STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355080	A. BUILDING _____ B. WING _____	01/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNSEITH COM NURSING HOME	15 1ST ST NE DUNSEITH, ND 58329

(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 01/04/16 and completed on 01/07/16, the sample included 2 residents for complete review, 7 residents for focused review, and 1 closed record for review. The sample include 9 additional residents to verify specific concerns during the survey.	F 000		
F 156 SS=B	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		

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

Electronically Signed | 01/22/2016

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F 156	Continued From page 1 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 the advance directives requirements.	F 156		

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F 156	Continued From page 2 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 the facility's Medicare billing records, and staff interview, the facility failed to provide the Notice of Medicare Non-coverage (CMS 10123) for 1 of 1 Medicare file (Resident #5) reviewed. Failure to provide all required notices is a violation of resident rights. Findings include: Review of the facility's Medicare billing notices occurred on the afternoon of 01/06/16 with an office manager (#3). Resident #5's records identified staff provided Resident #5's guardian with a Medicare Denial Notice on 07/24/15, but failed to provide the Notice of Medicare Non-Coverage. During an interview on 01/07/16 at 9:15 a.m., a social services staff member (#4) stated she was unable to find evidence staff had provided the required Notice of Medicare Non-Coverage to	F 156	1.) Resident #5's admission paperwork, including Notice of Medicare Non-Coverage, will be reviewed with the resident and guardian and will be signed appropriately. 2.) All residents who admit to DCNH have the potential to be affected by this deficient practice. All residents in the facility will be audited by SSDD/Designee and appropriate admission paperwork, including Notice of Medicare Non-Coverage, will be verified as complete. 3.) Staff will be inserviced on the admissions process, including Notice of Medicare Non-Coverage, and the timeliness of admission paperwork review. Admission paperwork, including Notice of Medicare Non-Coverage will be checked by the SS Department or designee to ensure all admission	

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F 156	Continued From page 3 Resident #5's guardian.	F 156	paperwork has been reviewed and appropriately signed. When a resident is scheduled for admission to DCNH the SSDD/Designee will contact the resident/family/guardian to schedule a time to complete the admission paperwork. This will be scheduled prior to admission or in a timely manner after the admission occurs. 4.) 02-11-16 5.) An admission process review CQI tool will be completed once weekly x 4, bi-weekly x 2, and then monthly thereafter by the SSDD or designee. The admission process review CQI audit tool will be reviewed by the QA committee at the scheduled meeting. This monitor will continue for 6 months after which the QA team will re-evaluate the continued need for the audit.	
F 203 SS=D	483.12(a)(4)-(6) NOTICE REQUIREMENTS BEFORE TRANSFER/DISCHARGE Before a facility transfers or discharges a resident, the facility must notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand; record the reasons in the resident's clinical record; and include in the notice the items described in paragraph (a)(6) of this section. Except as specified in paragraph (a)(5)(ii) and (a)(8) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or	F 203		2/11/16

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F 203	Continued From page 4 discharged. Notice may be made as soon as practicable before transfer or discharge when the health of individuals in the facility would be endangered under (a)(2)(iv) of this section; the resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(i) of this section; an immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(ii) of this section; or a resident has not resided in the facility for 30 days. The written notice specified in paragraph (a)(4) of this section must include the reason for transfer or discharge; the effective date of transfer or discharge; the location to which the resident is transferred or discharged; a statement that the resident has the right to appeal the action to the State; the name, address and telephone number of the State long term care ombudsman; for nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and for nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to notify the resident and/or the	F 203	1.) DCNH must notify the resident and if known, a family member or legal	

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F 203	Continued From page 5 resident's family/legal representative, in writing, of a transfer, including the destination and the reason for the transfer, and the resident's right to appeal the action for 2 of 2 sampled residents (Resident #1 and #5) transferred to the hospital. Findings include: - Resident #5's medical record, reviewed on all days of survey, identified the facility transferred the resident to a hospital on 07/14/15. The record lacked evidence the facility provided the resident's guardian with a written notice of transfer. - Resident #1's medical record, reviewed on all days of survey, identified the facility transferred the resident to a hospital on 12/05/15. The record lacked evidence the facility provided the resident or the resident's family with a written notice of transfer. During an interview on 01/07/16 at 9:15 a.m., a social services staff (#4) member stated she was unable to find evidence the facility provided the above notices.	F 203	representative of the resident of a transfer or discharge and the reasons for the move in writing or a language in a manner they understand and record the reason in the resident's medical record. An updated transfer/discharge form for Resident #5 will be completed and provided to the appropriate family/legal representative. An updated transfer/discharge form for Resident #1 will be completed and provided to appropriate family/legal representative. 2.) All residents in DCNH have the potential to be affected by this deficient practice. An audit will be completed on transfer/discharges within the last month to ensure that the appropriate forms are completed by the SSDD and/or designee. 3.) SSDD/designee will conduct audits on transfer/discharge forms to monitor the correct policy and procedure is occurring. All licensed staff will be inserviced by the SSDD/designee on proper transfer/discharge documentation before 02-11-16. The current transfer/discharge checklist will be evaluated and will be completed by all licensed staff when transferring or discharging a resident from DCNH. The SSDD/designee will ensure checklist forms are completed appropriately. 4.) 02-11-16 5.) A Discharge/Transfer CQI tool will be utilized by the SSDD/designee weekly x 4 weeks, monthly x 2 months and quarterly x 1, for a total of at least 6 month. Completed audit tools will be submitted to the QA committee for review at the	

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F 203	Continued From page 6	F 203	scheduled QA Meeting.	
F 205 SS=D	483.12(b)(1)&(2) NOTICE OF BED-HOLD POLICY BEFORE/UPON TRANSFR Before a nursing facility transfers a resident to a hospital or allows a resident to go on therapeutic leave, the nursing facility must provide written information to the resident and a family member or legal representative that specifies the duration of the bed-hold policy under the State plan, if any, during which the resident is permitted to return and resume residence in the nursing facility, and the nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (b)(3) of this section, permitting a resident to return. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and a family member or legal representative written notice which specifies the duration of the bed-hold policy described in paragraph (b)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to provide the resident and/or the resident's family/legal representative a notice of the facility's bed-hold policy for 2 of 2 sampled residents (Resident #1 and #5) transferred to the hospital. Failure to provide the notice did not allow the resident, family/legal representative the opportunity to make a decision to hold or not hold the bed during the resident's hospital stay.	F 205	1.) DCNH must provide the resident and if known, a family member or legal representative of the resident written notice of the facility's bed-hold policy. An updated bed-hold form will be completed by Resident's #1 and #5 and family member or legal representative and placed in the medical record. 2.) All residents who reside in DCNH have the potential to be affected by the	2/11/16

