STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355063	A. BUILDING _____ B. WING _____	01/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKES HOME	242 10TH ST W DICKINSON, ND 58601

(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 01/19/16 and completed on 01/25/16, the sample included four (4) residents for complete review, 10 residents for focused review, and three (3) closed records for review. The sample included 14 additional residents to verify specific concerns during the survey.	F 000		
F 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.	F 156		2/29/16

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

Electronically Signed | 02/13/2016

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F 156	Continued From page 1	F 156		

The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.

The facility must furnish a written description of legal rights which includes:
A description of the manner of protecting personal funds, under paragraph (c) of this section;

A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.

A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with

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F 156	Continued From page 2 the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on review of Medicare billing records and staff interview, the facility failed to provide Medicare notices in a timely manner to 2 of 2 sampled residents (Resident #4 and #14) and 1 supplemental resident (Resident #26) reviewed. Failure to provide the "Notice of Medicare Non-Coverage" at least two days in advance of the service termination prevents the resident from requesting an expedited review of the decision to terminate the services and is a violation of the resident's rights. Findings include: Resident #4, #14, and #26's billing records were reviewed on the afternoon of 01/19/16. Each record showed the Mandatory Denial Notice was provided in a timely manner, but lacked evidence the residents also received a Notice of Medicare Provider Non-Coverage.	F 156	Identified residents (#4 and #14) were given the Notice of Medicare Provider Non-Coverage. Due to potential of all residents being affected by the same deficiency a policy titled Changes to Medicare Beneficiary Health Coverage was developed. All interdisciplinary team members (includes nurse managers, administrator, social services, dietary manager, activity manager, quality/risk nurse, director of nursing) and business office staff (accounts payable and billing personnel) were educated by the Administrator regarding policy Changes to Medicare Beneficiary Health Coverage. Monitoring for ensuring Notice of	

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F 156	Continued From page 3 During an interview on the afternoon of 01/19/16, a managerial staff member (#3) confirmed the facility failed to provide the residents with a Notice of Medicare Provider Non-Coverage at least two days prior to termination of Medicare services. Resident #4, #14, and #26's record lacked documentation staff contacted the resident's representative prior to termination of services, explained the right to an expedited appeal, mailed the written notice with a copy for the resident's record, or provided notice per certified mail.	F 156	Medicare Provider Non-Coverage form is given to Medicare A residents no longer receiving therapies will start the week of 2/8/16. The Director of Nursing or designee shall monitor and report to the quality committee as follows: Monitor: Weekly x4; Monthly x3; Quarterly x4	
F 167 SS=B	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure the most recent life safety code survey results were available for examination for 2 of 3 days (January 19-21, 2016) of survey.	F 167	Life Safety Code Survey conducted in 2015 was printed and placed in binder with other previous health surveys. Due to potential of all residents being affected by the same deficiency found, all	2/10/16

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F 167	Continued From page 4 Findings include: Observation on January 19-20, 2015 showed the results of the previous health surveys, conducted on 12/04/14, 06/04/15, and 08/13/15, in a binder lying on a table in the hallway next to the receptionist's office on first floor. The results of the life safety code survey were not present in the binder. During the facility environmental tour on 01/20/16 at 9:30 a.m., an administrative staff member (#14) confirmed the facility failed to post the life safety code survey results.	F 167	interdisciplinary team members (includes nurse managers, administrator, social services, dietary manager, activity manager, quality/risk nurse, director of nursing) and director level staff (includes managers of assisted living, human resources, environmental services) were educated by Amy Kreidt, administrator regarding F 167 requirements.	
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, resident interview, and staff interview, the facility failed to provide care in a manner that enhanced dignity/self-esteem for 1 of 14 sampled residents (Resident #6) and 6 supplemental residents (Resident #18, #19, #20, #21, #22, and #23). Failure to ensure dignity and respect during personal cares and regarding personal appearance does not recognize the individuality or enhance the quality of life for each resident. Findings include:	F 241	Identified residents (#19, 21, 18, and 20) were assessed for excessive facial hair on chin and removed as needed. Identified residents (#6) regarding performance of cares, CNA was educated by director of nursing, unit manager, and social services director regarding policy titled Quality of Life-Dignity and facilities expectations when caring for residents regarding application of briefs, dressing of resident, communicating with and explaining items to resident, and facility□s	2/29/16

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F 241	Continued From page 5 Review of the facility policy and procedure titled "Quality of Life - Dignity" occurred on 01/21/16. This policy, revised September 2011, stated, ". . . 1. Residents shall be treated with dignity and respect at all times. 2. 'Treated with Dignity' means the resident will be assisted in maintaining and enhancing his or her self-esteem and self-worth. 3. Residents shall be groomed as they wish to be groomed (hair styles, nails, facial hair, etc.). . . . 8. Staff shall keep the resident informed and oriented to their environment. Procedures shall be explained before they are performed . . . 11. Demeaning practices and standards of care that compromise dignity are prohibited. . . ." - Observation during initial tour on 01/19/16 at 9:10 a.m. showed a female resident (Resident #19) with excessive facial hair on her chin. - Observation during medication pass on 01/19/16 at 4:05 p.m. showed a female resident (Resident #21) with excessive facial hair on her chin. - Observation on 01/20/15 at 7:48 a.m. showed a female resident (Resident #18) with excessive facial hair above her lip and on her chin. - Observation on 01/20/16 at 8:23 a.m. showed a female resident (Resident #20) with excessive facial hair on her chin. - Observation on 01/20/16 at 7:11 a.m. showed Resident #6 in her bed and a certified nursing assistant (CNA) (#10) assisting with perineal cares. The CNA (#10) forcefully spread the resident's legs and applied a brief, then held the	F 241	expectations associated with policy title Quality of Life-Dignity. Identified resident #22, regarding feeding, CNA was educated by director of nursing, unit manager, and social services director regarding policy titled Quality of Life-Dignity and facilities expectations when caring for residents regarding feeding, communication/explaining to resident, and moving resident□s tray. Due to the potential of other residents being affected by deficiency, education regarding areas associated with excessive facial hair, performing cares, and feeding was completed with all nursing staff (including CNA□s and nurses) per policy titled Quality of Life-Dignity. Monitoring for ensuring Quality of Life-Dignity (excessive facial hair, performing cares, and feeding) will be monitored starting the week of 2/8/16. The Director of Nursing or designee shall monitor and report to the quality committee as follows: Monitor: Weekly x4; Monthly x3; Quarterly x4	

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F 241	Continued From page 6 resident's left leg in the air and put it in the pant leg, and let her leg drop to the mattress. He repeated this with the resident's right leg. The CNA (#10) proceeded to pull the resident's pants up, forcefully turning the resident from side to side with no communication or explanation as to what he was doing. The resident moaned out "ow" during cares. During an interview on 01/20/16 at 7:35 a.m., Resident #6 stated, the CNA (#10) ". . . is rough sometimes . . ." - Observation on 01/20/16 at 8:58 a.m., showed a CNA (#10) seated next to Resident #22 in the dining room. The CNA (#10) assisted Resident #22 with eating and used the clothing protector tied around the resident's neck to wipe away food from the resident's chin. Resident #23, seated across the table from Resident #22, reached for the food items placed in front of Resident #22. The CNA (#10) asked Resident #23 what she was doing and the resident did not answer. The CNA (#10) then grabbed a tissue box, and with the tissue box, moved the food items out of Resident #23's reach. The CNA (#10) failed to explain to Resident #23 why he was moving the food items. During an interview on 01/21/16 at 11:16 a.m., a supervisory nurse (#5) stated facility staff should use a napkin to wipe food from a resident's face. She stated using a tissue box to move a resident's food is not the expectation of staff assistance. The supervisory nurse (#5) stated she was unsure of why Resident #20 was not shaved and stated the facility had contacted the families for both Resident #18 and #19 regarding	F 241		

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F 241	Continued From page 7 razors on 01/21/16. The supervisory nurse (#5) stated she has had several conversations with the CNA (#10) in reference to the way he provides care to the residents. The facility failed to ensure dignity and respect during personal cares and with personal appearance. Staff handling the resident roughly during personal cares, utilizing a clothing protector to wipe food from a resident's face, utilizing a tissue box to move food from a resident, and not maintaining personal appearance for female resident's with facial hair does not recognize the individuality or enhance the quality of life for each resident.	F 241		
F 272 SS=C	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions;	F 272		2/29/16

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F 272	Continued From page 8 Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. 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), facility staff failed to identify the location and/or date of the Care Area Assessment (CAA) documentation on Section V of the Minimum Data Set (MDS) for 14 of 14 sampled resident records (Resident #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, and #14) reviewed. Failure to identify the location and/or date of the CAA documentation limits the ability of the interdisciplinary team to locate information related to the resident's complicating factors, risks, and any referrals for the CAA area. Findings include: The Long-Term Care Facility RAI User's Manual,	F 272	For identified residents (#1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13 &14) for Section V lacking location and/or date of the CAA information will be corrected and submitted via modification. Due to potential of all residents being affected by this deficient practice, as RAIs/MDSs are completed on all residents. As of 2/9/16 education regarding Section V lacking location and/or date of the CAA information. Director of nursing provided education and handouts of Section V of the RAI User□s Manual and completed this with interdisciplinary team members (includes nurse managers, social services, dietary manager, activities manager, and	

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F 272	Continued From page 9 Version 3.0, dated October 2015, Chapter 2, page V-5, stated ". . . Items V0200A 01 through 20 document which triggered care areas require further assessment, decision as to whether or not a triggered care area is addresses in the resident care plan, and the location and date of CAA documentation . . . ." Review of Resident #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, and #14's medical records occurred on January 19-21, 2016. Review of the current comprehensive assessment for each resident identified MDS Section V (CAA Summary) "Location and Date of CAA Documentation" failed to indicate the date of the CAA information. The location for one or more care areas triggered for all the resident's stated "See CAA Worksheet". The "CAA Worksheets" contained a section titled "Location and Date of CAA Information" but documentation by facility staff in this section included general information such as history and physical, nurses notes, plan of care (no dates). The following CAA Summaries (Section V0200A) lacked location and dates for the Care Areas triggered: *Resident #1 - Admission MDS, dated 12/25/15 *Resident #2 - Significant Change in Status assessment, dated 10/14/15 *Resident #3 - Admission MDS, dated 11/26/15 *Resident #4 - Admission MDS, dated 09/25/15 *Resident #5 - Admission MDS, dated 01/10/16 *Resident #6 - Admission MDS, dated 11/12/15 *Resident #7 - Annual MDS, dated 12/23/15 *Resident #8 - Admission MDS, dated 11/27/15 *Resident #9 - Annual MDS, dated 08/22/15 *Resident #10 - Admission MDS, dated 09/10/15	F 272	administrator). Director of nursing or designee monitors accuracy of Section V locations and dates of the CAA information documented prior to submission. Monitoring to ensure Section V locations and dates of the CAA information will be monitored starting the week of 2/8/16. The Director of Nursing or designee shall monitor and report to the quality committee as follows: Monitor: Weekly x4; Monthly x3; Quarterly x4	

