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 _____	11/20/2014

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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 November 17, 2014 and completed on November 20, 2014, the sample included two (2) residents for complete review, seven (7) residents for focused review, and one (1) closed record for review. The sample included one (1) additional resident to verify specific concerns during the survey.	F 000		
F 164 SS=B	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment	F 164		

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

Darrell J. Brenno | Nursing Home Administrator | 12/19/14

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 164	Continued From page 1 contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation, and review of the facility's resident rights, the facility failed to maintain the privacy and confidentiality of the residents' medical and personal information for 4 of 4 days of survey (November 17 - 20, 2014). Failure to maintain confidentiality of residents' medical and personal information could allow resident's information to be viewed by unauthorized individuals. Findings include: Review of a facility's posted Resident Rights document occurred on 11/18/14. This document stated, ". . . The right to have privacy . . . and to have confidentiality in the treatment of personal and medical records. . . ." - Observation of the nurses' station on all days of survey showed the following taped to the top of the desk with resident names visible: * Bedside I&O [intake and output] for two residents. * Bed Patient Turn Record for one resident Observation on 11/17/14 at 5:00 p.m. showed the medication cart positioned in front of the nurses' station and a Resident Report Sheet visible on top of the cart. The report sheet listed all the residents in the facility and identified specific medications for approximately five residents.	F Tag 164	1.) Residents have the right to personal privacy and confidentiality of his/her medical record. 2.) All residents with a medical record have potential to be affected by this deficient practice. 3.) A) The I/O sheets and turning records have been removed from counter at nurse's station and placed in a private area behind the nurse's station. B) Nursing staff will be inserviced on 12-16-14 and 12-17-14 on keeping all MARs closed anytime they are administering medications and are away from the medication cart. They will also be reminded to keep the resident report sheet covered at all times. C) Nursing staff will be inserviced on the resident's right to personal privacy and confidentiality of his/her medical record on 12-16-14 and 12-17-14 and annually thereafter. 4.) 01-01-15 5.) DON/designee will visually monitor nurse's station and medication cart (MARs) 3 times/week for 8 weeks, then 3 times/month until 100% compliance for 2 months. This will be reviewed at the Quality Assurance Meeting.	
F 224 SS=D	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN	F 224		

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F 224	Continued From page 2 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: Based on record review, review of facility policy and procedure, staff interview, the facility failed to ensure reporting and investigation of potential neglect for 1 of 1 sampled resident (Resident #6) who received an injury after falling from his/her wheelchair while transported by staff. Failure to report and investigate potential incidents of neglect placed all residents at risk of neglect. Findings include: Review of the facility's policy and procedure, "Abuse, Neglect and Misappropriation of Resident Property - Investigation and Reporting," occurred on 11/13/14. This policy, revised September 2014, stated, "POLICY: . . . Abuse, neglect . . . are prohibited within our facility and scope of services and will not be tolerated. Residents, have the right to be free from such behavior, and staff work to ensure these negative events do not occur. . . . Neglect - means failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. This includes . . . failure to give proper attention to residents, or failure to carry out resident services through careless oversight. . . . Reporting: . . . 4. The facility will immediately address any report of	F 224	1.) Resident #6 has the right to be free from neglect. It is the responsibility of the DCNH to report and investigate potential incidents of neglect in a timely manner. It must also include actions taken and safeguards implemented to prevent further neglect. A thorough fall investigation has been completed for the fall that occurred on 10-31-14 on resident #6. 2.) Failure to report and investigate potential incidents of neglect placed all residents at risk of neglect. 3.) Education will be provided to nursing staff at inservice on following the policy and procedure in place at DCNH for Abuse, Neglect and Misappropriation of Resident Property-Investigation and Reporting. The definition of neglect will be reviewed. The post fall investigation tool has been revised to a more comprehensive and thorough assessment. (see the form attached to F Tag 323) This tool will also remind nursing staff to assess for possible neglect. Resident #6's care plan has been updated to reflect his current mobility. The above will be inserviced by DON on 12-16-14 and 12-17-14. 4.) 01-01-15	

