluid restriction, but staff had "overlooked" updating the Bedside Kardex.

- Review of Resident #6's medical record occurred on all days of survey. Diagnoses

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included heart failure. A physician order, dated 02/09/17, stated, "Clarification of orders: Fluid restriction is 2000 ml daily." The current care plan identified problems and interventions of "Focus: CHRONIC CARDIAC CONDITIONS . . . CHF [congestive heart failure] . . . Daily diuretic Interventions: 1800 ml/day Fluid restriction . . . Focus: NUTRITION . . . CHF . . . Interventions . . . 2000cc [cubic centimeters] Fluid Restriction . . ."

The admission MDS, dated 12/19/16, identified extensive assistance of one person required with toileting. The current care plan stated "Focus: TOILETING / CONTINENCE / ELIMINATION: Resident is able to self toilet, occasionally needing prompts or direction to the bathroom. . . . Interventions . . . TOILETING: Extensive to total assist. . . ." The problem identified is inconsistent with the interventions developed.

During an interview on 02/16/17 at 9:35 a.m., an administrative nurse (#2) confirmed Resident #6's 2000 ml/day fluid restriction per day and confirmed Resident #6 required extensive assistance with toileting.

- Resident #12's medical record was reviewed on all days of survey. Medical diagnoses included Alzheimer's disease and mood disorders. The annual MDS, dated 03/20/16, identified severe cognitive impairment. The current care plan stated, ". . . Focus . . . MOOD/DEPRESSION: . . . Hx [history] of resident attempting to be affectionate with staff and residents. (May try to kiss them or put his arm around them and will say 'I love you'. Makes sexual advances and touches inappropriately to other resident's and staff at times. . . . Focus . . .

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F 280	Continued From page 22 BEHAVIOR/REJECTION OF CARE: . . . Resident has a history of making sexual advances towards staff (trying to pull CNA into his bed, asking her to join him) and residents. . . . Interventions . . . Encourage appropriate displays of affection (eg [example] shaking hands, quick hugs) . . . If another male resident enters [name of resident] room, redirect the resident and explain to [name of resident] that this was a friend coming to visit him. . . . Praise use of appropriate behavior. . . . Remove resident from others if upset in the Dining room." - The facility failed to develop a care plan to address Resident #12's sexual behaviors towards other female residents. Resident #12's progress notes stated the following: * 03/26/16 at 9:20 a.m.: "Staff observed resident sitting in wheelchair by birds. Resident was sitting next to another resident [Resident #13]. Resident had his hand resting on [Resident #13's] upper thigh near groin. [Resident #13] was sleeping at the time. Staff did intervene and brought resident to his room." * 07/10/16 at 11:00 a.m.: "A visitor reported that resident was grabbing at a female residents abdominal areas she was giggling and pushing his hand away. This occurred in the activity room. . . . Resident was removed from area and brought to his room. Monitor resident around other female residents." * 07/10/16 at 4:15 p.m.: ". . . Resident holding resident [Resident #17] hand by public sitting area by birdcage and rubbing her stomach. This resident removed from public sitting area to area by dining room."	F 280		

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F 280	Continued From page 23 * 07/10/16 at 6:02 p.m.:". . . Resident holding resident [Resident #19] hand and other hand was in her lap. This resident removed from situation and brought back to his room." * 07/15/16 at 2:28 p.m.: "Resident has been redirected away from several female residents today. He has not touched anyone inappropriately today or had any physical alterations." * 07/16/16 at 1:28 p.m.: "Please make note of any and all physical, sexual and aggressive verbal behaviors on shift. every shift for behaviors until 07/20/16 [11:59 p.m.] We will closely monitor for one week related to increased behaviors. . . ." 07/30/16 at 3:16 p.m.: "Resident did have behaviors this shift. [Resident #12] was sitting by the birds next to [Resident #13]. Staff approached and [Resident #12's] hand was on [Resident #13] thigh moving up and down. Staff moved [Resident #12] away stating that was inappropriate. [Resident #12] kept going back to [Resident #13] and told staff that it didn't matter how many times they moved him, he would keep coming back. [Resident #12] was then directed to his room . . ." * 09/28/16 at 2:22 p.m.: ". . . discussed his recent behaviors of advances towards female residents. Educated family on interventions that are being put in place. Staff will be bringing him to his wing after meals instead of in front aviary or activity room. This will provide some space between most of the residents that may be affected. . . ." * 11/19/16 at 10:41 p.m.: ". . . Res [resident] found in room [Resident #18's room number] this shift after he was escorted to his room to go to bed for the night. Res [resident] was sitting on the recliner in room [Resident #18's room	F 280		

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number] when he was located by staff. Res in room [Resident #18 room number] when he was located by staff. . . ."
* 01/25/17 at 12:54 p.m.: ". . . Resident was in chapel et [and] was discovered by activities aide with hand on another resident under a blanket. . . ." This incident occurred with Resident #10.