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F 272	Continued From page 10 *Resident #11 - Admission MDS, dated 05/08/15 *Resident #12 - Admission MDS, dated 09/15/15 *Resident #13 - Admission MDS, dated 04/07/15 *Resident #14 - Annual MDS, dated 09/08/15	F 272		
F 273 SS=D	483.20(b)(2)(i) COMPREHENSIVE ASSESSMENT 14 DAYS AFTER ADMIT A facility must conduct a comprehensive assessment of a resident within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or for therapeutic leave.) This REQUIREMENT is not met as evidenced by: Based on record review, review of the federal database for Long-Term Care surveys, review of the Resident Assessment Instrument (RAI) User's Manual, and staff interview, the facility failed to complete the Admission Minimum Data Sets (MDSs) within 14 days from admission to the facility for 1 of 14 sampled residents (Resident #1) and 1 of 7 closed resident records (Resident #24) reviewed. Failure to complete in admission MDSs in a timely manner, delays the facility in obtaining the assessment information necessary to develop a care plan and to provide the appropriate care and services for these residents. Findings include: The Long-Term Care Facility RAI User's Manual, dated October 2015, Chapter 2, pages 18-19,	F 273	Due to potential of all residents being affected by the deficient practice as RAIs/MDSs are completed on all residents. As of 2/9/16 education regarding RAI User□s Manual Chapter 2, pages 18-19 regarding timeliness of comprehensive assessment 14 days after admission was completed with interdisciplinary team members (includes nurse managers, social services, dietary manager, activities manager, and administrator). Director of nursing provided this education and handouts. Director of nursing or designee monitors timeliness of completion of comprehensive assessment within 14 days after admission as identified by using internal MDS calendar and	2/29/16

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F 273	Continued From page 11 stated, "Admission Assessment (A0310A=01): The Admission assessment is a comprehensive assessment for a new resident . . . The ARD [Assessment Reference Date] (Item A2300) must be set no later than day 14, counting the date of admission as day 1. . . . The MDS completion date (Item Z500B) must be no later than day 14. This date may be earlier than or the same as the CAA(s) [Care area assessments] completion date, but not later than. The CAA(s) completion date (Item V0200B2) must be no later than day 14. . . ." - Rever of Resident #1's Admission MDS on January 20-21 showed an entry date (A1600) of 12/18/15. The CAA completion date at V0200B2 was 01/04/16 (day 18). - Review of Resident #24's Admission MDS on January 20-21, 2016 showed an entry date (A1600) of 12/07/15. The MDS completion date at Z0500B was 12/21/15 (day 15). During an interview on the morning of 01/21/16, an administrative nursing staff member (#3) agreed Resident #1 and #24's Admission MDSs were completed late.	F 273	available reports from Matrix. Implemented an internal process to have MDS completed by day 9 of the 14 days after the ARD to allow for accuracy review and timely submission. Will also use validation report to determine if interventions are effective. Monitoring for timelines of comprehensive assessment 14 days after admission will be monitored starting the week of 2/8/16. The Director of Nursing or designee shall monitor and report to the quality committee as follows: Monitor: Weekly x4; Monthly x3; Quarterly x4	
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve	F 274		2/29/16

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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 274	Continued From page 12 itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on review of the federal database for Long-Term Care surveys, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, and staff interview, the facility failed to complete a Significant Change in Status Minimum Data Set (MDS) in a timely manner for 1 of 3 closed resident records (Resident #16) reviewed. Failure to complete a Significant Change in Status Assessment (SCSA) in a timely manner, delays the facility in obtaining the assessment information necessary to develop a care plan and to provide the appropriate care and services for the residents. Findings include: The Long-Term Care Facility RAI User's Manual, October 2015, Chapter 2, pages 20 and 22, stated, "Significant Change in Status Assessment (SCSA) (A0310A=04): The SCSA is a comprehensive assessment for a resident that must be completed when the IDT [interdisciplinary team] has determined that a resident meets the significant change guidelines for either improvement or decline. . . . The MDS completion date (Item Z0500B) must be no later than 14 days from the ARD [Assessment	F 274	Due to potential of all residents being affected by the deficient practice as RAIs/MDSs are completed on al residents. As of 2/9/16 education regarding RAI User□s Manual Chapter 2, pages 20 and 22 regarding Comprehensive Assessment after a Significant Change was completed with interdisciplinary team members (includes nurse managers, social services, dietary manager, activities manager, and administrator).Director of nursing provided this education and handouts. Director of nursing or designee monitors timeliness of completion of comprehensive assessment within 14 days after significant change is identified by using internal MDS calendar and available reports from Matrix. Implemented an internal process to have MDS completed by day 9 of the 14 day after the ARD to allow for accuracy review and timely submission. Will also use validation report to determine if interventions are effective. Monitoring for timeliness of	

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	355063	A. BUILDING _____ B. WING _____	01/25/2016

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F 274	Continued From page 13 Reference Date] (ARD + 14 calendar days) and no later that 14 days after the determination that the criteria for a SCSA were met. This date may be earlier than or the same as the CAA(s) [Care Area Assessments] completion date, but not later than. . . . The CAA(s) completion date (Item V0200B2) must be no later than 14 days after the ARD (ARD +14 calendar days) and no later that 14 days after the determination that the criteria for a SCSA were met. This date may be the same as the MDS completion date, but not earlier that MDS completion. . . ." Review of Resident #16's Significant Change in Status MDS on January 20-21, 2016 showed an ARD of 12/31/15. The CAA completion date at V0200B2 was 01/19/16 (ARD + 19 days) and the MDS completion date at Z0500B was 01/19/16 (ARD + 19 days). During an interview on the morning of 01/21/16, an administrative nursing staff member (#3) confirmed the late completion of Resident #16's Significant Change in Status MDS.	F 274	comprehensive assessment after significant change will be monitored starting the week of 2/8/16. The Director of Nursing or designee shall monitor and report to the quality committee as follows: Monitor: Weekly x4; Monthly x3; Quarterly x4	
F 276 SS=E	483.20(c) QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on record, review of the federal database for Long-Term Care surveys, review of the Long-Term Care Facility Resident Assessment	F 276	Due to potential of all residents being affected by the same deficient practice as RAIs/MDSs are completed on all	2/29/16

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F 276	Continued From page 14 Instrument (RAI) User's Manual, and staff interview, the facility failed to complete Quarterly Minimum Data Sets (MDSs) for 1 of 9 sampled residents (Resident #14), and 6 of 7 supplemental residents (Resident #25, #26, #27, #28, #29, and #30) within 92 days after the Assessment Reference Date (ARD) of the previous Omnibus Budget Reconciliation Act (OBRA) assessment or failed to complete the quarterly assessment in a timely manner as identified by the date at Z0500B. Failure to complete quarterly assessments in a timely manner, delays the facility in obtaining the assessment information necessary to revise a care plan and to provide the appropriate care and services for the residents. Findings include: The Long-Term Care Facility RAI User's Manual, October 2015, Chapter 2, page 31, stated, "The Quarterly assessment is an OBRA non-comprehensive assessment for a resident that must be completed at least every 92 days following the previous OBRA assessment of any type. It is used to track a resident's status between comprehensive assessments to ensure critical indicators of gradual change in a resident's status are monitored. . . . The ARD must be within 92 days after the ARD of the previous OBRA assessment . . . The MDS [Minimum Data Set] completion date (Item Z0500B) must be no later than 14 days after the ARD (ARD + 14 calendar days)." Review of the MDSs for Resident #14, #25, #26, #27, #28, #29, and #30's on January 20-21, 2016 identified the following:	F 276	residents. As of 2/9/16 education regarding RAI User□s Manual Chapter 2, page 31 regarding timeliness of quarterly assessment was completed with interdisciplinary team members (includes nurse managers, social services, dietary manager, activities manager, and administrator). Director of nursing provided this education and handouts. Director of nursing or designee monitors timeliness of completion of comprehensive assessment at least every three months is identified by using internal MDS calendar and available reports from Matrix. Implemented an internal process to have MDS completed by day 9 of the 14 days after the ARD to allow for accuracy review and timely submission. Will also use validation report to determine if interventions are effective. Monitoring for timeliness of quarterly assessments will be monitored starting the week of 2/8/16. The Director of Nursing or designee shall monitor and report to the quality committee as follows: Monitor: Weekly x4; Monthly x3; Quarterly x4	

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F 276	Continued From page 15 - Resident #14's Annual MDS showed an ARD of 09/08/15. The next OBRA Quarterly MDS showed an ARD of 12/18/15, 101 days after the previous ARD. - Resident #25's Quarterly MDS showed an ARD of 10/06/15. The next OBRA Quarterly MDS showed an ARD of 01/07/16, 93 days after the previous ARD. - Resident #26's Quarterly MDS showed an ARD of 07/09/15. The next OBRA Quarterly MDS showed an ARD of 12/08/15, 152 days after the previous ARD. - Resident #27's Quarterly MDS showed an ARD of 07/31/15. The next OBRA Quarterly MDS showed an ARD of 12/05/15, 127 after the previous ARD. - Resident #28's Annual MDS showed an ARD of 04/24/15. The next OBRA Quarterly MDS showed an ARD of 10/24/15, 274 days after the previous ARD. - Resident #29's Quarterly MDS showed an ARD of 04/26/15. The next OBRA Quarterly MDS showed an ARD of 10/25/15, 182 days after the previous ARD. - Resident #30's Quarterly MDS showed an ARD of 10/07/15. The MDS completion date at Z0500B was 11/23/15, 47 days after the ARD. During an interview on the morning of 01/21/15, an administrative nursing staff member (#3) confirmed the above quarterly MDSs were	F 276		

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F 276	Continued From page 16 completed late.	F 276		
F 278 SS=E	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. This REQUIREMENT is not met as evidenced by: 1. Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual (Version 3.0),	F 278	As of 2/11/16 for identified residents (#3&5) MDS errors related to Section H-2 were corrected and resubmitted to State	2/29/16