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F 224	Continued From page 3 abuse, neglect, physical injury, or involuntary seclusion. Nursing and Administration will assign an investigation team (which includes Social Services and Nursing), and they will conduct an immediate investigation. Necessary action will be implemented based on their findings . . . Investigations: 1. . . Investigations will be done on a timely basis, and the investigation (along with documentation of actions taken and safeguards that are implemented) will be forwarded to the State Health Department within 5 working days of the initial reporting of the abuse or neglect situation. . . ." Review of Resident #6's medical record occurred on all days of survey. Medical diagnoses included dementia, end stage renal disease (ESRD), and glaucoma. The current care plan stated, "He uses a w/c [wheelchair] for almost all . . . mobility. . . ." Observations during all days of survey identified staff transported Resident #6 in his wheelchair for mobility. Review of the "Post Fall Assessment" form identified a fall on 10/31/14 at 12:30 p.m. and stated, "Resident slipped out of wheelchair at KDU [kidney dialysis unit] . . . Bit lip - KDU nurse assessed and treated Abrasion to upper R [right] eye Bleeding tooth Abrasion at left nostril. . . ." Resident #6's Nurse's Notes, dated 10/31/14 1:00 p.m., stated, "Reported by nurse [name] at KDU that [resident's name] fell out of wheelchair just prior to KDU. Will begin post fall tonight. [Family] was called." During an interview on 11/20/14 at 11:00 a.m. and 12:30 p.m., an administrative nurse (#1) verified a post-fall investigation started on 10/31/14	F 224	5.) DON/Designee will review all falls daily to assess for potential neglect. A monitor will be put in place to assess if the nursing staff is performing the proper investigation, assessments, treatment, follow up and documentation. The quality monitor put in place for F Tag 323 will include this tag as well. (See F Tag 323's monitor for details) This quality monitor will be reviewed at the Quality Assurance Meeting.	

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F 224	Continued From page 4 identified a facility staff member pushed Resident #6 in his wheelchair from the facility's van to the KDU. The nurse (#1) indicated the staff member hurried too fast while also looking for the resident's glasses when the resident slipped out of the wheelchair. The nurse (#1) agreed the initial investigation did not include specific details to identify how the fall and facial injuries occurred, no follow-up completed after the initial investigation with recommendations to prevent future falls, and no initial report, as per facility policy, communicated to the State agency.	F 224		
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 by: MEDICATION RECONCILIATION 1. Based on observation, record review, review of policy and procedure, and staff interview, the facility failed to ensure staff reconciled physicians' recertification orders at the beginning of each month with the medication administration record (MAR) for 1 of 9 residents (Resident #11) observed during medication administration. Failure to reconcile recertification orders with each new month's MAR may result in residents not receiving the correct medication and/or dose. Findings include: Review of the facility policy, "Medication Administration," occurred on 11/20/14. This	F 281		

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F 281	Continued From page 5 policy, revised September 2006, stated, ". . . 10) Medication essential points: a) No medication is to be administered without a physician's order. . . ." Observation on 11/18/14 at 11:44 a.m. showed a nursing staff member (#2) administered Ativan 0.5 milligrams (mg) to Resident #11 as indicated on the November 2014 MAR. Review of Resident #11's medical record occurred on 11/18/14 and identified a signed physician's order, dated 09/25/14, for "Ativan 0.5 mg one tab PO [by mouth] daily. . . ." The current "Physician Orders/Recertification" form, signed by the physician on 10/30/14, lacked the Ativan 0.5 mg daily order. During an interview on 11/18/14 at 3:30 p.m., an administrative staff nurse (#1) indicated staff did not enter the Ativan order into the facility's medication order system which would have updated the current signed "Physician Orders/Recertification" form. Staff did not accurately reconcile the November 2014 MAR with the "Physician Order/Recertification" form to identify the Ativan discrepancy. Two nurses initialed the November 2014 MAR indicating the reconciliation process was complete and accurate. MEDICATION DOCUMENTATION 2. Based on observation, review of facility policy, review of professional reference, and staff interview, the facility failed to ensure 1 of 4 nurses (#2) followed professional standards of practice during medication pass. Failure to ensure nurses are not signing off medications as given prior to	F Tag 281	1.) Residents have the right to professional standards of quality as evidenced by accurate verification and reconciliation of medication administration record and provider recertification sheets. Resident #11's MAR and Recertification Sheet have been checked for accuracy and a revised policy for this process has been implemented. They also have the right to have nurses administer medications in the manner which is deemed the professional standard of practice. A resident that experiences a fall will be assessed and treated appropriately for injury or condition. If resident #6 experiences a fall he will be assessed and treated for his condition. Resident #6's careplan has been updated to reflect his current mobility status. We have also received a copy of his KDU visit for the day he fell. 2.) All residents receiving medications have potential to be affected by this deficient practice. All residents at risk for falls have potential to be affected by this deficient policy.	