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F 205	Continued From page 7 Findings include: - Resident #5's medical record, reviewed on all days of survey, identified the facility transferred the resident to a hospital on 07/14/15. The record lacked evidence the facility provided the resident's guardian with a bed-hold notice. - Resident #1's medical record, reviewed on all days of survey, identified the facility transferred the resident to a hospital on 12/05/15. The record lacked evidence the facility provided the resident or the resident's family with a bed-hold notice. During an interview on 01/07/16 at 9:15 a.m., a social services staff member (#4) stated she was unable to find evidence the facility provided the above notices.	F 205	deficient practice. An audit will be completed on all resident medical records to determine if, upon transfer/discharge, bed-hold documents were completed in the last month. 3.) SSDD/designee will conduct audits on bed-hold forms to monitor the correct policy and procedure is occurring. All licensed staff will be inserviced by the SSDD/designee on proper bed-hold documentation by 02-11-16. The transfer/discharge checklist, including bed-hold documentation, will be evaluated/updated and will be completed by all licensed staff when transferring/discharging a resident from DCNH. SSDD/designee will ensure checklist forms are completed appropriately. 4.) 02-11-16 5.) A bed-hold CQI tool will be utilized by the SSDD/designee weekly x 4 weeks, monthly x 2 months and quarterly x 1, for a total of at least 6 months. Completed audit tools will be submitted to the QA Committee for review at the scheduled QA Meeting.	
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by:	F 221		2/5/16

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F 221	Continued From page 8 Based on observation, record review, review of facility policy, and staff interview, the facility failed to assess, care plan, and develop interventions for the use of a restraint for 1 of 2 sampled residents (Resident #6) with a seatbelt while in a wheelchair. Failure to complete the necessary assessment, care plan for the use, and include directions for staff prior to the placement of a seat belt placed the resident at risk for injury. Findings include: Review of facility policy titled "Restraints" occurred on 01/07/16. This policy, revised April 2001, stated, ". . . PROCEDURE: 1. Residents will not have restraints imposed for the purposes of discipline or convenience. 2. All other means of dealing with the resident's condition must be documented as being attempted. 3. Physical Therapist and Occupational Therapist will have input on residents care. 4. In all cases the family/guardian will be informed of possible alternative measures, possible complications, and approve of the residents care plan. 5. Residents restrained will have the restraint released every two hours and PRN [as needed] for exercising, toiteting [sic], re-positioning, or to have other needs met. 6. A Physicians order is required for restraints. 7. The care plan and restraint assessment will be kept up to date for resident's current cares. 8. The restraint plan of action will be re-evaluated with any change in residents physical condition, after any falls, and at least every quarter. . . ." Review of Resident #6's medical record occurred on all days of survey. Resident #6's current care plan stated, "PROBLEM: Left sided paralysis	F 221	1.) Resident #6 has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. 2.) All residents have the potential to be affected by this deficient practice. 3.) a.) The seat belt was removed from the wheelchair of resident #6 on 01-08-16. b.) Nursing staff will review care plan and care card for resident #6 which does not include a seat belt. c.) Nursing staff will be inserviced on the Restraint Policy of DCNH. They will also be instructed in regards to the new sign off form. (see below) d.) Maintenance will remove seat belts from wheelchairs of residents immediately after restraint assessment shows there is no longer a need for it. e.) DON will implement a sign off form that will show that staff have reviewed the care plan and/or care card for each resident. This form will be signed after quarterly review and after changes in condition or plan of care. 4.) 02-05-16 5.) A quality monitor will be put in place to review the sign off form. This form should ensure that nursing staff are aware of any restraints and the complete plan of care for that resident. This form will be monitored by the DON/Designee weekly x 4, biweekly x 8 and monthly thereafter. This will begin 02-01-16.	

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F 221	Continued From page 9 unable to ambulate. . . . APPROACHES . . . Staff to have protective padding (pillow on left side of w/c [wheelchair] for positioning as he allows). . . . Staff to be sure he is positioned well when in Geri chair . . . PROBLEM: 1.) Contractures . . . 2.) Decreased functional mobility. 3.) Requires w/c repositioning . . . APPROACHES: 1.) w/c repositioning as needed to be sure he is correctly positioned in w/c. . . ." The care plan failed to address the use of a seatbelt while Resident #6 is seated in a geri chair. Observations showed Resident #6 seated in a geri chair and a seat belt around his waist on: * 01/04/16 at 3:10 p.m. and 4:50 p.m. * 01/05/16 at 8:30 a.m., 10:08 a.m., 11:44 a.m., and 3:22 p.m. During an interview on 01/06/16 at 8:00 a.m., an administrative nurse (#1) stated she was unaware Resident #6 used a seat belt. The facility failed to assess, care plan, and provide direction for the use of Resident #6's seat belt to ensure the resident's safety.	F 221		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: SCREENING	F 226	1.) DCNH must develop and implement	2/5/16

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F 226	Continued From page 10 1. Based on review of personnel files, facility policy review, and staff interview, the facility failed to implement policies regarding the prevention of abuse and neglect for 4 of 5 employees hired in the last four months (Employee A, B, C, and D). Failure to ensure employees are screened prior to hiring places residents at risk for abuse and mistreatment. Findings include: Review of the facility policy titled, "Abuse, Neglect and Misappropriation of Resident Property - Investigation and Reporting" occurred on 01/07/16. This policy, revised 06/10/15, stated, ". . . PROTECTIVE PROCEDURES: In an effort to assure protection of our vulnerable resident population, all potential employees are screened. Screening consists of: . . . d. Contacting appropriate certification or licensing Board to assure the applicant has accurate credentials, that their licenses are unencumbered, or to determine what capacity, if any, the licensing/certifying board will permit the individual to work. . . ." Review of employee personnel files showed the following: *Employee A: hire date 09/04/15 *Employee B: hire date 10/14/15 *Employee C: hire date 10/15/15 *Employee D: hire date 11/02/15 The facility failed to provide evidence the certified nursing assistant (CNA) abuse/neglect registry on the above employees had been checked prior to employment. During an interview on the morning of 01/05/16,	F 226	written policies and procedures that prohibit mistreatment, neglect and abuse of residents and misappropriation of resident property. 2.) All residents have the potential to be affected by the deficient practice. 3.) a.) The ND CNA Abuse List was printed and reviewed by the DON on 01-05-16. It showed that no CNA's on that registry are employed by the DCNH. This copy will be placed in the DON's CNA/CMA licensing folder. Effective immediately, new CNA's will have a copy of the CNA Abuse List placed in their personnel file for proof of screening. b.) Nursing Staff/Social Services will be inserviced on the DCNH Abuse/Neglect Policy. The importance of timely reporting to the State Health Department will be reviewed. A protocol will be developed for the staff to follow if an incident happens when the Administrator, DON or Social Services are not available to notify The State Health Department. 4.) 02-05-16 5.) A quality monitor to review all reportable incidents of Abuse/Neglect will be implemented. All incidents will be reviewed by DON/Designee as they occur to ensure timely reporting. This will be reviewed by the Quality Assurance Committee.	