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F 278	Continued From page 17 and staff interview, the facility failed to ensure the Minimum Data Sets (MDSs) accurately reflected the residents' status for 2 of 14 sampled residents (Resident #3 and #5) and 2 of 3 closed resident records reviewed (Resident #15 and #16). Failure to code portions of the MDS correctly for items related to urinary continence, constipation, colostomy, turning/repositioning, and locomotion on the unit does not provide an accurate assessment of a resident's current status and needs. Findings include: The Long-Term Care Facility RAI User's Manual, revised October 2015, page H-2 stated, "Check next to each appliance that was used at any time in the past 7 days . . . * H0100C, ostomy (including urostomy, ileostomy, and colostomy). . . ." - Review of Resident #5's medical record occurred on all days of survey and identified a colostomy during the look-back period. The admission/discharge return anticipated MDS, dated 01/10/16, failed to code H0100C for the resident's colostomy. The Long-Term Care Facility RAI User's Manual, revised October 2015, pages M 38-39 stated, ". . . M1200C Turning/Repositioning Program: The turning/repositioning program is specific as to the approaches for changing the resident's position and realigning the body. The program should specify the intervention (e.g., [example given] reposition on side, pillows between knees) and frequency (e.g., every 2 hours). . . ."	F 278	and Federal CMS via modification. Due to potential of all residents being affected by the same deficient practice as RAIs/MDSs are completed on all residents. As of 2/9/16 education regarding urinary continence, bowel patterns/constipation, colostomy, turning/reposting and locomotion on the unit was completed. Director of nursing provided education and handouts of RAI User□s Manual pages H-2, M 38-39, and G-6 and completed this with interdisciplinary team members (includes nurse managers, social services, dietary manager, activities manager, and administrator). Prior to submission, director of nursing or designee monitors accuracy of MDS for urinary continence, bowel patterns/constipation, colostomy, turning/reposting and locomotion on the unit identified by using internal MDS calendar and available reports from Matrix. Will also use validation report to determine if interventions are effective. Monitor for urinary continence, bowel patterns/constipation, colostomy, turning/reposting and locomotion on the unit will be monitored starting the week of 2/8/16. The Director of Nursing or designee shall monitor and report to the quality committee as follows: Monitor:	

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F 278	Continued From page 18 - Review of Resident #15's medical record occurred on January 19-20, 2016. The admission MDS, dated 06/16/15, identified extensive assistance of one person required for bed mobility/transfers and on a turning/repositioning program. Resident #15's current care plan stated ". . . Do not place resident on back when in bed. Reposition side to side only. Reposition frequently to avoid skin break down. . . ." The "Turning/Repositioning History" identified staff repositioned Resident #15 on five occasions during the seven day look-back period. The resident's medical record failed to identify an individualized repositioning program. During an interview on the afternoon of 01/20/16, an administrative nurse (#2) confirmed Resident #15's medical record lacked sufficient evidence to support the coding of a turning/repositioning program on the MDS. The Long-Term Care Facility RAI User's Manual, revised October 2015, page H-8, stated, "Urinary Continence: . . . Coding Instructions: . . . Code 9, not rated: if during the 7-day look back period the resident had an indwelling bladder catheter . . . for the entire 7 days. . . ." Page H-12 stated, Bowel Patterns: Definition-Constipation: If the resident has two or fewer bowel movements [BMs] during the 7-day look-back period or if for most bowel movements their stool is hard and difficult for them to pass (no matter what the frequency of bowel movements). . . . Steps for Assessment: 1. Review the medical record for bowel records or flow sheets, nursing assessments and progress notes, physician history and physical examination to determine if the resident has had problems with constipation	F 278	Weekly x4; Monthly x3; Quarterly x4 Due to potential of all residents being affected by the same deficient practice as RAIs/MDSs are completed on all residents. As of 2/9/16 education regarding RAI User□s Manual Chapter 2 page 28 regarding significant correction to prior comprehensive assessment was completed. Director of nursing provided education and handouts to the interdisciplinary team members (includes nurse managers, social services, dietary manager, activities manager, and administrator). Prior to submission, director of nursing or designee monitors significant correction to prior comprehensive assessment identified by using internal MDS calendar and available reports from Matrix. Will also use validation report to determine if interventions are effective. Monitoring significant correction to prior comprehensive assessment will be monitored starting the week of 2/8/16. The Director of Nursing or designee shall monitor and report to the quality committee as follows: Monitor: Weekly x4; Monthly x3;	

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F 278	Continued From page 19 during the 7-day look-back period. . . . Code 0, no: if the resident shows no signs of constipation during the 7-day look-back period. . . ." - Review of Resident #3's medical record occurred on all days of survey and identified a suprapubic urinary catheter present on admission. Daily medications included Miralax (a stool softener). The medication administration record (MAR) showed the resident received no as needed (PRN) medications to aide in bowel elimination from November 19-26, 2015. Review of the resident's bowel records identified BMs November 21, 23, and 26 of 2015. The Admission MDS, dated 11/26/15, showed the facility coded Resident #3 continent of urine instead of "not rated." The facility also coded the resident as experiencing constipation during the 7-day assessment period November 19-26, 2015) even though the bowel records showed frequent BMs. The Long-Term Care Facility RAI User's Manual, revised October 2015, page G-6, stated, Code 4, total dependence: if there was full staff performance of an activity with no participation by resident for any aspect of the ADL [Activities of Daily Living] activity and the activity occurred three or more times. The resident must be unwilling or unable to perform any part of the activity over the entire 7-day look-back period. - Review of Resident #16's medical record occurred on 01/21/15. The care plan stated, ". . . [Resident name] likes to move around the unit using her wheelchair but tends to wander . . ."	F 278	Quarterly x4 Due to potential of all residents being affected by the same deficient practice as RAIs/MDSs are completed on all residents. As of 2/9/16 education regarding RAI User□s Manual Chapter 2 page 32 regarding significant correction to prior quarterly assessment was completed. Director of nursing provided education and handouts to the interdisciplinary team members (includes nurse managers, social services, dietary manager, activities manager, and administrator). Prior to submission, director of nursing or designee monitors significant correction to prior quarterly assessment identified by using internal MDS calendar and available reports from Matrix. Will also use validation report to determine if interventions are effective. Monitoring for significant correction to prior quarterly assessment will be monitored starting the week of 2/8/16. The Director of Nursing or designee shall monitor and report to the quality committee as follows: Monitor: Weekly x4; Monthly x3; Quarterly x4	

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F 278	Continued From page 20 A progress note, dated 12/26/16, stated, "Resident up in chair wandering up and down the halls, found in other Residents rooms, going thru [sic] room 239 drawers, Redirected with little effect found in another room 221. . . ." The Significant Change MDS, dated 12/31/15, identified total assistance required for locomotion during the 7-day look-back period. The facility coded total dependence for locomotion even though the progress notes showed locomotion independently in a wheelchair. During an interview on the afternoon of 01/21/16, an administrative nurse (#6) confirmed Resident #16's medical record lacked sufficient evidence to support total dependence with locomotion. 2. Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, review of the federal database for Long-Term Care surveys, and staff interview, the facility failed to accurately code the reason for completing an assessment (A0310), failed to accurately code the assessment reference date (A2300), failed to complete/submit discharge assessments, and failed to ensure a registered nurse accurately certified completion of the MDS for 3 of 14 sampled residents (Resident #3, #9, and #13) and 2 of 8 supplemental residents(Resident #26 and #31) reviewed for Minimum Data Set (MDS) purposes. Failure to accurately code portions of the MDS and/or failure to complete discharge assessments did not provide an accurate assessment of these residents' current status and needs.	F 278	Due to potential of all residents being affected by the same deficient practice as RAIs/MDSs are completed on all residents. As of 2/9/16 education regarding RAI User□s Manual Chapter 2 pages 2-19, 40-41 regarding assessment reference date window was completed. Director of nursing provided education and handouts to the interdisciplinary team members (includes nurse managers, social services, dietary manager, activities manager, and administrator). Prior to submission, director of nursing or designee monitors assessment reference date windows identified by using internal MDS calendar and available reports from Matrix. Will also use validation report to determine if interventions are effective. Monitoring for assessment reference date window will be monitored starting the week of 2/8/16. The Director of Nursing or designee shall monitor and report to the quality committee as follows: Monitor: Weekly x4; Monthly x3; Quarterly x4 As of 2/11/16 for identified residents (#26 and #31) MDS error regarding discharge assessment- return not anticipated was corrected via modification and	

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F 278	Continued From page 21 Findings include: SIGNIFICANT CORRECTION TO PRIOR COMPREHENSIVE ASSESSMENT The Long-Term Care Facility RAI User's Manual, October 2015, Chapter 2, page 28, stated, "Significant Correction to Prior Comprehensive Assessment (SCPA) (A0310A=05): The SCPA is a comprehensive assessment for an existing resident that must be completed when the IDT [interdisciplinary team] determines that a resident's prior comprehensive assessment contains a significant error. It can be preformed at any time after the completion of an Admission assessment, and it's ARD [Assessment Reference Date] and completion dates (MDS/CAA(s) [Care Area Assessments]/care plan) depend on the date the determination was made that the significant error exists in a comprehensive assessment. . . . A SCPA is appropriate when: the erroneous comprehensive assessment has been completed and transmitted/submitted into the MDS system; and there is not a more current assessment in progress or completed that includes a correction to the item(s) in error. The ARD must be within 14 days after the determination that a significant error in the prior comprehensive assessment occurred (determination date + 14 calendar days). - Review of Resident #3's MDSs on January 20-21, 2016 showed the facility completed an entry tracking form dated 07/24/15. The next MDS, a combined PPS (Prospective Payment System) 5-day and an OBRA (Omnibus Budget Reconciliation Act) significant correction to prior	F 278	resubmitted to State and Federal CMS. Due to potential of all residents being affected by the same deficient practice as RAIs/MDSs are completed on all residents. As of 2/9/16 education regarding RAI User□s Manual Chapter 2 page 34 regarding discharge assessment- return not anticipated was completed. Director of nursing provided education and handouts to the interdisciplinary team members (includes nurse managers, social services, dietary manager, activities manager, and administrator). Prior to submission, director of nursing or designee monitors discharge return assessment-not anticipated identified by using internal MDS calendar and available reports from Matrix. Will also use validation report to determine if interventions are effective. Monitoring discharge return-not anticipated will be monitored the week of 2/8/16. The Director of Nursing or designee shall monitor and report to the quality committee as follows: Monitor: Weekly x4; Monthly x3; Quarterly x4 Due to potential of all residents being	

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F 278	Continued From page 22 comprehensive assessment (A0310A=5), showed an ARD of 07/31/15. The MDS should not have been coded as an OBRA significant correction to the prior comprehensive assessment, rather it should have been coded as a quarterly, annual, or a significant change in status assessment. The last comprehensive assessment, an Annual, had an ARD of 01/23/15 (6 months prior) and would not require a SCPA. SIGNIFICANT CORRECTION TO PRIOR QUARTERLY ASSESSMENT The Long-Term Care Facility RAI User's Manual, October 2015, Chapter 2, page 32, stated, "Significant Correction to Prior Quarterly Assessment (SCQA) (A0310A=06): The SCQA is an OBRA [Omnibus Budget Reconciliation Act of 1987] non-comprehensive assessment that must be completed when the IDT determines that a resident's prior Quarterly assessment contains a significant error. It can be performed at any time after the completion of a Quarterly assessment, and the ARD (Item A2300) and completion dates (Item Z0500B) depend on the date the determination was made that there is a significant error in a previous Quarterly assessment. . . . A SCQA is appropriate when: the erroneous Quarterly assessment has been completed (MDS completion date, Item Z0500B) and transmitted/submitted into the MDS system; and there is not a more current assessment in progress or completed that includes a correction to the item(s) in error. The ARD must be less that or equal to 14 days after the determination that a significant error in the prior Quarterly has occurred. . . ."	F 278	affected by the same deficient practice as RAIs/MDSs are completed on all residents. As of 2/9/16 education regarding RAI User□s Manual Chapter 3 pages Z7-8 regarding certifying completion of the assessment was completed. Director of nursing provided education and handouts to the interdisciplinary team members (includes nurse managers, social services, dietary manager, activities manager, and administrator). Prior to submission, director of nursing or designee monitors certifying completion assessment date identified by using internal MDS calendar and available reports from Matrix. Will also use validation report to determine if interventions are effective. Monitoring certifying completion of the assessment will be starting the week of 2/8/16. The Director of Nursing or designee shall monitor and report to the quality committee as follows: Monitor: Weekly x4; Monthly x3; Quarterly x4	