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F 281	Continued From page 6 administration may result in medication errors. Findings include: Berman and Snyder, "Kozier & Erb's Fundamentals of Nursing: Concepts, Process, and Practice," 9th ed., Pearson Education, Inc., New Jersey, pages 862-863, stated ". . . Process of Administering Medications . . . 3. Administer the drug. . . . 5. Record the drug administered. . . ." Page 869 stated, ". . . Administering Oral Medications . . . Stay with the client until all medications have been swallowed. . . ." Review of the facility policy, "Medication Administration," occurred on 11/20/14. This policy, revised September 2006, stated, ". . . Procedure: . . . 4) Document all scheduled doses given with your initials on the MAR immediately after administration is complete. . . ." Observation on 11/18/14 during the morning and afternoon medication administration passes identified a nursing staff member (#2) initialed the MAR before administering medications to three residents. During an interview on 11/20/14 at 11:00 a.m., an administrative staff nurse (#1) agreed nursing staff did not follow the facility's policy of initialing the MAR after administering resident medications. NEUROLOGICAL CHECKS 3. Based on record review, review of facility policy, and staff interview, the facility failed to ensure staff completed neurological checks for 1	F 281	3.) The policy on transcription of orders and verification of recertification has been revised. (see attached) The nursing staff will be inserviced on the new policy. The nursing staff will be inserviced on the policy in place regarding documentation of medications after administration is complete. Nursing staff will be reminded of the importance of following the current fall policy regarding residents that sustain head injury or suspected head trauma. It states that neurological checks will be included with vital signs. DON will inservice all of the above on 12-16-14. 4.) 12-24-14 5.) The DON/Designee will review MARs/Recert Sheets/Medical Records each month for 6 months or until 100% compliance for 2 months of following the revised policy. DON/Designee will perform a random visual monitor 3 times/week for 2 months or until 100% compliance for 2 months by observing different nurses/CMA administering medications to see that they are charting appropriately.	

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F 281	Continued From page 7 of 1 resident (Resident #6) who had a fall with facial injuries. Failure to ensure staff completed neurological assessments after falls with head injuries may result in not identifying any further injuries or decline in mental status. Findings include: Review of the facility policy, "Falls/Falls Prevention and Management," occurred on 11/20/14. This policy, revised June 2009, stated, "Policy: 1. All residents experiencing a fall will be assessed and treated for injuries. If the resident has sustained a head injury or suspected head trauma, crani [neurological] checks must be included with the vital signs. . . ." Review of Resident #6's medical record occurred on all days of survey. The current care plan stated, "He uses a w/c [wheelchair] for almost all . . . mobility. . . " Observations during all days of survey identified staff pushed Resident #6 in his wheelchair for mobility. Review of the "Post Fall Assessment" form identified a fall on 10/31/14 at 12:30 p.m. and stated, "Resident slipped out of wheelchair at KDU [kidney dialysis unit] . . . Bit lip - KDU nurse assessed and treated Abrasion to upper R [right] eye Bleeding tooth Abrasion at left nostril. . . ." The form included a post fall assessment started by staff when the resident returned to the facility that afternoon and included assessments for 11/01/14 and 11/03/14. The "Injury Follow-up" column did not address the lip, tooth, or nostril injury for the three days. During an interview on 11/20/14 at 11:00 a.m. and 12:30 p.m., an administrative nurse (#1) agreed	F 281	DON/Designee will monitor each post fall assessment to ensure that the proper assessments are being performed. The quality monitor put in place for F Tag 323 will include this tag as well. This quality monitor will be reviewed at the Quality Assurance Meeting.	