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F 226	Continued From page 11 an administrative nurse (#1) stated she checks the CNA abuse/neglect registry but does not document her findings. REPORTING 2. Based on record review, review of facility policy, and staff interview, the facility failed to implement policies regarding abuse/neglect and failed to report 2 of 3 abuse allegations to the State Agency (SA) within 24 hours. Failure to implement the abuse/neglect policies and procedures may have contributed to the delay in reporting to the SA and placed all residents at risk without protective measures from abuse and neglect. Findings include: Review of the facility policy titled, "Abuse, Neglect and Misappropriation of Resident Property - Investigation and Reporting" occurred on 01/07/16. This policy, revised 06/10/15, stated, ". . . CONTROL PROCEDURES: Reporting: 1. Every employee of DCNH [Dunseith Community Nursing Home] must make an immediate report to Administrator, DON [director of nursing], and the person-in-charge whenever: A. Abuse, neglect, misappropriation is witnessed (heard or seen); B. The employee is told by a resident or other party that abuse/neglect has happened; C. The employee suspects abuse or neglect. 2. The Administrator, Director of Nursing, or Director of Social Services will make a telephone report to the State Health Department immediately. 'Immediately' means as soon as possible, but ought not exceed 24 hours after discovery of the incident. . . ."	F 226		

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DUNSEITH COM NURSING HOME	15 1ST ST NE DUNSEITH, ND 58329

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F 226	Continued From page 12 Review of the facility's investigation file revealed the following: * Incident occurred on 05/24/15 and the facility reported the incident to the SA on 05/26/15. * Incident occurred on 11/06/15 and the facility reported the incident to the SA on 11/09/15. During an interview on the afternoon of 01/06/16, an administrative nurse (#1) verified both allegations were not reported to the SA within 24 hours.	F 226		
F 272 SS=F	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; Dental and nutritional status; Skin conditions; Activity pursuit; Medications;	F 272		2/10/16

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F 272	Continued From page 13 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, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual (Version 3.0), and staff interview, the facility staff failed to determine underlying causes, contributing factors, and risk factors for the triggered Care Area Assessments (CAAs) for 9 of 9 sampled residents (Resident #1, #2, #3, #4, #5, #6, #7, #8, and #9) reviewed. Failure to determine underlying causes, contributing factors, and risk factors for the triggered CAAs limits the ability of the interdisciplinary team to determine the areas that require care plan intervention(s) and develop, revise, or continue the individualized care plan. Findings include: Review of Resident #1, #2, #3, #4, #5, #6, #7, #8, and #9's medical records occurred on January 04-07, 2016. The following comprehensive MDSs lacked CAA documentation:	F 272	1.) The documentation for the triggered CAAs (Care Area Assessments) for residents #1, 2, 3, 4, 5, 6, 7, 8, and 9 (See MDS dates on Tag 272) will be completed. DCNH is responsible to conduct comprehensive assessments of a resident's needs. This allows the IDT to determine areas that require care plan interventions that are individualized to that resident. 2.) All residents have the potential to be affected by this deficient practice. 3.)a.) MDS Coordinator/designee will complete the CAAs documentation for the above named residents. b.) Revise the current MDS Completion Policy. Revisions will include a workflow process that includes timeframes, department responsibilities and following the current RAI Users Manual. c.) Develop a checklist to be used by MDS Coordinator/Designee to ensure all	

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F 272	Continued From page 14 * Resident #1: Annual MDS, dated 09/01/15 * Resident #2: Significant change MDS, dated 03/16/15 * Resident #3: Annual MDS, dated 07/02/15 * Resident #4: Annual MDS, dated 09/11/15 * Resident #5: Significant change MDS, dated 07/28/15 * Resident #6: Annual MDS, dated 12/07/15 * Resident #7: Annual MDS, dated 12/18/14 * Resident #8: Significant change MDS, dated 06/25/15 * Resident #9: Significant change MDS, dated 10/30/15 During an interview on 01/06/16 at 10:10 a.m., the MDS nurse (#2) stated she did not complete any documentation regarding the triggered CAAs for the above residents.	F 272	aspects of the Resident Assessment Instrument are being followed according to the federal/state guidelines. d.) DON, MDS Coordinator and SSDD will attend MDS Training 01-11 thru 01-14-16 sponsored by the NDDOH. 4.) 02-10-16 5.) DON/Designee will audit the CAAs that are due to ensure they are completed on time. This quality monitor will be done weekly for 6 months and monthly thereafter. This quality monitor will be reviewed by the Quality Assurance Committee at the scheduled QA Meeting.	
F 275 SS=D	483.20(b)(2)(iii) COMPREHENSIVE ASSESS AT LEAST EVERY 12 MONTHS A facility must conduct a comprehensive assessment of a resident not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual Version 3.0, and staff interview, the facility failed to ensure staff completed annual Minimum Data Set (MDS) assessments not less than once every twelve months for 1 of 9 sampled residents (Resident #7). Failure to complete assessments as scheduled may result in the residents' care plans not reflecting the residents' current status and	F 275	1.)DCNH is responsible to conduct a comprehensive assessment of each resident not less than once every 12 months. MDS Coordinator/Designee will provide documentation on the medical record for resident #7 of the completed annual MDS that was due no later than 12-19-15. 2.) All residents have the potential to be affected by this deficient practice.	2/11/16

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F 275	Continued From page 15 needs. Findings include: The Long-Term Care Facility RAI User's Manual Version 3.0, revised October 2015, page 2-19 stated, ". . . The Annual Assessment is a comprehensive assessment for a resident that must be completed on an annual basis (at least every 366 days) unless a SCSA [significant change in status assessment] . . . has been completed since the most recent comprehensive assessment was completed. . . ." Resident #7's medical record, reviewed on all days of survey, identified the most recent comprehensive MDS on record as: * Resident #7: Annual MDS with Assessment Reference Date (ARD) of 12/18/14 - next MDS due no later than 12/19/15 During an interview on 01/06/16 at 3:00 p.m., the MDS nurse (#2) failed to provide documentation staff had completed the above annual MDS, due in December 2015.	F 275	3.) a.) MDS Coordinator/Designee will place documentation of the annual MDS due by 12-19-15 for resident #7 on the medical record. b.) Revise the current MDS Completion Policy. Revisions will include a workflow process that includes timeframes, department responsibilities and following the current RAI Users Manual. c.) Develop a checklist to be used by MDS Coordinator/Designee to ensure all aspects of the Resident Assessment Instrument are being followed according to the federal/state guidelines. d.) DON/MDS Coordinator/SSDD will attend MDS Training 01-11 thru 01-14-16 that is sponsored by the NDDOH. 4.) 02-10-16 5.) DON/Designee will audit the annual MDS's that are due weekly to ensure timely and thorough completion. The audit will include assuring that the MDS is placed on the medical record. This monitor will continue for 6 months and be reviewed by the Quality Assurance Committee at the scheduled QA meeting.	
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, review of the	F 276	1.) DCNH is responsible to complete a	2/10/16