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F 278	Continued From page 23 - Review of Resident #9's MDSs on January 20-21, 2016 showed the facility completed two separate MDSs, a Quarterly and an OBRA Significant Correction to Prior Quarterly Assessment (A0310A=06), both with an ARD of 11/21/14. An OBRA Significant Correction to Prior Quarterly Assessment would not be completed to correct a quarterly assessment having the same exact ARD. ASSESSMENT REFERENCE DATE WINDOW The Long-Term Care Facility RAI User's Manual, October 2015, Chapter 2, pages 2-19 and 40-41, and Appendix A, page A-2, stated, "The assessment window "is the period of time defined by Medicare regulations that specifies when the ARD must be set." Each of the Medicare-required scheduled assessments has defined days within which the ARD must be set. The facility is required to set the ARD on the MDS form itself or in the facility software within the appropriate timeframe of the assessment type being completed. For example, the ARD for the Medicare-required 5-day scheduled assessment must be set on days 1 through 8. Timeliness of the PPS assessment is defined by selecting an ARD within the prescribed ARD window. ARDs cannot be opened/backdated into a window after the allowable window has passed, whether it is a PPS or an OBRA. The window to open an ARD for an OBRA admission, for example, is no later than the 14th calendar day of the resident's admission. If a late admission	F 278		

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assessment is recognized on day 16, the admission ARD can be set no sooner that the date the error was identified (day 16 in this example). Once the ARD window has closed, providers cannot set an ARD back into that window nor can they change an ARD already set inside that window. Backdating the ARD is not allowed. If you are still in the ARD window for the assessment, it is not considered backdating to set or move the ARD for any day within that assessment window. Backdating occurs when, after the allowable window of time has closed (i.e. after day 8 for a 5-day PPS assessment), and an ARD is opened back inside the window.

The Long-Term Care Facility RAI User's Manual, October 2015, Chapter 5, pages 5-11, stated, "A Modification Request should be used when an MDS record (assessment, Entry tracking record or Death in Facility tracking record) is in the QIES [Quality Improvement and Evaluation System] ASAP [Assessment Submission and Processing System] system, but the information in the record contains clinical or demographic errors. . . .
*Note: The ARD (Item A2300) can be changed when the ARD on the assessment represents a data entry/typographical error. However, the ARD cannot be altered if it results in a change in the look back period and alters the actual assessment timeframe. . . ."

- Review of Resident #9's MDSs on January 20-21, 2016 showed the facility completed two separate MDSs, a Quarterly and an OBRA Significant Correction to Prior Quarterly Assessment (A0310A=06), both with an ARD of 11/21/15. An OBRA Significant Correction to Prior Quarterly Assessment would not contain the

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same ARD as the Quarterly assessment being correct. The ARD on the OBRA Significant Correction to Prior Quarterly Assessment must be later than the ARD of the quarterly assessment identified as having the significant error.

DISCHARGE ASSESSMENT - RETURN NOT ANTICIPATED

The Long-Term Care Facility RAI User's Manual, October 2015, Chapter 2, page 34 stated, "Discharge Assessment-Return Not Anticipated (A0310F=10): Must be completed when the resident is discharged from the facility and the resident is not expected to return to the facility within 30 days."

- Review of Resident #26's MDSs on January 20-21, 2016 showed the facility completed a Quarterly MDS with an ARD of 07/09/15. The next record showed an Entry Tracking Record, dated 09/10/15. The facility failed to complete/submit a Discharge assessment.

- Review of Resident #31's MDSs on January 20-21, 2016 showed the facility completed an Admission MDS with an ARD of 07/21/15. The next record showed an Entry Tracking Record, dated 12/15/15. The facility failed to complete/submit a discharge assessment, which is required prior to completing an Entry Tracking Record.

During an interview of the morning of January 21, 2016, an administrative nursing staff member (#3) confirmed the facility completed/submitted MDSs incorrectly, which is required prior to

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F 278	Continued From page 26 completing an Entry Tracking Record. CERTIFYING COMPLETION OF THE ASSESSMENT The Long-Term Care Facility RAI User's Manual, revised October 2015, Chapter 3, page Z-7 and Z-8 stated, "Z0400 . . . To obtain the signature of all persons who completed any part of the MDS . . . All staff who complete any part of the MDS must enter their signatures, titles, sections or portion(s) of section(s) they completed, and the date completed . . . Z0500: Signature of RN (registered nurse) Assessment Coordinator Verifying Assessment Completion . . . [the RN assessment coordinator is to] Verify that all items on this assessment are completed." - Review of Resident #13's Quarterly MDS, with an ARD of 12/31/15, occurred on 01/21/16. Review of the MDS showed a registered nurse certified completion of the MDS (Z0500) on 01/04/16; and Section Z0400 identified two sections of the MDS (Section L and Section O)completed after the registered nurse certified completion date of 01/04/16. Section L and Section O were completed a day later, on 01/05/16, by the same registered nurse who signed and dated Z0500.	F 278		
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable	F 279		2/29/16

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F 279	Continued From page 27 objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to develop a comprehensive care plan for 9 of 14 sampled residents (Resident #2, #3, #4, #6, #8, #9, #10, #12, and #13) and 2 closed resident records (Resident #16 and #17) reviewed that included measurable objectives and interventions to meet the resident's medical and nursing needs related to the focused triggered areas identified in the Care Area Assessments (CAAs) using section V of the Minimum Data Set (MDS). Failure to develop a comprehensive care plan based on resident specific needs does not allow staff to communicate care needs and ensure continuity of care for each resident. Findings include: Review of the facility policy and procedure titled "Care Plans - Comprehensive" occurred on	F 279	Identified residents (#2, #3, #4, #6, #8, #9, #10, #12, and #13) care plans were reviewed and updated to form a comprehensive care plan based on resident specific needs utilizing the triggered focus areas from the CAA□s, Section V of the MDS. Due to the potential of all residents being affected by this same deficiency found all interdisciplinary team members (includes nursing managers, administrator, social services, dietary manager, activity manager, quality/risk nurse, director of nursing) were educated by director of nursing on policy Care Plans-Comprehensive. Monitoring for a comprehensive care plan, which includes CAA□s from Section	

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F 279	Continued From page 28 01/21/16. This policy, revised February 2014, stated, ". . . An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident. . . . . 2. The comprehensive care plan is based on thorough assessment that includes, but is not limited to, the MDS. 3. Each resident's comprehensive care plan is designed to: a. Incorporate identified problem areas; . . . 4. Areas of concern that are triggered during the resident assessment are evaluated using specific tools (including Care Area Assessments) before interventions are added to the care plan. . . ." - Review of Resident #2's current care plan lacked measurable objectives and interventions for the triggered areas of psychosocial well being and dehydration-fluid maintenance as identified in the CAAs of the admission MDS, dated 07/31/15. - Review of Resident #3's current care plan lacked measurable objectives and interventions for the triggered areas of urinary incontinence/catheter, psychosocial well being, falls, dehydration-fluid maintenance, and pain as identified in the CAAs of the admission MDS, dated 11/26/15. - Review of Resident #4's current care plan lacked measurable objectives and interventions for the triggered areas of visual function, falls, and pressure ulcers as identified in the CAAs of the admission MDS, dated 09/28/15. - Review of Resident #6's current care plan	F 279	V of the MDS will start the week of 2/8/16. The Director of Nursing or designee shall monitor and report to the quality committee as follows: Monitor: Weekly x4; Monthly x3; Quarterly x4	

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lacked measurable objectives and interventions for the triggered areas of visual function, urinary incontinence/catheter, falls, dehydration-fluid maintenance, pressure ulcers, and pain as identified in the CAAs of the admission MDS, dated 11/12/15.

- Review of Resident #8's current care plan lacked measurable objectives and interventions for the triggered areas including visual function, falls, and pressure ulcers as identified in the CAAs of the admission MDS, dated 11/27/15.

- Review of Resident #9's current care plan lacked measurable objectives and interventions for the triggered area of communication as identified in the CAAs of the annual MDS, dated 08/22/15.

- Review of Resident #10's current care plan lacked measurable objectives and interventions for the triggered areas including visual function as identified in the CAAs of the admission MDS, dated 09/10/15.

- Review of Resident #12's current care plan lacked measurable objectives and interventions for the triggered areas of visual function, communication, mood state, dehydration-fluid maintenance, and psychotropic drug use as identified in the CAAs of the admission MDS, dated 04/07/12.

- Review of Resident #13's current care plan lacked measurable objectives and interventions for the triggered areas of dental care and pain as identified in the CAAs of the admission MDS, dated 09/08/15.

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F 279	Continued From page 30 - Review of Resident #16's current care plan lacked measurable objectives and interventions for the triggered areas of communication, pressure ulcers, and pain as identified in the CAAs of the significant change MDS, dated 12/31/15. - Review of Resident #17's current care plan lacked measurable objectives and interventions for the triggered areas including urinary incontinence/catheter as identified in the CAAs of the admission MDS, dated 11/25/15. During an interview on 01/21/16 at 11:16 a.m., a supervisory nurse (#5) acknowledged she failed to utilize the CAAs as a tool to develop measurable objectives and interventions for the resident's care plan. The facility failed to develop a comprehensive care plan based on resident specific needs utilizing the triggered focus areas from the CAAs, section V of the MDS.	F 279		
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility	F 280		2/29/16

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F 280	Continued From page 31 for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 12/04/14. Based on observation, record review, review of facility policy, and staff interview, the facility failed to review and revise care plans to reflect the residents' current status needs for 5 of 14 sampled residents (Resident #1, #2, #4, #6, and #9). Failure to ensure care plans reflected the residents' current status and needs limited staff's ability to ensure consistency and continuity of care. Findings include: Review of the facility policy "Care Plans - Comprehensive" occurred on 01/21/16. This policy, revised February 2014, stated, ". . . An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident. . . . 8. Assessments of residents are ongoing and care plans are revised as information about the resident and the resident's	F 280	Identified residents (#1, #2, #4, #6, and #9) care plans were updated to reflect the resident□s current status and needs to ensure consistency and continuity of care. Due to the potential of all residents being affected by this deficiency interdisciplinary team members (includes nurse managers, administrator, social services, dietary manager, activity manager, quality/risk nurse, director of nursing) were educated by director of nursing on policy Care Plans- Comprehensive. Monitoring to ensure the Development of a Comprehensive Care Plan will start the week of 2/8/16. The Director of Nursing or designee shall monitor and report to the quality committee as follows: Monitor: Weekly x4; Monthly x3; Quarterly x4	