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F 281	Continued From page 8 the investigation did not include: * A report from the KDU regarding evidence KDU staff monitored the resident's neurological status while at the KDU * Neurological checks by the facility after the resident's return	F 281		
F 323 SS=G	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, record review, review of facility policy and procedure, and staff and confidential individual interview, the facility failed to ensure staff safely transported and monitored 1 of 1 resident (Resident #6) who experienced an unavoidable fall with injuries while transported by wheelchair. Failure of staff to act in a safe manner resulted in Resident #6's fall with injuries. Findings include: Review of the facility policy, "Falls/Falls Prevention and Management," occurred on 11/20/14. This policy, revised June 2009, stated, "Policy: 1. All residents experiencing a fall will be assessed and treated for injuries. 2. All falls will be completely and accurately documented and reported . . . Purpose: 1. To ensure proper	F 323		

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F 323	Continued From page 9 documentation and reporting of all resident falls and resultant injuries . . . Procedure: . . . 5. Do vital signs and assessment at time of fall, every hour x [times] 2, and for the next 2 shifts. If the resident has sustained a head injury or suspected head trauma, crani [neurological] checks must be included with the vital signs . . . 8. Complete the Post Fall Assessment Form . . . and the Post-Fall Investigation Form . . . Chart 'see Post Fall Assessment' in the Nurses Notes . . . D. Investigation and Monitoring of Falls . . . 2. The DON [director of nursing] or designee will review documentation and interventions implemented after the fall for appropriateness. . . ." Review of Resident #6's medical record occurred on all days of survey. Medical diagnoses included dementia, end stage renal disease (ESRD), and glaucoma. The current care plan stated, "He uses a w/c [wheelchair] for almost all . . . mobility. . . " Observations during all days of survey identified staff pushed Resident #6 in his wheelchair for mobility. Review of the "Post Fall Assessment" form identified a fall on 10/31/14 at 12:30 p.m. and stated, "Resident slipped out of wheelchair at KDU [kidney dialysis unit] . . . Bit lip - KDU nurse assessed and treated Abrasion to upper R [right] eye Bleeding tooth Abrasion at left nostril. . . ." The form identified staff notified the family by phone and the physician by fax. The documentation lacked any orders or instructions received from the physician. The form included a post fall assessment started by staff when the resident returned to the facility that afternoon and included assessments for 11/01/14 and 11/03/14. The "Injury Follow-up" column did not address the lip, tooth, or nostril injury for the three days. Staff	F 323	1.) Resident #6 has the right to an environment that is as free of accident hazards as possible and he has the right to adequate supervision and assistive devices to prevent accidents. A thorough fall investigation has been completed for the fall that occurred on 10-31-14 on resident #6. 2.) All residents have the potential to be affected by this deficient practice. 3.) The policy on falls/falls prevention and management has been revised. The revisions include a post fall investigation form that is much more comprehensive, complete and thorough. This form includes obtaining information about the fall from other agencies if they are involved. (see attached) The post fall assessment form has also been revised to remind nurses to be assessing and charting more thoroughly after a fall. (see attached) The nursing staff will be reminded of the importance of following up with any injuries, starting neurological checks if indicated and documenting any instructions given by the provider. They will be reminded to initiate and document any interventions implemented after the fall. A policy for wheelchair safety has been developed. (see attached) The nursing staff will be inserviced on the revisions and updates. All staff that transport residents in wheelchairs will be inserviced on wheelchair safety. DON/Designee will inservice all of the above on 12-16-14 and 12-17-14.	