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F 276	Continued From page 16 Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual Version 3.0, and staff interview, the facility failed to ensure staff completed quarterly Minimum Data Set (MDS) assessments at least every three months for 3 of 9 sampled residents (Resident #2, #4, and #8) and 2 supplemental residents (Resident #11 and #13). Failure to complete assessments as scheduled may result the residents' care plans not reflecting the residents' current status and needs. Findings include: The Long-Term Care Facility RAI User's Manual Version 3.0, revised October 2015, page 2-30 stated, "The Quarterly Assessment is an OBRA [Omnibus Budget Reconciliation Act] non-comprehensive assessment for a resident that must be completed at least every 92 days following the previous OBRA assessment of any type. . . ." Resident #2, #4, #8, #11, and #13's medical records, reviewed on January 4-6, 2016, identified the most recent MDSs on the record as follows: * Resident #2: Quarterly MDS with ARD of 09/16/15 - next MDS due no later than 12/17/15 * Resident #4: Quarterly MDS with ARD of 09/11/15 - next MDS due no later than 12/12/15 * Resident #8: Quarterly MDS with ARD of 09/25/15 - next MDS due no later than 12/26/15 * Resident #11: Quarterly MDS with ARD of 09/19/15 - next MDS due no later than 12/201/5 * Resident #13: Quarterly MDS with ARD of 09/26/15 - next MDS due no later than 12/27/15	F 276	non-comprehensive assessment for all residents at least every 92 days. Proof of staff completion of this requirement for residents # 2, 4, 8, 11, and 13 will be placed on the medical record. Failure to do this may result in care plans not reflecting the residents' current status and needs. 2.) All residents at DCNH have the potential to be affected by this deficient practice. 3.) a.) MDS Coordinator/Designee will complete and place the required quarterly MDS assessments on the medical records of the above named residents. b.) The current MDS Completion Policy will be revised. The revisions will include a workflow process with time frames, department responsibilities and following the current RAI Users Manual. c.) Develop a checklist to be used by MDS Coordinator/Designee to ensure all aspects of the Resident Assessment Instrument are being followed according to the federal/state guidelines. d.) DON/MDS Coordinator/SSDD will attend MDS Training 01-11 to 01-14-16 provided by the NDDOH. 4.) 02-10-16 5.) DON/Designee will audit quarterly MDS assessments weekly to ensure timely and thorough completion. This will include ensuring they are placed on the medical record. This monitor will be done weekly for 6 months and reviewed by the Quality Assurance Committee at the scheduled Quality Assurance Meetings.	

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F 276	Continued From page 17 When interviewed on 01/06/16 at 3:00 p.m., the MDS nurse (#2) provided no information indicating staff had completed the above Quarterly MDSs, all due in December 2015.	F 276		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by:	F 278		2/10/16

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F 278	Continued From page 18 ACCURACY OF ASSESSMENTS 1. Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual Version 3.0, and staff interview, the facility failed to ensure staff accurately coded the Minimum Data Sets (MDSs) for 2 of 9 sampled residents regarding delusions (Resident #5) and nutritional interventions for skin problems (Resident #3). Failure to accurately code portions of the MDS does not provide an accurate assessment of the residents' current status and needs. Findings include: Review of the Long-Term Care Facility RAI User's Manual Version 3.0, revised October 2015, pages E-1-E-2 stated, "Delusion: A fixed, false belief not shared by others that the resident holds even in the face of evidence to the contrary. . . . When a resident expresses a clearly false belief, determine if it can be readily corrected by a simple explanation of verifiable (real) facts (which may only require a simple reminder or reorientation) or demonstration of evidence to the contrary. . . . Check E0100B, delusions: if delusions were present in the last 7 days. . . ." Pages M-39-M-40 stated, "Nutrition or Hydration Intervention to Manage Skin Problems: Dietary measures received by the resident for the purpose of preventing or treating specific skin conditions, e.g. [such as] . . . high-protein supplementation for wound healing. . . . The facility should document the nutrition or hydration factors that are influencing skin problems and/or wound healing . . ."	F 278	1.) The MDS for residents #5 and 3 will be accurately coded. Residents #2 and 4 will have the current MDS in the medical record with the proper verification of completion and accuracy. (Z0400 and Z0500A) 2.) All residents have the potential to be affected by this deficient practice. 3.)a.) MDS Coordinator/Designee will accurately code the sections of the MDS identified for residents #5 and 3. b.) MDS Coordinator/Designee will place the current MDS for residents #2 and 4 on the medical record with the proper verification of completion and accuracy. c.) MDS Coordinator/DON and SSDD will attend MDS Training sponsored by the NDDOH on Jan. 11 - 14, 2016. d.) Revisions will be made to the current MDS Completion Policy that will include improving the workflow process and following the RAI Users Manual. e.) A checklist will be developed to be used by the MDS Coordinator/Designee to ensure that all aspects of the Resident Assessment Instrument are being followed according to the federal/state guidelines. f.) All staff involved in the MDS process will be inserviced on the revised policy and the checklist. 4.) 02-10-16 5.) DON/Designee will do a quality monitor to audit the checklist developed. This will be done weekly to ensure that it is complete and that the RAI guidelines are being followed. This monitor will be	

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F 278	Continued From page 19 - Resident #5's medical record, reviewed on all days of survey, identified diagnoses including dementia, anxiety disorder, Bipolar disorder, and psychotic disorder. A Significant Change in Status MDS, dated 07/28/15, identified the resident experienced delusions during the 7-day assessment period. Resident #5's medical record lacked evidence of the resident experiencing delusions during that time frame. - Resident #3's medical record, reviewed on all days of survey, identified diagnoses including paraplegia and chronic buttock wounds. The annual MDS, dated 07/02/15, and quarterly MDS, dated 10/02/15, identified Resident #3 as having stage 2 pressure ulcers and nutritional interventions in place for the pressure ulcers. Resident #3's record lacked evidence staff documented the nutrition factors that influence wound healing or the need for high-protein supplementation to aid wound healing during the assessment period for the MDSs. During an interview on 01/07/16 at 11:40 a.m., the MDS coordinator (#2) and dietary manager (#9) confirmed Resident #3's record lacked documentation regarding nutritional interventions during the assessment period for the 07/02/15 and 10/02/15 MDSs. The MDS coordinator (#2) also confirmed Resident #5's record lacked documentation regarding delusions during the assessment period for the 07/28/15 MDS. MINIMUM DATA SET - ITEM Z0400 (ATTESTATION STATEMENT) AND Z0500A (REGISTERED NURSE SIGNATURE VERIFYING ASSESSMENT COMPLETION)	F 278	reviewed by the Quality Assurance Committee at the scheduled QA Meeting.	

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F 278	Continued From page 20 2. Based on record review and review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual (Version 3.0), the facility staff failed to ensure each individual staff member who completed a portion of the MDS assessment accurately identified the section(s) or portion(s) they completed and failed to ensure the Registered Nurse (RN) verified the completion of the assessment for 2 of 9 sampled residents (Resident #2 and #4). Legally, item Z0400 is an attestation of accuracy with the primary responsibility for its accuracy with the person selecting the MDS item response and item Z0500A is the RN's verification the assessment is completed. Findings include: The Long-Term Care Facility RAI User's Manual, October 2015, Chapter 3, page Z-6 stated, ". . . The importance of accurately completing and submitting the MDS cannot be over-emphasized. . . ." Each person completing a section of the MDS is required to sign the attestation statement (Z0400) as identified on page Z-6 that reads, "I certify that the accompanying information accurately reflects resident assessment information for this resident . . . I understand that this information is used as a basis for ensuring that residents receive appropriate and quality care . . ." Page Z-7 stated, ". . . All staff who completed any part of the MDS must enter their signatures, titles, sections or portion(s) of section(s) they completed, and the date completed. . . ." Page Z-8 stated, ". . . Federal regulation requires the RN assessment coordinator to sign and thereby certify that the	F 278		