- Review of Resident #10's medical record occurred on all days of survey. Medical diagnoses included profound intellectual disabilities.

Resident #10's progress note dated 01/25/17 at 1:00 p.m. stated "During church service this morning another resident was next to her et [and] placed hand on resident's lower abd [abdomen] under her blanket. Other resident was removed from area per facility staff et brought to a different activity. Resident made no c/o [concerns of] et resident's POA [power of attorney] was updated et had no concerns regarding what happened."

- Review of Resident #13's medical record was reviewed on February 15-16, 2017. Medical diagnoses included dementia.

Resident #13's progress note on 07/30/16 at 3:19 p.m. stated, ". . . [Resident #12] was sitting by the birds next to [Resident #13]. Staff approached and [Resident #12] hand was on [Resident #13]'s thigh moving up and down. Staff moved [Resident #12] away stating that was in appropriate. [Resident #12] kept going back to [Resident #13] and told staff that it didn't matter how many times they moved him, he would keep coming back."

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EVENTIDE HEARTLAND	620 14TH AVE NE DEVILS LAKE, ND 58301

(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 280	Continued From page 25 - Review of Resident #17's medical record occurred on February 15-16, 2017. Medical diagnoses included dementia. Resident #17's progress notes stated the following: * 07/11/16 at 5:47 p.m.: "Message left for son to call back regarding resident to resident in activity room yesterday." * 07/12/16 at 8:29 a.m.: "Writer received a call from resident's son . . . Updated on . . . a resident to resident incident with [Resident #12] on Sunday. . . ." - Review of Resident #18's current care plan occurred on February 15-16, 2017. - Review of Resident #19's current care plan occurred on February 15-16, 2017. The facility failed to develop a care plan for Residents #10, #13, #17, #18, and #19 to ensure these residents were protected from another resident's sexual advances towards them. During an interview on 02/15/17 at 3:55 p.m., an administrative nurse (#14) confirmed Residents # 10, #12, #13, #17, #18, and #19's care plan lacked measures to protect them from Resident #12's sexually inappropriate behaviors.	F 280		
F 314 SS=D	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that-	F 314		3/23/17

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F 314	Continued From page 26 (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, facility policy and protocol, and staff interview, the facility failed to provide appropriate interventions and treatment to promote healing for 1 of 5 sampled residents (Resident #4) with a current pressure ulcer. Failure to provide timely and appropriate interventions and ensure staff consistently implemented those interventions has the potential to cause further deterioration of Resident #4's existing pressure ulcer. Findings include: Review of facility policy titled "PRESSURE RELIEF FOR HIGH RISK RESIDENTS" occurred on 02/16/17. This undated policy stated, "Purpose: . . . to prevent skin breakdown . . . Procedure: . . . Wash skin with mild soap and soft wash cloth . . . skin should be cleansed at the time of soiling and at routine intervals. . . ." Review of facility protocol for skin care titled "Eventide Heartland Skin Care Protocol," occurred on 02/16/17. This protocol, revised	F 314	1. Resident #4 on 2-14-17 wound nurse completed treatment to pressure injury and applied the dressing as ordered. 2. All residents with pressure injuries have the potential to be affected. 3. All residents at risk for skin breakdown will be evaluated and pressure injuries will be reviewed weekly during Inter Disciplinary Team meetings including current treatments and any need for change in treatment. Treatment orders on all residents with current pressure injuries will also be reviewed and monitoring of dressings to ensure the correct dressing is in use. Education will be completed for all Nurses by 3/23/17. 4. Auditing of residents at risk for skin breakdown and pressure injuries will be completed as follows: 3 times/week for 1 month, 8 times/month for 2 months, and prn. The DON/designee will be	