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F 323	Continued From page 10 documented an upper right eye abrasion one day and an upper left eye abrasion the next day. The initial report noted an upper right eye abrasion. Staff documented "denies pain" for all three days and lacked documentation under "falls prevention strategies." Resident #6's Nurse's Notes identified the following: * "10/31/14 1 pm Reported by nurse [name] at KDU that [resident's name] fell out of wheelchair just prior to KDU. Will begin post fall tonight. [Family name] was called." * "11-1-14 5:30 am Resident slept all noc [night] . . . voices no pain and has no concerns. . . ." * "11-3-14 Post fall complete - denies injury - abrasion to lt [left] eye. . . ." * "11-18-14 Noon: Have called [family] . . . [resident] lost . . . front tooth yesterday. No pain reported. . . ." During a confidential interview on 11/19/14 at 3:45 p.m., the individual (A) indicated staff reported Resident #6 fell forward from his wheelchair after staff, pushing the wheelchair too fast, hit a curb on the way into the KDU. This individual verified staff reported Resident #6's tooth bleeding after the fall, and on 11/18/14 staff reported the tooth had fallen out. During an interview on 11/20/14 at 11:00 a.m. and 12:30 p.m., an administrative nurse (#1) verified a post-fall investigation started on 10/31/14 identified a facility staff member pushed Resident #6 in his wheelchair from the facility's van to the KDU. The nurse (#1) indicated the staff member hurried too fast while also looking for the resident's missing glasses. The resident "slipped out" of the wheelchair before reaching the KDU	F 323	4.) 01-01-15 5.) DON/Designee will continue to review each fall daily. A monitor will be put in place to assess if the nursing staff is performing the proper investigation, proper assessment/treatment of injuries and documentation is being completed. DON/Designee will review all the falls monthly x 6 months then 50% of falls for another 6 months and greater than 90% charting compliance. This quality monitor will be reviewed at the Quality Assurance Meeting.	

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F 323	Continued From page 11 door. The nurse (#1) agreed the investigation did not include: * Specific details to identify how the fall and facial injuries occurred * A report from the KDU regarding the resident's injuries, treatment, or evidence KDU staff monitored the resident's neurological status while at the KDU * Neurological checks by the facility after the resident's return * Accurate and complete documentation and monitoring regarding the fall and injuries * A follow-up to the initial investigation Failure of staff to safely transport Resident #6 in his wheelchair resulted in his fall with injuries. Incomplete documentation and failure to monitor and follow-up may have contributed to Resident #6's tooth falling out 18 days later.	F 323		
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on the group interview, resident interviews, record review, and surveyors' sampling of a noon meal tray, the facility failed to prepare food using methods to enhance flavor and texture for 5 of 5 residents (Resident C, D, E, F, and G) who attended the group interview and for 4 of 4 residents interviewed (Resident #3,	F 364	**F 364** **#1. Resident # 3, identified a complaint that food doesn't have any taste.** **A. The resident will be given a food satisfaction survey on current foods. Dietary Staff will be in-serviced by the** **A. DCNH Consulting Dietitian R.D., and** **B. Local Hospital Head Cook/ Local Caterer on December 12th, 2014 on the importance of taste, flavor, texture, nutritive value, and appearance; and that the food is palatable, attractive, and at the proper temperature.** **Food service complaints will be addressed at the Resident Council.** **#2. All residents are potentially affected by this deficient practice.**	

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	355080	A. BUILDING _____ B. WING _____	11/20/2014