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F 278	Continued From page 21 assessment is complete. Steps for Assessment: 1. Verify that all items on this assessment are complete. 2. Verify that Item Z0400 (Signature of Persons Completing the Assessment) contains attestation for all MDS sections. . . . For Z0500B, use the actual date that the MDS was completed, reviewed, and signed as complete by the RN assessment coordinator. This date will generally be later than the date(s) at Z0400, which documents when portions of the assessment information were completed by assessment team members. . . ." - Review of Resident #2's medical record occurred on all days of survey. The record (MDS binder) failed to contain the most recent MDS (December 2015). When asked, the MDS nurse (#2) provided a revised copy of the quarterly MDS, dated 09/24/15 and not the December MDS (see F276). The revised MDS lacked signatures of items Z0400 and Z0500A. - Review of Resident #4's medical record occurred on all days of survey. The record (MDS binder) failed to contain the most recent MDS (December 2015). Whe asked, the MDS nurse (#2) provided a revised copy of the annual MDS, dated 09/11/15 and not the December MDS (see F276). The revised MDS lacked signatures of items Z0400 and Z0500A.	F 278		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced	F 281		2/11/16

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F 281	Continued From page 22 by: Based on observation, record review, and review of facility policy, the facility failed to follow professional standards of practice regarding medication administration for 2 of 9 sampled residents (Resident #1 and #7). Failure to ensure accurate transcription of medication orders to the recertification sheet and medication administration record (MAR) may result in medication errors and adverse drug reactions. Findings include: Review of the facility policy titled "Transcription of Orders/Verification of Recertification Sheet" occurred on 01/07/16. This policy, revised December 2014, stated, ". . . POLICY: Medication orders will be transcribed by a licensed nurse or ward clerk onto the MAR and Recertification Sheet (recert sheet) promptly and accurately. . . . PROCEDURE: A. Routine medications will be transcribed onto the MAR as follows: 1. List the medication, dose, route and frequency . . . 4. When a medication is discontinued or changed in any way, pink out the entire order on the MAR and Recert Sheet. Make a note of the discontinuation (ie dc'd [in example discontinued] and date) on the MAR and the Recert sheet. If the medication was changed, it should be rewritten on the MAR and Recert Sheet. . . . 7. All medications transcribed to MAR must also be written on the Recert Sheet unless it is only a one time order. 8. Double-check the transcription of the order by comparing the MAR and Recert Sheet with the Provider's orders. . . ." - Review of Resident #1's medical record occurred on all days of survey. On 12/29/15	F 281	1.)DCNH will follow the professional standards of practice regarding medication administration. Accurate transcription of medication orders to the recertification sheet and MAR will eliminate medication errors an possible adverse drug reactions for all residents of DCNH. 2.) All residents who receive medications have the potential to be affected by this deficient practice. 3.) a.) Resident # 1's recertification sheet has been reviewed and reconciled with the physician's orders. Corrections have been made. Resident #7's MAR has been reviewed and the instructions now match the physician's orders. b.) Nursing staff will review the facility policy "Transcription of Orders/Verification of Recertification Sheet". They will be inserviced on the importance of following this policy. 4.) 02-11-16 5.) DON/Designee will monitor MARs/Recertification Sheets/Physician's Orders every month to ensure the policy is followed. This monitor will continue for 6 months and greater than 95% compliance for 2 months. The results will be reviewed by the Quality Assurance Committee at the scheduled meeting.	

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F 281	Continued From page 23 Resident #1's Omeprazole and potassium chloride were decreased. The recertification sheet still included the old physician orders for Omeprazole and potassium chloride, dated 12/07/15, in addition to the new physician orders, dated 12/29/15. Facility staff failed to discontinue the 12/07/15 orders for Omeprazole and potassium chloride on Resident #1's recertification sheet. - Review of Resident #7's medical record occurred on 01/04/16. The current physician's orders for artificial tears, stated, "Artificial Tears OD [right eye] 1 gtt [drop] QID [four times a day]." Observation of medication pass occurred on 01/04/16 at 3:55 p.m. A licensed nurse (#12) administered Artificial Tears one drop in Resident #7's right eye. The MAR stated, "ARTIFICIAL DRO [sic] TEARS APPLY TO RIGHT EYE FOUR TIMES A DAY." The staff failed to ensure the instructions on the MAR matched the physician's orders.	F 281		
F 287 SS=E	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	F 287		2/11/16

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F 287	Continued From page 24 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. (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:	F 287		

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F 287	Continued From page 25 Based on record review, review of the Centers for Medicare and Medicaid Services (CMS) Final Validation Reports, and staff interview, the facility failed to electronically transmit encoded and completed Minimum Data Set (MDS) data to the CMS Quality Improvement Evaluation System (QIES) Assessment Submission and Processing (ASAP) system within 14 days of completion of the MDS assessments for 2 of 9 sampled residents (Resident #4 and #6) and 7 supplemental residents (Resident #12, #14, #15, #16, #17, #18, and #19). Findings include: Review of the CMS Final Validation Reports occurred on 01/06/16 and identified Assessment Reference Dates (ARDs) and submission dates as follows: * Resident #4: ARD 09/05/15 submitted 12/19/15 * Resident #6: ARD 12/07/15 submitted 01/03/16 * Resident #12: ARD 11/26/15 submitted 01/06/16 * Resident #14: ARD 10/29/15 submitted 12/17/15 * Resident #15: ARD 11/06/15 submitted 12/02/15 * Resident #16: ARD 12/07/15 submitted 12/31/15 and ARD 12/12/15 submitted 01/04/16 * Resident #17: ARD 11/21/15 submitted 12/07/15 * Resident #18: ARD 11/18/15 submitted 12/14/15 and ARD 11/24/15 submitted 12/21/15 * Resident #19: ARD 11/30/15 submitted 12/19/15 During an interview on 01/06/16 at 3:00 p.m., the MDS coordinator (#2) stated she received no	F 287	1.) N/A 2.) All residents have potential to be affected by this deficient practice. 3.) DCNH will transmit resident MDS data to the CMS QIES ASAP system per federal and state regulation guidelines. a.) MDS Coordinator/DON and SSDD will attend MDS Training sponsored by the NDDOH on Jan 11 to Jan 14, 2016. b.) Revisions to the current MDS Completion Policy will be done. They will include a work flow process, department responsibilities and following the guidelines in the current RAI Users Manual. c.) A checklist will be developed to be used by MDS Coordinator/Designee to ensure that all aspects of the RAI are being followed. This includes the correct timeframes for completion and transmittal of MDS data. d.) A paper log will be used to identify residents and the time frames for MDS completion and submission. The MDS Coordinator will complete this log to ensure the MDSs are being submitted in a timely manner. e.) All staff involved in the MDS process will be inserviced on the revised policy and the check list. 4.) 02-11-16 5.) DON/Designee will audit the checklist and the paper log each week x 8, biweekly x 8 and monthly for a total of 6 months and 100% compliance. This data will be reviewed by the Quality Assurance Committee at the scheduled QA Meeting.	