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F 314	Continued From page 27 October 2014, stated, " . . . Stage II . . . Relieve pressure Maintain moist environment and absorb excess exudate [drainage] . . . Dressing Choices . . . Cleanse . . . Hydrocolloid [absorbs drainage and forms a jell in the bed of the wound] or Foam Dressing . . ." Review of Resident #4's medical record occurred on all days of survey. Diagnoses included pressure ulcer to right heel stage 2 and dementia. The annual Minimum Data Set (MDS), dated 12/04/16, identified severely impaired cognition, at risk for developing pressure ulcers, and a pressure reducing device for the bed. Resident #4's current care plan stated, "Focus . . . SKIN INTEGRITY/RISK FOR PRESSURE WOUND: . . . stage II to R [right]) heel; blanchable redness noted to L [left]) heel . . . Interventions . . . Skin risk assessments per protocol . . . treatments to bilat [bilaterally] heels-see TAR [treatment administration record] for specifics. . . ." The physician's order, located on the TAR with a discontinue date of 02/06/17, identified, "Monitor for allevyn [a foam dressing] placement to right Achilles [heel] area Stage II. Change dressing PRN and on bath day. Protect left heel with allevyn also." A new physician's order dated on 02/06/17 identified, "Monitor for hydrocellular [absorbent] foam placement to right achilles area Stage II. Change dressing PRN [as needed] and on bath day. Protect left heel with allevyn also. Frequency: every day shift . . ."	F 314	responsible to monitor and report audits at scheduled QA meetings.	

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F 314	Continued From page 28 The progress notes identified the following: * 01/12/17, "Deep tissue injury right achilles area measuring 0.5 centimeter (cm) x 0.5 cm, applied allevyn . . . ." * 01/17/17, " . . . right achilles stage 2: scant amount of serosanguineous [yellow and bloody] drainage on old dressing. . . . Area 0.5 cm x 0.5 cm . . ." * 01/23/17, " . . . scant amount of serosanguineous drainage noted. Area measures 0.4 cm x 0.4 cm. . . ." * 01/26/17, ". . . Allevyn stage II right heel and for protection to left heel . . ." * 01/30/17, " . . .Stage II scant amount of serosanguineous 1 cm x 1 cm last weeks 0.4 cm x 0.4 cm wound bed is red. . . . Allevyn applied to right and left achilles as ordered. . . ." 02/02/17, "Allevyn applied to right heel and left achilles as ordered . . ." 02/06/17, " . . . stage 2 moderate thick yellow drainage 1.5 cm x 1 cm . . . wound bed red . . . will plan to change to hydrocellular foam dressing. . . ." 02/09/17, " . . . new Allevyn placed to back of heels . . ." 02/14/17, " . . . new Allevyn dressing applied to right achilles . . ." The progress notes showed the nursing staff failed to apply the correct dressing starting on 02/06/17 per physician's order. Observation on 02/14/17 at 1:00 p.m. showed a staff nurse (#9) removed Resident #4's allevyn dressing from her right achilles pressure ulcer. The dressing showed a moderate amount serosanguineous and slightly green drainage. The pressure ulcer measured approximately 1 cm in diameter. Without cleansing the area, the	F 314		

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F 314	Continued From page 29	F 314		

nurse applied a clean allevyn dressing. The nurse (#9) stated the same allevyn dressing is applied to the right achilles and the left ankle weekly and as needed, and the pressure ulcer was acquired from the shoe rubbing on the back of her right lower leg. The staff nurse (#9) failed to cleanse the pressure ulcer and complete the dressing change per physician's order dated 02/06/17.

During an interview on 02/15/17 at 8:30 a.m., a staff nurse (#9) confirmed she applied the wrong dressing and signed off the TAR to verify the dressing was monitored from 02/07/17 through 02/14/17. The staff nurse failed to complete the dressing change as ordered and identify the proper dressing was applied.

Observation on 02/14/17 at 2:30 p.m. showed a staff nurse (#12) remove Resident #4's allevyn dressing from the right achilles. No visible drainage noted on dressing. The nurse cleansed the pressure ulcer with a PH balanced cleanser spray and wiped the area with a 4 x 4 dressing. The pressure ulcer measured 1 cm x 0.3 cm with a yellow center. The staff nurse stated, "It looks like she could use some debridement (removal of dead or damaged tissue) to it or maybe I'll just order a medihoney (antibiotic honey-based) and zero form (a highly absorbent foam) dressing, that usually works well." The staff nurse (#12) applied a hydrocellular foam dressing to the right achilles.

During an interview on 02/14/17 at 2:30 p.m. and 02/15/17 at 4:30 p.m. a staff nurse (#12) confirmed she requested an order change from allevyn to hydrocellular foam dressing on

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F 314	Continued From page 30 02/06/17. The nurse (#12) stated the resident had the wrong dressing on and applied the correct one this afternoon. The nurse (#12) verified staff had not followed the physician's order, dated 02/06/17, for the hydrocellular dressing.	F 314		
F 328 SS=D	483.25(b)(2)(f)(g)(5)(h)(i)(j) TREATMENT/CARE FOR SPECIAL NEEDS (b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments (f) Colostomy, ureterostomy, or ileostomy care. The facility must ensure that residents who require colostomy, ureterostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. (g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to … prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers.	F 328		3/23/17