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F 280	Continued From page 32 condition change. . . ." - Observation on 01/19/16 at 4:05 p.m. and on 01/20/16 at 9:36 a.m., showed a styrofoam cup with a straw located on a bedside table in Resident #1's room. The dietary label on the cup's lid stated, "*No Straws*." Two certified nursing assistants (CNAs) (#7 and #8), on 01/19/16, offered the resident the cup, and the resident drank from the straw. Review of Resident #1's medical record occurred on all days of survey. The current care plan stated, "Problem . . . Resident has swallowing difficulties and requires altered consistencies . . . Goal . . . Resident will show no signs or symptoms of aspiration . . . Approach . . . REGULAR . . DIET . . . MECHANICAL SOFT. . . ." The Care Area Assessment (CAA), dated 12/25/15, stated, "Resident is on a regular diet . . . and mechanical soft foods with nectar liquids (r/t [related to] swallowing difficulties). . . ." Review of the physician orders showed no order regarding the use of straws. The medical record failed to identify when and why dietary staff implemented the "No Straws" on the cup's label. During an interview on the afternoon of 01/21/16, a supervisory nurse (#4) was unable to explain why the dietary label stated "No Straws." Review of Resident #1's progress notes showed a urinary catheter placed on 12/22/15 and discontinued on 01/12/16. The current care plan stated, "Problem Start Date: 01/02/16 . . . Resident requires an external catheter R/T chronic urinary retention . . . Approach: Currently has an indwelling catheter. . . ." The care plan	F 280		

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F 280	Continued From page 33 failed to reflect the discontinued catheter. During an interview on 01/21/15 at 10:45 a.m., a supervisory nurse (#5) stated unit managers update the nursing section of the care plans. - Review of Resident #4's medical record occurred on all days of survey. The current care plan stated, ". . . Problem . . . ADL [activity of daily living] Functional/Rehabilitation Potential . . . Approach . . . Primary locomotion will be self propelled FWW [front wheel walker]. . . ." Observation on 01/19/16 at 3:47 p.m. showed Resident #4 seated in her wheelchair. The CNA (#12) transferred Resident #4 into the bathroom utilizing the wheelchair for toileting. The CNA then transferred the resident utilizing a wheelchair into the dining room. Observation on 01/20/16 at 7:43 a.m. showed Resident #4 in the dining room seated in a recliner with a wheelchair parked next to her. Observation on 01/20/16 at 8:33 a.m. showed a CNA (#13) transferred Resident #4 from a recliner into her wheelchair and to the dining room table. During an interview on 01/21/16 at 11:16 a.m., a supervisory nurse (#5) acknowledged Resident #4's care plan was not updated to reflect her primary locomotion with the use of a wheelchair. - Review of Resident #6's medical record occurred on all days of survey. Diagnoses include cerebral infarction, weakness, and a stage four pressure ulcer to the coccyx. The	F 280		

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admission Minimum Data Set (MDS), dated 11/12/15, identified extensive assistance of two people required with bed mobility and transfers, and one unhealed pressure ulcer.

Resident #6's current care plan stated, ". . . Problem . . . ADL Functional/Rehabilitation Potential Resident requires 2 person total assistance with all ADLs r/t recent stroke. . . . Approach . . . 2 person with Hoyer for all transfers. 2 person assist for q2h [every two hours] turning/repositioning. . . ." The care plan failed to address Resident #6's current pressure ulcer as a problem with interventions to include specific repositioning needs. See F314.

During an interview on 01/21/16 at 11:16 a.m., a supervisory nurse (#5) stated Resident #6 should be seated on one hip or the other, not directly on both buttocks. She verified the care plan did not address Resident #6's pressure ulcer or the current repositioning needs.

- Review of Resident #9's medical record occurred on all days of survey. Diagnoses include convulsions and history of falling. The annual MDS, dated 08/22/15, identified one fall.

Resident #9's current care plan stated, ". . . Problem . . . Falls . . . Resident has history of falling R/T seizure activity and loss of coordination. Created: 09/16/2014 . . . Approach . . . Keep personal items and frequently used items within reach. . . . Provide resident an environment free of clutter. Assure floor is free of glare, liquids, foreign objects. Provide assistance PRN [as needed] and encourage resident to call for help if feeling dizzy. . . ."

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F 280	Continued From page 35 Review of the nurse's progress notes showed the following: * 01/06/15 at 1:09 p.m.: "Resident reported having fainting episodes in the coffee shop, CNA walked back with him. Nurse observed resident faint while entering room and while taking blood pressure. . . ." * 11/24/15 at 2:08 p.m.: ". . . FNP [family nurse practitioner] noted communication regarding fall outside facility on 11/18/15. . . ." During an interview on 01/21/16 at 11:16 a.m., a supervisory nurse (#5) stated other interventions were put into place for the resident such as having him wear a reflective vest outside, wearing an identification lanyard, and offering frequent supervised walks outside. She acknowledged the care plan was not updated to reflect any new fall interventions. - Review of Resident #2's medical record occurred on all days of survey. Diagnoses included dementia with behavioral disturbances, peripheral vascular disease (PVD), diabetes mellitus, and bilateral foot ulcers.	F 280		

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F 280	Continued From page 36 On 12/09/15, the facility implemented an air mattress. Observation on all days of survey showed Resident #2 on an air mattress. The resident's care plan identified two unstageable pressure areas to the left lateral foot and a pressure area to the right lateral foot. Interventions included bilateral suspension boots but failed to include an air mattress. The facility failed to ensure care plans reflected the residents' current status and needs limiting staff's ability to ensure consistency and continuity of care.	F 280		
F 287 SS=D	483.20(f) ENCODING/TRANSMITTING RESIDENT ASSESSMENT (1) Encoding Data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. (2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State.	F 287		2/29/16

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F 287	Continued From page 37 (3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i) Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on a resident that does not have an admission assessment. (4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on record review, review of the federal database for Long-Term Care surveys, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual (Version 3.0), and staff interview, the facility submitted Start of Therapy (SOT) and End of Therapy (EOT) OMRAs (Other Medicare-required Assessments) to the CMS Quality Improvement Evaluation System (QIES) Assessment Submission and Processing (ASAP) system for 2 of 2 sampled residents (Resident #2	F 287	Due to potential of all residents being affected by the same deficient practice as of 2/9/16 education regarding submission of the Start of Therapy (SOT) and the End of Therapy (EOT) Other Medicare Required Assessments (OMRA) to appropriate entity (State, CMS). Director of nursing provided education and handouts of RAI User□s Manual Chapter 2 pages 47-49; Chapter 5 pages 5-11 with interdisciplinary team members (includes	

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F 287	Continued From page 38 and #10) who received therapy services but not Medicare Part A. Findings include: The Long-Term Care Facility RAI User's Manual, October 2015, Chapter 2, pages 47-49, stated, "There are several unscheduled assessment types that may be required to be completed during a resident's [Medicare] Part A SNF [Skilled Nursing Facility] covered stay. Start of Therapy (SOT) OMRA . . . End of Therapy (EOT) OMRA . . ." The Long-Term Care Facility RAI User's Manual, October 2015, Chapter 5, pages 5-11, stated, "Transmitting Data . . . Assessments that are completed for purposes other than OBRA or SNF PPS reasons are not to be submitted [to the CMS QIES ASAP system], e.g. private pay insurance, including but not limited to Medicare Advantage Plans." - Review of Resident #2's MDSs on January 20-21, 2016 showed a SOT with an ARD of 03/17/15 and an EOT with an ARD of 04/17/15. Review of these MDSs in the federal database showed Resident #2 did not receive Medicare Part A during that period of time, so the unscheduled assessments used for PPS [Prospective Payment Source] should not have been submitted to the CMS QIES ASAP. - Review of Resident #10's MDSs on January 20-21, 2016 showed an EOT with and ARD of 10/03/15. Review of this MDS in the federal database showed Resident #10 did not receive Medicare Part A during that period of time, so the	F 287	nurse managers, social services, dietary manager, activities manager, and administrator). By 2/24/16, education and handouts will be provided by director of nursing to the interdisciplinary team members (includes nurse managers, social services, dietary manager, activities manager, and administrator) regarding ND Department of Human Services Submission of MDS 3.0 Assessments. Monitoring for submission of the Start of Therapy (SOT) and the End of Therapy (EOT) Other Medicare Required Assessments (OMRA) to appropriate entity (State, CMS) will be starting the week of 2/8/16. The Director of Nursing or designee shall monitor and report to the quality committee as follows: Monitor: Weekly x4; Monthly x3; Quarterly x4	

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F 287	Continued From page 39 unscheduled assessments used for PPS should not have been submitted to the CMS QIES ASAP. During an interview on the morning of 01/21/16, an administrative nursing staff member (#3) confirmed Resident #2 and #10 were not receiving Medicare Part A when the unscheduled assessments stated above were completed and submitted to the CMS QIES ASAP.	F 287		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to ensure staff provided the care and services necessary for 1 of 2 sampled residents (Resident #4) with an esophageal (swallowing) disorder and at risk of aspiration. Failure to ensure staff properly supervised Resident #4 during a meal placed the resident at a high risk for aspiration. Findings include: Review of Resident #4's medical record occurred on all days of survey. Diagnoses include esophageal obstruction, dysphagia, and	F 309	Identified resident #4, regarding performance of redirecting, feeding and oral intake protocol via care plan education was outlined by the Resident Care Manager for all unit staff (nurses and CNA□s) to review to ensure highest well-being care is provided. Due to potential of all residents being affected by same deficiency education regarding areas of deficiency associated with failing to provide care and services was completed with nursing staff including CNA□s per policy titled Quality	2/29/16

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F 309	Continued From page 40 dementia. The quarterly Minimum Data Set (MDS), dated 12/21/15, identified extensive assistance of one person required with eating. The physician orders stated, ". . . Liquid Pureed Diet: made to drinkable through a straw of nectar thick or less. May receive 120 ml [milliliters]/4 oz [ounces] at a time - with 1 hour between each feeding. . . ." The current care plan stated, ". . . Problem . . . ADL [activity of daily living]/ Rehabilitation Potential Resident has an esophageal disorder: Esophageal blockage limiting swallowing ability. . . . Goal . . . Resident will not aspirate. . . . Approach . . . Resident tends to remove food items from other residents trays, food service areas, other resident's rooms, snack carts and other areas where food is available. If she is noted to be doing this suggestions to redirect include: offer popsicles or ice chips, Call unit manager, unit coordinators, activities or CN [sic] to assist in redirecting her until the tables can be cleared, redirect to another area, offer her next food/fluids if possible. Remove resident from dining room after meals, offer activities of choice to help redirect. . . . Problem . . . Nutritional Status Resident has difficulty swallowing related to esophageal mass and is on a liquid pureed diet with limited intake, which puts her at nutritional risk. . . . Goal . . . Resident will tolerate diet with no signs or symptoms of aspiration. . . . Approach . . . Set up resident at meals and snacks, and observe resident for signs of aspiration. . . ." Observation on 01/20/16 at 8:45 a.m. showed Resident #4 seated at the dining room table eating pureed nectar thickened liquid food with a	F 309	of Life-Dignity. Due to potential of all residents being affected by same deficiency, Dietary worked with Speech Therapy to develop and implement a Speech Therapy Recommendations form to enhance communication and instructions from speech therapy. Monitoring to ensure residents following special feeding techniques and equipment to start the week of 2/8/16. The Director of Nursing or designee shall monitor and report to the quality committee as follows: Monitor: Weekly x4; Monthly x3; Quarterly x4	