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F 287	Continued From page 26 warning messages from her MDS vendor when she submitted MDSs later than the required time frame.	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 necessary care and services to maintain skin integrity for 1 of 2 sampled residents (Resident #5) requiring total assistance with bed mobility and personal hygiene. Failure to reposition, shift weight, and check and change the resident in accordance with the care plan placed the resident at risk for skin breakdown. Findings include: Resident #5's medical record, reviewed on all days of survey, identified diagnoses including diabetes mellitus, dementia, neurogenic bladder, paraplegia (paralysis of the lower body), and anxiety disorder. A quarterly Minimum Data Set, dated 10/22/15, identified the resident had mild cognitive impairment, required total assistance with bed mobility, transfers, dressing, toilet use, and personal hygiene, always incontinent of	F 309	1.) Resident #5 will receive the necessary care and services to maintain skin integrity. 2.) All residents have the potential to be affected by this deficient practice. 3.) a.) Nursing staff will review resident #5's care plan and interventions in place for skin integrity. b.) All nursing staff will be inserviced on DCNH Skin Care Program Section A.4 (Preventive Skin Measures) c.) A sign off form for care plans/care cards will be implemented for nursing staff to acknowledge review and understanding of the plan of care for each resident. This will be signed at admission, change of condition, and quarterly. 4.) 02-09-16 5.) A quality monitor will be implemented to observe CNA's with incontinent cares and repositioning and the frequency of	2/9/16

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F 309	Continued From page 27 urine, and frequently incontinent of bowel. Resident #5's current care plan, dated 10/29/15, included the following problems: 05/16/14: "Resident is incontinent of bowel and bladder. . . ." Approaches included: "Resident will be checked and changed on rounds and prn [as needed]." 05/16/14: "Resident is a risk for pressure ulcers. . . ." Approaches included: ". . . MOISTURE MANAGEMENT: . . . 2.) Minimize skin exposure to moisture due to incontinence . . . a.) Clean resident immediately upon recognition of incontinence/moisture. . . . PRESSURE MANAGEMENT: 1.) Reposition at least every 2 hours, or more frequently if indicated. 2.) Avoid uninterrupted sitting in chair or w/c [wheel chair]. Residents bound to a chair or w/c should be repositioned at least every hour or be put back to bed for intervals, have resident shift weight at frequent intervals as able. . . ." 05/16/14: "Resident requires assistance with ADL's [Activities of Daily Living]." Approaches included: ". . . She requires assistance of 1 or 2 staff with bed mobility, transfers with hoyer (full body) lift, dressing, and toileting. . . ." Observations during the survey identified the following: 01/05/16: * 9:15 a.m.: Two Certified Nursing Assistants (CNAs) (#7 and #10) provided morning cares for Resident #5. Observation showed the resident's brief soaked with urine and identified three soaker pads under the resident. After providing cares, the CNAs (#7 and #10) assisted Resident #5 from her bed to the geri chair using a Hoyer lift.	F 309	the cares. DON/designee will monitor 3 CNA's per week for 4 weeks, 2 CNA's per week for 8 weeks and 1 CNA per week for a total of 6 months and greater than 90% compliance. DON/designee will audit the sign off form 1 week after implementation and monthly thereafter to ensure staff compliance. The monitor and audit will be reviewed by the Quality Assurance Committee at the scheduled QA Meeting.	

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F 309	Continued From page 28 * 11:10 a.m.: Resident #5 seated in the geri chair in the activity room. * 11:45 a.m.: Resident #5 seated in the geri chair in the dining room. * 1:17 p.m.: Two CNAs (#7 and #10) transferred Resident #5 from the geri chair to her bed utilizing a Hoyer lift. The resident moaned and cried out with pain during the transfer. A strong urine odor was evident during cares. Observation revealed the resident's brief saturated with urine and her shirt, pants, soaker pad, and lift sling were also wet with urine. Following incontinence cares, the CNAs (#7 and #10) transferred Resident #5 back to the geri chair. * 4:50 p.m.: Resident #5 seated in the geri chair in the dining room. * 5:30 p.m.: Resident #5 seated in the geri chair in her room. During the above four hour time frames of uninterrupted sitting in the chair (9:15 a.m. to 1:17 p.m. and 1:17 p.m. to 5:30 p.m.) staff failed to reposition the resident or assist her to shift her weight in the chair. 01/06/16: 9:02 a.m.: Two CNAs (#10 and #11) assisted the resident with morning cares. Observation showed the resident's brief and soaker pad soaked with urine. During an interview on 01/05/16 at 4:00 p.m., an administrative nurse (#1) stated checking and changing the resident "on rounds" meant every two to three hours. When asked, on 01/06/16 at 4:05 p.m., the nurse (#1) stated staff do not document when they check and change or reposition residents. Staff's failure to check and change Resident #5	F 309		

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F 309	Continued From page 29 every two to three hours resulted in the resident's brief, clothing, soaker pad, and lift sling becoming wet with urine. Because of her paraplegia, Resident #5 is unable to shift her weight in the chair. Failure to reposition the resident or assist her to shift her weight in the chair at least every hour during periods of uninterrupted sitting, as identified in the care plan, placed Resident #5 at risk for skin breakdown.	F 309		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, facility policy review, and review of manufacturer's instructions, the facility failed to ensure a medication error rate of less than five percent affecting 2 of 3 residents (Resident #8 and #11) observed during insulin administration. Failure to provide medication by the right technique may adversely affect the desired benefits of the medication or cause unwanted side effects for the residents. Two errors occurred during staff administration of 37 medications, which resulted in a five percent error rate. Findings include: Review of the facility policy titled "INSULIN INJECTIONS" occurred on 01/07/16. This policy, revised October 2012, stated, ". . . PROCEDURE . . . 6. If using an insulin pen . . . Perform an air	F 332	1.)DCNH must ensure that it is free of medication error rates of 5% or greater. 2.) All residents have the potential to be affected by this deficient practice. 3.) a.) Nursing staff will be inserviced on the DCNH Policy on Insulin Injections and the importance of following the procedure for Insulin Pens. The nurses will give a verbal demonstration of the procedure to the DON. 4.) 02-10-16. 5.) A quality monitor will be implemented to ensure the procedure is being followed. DON/Designee will observe nurses at random times during insulin pen administration for proper technique. This monitor will be 3 times per week for 4 weeks, 2 times per week for 8 weeks and weekly for 12 weeks and 100%	2/10/16

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F 332	Continued From page 30 shot by turning the dial to 2 units. While the needle is pointing up, tap the cartridge gently with your finger a few times to make any air bubbles collect at the top of the cartridge. Push the button and verify a drop of insulin appears at the tip. Verify the dose selector is at zero. . . ." Review of the manufacturer's instructions for NovoLog FlexPen occurred on 01/07/16. This insert stated, ". . . Small amounts of air may collect in the cartridge during normal use. To avoid injecting air and to ensure proper dosing: . . . E. Turn the dose selector to select 2 units. F. Hold your NovoLog FlexPen with the needle pointing up. Tap the cartridge gently with your finger a few times to make any air bubbles collect at the top of cartridge. G. Keep the needle pointing up, press the button all the way. The dose selector turns to zero. A drop of insulin should appear at the needle tip. If not, change the needle, and repeat the procedure. . . ." - Observation on 01/04/16 at 4:02 p.m. showed a licensed nurse (#13) checked Resident #8's blood sugar. The nurse obtained Resident #8's Novolog FlexPen, dialed the FlexPen to 4 units per the physician order, and injected the dose into Resident #8's arm. The nurse failed to perform the airshot. - Observation on 01/04/16 at 4:07 p.m. showed a licensed nurse (#13) checked Resident #11's blood sugar. The nurse obtained Resident #11's Novolog FlexPen, dialed the FlexPen to 20 units per the physician orders, and injected the dose into Resident #11's abdomen. The nurse failed to perform the airshot.	F 332	compliance.	
F 365	483.35(d)(3) FOOD IN FORM TO MEET	F 365		2/9/16