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F 364	Continued From page 12 Resident A, H, and I). Failure to ensure foods are prepared to promote palatability may impact food intake by residents and may have placed the residents at risk of unintended weight loss. Findings include: During the resident group interview, completed on 11/18/14 at 10:30 a.m., all 5 residents present reported the food is tasteless, the meat (especially roast pork and beef) is dry, and the menu alternates are leftovers of food no one ate "the first time it was served." Resident C stated he/she buys canned and frozen foods to eat and it gets expensive. The resident further stated residents talk about food issues at the monthly council meetings and nothing changes. - Review of the Resident Council meeting minutes for the last six months failed to identify any resident concerns. - During an interview on 11/17/14 at 3:50 p.m., Resident #3 identified the following: * Food is his "only complaint" about the facility - "it doesn't have any taste" * Potatoes and pasta are bland * Often buys his own food to eat, and stated it gets expensive to buy his own food * When offered other choices, Resident B stated it is the left-overs from other meals, which he didn't like * Stated that at lunch today (11/17/14), the dumpling soup had "no taste" and it had "one large ball" for a dumpling * Stated he has told the staff about his food complaints - Review of Resident #3's medical record	F 364	**#3. The A. DCNH Consulting Dietitian R.D., and B. Local Hospital Head Cook/ Local caterer will in-service Dietary Staff on December 12th, 2014 on the importance of taste, flavor, texture, nutritive value, and appearance; and that the food is palatable, attractive, and at the proper temperature.** **The Dietary Manager will survey interviewable residents using a Food Satisfaction Survey on current foods.** **Food service complaints will be addressed at the Resident council.**	

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F 364	Continued From page 13 occurred on all days of survey. Social Progress notes, dated 10/07/14, identified, ". . . states that he also buys extra food because he doesn't like the food served. Res [resident] said this happens more than half the days of the two weeks. Will let [dietary supervisor] know." - During a confidential resident interview on 11/18/14 at 10:30 a.m., Resident A identified the following: * Doesn't like most of the food * Tries to buy own food from the store or get snacks from the vending machine * Has brought up the food dislike issues at the Resident Council Meetings but nothing really changed - During a confidential resident interview on 11/18/14 at 12:15 p.m., Resident H identified the following: * The food is no good - it has no taste * The dumpling in his/her soup not cooked and doughy * The soup broth had no flavor - During a confidential resident interview on 11/18/14 at 4:45 p.m., Resident I identified the following: * Doesn't like most of the food * The food has no flavor * Tries to buy meals and snacks from restaurants and vending machines when he/she is able - Survey staff requested a test tray during the evening meal on 11/17/14 and the noon meal on 11/18/14. The surveyors confirmed the chicken dumpling soup (served as a substitute choice) on 11/18/14 was bland and the large, baseball-sized dumpling tasted bland and dough-like, as if not	F 364	**# 4. The Dietary Manager or designee will monitor the food satisfaction of Residents. Upon the completion of the designated resident's meal they will be given a Meal Satisfaction Survey.** **Initiate the Meal Satisfaction Survey:** **The Monitor:** **3 residents on a meal** **3 days of the week** **for 4 weeks;** **After 4 weeks we will then monitor:** **3 residents on a meal** **3 days of the week** **for 1 week a month** **for 12 months** **The Dietary Manager will make adjustments from information gathered .** **Results of the monitoring will be reviewed at the Quality Assurance Meeting.** **#5.** Completion Date: January 1, 2015	

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F 364	Continued From page 14 thoroughly cooked.	F 364	**F 371**	
F 371 SS=D	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, review of facility policy, and staff interview, the facility failed to ensure left-over foods were reheated to 165 degrees Fahrenheit for 2 of 2 observations of staff reheating left-over food (11/18/14 at 11:50 a.m. and 11:55 a.m.). Failure to ensure proper reheating of left-over food has the potential to result in a food-borne illness. Findings include: Review of facility policy, "FOOD HANDLING OF LEFTOVERS" occurred on 11/20/14. This policy, dated 10/20/12, stated, "PURPOSE: TO ASSURE QUALITY FOOD. POLICY: POTENTIALLY HAZARDOUS FOOD SHALL BE: . . . c. Thoroughly reheated to at least 165 F [Fahrenheit] or higher before being served or being placed in hot food storage equipment." Observation on 11/18/14 at 11:50 a.m. and 11:55	F 371	**#1. No specific residents identified.** **#2. All residents are potentially affected by this deficient practice.** **#3. A. The DCNH Consulting Dietitian R.D., and B. Local Hospital Head Cook/ Local caterer will in-service Dietary Staff December 12th, 2014 on the importance of thoroughly reheating leftovers to at least 165F or higher in the microwave and other heating sources before being served or being placed in hot food storage equipment. Temperatures of the meal substitutions that need reheating will be recorded by staff on the DCNH Meal Substitution Sheet next to the substitution chosen for each individual.**	