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F 309	Continued From page 41 spoon. The CNA (#10) was seated across from Resident #4 assisting another resident with eating. Resident #4 took a cup of yogurt from Resident #23 who was seated on Resident #4's left side. The CNA (#10) watched Resident #4 eat the yogurt without redirecting the resident or notifying his supervisors as care planned. Resident #4 ate the entire contents of the yogurt, and then placed the empty container back in front of Resident #23. During an interview on 01/21/16 at 11:16 a.m., a supervisory nurse (#5) verified staff are to supervise Resident #4 during her meals and redirect her from taking other resident's food.	F 309		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. 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 necessary treatment and services to promote healing of pressure ulcers for 2 of 4 sampled residents (Resident #2 and #6) with current pressure ulcers. Failure to monitor pressure ulcers, document the findings,	F 314	Identified residents (#2 and #6) regarding cares and treatment of pressure ulcer, interventions (measuring/documentation, positioning, following MD orders, placement of therapeutic equipment) via care plan was outlined by the Resident Care Manager for all unit staff (nurses	2/29/16

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F 314	Continued From page 42 implement pressure-relieving interventions, and position residents as care planned may result in delayed healing and/or the development of new pressure ulcers. Findings include: Review of the facility policy and procedure titled "Pressure Ulcer Risk Assessment" occurred on 01/21/16. This policy, revised August 2015, stated, "Residents determined as at risk for developing pressure ulcers will have interventions documented in plan of care based on specific factors identified in the risk assessment." Review of the facility policy and procedure titled "Pressure Ulcer Prevention and Management" occurred on 01/21/16. This policy, revised August 2015, stated, ". . . The facility shall establish and utilize a systemic approach for pressure ulcer prevention and management . . . c. Assessments of pressure ulcers will be performed by a licensed nurse, and documented in Matrix [electronic chart system] . . . 2. a. Interventions will be based on specific factors identified in the risk assessment, skin assessment, and any pressure ulcer assessment . . . c. Evidenced-based treatments in accordance with current standards of practice will be provided for all residents who have a pressure ulcer present. . . . d. Interventions will be documented in care plan and communicated to all relevant staff. . . . 3. Monitoring . . . a. The RN [registered nurse] Unit Manager, or designee, will review all relevant documentation regarding skin assessments, pressure ulcer risks, progression towards healing, and compliance. . . . 4. b.	F 314	and CNA□s) to review to ensure highest well-being care is provided. Due to potential of all residents being affected by same deficiency found, education associated with care and treatment to prevent/heal pressure ulcers was completed with nursing staff, including CNA□s per policies titled Pressure Ulcer Risk Assessment and Pressure Ulcer Prevention and Management and written education titled repositioning. Monitoring to ensure pressure ulcer prevention/healing (includes: following doctors□ orders, interventions listed on care plan performed, and documentation and measurements) to start the week of 2/8/16. The Director of Nursing or designee shall monitor and report to the quality committee as follows: Monitor: Weekly x4; Monthly x3; Quarterly x4	

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F 314	Continued From page 43 Interventions on resident's plan of care will be modified as needed. . . .6. Documentation may include but is not limited to the following: a. Location, dressing status, wound bed, exudate amount, exudate type, odor, pain, treatments/interventions, resident compliance, and measurements . . . i. Wound measurements shall occur per physician order or as correlates with treatment regime. . . ." Review of facility policy and procedure titled "Repositioning" occurred on 01/21/16. This policy, revised December 2014, stated, ". . . 2. Evaluation of a resident's skin integrity after pressure has been reduced or redistributed should guide the development and implementation of repositioning plans. Such plans should be addressed in the comprehensive plan of care consistent with the resident's needs and goals. . . . 5. Positioning the resident on an existing pressure ulcer should be avoided since it puts additional pressure on tissue that is already compromised and may impede healing. . . . Repositioning the Resident in Bed . . . 15. Skin-to-skin contact will be prevented with the use of pillows, positioning devices and/or with use of sheets, pillows &/or positioning devices as needed. . . . Repositioning the Resident in the Chair . . . 6. . . . Prevent skin to skin contact with use of sheets, pillows or positioning devices. . . ." - Review of Resident #6's medical record occurred on all days of survey. Diagnoses include cerebral infarction, weakness, and a stage four pressure ulcer to the coccyx. The admission Minimum Data Set (MDS), dated 11/12/15, identified extensive assistance of two people required with bed mobility and transfers,	F 314		

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F 314	Continued From page 44 and one unhealed stage four pressure ulcer. Resident #6's current care plan stated, ". . . Problem . . . ADL [activity of daily living] Functional/Rehabilitation Potential Resident requires 2 person total assistance with all ADLs r/t [related to] recent stroke. . . . Approach . . . 2 person with Hoyer for all transfers. 2 person assist for q2h [every two hours] turning/repositioning. . . ." The care plan failed to address Resident #6's current pressure ulcer as a problem with interventions to include specific repositioning needs. Review of the physician's orders identified the following: * 11/25/15: ". . . Under no circumstances [is] the patient to be in a position where she is sitting in a traditional fashion. She is to be leaning to one side either on her right or left buttock with the intervening area adequately padded. She should spend most of her time on either side laying down or on her abdomen. Two-hour turns should be continued, even when the patient is sleeping. Sitting up on either her right or left buttock should be saved for eating and physical therapy only. * 1/19/16: ". . . She is to continue offloading of the central area of her back, sitting on either hip when she is sitting and turning every 2 hours. . . ." Review of Resident #6's nursing progress notes showed the following: * 11/19/15 at 4:20 p.m.: ". . . Staff are to position her up on her hip with pillows while up in chair. . . ." * 11/25/15 at 1:36 p.m.: "Resident returned from appointment with [name of physician] who	F 314		

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F 314	Continued From page 45 relayed to NH [nursing home] that dressing was not placed properly and to see her discharge instructions from previous appointment. . . . MD [medical doctor] also stated, at this appointment, that the tubing is to lie north or south of the wound and not side to side. . . ." * 12/01/15 at 2:37 a.m.: "Received fax from [name of physician]. Res [resident] needs to be positioned on either hip & can have pillows in that position to support her. She can remain in an upright position while positioned on either one of her hips. Cannot be positioned on her buttocks. Res repositioned side to side. . . ." Observation on 01/20/16 at 7:58 a.m. showed a certified nursing assistant (CNA) (#10) placed two pillows side by side on Resident #6's wheelchair. The CNA and a licensed nurse (#9) transferred Resident #6 from bed to the wheelchair with a Hoyer lift (full body mechanical lift). The CNA and nurse failed to position Resident #6 on one side to decrease pressure to her buttocks as ordered by the physician. Resident #6's event report, dated 11/06/15, stated, ". . . Pressure sore to sacral area: Chart Q [every] Fridays . . . PRESSURE ULCER -Location And Size . . . 9.5 cm [centimeter] x [by] 5 cm. Unknown in depth eschar . . ." The nurse's progress notes showed facility staff failed to document measurements eight times from November 2015 through January 15, 2016: November 13 and 20, December 11, 18, and 25, and January 1, 8, and 15, 2016. Resident #6's pressure ulcer measured 5 cm x 4.5 cm on 01/19/16. During an interview on 01/21/16 at 11:16 a.m., a	F 314		

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supervisory nurse (#5) stated staff should not position Resident #6 directly on her buttocks. She verified the care plan did not address Resident #6's pressure ulcer or her current repositioning needs. The supervisory nurse acknowledged the facility failed to consistently measure Resident #6's pressure ulcer every Friday.

Failure of the facility to develop and implement specific positioning interventions and ensure weekly monitoring of the progression of Resident #6's pressure ulcer may result in delayed healing and development of new pressure ulcers.

- Review of Resident #2's medical record occurred on all days of survey. Diagnoses included dementia with behavioral disturbances, peripheral vascular disease (PVD), diabetes mellitus, and bilateral foot ulcers.

Resident #2's quarterly MDS, dated 10/30/15, identified two unstageable pressure ulcers. The current care plan stated, "Problem: . . . complaints of chronic pain to bilateral feet . . . Approach: . . . Support affected area with suspension boots . . . Problem: 2 unstageable pressure areas to L [left] lateral foot . . . Approach: . . . Pressure area to R [right] lateral malleolus [ankle]. Dressing changes as orders. Measure wounds weekly . . ."

The progress notes identified Resident #2 returned from the hospital on 07/24/15 after a left foot, fifth toe amputation. A note, dated 07/28/15, stated, ". . . Unable to assess wound bed to amputated area due to dressing not to be removed per MD [medical doctor] orders . . ." A

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progress note, dated 08/04/15, identified Resident #2 returned from a doctor's appointment with a new dressing on the surgical site.

A progress note, dated 08/10/15 at 11:20 a.m., stated, ". . . Bruising noted to Lf. [left] Achilles tendon and Lf. anterior ankle. Had ace wrap on with cling after surgical procedure, then just cling. May have been rubbing and caused bruising due to surface of cling is slightly rough and resident has no edema. Also has diagnoses of PVD, neuropathy and diabetes. Will only wrap cling over top of Lf. foot surgical site and leave ankle area, open to air. . . . MD updated . . ."

A progress noted, dated 08/10/15 at 2:06 p.m., stated, ". . . Noted purple non-blanchable area to lateral Lf. foot over bony prominence by surgical sited [sic]. Had ace wrap with cling prior to today due to amputation of Lf. 5th toe and orders from [doctor name] not to touch dressing for almost 2 weeks. Seen [doctor name] on 8/4/15, came back with 4x [by] 4 [dressing] and ace wrap. Clarified orders, apply 4x4 with cling and change dressing daily. Due to area has been wrapped with ace and cling for a period of time, purple area to Lf. lateral foot is considered a DTI [deep tissue injury]. Will have resident wear blue boots at all times, except transfers. Apply pillow under feet as he allows, MD notified . . ."