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F 365 SS=D	Continued From page 31 INDIVIDUAL NEEDS Each resident receives and the facility provides food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on observation, facility policy review, review of manufacturer's instructions, record review, and staff interview, the facility failed to provide fluids in a form designed to meet the resident's needs for 1 of 2 sampled resident (Resident #6) with nectar thick liquids. Failure to provide nectar thick liquids to residents as ordered increases the risk of aspiration and pneumonia. Findings include: Review of the facility policy titled "Thickened Liquids" occurred on 01/07/16. This policy, dated 01/06/16, stated, ". . . Thickened Liquids to follow . . . Instructions on Hormel can Thick & Easy." Review of the Hormel Thick & Easy instructions occurred on 01/05/16 at 4:07 p.m. The instructions stated, mix one tablespoon of thickener in four ounces of water for nectar thick consistency. Review of Resident #6's medical record occurred on all days of survey. The current care plan stated, "PROBLEM . . . He will sometimes cough when taking liquids. . . . APPROACHES . . . Thickened (nectar consistency) liquids are being used to avoid swallowing problems. . . ."	F 365	1.) Each resident at DCNH receives and DCNH provides food that is prepared in a form designed to meet individual needs. Resident #6 will receive the correct consistency of fluids to decrease his risk of swallowing problems and aspiration. 2.) Any resident needing specially prepared food or drink could be affected by this deficient practice. 3.)a.) Nursing and Dietary staff will be inserviced on the DCNH Policy regarding thickened liquids. The Hormel Thick and Easy instructions will be reviewed. b.) 5 ounce drink cups have been purchased for medication cart to ensure that the proper amount of liquid will fit into cup with the thickener. 4.) 02-09-16 5.) A quality monitor will be implemented to view if the proper cups are on medication cart and if the nursing staff are mixing the liquids appropriately. The DON/Dietary Manager/Designee will visually check cart for 5 ounce or greater drink cups 3 times/week for 4 weeks, 2 times/week for 8 weeks and weekly for a total of 6 months and 100% compliance. The DON/Dietary Manager/Designee will visually monitor the nursing staff to	

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F 365	Continued From page 32 Observation during medication pass on 01/04/16 at 3:35 p.m. showed a licensed nurse (#12) prepared Resident #6's medications and mixed thickener in water. The licensed nurse stated she mixed, "one to one and a half teaspoons of thickener in water." When asked what consistency of thicken liquids (nectar, honey, or pudding) Resident #6 required the licensed nurse (#12) stated "thickened." Observation during medication pass on 01/05/16 at 3:40 p.m. showed a licensed nurse (#12) prepared Resident #6's medications and mixed one tablespoon of thickener in water. During an interview on 01/06/15 at 1:20 p.m. a dietary manager stated she would expect staff to follow the manufacturer's instructions when thickening liquids.	F 365	ensure they are mixing the thickened liquids correctly. This monitor will be 3 times/week for 4 weeks, 2 times/week for 8 weeks and weekly for a total of 6 months and 100% compliance. This monitor will be reviewed by the Quality Assurance Committee at the scheduled meetings.	
F 371 SS=B	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or 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 and staff interview, the facility failed to prepare and store food in a safe	F 371	1.)All residents at DCNH have the right to food that is stored, prepared and	

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F 371	Continued From page 33 and sanitary manner in 1 of 1 medication cart. Failure to store thickener in a sanitary manner placed all residents who drink thicken liquids prepared in the facility at risk for foodborne illness. Findings include: Observation on 01/05/16 at 3:40 p.m. showed a medication cup left in the thickener container in the medication cart. Observation on 01/07/16 at 9:35 a.m. showed a scoop and a medication cup left in the thickener container in the medication cart. The medication cups and the handle of the scoop were in direct contact with the food products. During an interview on 01/07/16 at 10:23 a.m., the dietary manager (#9) stated no medication cups or scoops should be left in the thickener container.	F 371	distributed under sanitary conditions. 2.)All residents have the potential to be affected by this deficient practice. 3.) a.) Medication cups/scoops will not be stored in the thickener container. b.) Nursing/Dietary Staff will be inserviced on the proper and sanitary storage of thickener. 4.) 02-10-16 5.) A quality monitor will be implemented to observe and ensure that no cups or scoops are stored in the thickener. DON/Dietary Manager/Designee will visually monitor the thickener 3 times/week for 4 weeks, 2 times/week for 4 weeks and weekly for a total of 3 months and 100% compliance. The results will be reviewed by the Quality Assurance Committee at the scheduled Quality Assurance Meeting.	
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by:	F 428		2/11/16

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F 428	Continued From page 34 Based on record review, review of facility policy, and staff interview, the consulting pharmacist failed to report irregularities to the attending physician and the director of nursing for 2 of 6 sampled residents (Resident #1 and #4) receiving antianxiety and/or antipsychotic medications. Failure to report irregularities has the potential for residents to receive unnecessary medications and to experience side effects from the medications. Findings include: Review of the facility policy "PHARMACEUTICAL SERVICE" occurred on 01/07/16. The policy, revised December 2014, stated, ". . . The consulting Pharmacist will review all medical charts every month for drug irregularities including any gradual dose reductions needed. If GDR's [gradual dose reductions] are recommended, they will be relayed to the Physician. . . ." - Resident #4's medical record, reviewed on all days of survey, identified diagnoses including chronic airway obstruction, carcinoma [cancer] of the lung, and anxiety state. The record indicated the physician initiated alprazolam (an antianxiety medication) 1 milligram (mg) three times a day on 09/10/14 and decreased the dose to 1 mg in the morning and at bedtime and 0.5 mg at 2:00 p.m. on 01/15/15. The record lacked evidence of further attempts to reduce the alprazolam dose. Review of Resident #4's pharmacy reviews for the past year failed to identify the pharmacist recommended a gradual dose reduction of Resident #4's alprazolam in the past 11 months.	F 428	1.) Resident #1 and #4 have the right to have their drug regimen reviewed at least once per month by a licensed pharmacist. The pharmacist must then report any irregularities to the attending provider and the director of nursing for further action. 2.) All residents have the potential to be affected by this deficient practice. 3.)a.) Resident #1 and #4's drug regimen will be reviewed by the pharmacist and if recommended a GDR will be relayed to the provider. b.) The Pharmaceutical Service Policy will be revised to include using a GDR (gradual dose reduction) Form for residents that receive drugs that require GDR. The DON/Designee will provide the pharmacist with a GDR Form to complete. c.) The GDR form will be completed by the pharmacist at the monthly medication review. It will be relayed to the provider and reviewed by the empowerment committee at the scheduled Empowerment Meeting. Medication changes will be made accordingly. d.) DCNH will follow the CMS Guidelines for how often GDR should be reviewed. Residents who are on medications that require GDR review will be assessed accordingly. 4.) 02-11-16 5.) DON/Designee will audit each record for residents that receives drugs that require a GDR to ensure a GDR form is completed. This monitor will be ongoing. This data will be reviewed by the Quality Assurance Committee at the scheduled meeting.	