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F 328	Continued From page 31 (h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. (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. (j) Prostheses. The facility must ensure that a resident who has a prosthesis is provided care and assistance, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, to wear and be able to use the prosthetic device. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to provide the necessary care and services for 1 of 1 sampled resident (Resident #6) with physician's orders for continuous oxygen. Failure to provide oxygen as ordered has the potential for residents to experience complications and/or hospitalization related to inadequate oxygen saturation levels. Findings include: - Review of Resident #6's medical record	F 328	1. Resident #6 will have oxygen administered according to Physician orders. 2. All residents requiring continuous oxygen therapy have the potential to be affected. 3. Monitoring to Ensure Compliance: All Nurses and CNA□s to be re-educated regarding oxygen use during transfers and ADL□s by 3/23/17.	

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F 328	Continued From page 32 occurred on all days of survey. Diagnoses included congestive heart failure, pulmonary hypertension, and respiratory failure. The current care plan stated "Focus: CHRONIC CARDIAC CONDITIONS: Hyperlipidemia/HTN [hypertension]/CHF [congestive heart failure] AEB [as evidenced by] daily Rx [prescriptions] to manage. Resident had pacemaker placed on 11/29/16. Daily diuretic . . . Interventions . . . oxygen 2L [liters]/NC [nasal cannula] continuous . . ." A physician order, dated 02/09/17, stated, "O2 [oxygen] at 2 liters per nasal cannula continuous." Observation on 02/13/17 at 4:53 p.m. showed Resident #6 removed her oxygen nasal cannula. Two certified nursing assistants (CNAs) (#7 and #8) transferred Resident #6 with a mechanical stand lift from the recliner to the commode and then transferred her back to the recliner. The CNAs (#7 and #8) exited the room at 5:20 p.m. and failed to apply Resident #6's oxygen. Observation at 5:38 p.m. showed Resident #6 sitting in her recliner without her oxygen on. Staff failed to provide Resident #6's oxygen for approximately 45 minutes. During an interview on 02/16/17 at 9:35 a.m., an administrative nurse (#2) stated Resident #6 should have had her oxygen on.	F 328	4. Auditing of residents on oxygen therapy will completed as follows: 3 times/week for 1 month, 8 times/month for 2 months, and prn. The DON/designee will be responsible to monitor and report audits at scheduled QA meetings.	
F 431 SS=D	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in	F 431		3/23/17

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F 431	Continued From page 33 §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (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. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (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. (h) Storage of Drugs and Biologicals. (1) In accordance with State and 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.	F 431		

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F 431	Continued From page 34 (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 record review, observation, professional reference review, and staff interview, the facility failed to ensure proper labeling of a medication during 1 of 4 observations (02/14/17 at 9:45 a.m.) of medication administration. Failure to ensure labeling of mediations with the most current physician's order may result in medication errors. Finding include: Berman and Snyder, "Kozier & Erb's Fundamentals of Nursing: Concepts, Process and Practice," 10th Edition, Pearson Education, Inc, New Jersey, page 776 states, ". . . Compare the label of the medication container or unit-dose package against the order on the MAR [medication administration record] . . . If these are not identical, recheck the prescriber's written order . . ." The facility did not provide a policy on medication administration when requested. Observation during medication pass on 02/14/17 at 9:45 a.m. showed a staff nurse (#9) administered fluticasone (nose spray) to	F 431	1. Pharmacist contacted and a new label was placed on the Flonase for resident #20 on 2/15/17 and medication error report completed. Current process for transcribing orders and medication orders and medication administration reviewed with nurses. 2. All residents with a change to medication dose have the potential to be affected. 3. Pharmacy will be notified for all residents with a change in dose of medication and will have a new label placed on medication. All Nurses and CMA'□s to be re-educated on proper procedure for the transcription of orders, labeling medications and five rights of medication administration by the by 3/23/17. 4. Auditing of dose changes in medication orders to be completed as follows: 3 times/week for 1 month, 8 times/month for 2 months, 4 times/month for 3 months and prn. The DON/designee will be	

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F 431	Continued From page 35 Resident #20 with two puffs to each nare. The medication label stated "fluticasone 50 micrograms (mcg) 2 sprays in each nostril daily." The current physician order stated "fluticasone 50 mcg one spray in both nostrils every 12 hours." The facility failed to update the medication label to coincide with the physician order. During an interview on 02/15/17 at 8:30 a.m., a staff nurse (#9) confirmed the label of the fluticasone did not match the doctor's order and the wrong dose of this medication was administered to Resident #20.	F 431	responsible to monitor and report audits at scheduled QA meetings.	