A progress note, dated 11/30/15, stated, "Resident noted have [sic] wound at right fibula measuring 2.5 cm in diameter with redness around 6 cm in diameter associated with aching pain at 10/10 [pain scale from 0 to 10]. Wound is

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F 314	Continued From page 48 unstageable, with base of ulcer opened, black or dark purple in color, moist . . ." The facility provided a "Root Cause Analysis" related to the unstageable pressure ulcer on Resident #2's right foot. After an investigation and interviews with staff members, the facility concluded the ulcer as unavoidable due to Resident #2's diagnoses. On 12/09/15, the facility implemented an air mattress and changed the blue pillow heel protectors to suspension protective boots. Resident #2's care plan failed identify the implementation of an air mattress. Observation on 01/19/16 at 3:30 and 5:15 p.m., showed Resident #2 in bed and positioned on his left side with bilateral blue pillow heel protectors on and his left foot resting directly on the mattress. Observation on 01/20/16 at 9:55 a.m. showed the nurse (#16) removed the blue pillow heel protectors from Resident #2's feet and assessed the pressure ulcers. During the assessment, the resident complained of pain to his right heel. Observation on 01/20/16 at 2:00 p.m. showed Resident #2 in bed with bilateral blue pillow heel protectors on and both heels/feet resting directly on the mattress. Failure of the facility to apply the suspension protective boots implemented on 12/09/15 and elevate Resident #2's feet, even after he complained of pain, may result in increased pain, delayed healing of pressure ulcers, and development of new pressure ulcers.	F 314		
F 315	483.25(d) NO CATHETER, PREVENT UTI,	F 315		2/29/16

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F 315 SS=D	Continued From page 49 RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. 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 evidence to support the appropriate indications for continued use of an indwelling catheter and failed to maintain the catheter urine drainage systems per facility procedure for 1 of 4 sampled residents (Resident #6) with an indwelling catheter. Failure to evaluate the appropriate indications for continued use of the catheter and failure to maintain catheter drainage equipment below the level of the resident's bladder has the potential to increase the risk of urinary tract infections (UTIs). Findings include: Review of the facility policy and procedure titled "Catheter Care, Urinary" occurred on 01/21/16. This policy, revised December 2014, stated, ". . . 3. The urinary drainage bag must be held or positioned lower than the bladder at all times to prevent urine from flowing back into the urinary	F 315	For identified resident (#6) indications for continued use of catheter was addressed with physician with orders provided. For identified resident (#6) regarding performing cares associated with level of catheter drainage bag, education regarding catheter bag placement below the bladder was completed with nursing staff including CNA□s. Due to potential of all residents being affected by the deficiency, Foley Insertion Removal Maintenance Sheet was implemented via nurse manager staff. All Resident Care Managers were instructed on the form by director of nursing. Education titled Infection Control was completed with nursing staff including CNA□s. Monitoring for catheter use/indication and	

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F 315	Continued From page 50 bladder. . . ." Review of Resident #6's medical record occurred on all days of survey. Diagnoses included urinary tract infection. The admission Minimum Data Set (MDS), dated 11/12/15, identified an indwelling catheter. Resident #6's current care plan stated, ". . . Problem: ADL [activity of daily living] Functional/Rehabilitation Potential Resident requires 2 person total assistance with all ADLs r/t [related to] stroke. . . . Approach . . . 1 person assist for catheter cares. . . ." Review of the nurse's notes dated 11/05/15 at 5:24 p.m. stated, "Received report from . . . RN [registered nurse] at St. Alexius. . . . Foley Catheter was changed yesterday 11/4/2015 r/t large amounts of blood, sediment and cloudy urine. . . ." The medical records lacked documentation and/or an assessment to justify the continued use of an indwelling catheter. Observation on 01/20/16 at 7:11 a.m. showed Resident #6 in bed and a certified nursing assistant (CNA) (#10) provided perineal cares. The CNA (#10) lifted the catheter bag in the air above the bladder level. The CNA (#10) failed to hold the catheter bag lower than the bladder. During an interview on 01/21/16 at 7:50 a.m., a supervisory nurse (#5) verified the facility failed to complete an assessment to determine the appropriate indications for the continued use of an indwelling catheter. During an interview on 01/21/16 at 11:16 a.m., a	F 315	care of Foley catheter to start the week of 2/8/16. The Director of Nursing or designee shall monitor and report to the quality committee as follows: Monitor: Weekly x4; Monthly x3; Quarterly x4	

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F 315	Continued From page 51 supervisory nurse (#5) acknowledged catheter drainage bags need to remain below the level of the resident's bladder.	F 315		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, review of product labels, and staff interview, the facility failed to maintain an environment free of hazardous chemicals on 3 of 4 units (1, 2, and 4) on 2 of 3 days of survey (January 19-20, 2016). This practice placed residents with memory loss and/or wandering behaviors at risk of exposure to hazardous chemicals. Findings include: The facility failed to provide a policy regarding hazardous chemical storage per request. The facility identified two residents that wander within the facility. Random observation on 01/20/16 at 3:30 p.m., showed an unidentified resident self-propel her wheelchair and sit unattended in the kitchenette on Unit 1. On 01/19/16 at 9:08 a.m. and 9:30 a.m. and	F 323	All unlocked chemicals were removed and/or locked. Due to potential of all residents being affected by deficiency, policy Hazardous Chemicals was developed and implemented. Education on policy Hazardous Chemicals was completed with all staff (managers, directors, administrator, assisted living, environmental services, human resources, business office, activities, nursing and purchasing). Monitoring for unlocked hazardous chemicals to start the week of 2/8/16. The Director of Nursing or designee shall monitor and report to the quality committee as follows:	2/29/16

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F 323	Continued From page 52 01/20/16 at 8:15 a.m. and 9:30 a.m., observation of the environment and kitchenettes revealed: * A counter in the unlocked clean utility room on Unit 1 containing the following chemical: Good Sense Deodorizer * A shelf in the unlocked bathroom in the therapy department located between Unit 1 and 2 contained the following chemicals: Good Sense Deodorizer, Sprayway Glass Cleaner, and Steriphere II Disinfectant Deodorant * A counter in the unlocked clean utility room on Unit 2 contained the following chemical: Good Sense Deodorizer * An unlocked drawer next to the stove in the kitchenette on Unit 4 contained the following chemical: Stainless Steel Cleaning Polish The product labels stated the following: * Good Sense Deodorizer: ". . . inhaling the contents can be harmful or fatal . . ." * Sprayway Glass Cleaner: ". . . repeat contact can result in dry skin . . . inhaling the contents can be harmful or fatal . . ." * Steriphere II Disinfectant Deodorant: ". . . causes substantial or temporary eye injury . . . harmful if absorbed through the skin. . . ." * Stainless Steel Cleaning Polish: ". . . may irritate eyes and skin. . ." During an interview on 01/20/16 at 9:30 a.m., an administrative staff member (#14) confirmed he expected chemicals to be kept locked and out of reach of the residents.	F 323	Monitor: Weekly x4; Monthly x3; Quarterly x4	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or	F 371		2/29/16

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F 371	Continued From page 53 considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of professional reference, review of facility policy, and staff interview, the facility failed to store food in a safe and sanitary manner as observed in 3 of 4 Kitchenette refrigerators (Unit 1, 2, and 4). Failure to follow safe food sanitation practices has the potential to increase the risk of foodborne illness and can affect residents who eat food stored in these areas. Findings include: The 2013 Food and Drug Administration Food Code, section 3-501.16 states, ". . . TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be maintained . . . At . . . 41 degrees Fahrenheit . . . ." The Annex 3 Public Health Reasons/Administrative Guidelines further identified, ". . . Bacterial growth and/or toxin production can occur if time/temperature control for safety food remains in the temperature "Danger Zone" of . . . 41 degrees to 135 degrees Fahrenheit too long. . . ." Review of the facility policy and procedure titled "Food Storage" occurred on 01/20/16. This policy, revised 12/01/14, stated, ". . . Cold foods	F 371	Due to potential of all residents being affected by the deficiency, education regarding F371 Sanitary Conditions: Facility must Store, Prepare, Distribute and Serve food under sanitary conditions. Education on new forms, process of checking temperatures and what to do if the temperature is out of range was provided to all dietary staff during their staff meeting. Work orders were written for maintenance to check refrigerators on Units 1, 2 and 4 for accurate temperatures or reasons for high temperatures and work orders completed at this time. Units temperature logs were revised and implemented. Monitoring for refrigerator temperatures within safe range of 33-41degrees and recorded accurately will be monitored starting the week of 2/8/16. The Dietary Manager or designee shall monitor and report to the quality committee as follows:	

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F 371	Continued From page 54 will be maintained at temperatures of 41 degrees Fahrenheit or below, in refrigeration of 35-39 degrees Fahrenheit. . . ." On 01/19/16 at 3:30 p.m. and 01/20/16 at 8:15 a.m. the surveyor obtained the following thermometer readings: * Unit 1 Kitchenette refrigerator: 44 and 43 degrees Fahrenheit * Unit 2 Kitchenette refrigerator: 44 and 48 degrees Fahrenheit * Unit 4 Kitchenette refrigerator: 46 and 45 degrees Fahrenheit The "Temperature Records" for January 2016, further showed: * Unit 2 Kitchenette refrigerator: a reading of 44 degrees Fahrenheit on two days and 47 degrees Fahrenheit on one day. Staff failed to document readings on three days. * Unit 4 Kitchenette refrigerator: a reading of 43 degrees Fahrenheit on two days. Staff failed to document readings on five days. The refrigerators contained the following items: * Unit 1 Kitchenette refrigerator: Boost (nutritional liquid supplement), butter, milk, thickened milk, and yogurt * Unit 2 Kitchenette refrigerator: Boost, butter, milk, pudding, soy milk, and thickened milk * Unit 4 Kitchenette refrigerator: Activia (yogurt that enhances digestive health), Boost, butter, cream, Ensure (nutritional liquid supplement), milk, thickened milk, and yogurt During an interview on 01/20/16 at 8:15 a.m. a managerial staff member (#5) confirmed dietary staff should ensure the refrigerators are	F 371	Monitor: Weekly x4; Monthly x3; Quarterly x4	

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F 371	Continued From page 55 operating at forty-one degrees Fahrenheit or less.	F 371		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. 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. 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. 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.	F 431		2/29/16

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F 431	Continued From page 56 This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, review of manufacturer's recommendations, and staff interview, the facility failed to properly secure, store, and label all medications in 2 of 4 resident units (Badlands and Homestead). Failure to store and label all medications correctly may result in unauthorized access to medications and/or medication errors. Findings include: Review of the facility policy titled "Labeling of Medication Containers" occurred on 01/21/16. This policy, revised December 2014, stated, ". . . All medications maintained in the facility shall be properly labeled in accordance with current state and federal regulations . . . Any medication packaging or containers that are inadequately or improperly labeled shall be returned to the issuing pharmacy . . . Only the dispensing pharmacy can label or alter the label on a medication container or package . . . The nursing staff must inform the pharmacy of any changes in physician orders for a medication. . . ." Review of the facility policy titled "Storage of Medications" occurred on 01/21/16. This policy, revised December 2014, stated, ". . . The facility shall store all drugs and biologicals in a safe, secure, and orderly manner . . . Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes.) containing drugs and biologicals shall be locked when not in use, and trays or carts used to transport such items shall not be left unattended	F 431	Identified resident (#3) insulin labels were corrected for dosage. Due to potential of all residents being affected by the deficiency, education regarding policies titled Storage of Medications, Insulin Storage, and Labeling of Medications Containers was reviewed with nursing staff (nurses). All residents on insulin had audit of insulin labels reviewed for accuracy. Each of the care areas were given a sticker to place on the medication to alert staff of a dose change; this will be utilized until the new label arrives from the pharmacy. Monitoring for the storage of insulin, labeling of dose changes and locking of insulin will start the week of 2/8/16. The Director of Nursing or designee shall monitor and report to the quality committee as follows: Monitor: Weekly x4; Monthly x3; Quarterly x4	