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F 371	Continued From page 15 p.m. showed a dietary staff member (#7) retrieved a pan of left-over chicken and dumpling soup from the walk-in cooler and dished two servings. The staff member heated each bowl of chicken and dumpling soup in the microwave. The staff member (#7) did not check the temperature of the soup. The surveyor checked the temperature of the large, single dumpling in the soup, with a reading of 156 degrees F. During interview on 11/18/14 at 3:00 p.m., an administrative dietary staff member (#6) confirmed staff should check the temperature of reheated left-over food.	F 371	**# 4. The Dietary Manager will monitor all the DCNH Meal Substitution Sheets for recorded staff temperatures to assure meals are heated correctly each week until 100% compliance for 2 consecutive weeks. Then monitor 1 time a month till 100% compliant for 2 consecutive months.** **Results of the Dietary Managers monitoring will be reviewed at the Scheduled Quality Assurance Meeting.** **#5.** Completion Date: January 1, 2015	
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.	F 425		

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F 425	Continued From page 16 This REQUIREMENT is not met as evidenced by: Based on record review, resident interview, and staff interview, the facility failed to ensure the availability of routine medication for 1 of 1 sampled resident (Resident #2) who did not receive a regularly scheduled Gentamicin flush. Failure to ensure the availability of the medication may result in Resident #2 experiencing recurrent urinary tract infections (UTIs). Findings include: - Review of Resident #2's medical record occurred on all days of survey and diagnoses included paraplegia, recurrent UTIs, chronic pain, and adjustment reaction with prolonged depressive reaction. Resident #2's care plan identified the following: ". . . Goals: Resident will have no complications from her catheter or colostomy over the next 90 days. Interventions: Staff will provide catheter cares and colostomy cares per facility policy. . . Observe for signs of infection. . ." The resident's current treatments included 100 cubic centermeters (cc) of 8% Gentamicin (an antibiotic) Solution instilled into the bladder three times per week. Review of Resident #2's Treatment Record identified the resident did not receive the Gentamicin flushes during the month of September and only two times during the month of October 2014. During an interview on the afternoon of 11/18/14, Resident #2 stated she had not been receiving	F 425	1.) Resident # 2 has the right to timely administration of medication that is ordered by her provider. Delayed acquisition of a medication may affect a resident's condition. 2.) All residents receiving medications have potential for being affected by this deficient practice. 3.) Gentamycin has been received and is being given as ordered. The pharmaceutical service policy has been revised to state that nursing should be notifying the provider immediately if a medication is unavailable so that an alternative medication may be ordered. (see attached) Nursing staff has been inserviced on 12-16-14 by DON of this revision and the importance of timely medication administration. 4.) 01-01-15 5.) The DON/Designee will monitor MARs weekly for new medications to assure timely acquisition of the medications. This monitor will be weekly x 8 weeks, then monthly x 4 months for a total of 6 months and 100% compliance. This quality monitor will be reviewed at the Quality Assurance Meeting.	

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F 425	Continued From page 17 her Gentamicin solution flushes because the facility cannot get the solution from the pharmacy in town. The resident further stated the flushes are necessary because she frequently has UTIs. During an interview on the morning of 11/19/14, an administrative nurse (#1) confirmed Resident #2 had not received the Gentamicin flushes due to difficulties with finding a pharmacy that carries the Gentamicin. The facility provided no evidence staff contacted the resident's physician to discuss an alternate treatment. Failure to ensure Resident #2 received medication as prescribed placed her at risk of experiencing recurrent UTIs, increased anxiety, and discomfort.	F 425		
F 431 SS=E	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	F 431		