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	355080	A. BUILDING _____ B. WING _____	01/07/2016

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F 428	Continued From page 35 - Resident #1's medical record, reviewed on all days of survey, identified diagnoses including bipolar disorder. Current physician orders indicated Seroquel (an antipsychotic medication) 50 mg twice a day ordered on 04/23/14 and Ativan (an antianxiety medication) 0.5 mg daily and 0.5 mg daily as needed ordered on 09/25/14. The record lacked evidence of attempts to reduce the Seroquel and Ativan dose. Review of Resident #1's pharmacy reviews for the past year failed to identify the pharmacist recommended a gradual dose reduction of Resident #1's Seroquel in the past 21 months and Ativan in the past 16 months. During an interview on 01/07/16 at 11:25 a.m., an administrative nurse (#1) verified the pharmacist did not recommend any gradual dose reductions in the last year.	F 428		
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	F 441		2/10/16

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F 441	Continued From page 36 actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to 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 procedure, and staff interview, the facility failed to ensure staff followed appropriate infection control procedures during resident cares for 3 of 4 sampled residents (Resident #5, #6, and #8) observed receiving toileting/incontinence cares. Failure to follow appropriate infection control practices may result in spread of infection within the facility. Findings include: Review of the facility's "HANDWASHING	F 441	1.)DCNH 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. 2.) All residents have the potential to be affected by this deficient practice. 3.) a.) The hand hygiene portion of the Infection Control Policy will be revised to include more detailed information in regards to when to change gloves, when to wash hands and when to use rubs.	

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F 441	Continued From page 37 PROCEDURE" occurred on 01/07/16. The procedure, revised on 11/12/02, stated, "PURPOSE: To remove dirt, organic material, and transient microorganisms, which will significantly reduce the transmission of potential pathogens from the hands. . . ." The procedure explained how to wash hands (soap, friction, etc.) but gave no guidance regarding when staff should wash their hands and/or don or change gloves. - Resident #5's medical record, reviewed on all days of survey, identified diagnoses including dementia, neurogenic bladder, and paraplegia (paralysis of the lower body). A quarterly Minimum Data Set, dated 10/22/15, identified the resident had mild cognitive impairment, required total assistance with toilet use and personal hygiene, always incontinent of urine, and frequently incontinent of bowel. Resident #5's current care plan, dated 10/29/15, identified a problem, dated 05/16/14: "Resident is incontinent of bowel and bladder . . ." Approaches to the problem included: ". . . Calmoseptine or Bag Balm will be applied to buttocks with cares as needed to prevent skin breakdown. . . ." Observations on 01/05/16 identified the following: * 9:15 a.m.: Two Certified Nursing Assistants (CNAs) (#7 and #10) provided morning cares for Resident #5. Observation showed the resident incontinent of urine. One CNA (#7) provided frontal perineal cares. The second CNA (#10) provided perianal cares. Observation showed the resident incontinent of a bowel. Without changing her gloves, the CNA (#10) placed her hand into a container of bag balm and applied the balm to	F 441	b.) All nursing staff will be inserviced on the new policy. c.) Hand hygiene will be reviewed upon hire and yearly at the annual education inservice. 4.) 02-09-16 5.) DON/Designee will observe random nursing staff at random times performing hand hygiene. This monitor will be done 3 times per week for 4 weeks, 2 times per week for 8 weeks and 1 time per week for a total of 6 months and 90% compliance. The quality monitor will be reviewed by the Quality Assurance Committee at the scheduled meetings.	

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F 441	Continued From page 38	F 441		

the resident's buttocks. The CNA (#10) then removed her gloves and washed her hands. The other CNA (#7) removed her gloves, and without washing her hands, left the room and returned with a Hoyer lift. The CNAs transferred Resident #5 to her chair using the lift. The CNA (#7) left the room with the lift, returned, combed the resident's hair, donned gloves, removed and brushed the resident's dentures, placed the dentures in the resident's mouth, then removed her gloves and washed her hands.

* 1:17 p.m.: Two CNAs (#7 and #10) provided incontinence cares for Resident #5. Observation revealed the resident's brief saturated with urine. The CNA (#10) provided perineal cares, and without changing her gloves, placed her hand into a container of bag balm and applied the balm to the resident's buttocks. The CNA then removed her gloves and, without washing her hands, assisted with transferring Resident #5 to her chair with the Hoyer lift, then washed her hands.

During an interview on 01/07/16 at 8:00 a.m., an administrative nurse (#1) stated staff should change gloves after providing perineal cares and prior to applying the balm.

- Review of Resident #6's medical record occurred on all days of survey. The annual MDS, dated 12/07/15, identified the resident required total assistance with toilet use and extensive assistance with personal hygiene, always incontinent of urine, and always incontinent of bowel. The current care plan stated, "PROBLEM: Incontinent of bowel and bladder, wears attends. Has diagnoses of neurogenic bladder. . . .

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F 441	Continued From page 39 APPROACHES: Staff to check and change brief every 2-3 hours and PRN [as needed], change attends providing good toileting hygiene after each incontinent episode. . . ." Observation on 01/05/16 at 10:08 a.m. showed two CNAs (#7 and #8) performed perineal care for Resident #6, who was incontinent of bowel, and removed their visibly soiled gloves. Without performing hand hygiene the CNA's transferred Resident #6 with a full body mechanical lift from the bed to his geri chair and fastened the seat belt in the chair. One CNA (#8) then exited the room and the other CNA (#7) washed her hands. The CNAs (#7 and #8) failed to perform hand hygiene after providing perineal care and before completing other tasks. The CNA (#8) failed to perform hand hygiene prior to exiting the room. - Observation on 01/06/16 at 2:32 p.m. showed two CNAs (#7 and #11) assisted Resident #8 to the bathroom. Following toileting, Resident #8 performed her own perineal cares. The CNAs (#7 and #11) assisted the resident to transfer to her wheelchair and to bed. The CNAs washed their hands and exited the room without encouraging or assisting Resident #8 to wash her hands after providing her own perineal care.	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;	F 493		2/9/16

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F 493	Continued From page 40 and responsible for the management of the facility This REQUIREMENT is not met as evidenced by: Based on staff interview, the facility failed to establish and implement policies regarding the Minimum Data Set (MDS), the staff member (job title) responsible for completing each section of the MDS and how the Care Area Assessment (CAA) processes and care planning should be accomplished. Failure to establish and implement policies related to all aspects of the MDS may result in inaccurate resident assessments and incomplete care plans. Findings include: During an interview on the morning of 01/07/16, an administrative nurse (#1) stated the facility lacked MDS policies and procedures.	F 493	1.)DCNH must establish policies and implement policies regarding the management and operation of the facility. 2.) N/A 3.) DCNH has an MDS Policy. This policy will be revised to include more detailed information, such as: a.) staff member responsible for completing each section of the MDS b.) how the CAA processes and care planning are accomplished c.) staff members involved in the MDS Process will be inserviced on the updated policy d.) policy will be reviewed annually and revised as needed 4.) 02-09-16 5.) DON/Designee/Administrator will observe revisions of the MDS policy when complete. The policy will be placed in the appropriate binders so available to staff involved. DON/Designee will visually monitor policy in binder monthly for 3 months and report to the Quality Assurance Committee at the scheduled meeting.	