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F 431	Continued From page 57 if open or otherwise potentially available to others. . . ." Review of the facility policy titled "Insulin Storage" occurred on 01/21/16. This policy, revised February 2014, stated, ". . . 3. Insulin storage guidelines are the following or per manufacturer's recommendations: 1 . . . Unused bottles, cartridges and pens can be stored in the refrigerator. In use insulin cartridges and pen store at room temperature. . . ." Review of manufacturer's recommendations for Lantus insulin pens stated, "Open (in-use) . . . Should not be refrigerated but should be kept at room temperature. . . ." - Review of Resident #3's medical record occurred on all days of survey. Diagnoses included diabetes mellitus. Physician orders, dated 01/13/16, included Levemir (a long-acting insulin) 56 units and Novolog (a fast-acting insulin) 20 units, both in the morning. Insulin orders discontinued on 12/23/15 identified Levemir 44 units and Novolog 12 units, both in the morning. Observation of the medication pass occurred on 01/20/16 at 9:20 a.m. and showed the nurse (#9) prepared Resident #3's morning medications, including insulin. The label affixed to the Levemir insulin pen identified 12 units be administered in the morning and the label affixed to the Novolog insulin pen identified 44 units to be administered in the morning. The nurse (#9) reviewed the electronic medication administration record (eMAR) before administering the insulin and found the labels and the eMAR did not match.	F 431		

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F 431	Continued From page 58 The nurse stated the eMAR correctly identified the amount of insulin to administer. The facility failed to obtain new labels with the correct physician's order for the insulin pens. The nurse (#9) entered Resident #3's room with the medications and closed the door. Observation showed two insulin pens, belonging to other residents, left unattended on top of the medication cart. The nurse (#9) failed to secure the medications in the cart. - Observation on 01/20/16 at 3:30 p.m. in the Homestead unit's medication room with a staff nurse (#11) showed 2 in-use Lantus insulin pens stored in the refrigerator.	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to	F 441		2/29/16

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F 441	Continued From page 59 prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to ensure staff followed appropriate infection control practices for 1 of 4 sampled residents (Resident #3) with pressure ulcers and failed to follow infection control practices when handling soiled linens (Resident #6). Failure to follow established infection control practices may result in the spread of infection within the facility. Findings include: Review of the facility policy and procedure titled "Wound Care Dressing Change" occurred on 01/21/16. This policy, revised October 2013, stated, ". . . Steps in the Procedure . . . 7. Wash and dry your hands thoroughly. 8. Put on clean gloves . . . remove soiled dressing. 9. Pull glove	F 441	Identified resident (#3 and #6) regarding performance of donning gloves, hand hygiene and soiled linens placed on the floor, nursing staff (nurses, CNA□s) were educated regarding handling soiled linens, gloving, hand hygiene and wound care education was completed with nursing staff regarding Clean Dressing Change Policy, Infection Control (catheter bags, standard precautions and assisting with dressing changes) and Handling of Soiled Items. Due to potential of all residents being affected by the deficiency, education regarding associated with handling soiled linens, gloving, hand hygiene and wound care education was completed with	

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F 441	Continued From page 60 over dressing and discard into plastic or biohazard bag. 10. Wash and dry your hands thoroughly. . . . 14. Put on clean gloves. 15. Assess the wound . . . 16. Cleanse the wound . . . 18. Apply the ordered dressing . . . 20. Remove disposable gloves and discard into designated container. Wash and dry your hands thoroughly. . . ." - Review of Resident #3's medical record occurred on all days of survey. The record identified two unstageable pressure ulcers. Observation on 01/21/16 at 9:35 a.m. showed the nurse (#9) donned gloves and removed dressings from Resident #3's suprapubic catheter site and left and right groin sites. The nurse failed to wash her hands and apply clean gloves between wound sites. The nurse (#9) then removed her gloves, donned new gloves, and removed a dressing from the resident's left ear. Without removing her gloves, the nurse proceeded to assist an unidentified certified nursing assistant (CNA) to transfer the resident from the bed to a wheelchair. The nurse removed a bandaid from Resident #3's arm, removed her gloves, sanitized her hands, and exited the room. The nurse (#9) failed to remove her gloves and wash her hands after removing the dressing from the resident's ear and failed to wash her hands before exiting the room. Observation on 01/21/16 at 10:37 a.m. showed the nurse (#9) donned gloves and cleansed Resident #3's coccyx wound. She then removed her gloves, sanitized her hands, packed the wound with gauze, removed her gloves, sanitized her hands, donned clean gloves,and applied a	F 441	nursing staff (nurses and CNA□s) regarding Clean Dressing Change Policy, Infection Control (catheter bags, standard precautions and assisting with dressing changes) and Handling of Soiled Items. Monitoring for handling soiled linens, gloving, hand hygiene and wound care to start week of 2/8/16. The Director of Nursing or designee shall monitor and report to the quality committee as follows: Monitor: Weekly x4; Monthly x3; Quarterly x4	

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	355063	A. BUILDING _____ B. WING _____	01/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKES HOME	242 10TH ST W DICKINSON, ND 58601

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F 441	Continued From page 61	F 441		

dressing to cover the coccyx wound. With the same gloves, the nurse (#9) cleansed the resident's suprapubic catheter site, removed her gloves, and sanitized her hands. With ungloved hands, the nurse applied a neosporin ointment to the catheter site with a Q-tip. The nurse then donned gloves and applied a dressing to the catheter site. The nurse (#9) removed her gloves, sanitized her hands, and measured Resident #3's wound on her left ear. The nurse then applied gloves, cleansed the ear, removed her gloves, sanitized her hands, donned clean gloves, and applied a dressing to the ear wound, removed her gloves, sanitized her hands, and exited the room.

The nurse (#9) returned to the room with additional supplies. Without washing her hands, the nurse donned gloves and an ungloved CNA (#16) positioned Resident #3 on her left side. The CNA then applied gloves and assisted by holding the resident's right groin area open while the nurse measured the wound site. The nurse (#9) removed her gloves, sanitized her hands, and donned clean gloves. The nurse packed gauze into the wound, touching the wound as she packed it. The nurse removed her gloves, sanitized her hands, donned clean gloves, and covered the wound with a dressing. The CNA (#16), without changing gloves, held the dressing in place while the nurse taped it. The nurse (#9) removed her gloves, sanitized her hands, and donned clean gloves. The nurse and the CNA positioned Resident #3 on her right side. The nurse removed the packing from the left groin wound, cleansed the wound, and packed the wound. The nurse realized she had forgotten to measure the wound site so, with ungloved hands,

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F 441	Continued From page 62	F 441		

she removed the packing and measured the wound. The nurse then sanitized her hands, donned clean gloves, repacked the wound, and covered it with a dressing. The CNA (#16), with the same gloves she had donned to assist with the previous wound, held the dressing in place while the nurse taped it. The nurse (#9) removed her gloves, placed a clean mattress protector under the resident, and sanitized her hands. The CNA (#16) removed her gloves, then removed the soiled mattress protector, and sanitized her hands. The nurse (#9) donned clean gloves, emptied Resident #3's catheter bag, flushed the catheter tubing, removed her gloves, and sanitized her hands. The nurse donned clean gloves, applied lotion to the resident's feet, remove her gloves, and sanitized her hands. Both the nurse (#9) and the CNA (#16) exited the room without washing their hands.

The nurse (#9) failed to wash her hands during the above observations. The nurse also failed to change gloves (between wounds and between dirty and clean dressings) as per policy. The CNA (#16) failed to remove her gloves between wounds and failed to removed the soiled mattress protector with gloved hands. Both the nurse and CNA failed to wash their hand before exiting Resident #3's room.

During an interview on the afternoon on 01/21/16, an administrative nurse (#5) confirmed the nurse (#9) did not follow the facility's infection control policy and procedure.

- Observation on 01/20/16 at 7:11 a.m. showed Resident #6 in bed and a certified nursing assistant (#10) provided perineal cares. The CNA

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F 441	Continued From page 63 (#10) removed Resident #6's soiled brief, cleaned her perineal area, removed the bed linen soiled with feces, and threw it on the floor. The CNA finished Resident #6's perineal cares, picked up the soiled chuck linen from the floor and placed it in a plastic bag. The CNA (#10) failed to follow established infection control practices when handling soiled linens.	F 441		
F 493 SS=C	483.75(d)(1)-(2) GOVERNING BODY-FACILITY POLICIES/APPOINT ADMN The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and the governing body appoints the administrator who is licensed by the State where licensing is required; and responsible for the management of the facility This REQUIREMENT is not met as evidenced by: Based on record review, review of facility's policies and procedures, review of the Resident Assessment Instrument (RAI) User's Manual, review of validation reports, review of Aspen Central Office (ACO), and staff interview, the facility failed to implement their RAI Process - MDS (Minimum Data Set) 3.0 policies regarding timely completion, accurate coding, accurate completion of the Care Area Assessment (CAA) process, adequate care planning, and proper transmission. Failure to implement policies related to all aspects of the RAI process resulted in untimely and inaccurate coding of resident assessments, and care plans that failed to	F 493	On 2/9/2016, education regarding policies Policy Completion of RAI Process 3.0 & Policy RAI Process MDS 3.0) with interdisciplinary team members (includes nurse managers, administrator, social services, dietary manager, activity manager, quality/risk nurse, director of nursing) was provided by director of nursing. Please see F272, F273, F274, F276, F278, F279, F280, and F287 for education, corrections completed, and monitoring.	2/29/16

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F 493	Continued From page 64 identify residents' current status and needs. Findings include: Review of the facility policy titled "Completion of the RAI Process - MDS 3.0" occurred on 01/21/16. This policy, dated September 2015, stated, ". . . The RAI process will be used to complete initial and periodic OBRA [Omnibus Budget Reconciliation Act] and PPS [Prospective Payment System] required MDS assessments for all residents in certified beds regardless of payer. Assessments will be completed within the guidelines outlined in the RAI Manual, and include the CAA and care planning processes to lead to the development of a plan of care to address and monitor each residents needs and function, and to track changes in the resident's status. Supporting documentation for RAI process will be completed utilizing CMS [Centers for Medicare & Medicaid Services] requirements of the RAI process in order to support the coding of the MDS. These assessments will be completed in accordance with CMS requirements and as issued by the state of North Dakota." Refer to F272, F273, F274, F276, F278, F279, F280, and F287 for evidence the facility failed to follow the RAI process established by CMS.	F 493		