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F 431	Continued From page 18 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. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to store all medications in a secure manner during 3 of 4 days of observation (November 17-19, 2014). Failure to store all medications securely could result in unauthorized access to medications. Findings include: Review of the facility policy, "Medication Administration," occurred on 11/20/14. This policy, revised September 2006, stated, ". . . e) The medication cart and the treatment cart (which carries medications) are to be kept in clear view and in reach of the person administering medications unless it is locked. . . ." Random observations on November 17-19, 2014 showed open plastic boxes on a rolling bedside table containing insulin vials, approximately 12 insulin flexpens, insulin syringes, and glucose	F 431	1.) DCNH must provide safe and secure storage for all resident medications. 2.) All residents have potential to be affected by this deficient practice. 3.) The medication administration policy has been revised to include the storage of insulin/syringes/needles/lancets in a locked cart or in clear view of the person administering the accucheck/insulin at all times. (see attached) A new cart for this purpose has been purchased. The nursing staff will be inserviced on the revisions to the medication administration policy. 4.) 01-01-15 5.) The DON/Designee will perform a random visual monitor of the accucheck cart to verify it is locked and items are stored appropriately 3-5 times per week for 2 months, then 3-5 times per month for 4 months and 100% compliance.	

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F 431	Continued From page 19 monitoring lancets. The nurses left the table unattended in the hallway and the dining room while obtaining blood sugars and administering insulin to a number of residents. Medication and supplies left on top of the table were unable to be secured to prevent unauthorized access. Nurses locked the table in the medication room when not in use. During an interview on 11/20/14 at 9:20 a.m., an administrative nurse (#1) agreed staff should not leave the table containing insulin and supplies unattended in resident hallways and the dining room.	F 431		
F 441 SS=E	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 prevent the spread of infection, the facility must isolate the resident.	F 441		

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F 441	Continued From page 20 (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, review of facility policy, and staff interview, the facility failed to ensure staff properly disinfected 3 of 3 resident care items/equipment (electric razors, whirlpool tub, and glucometer) used by multiple residents. Failure to correctly disinfect resident care items/equipment may result in the transmission of organisms and pathogens to other residents and staff. Findings include: Review of the facility policy, "Disinfection of Tub and Shower Area," occurred on 11/19/14. This policy, dated February 2009, stated, "Procedure for Tub Area . . . 4. Spray entire inside of tub with a disinfectant cleaner provided. 5. Using scrubbing brush provided, scrub the inside of the tub. 6. Fill tub with water. 7. Operate the whirlpool for 2-3 minutes . . . 9. Drain bathing system. 10. Rinse tub with clear water . . . Procedure for	F 441	1.) Dunseith Community Nursing Home will maintain an infection control program that will provide a safe and sanitary environment and that will help to prevent the transmission of disease and infection. 2.) All residents using the tub, using glucometers and the shared electric razors have potential to be affected by this deficient practice. 3.) This practice will be corrected by the following: a.) Nursing staff will be inserviced on the policy in place for disinfecting the shower/tub area. They will be reminded of the need to leave the disinfectant in place for 10 minutes to properly disinfect area. b.) The policy on blood glucose monitoring has been revised. (see attached) Each resident will be assigned a monitor and the procedures to clean and disinfect will be followed per manufacturer's instruction. Nursing staff will be educated on this per inservice. c.) The shared electric razors have been removed and each resident has their own personal razor. A policy for this has been put in place. (see attached) The procedure to clean the razors will be per manufacturer's instruction. Nursing staff will be educated on this per inservice. d.) All of the above will be inserviced by the DON on 12-16-14 and 12-17-14.	

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F 441	Continued From page 21 Shower Area . . . 2. Spray disinfectant cleaner on all surfaces of the shower (include floor and surrounding walls) and shower chair. 3. Leave disinfectant in place for 10 minutes to allow for destruction of harmful organisms. 4. Rinse area thoroughly with clean warm water. PLEASE NOTE: Disinfectant must remain on wet surface for 10 minutes to be effective!" Review of the facility policy, "Blood Glucose Monitoring - With Assure Pro," occurred on 11/19/14. This policy, dated August 2009, stated, "Procedure for Disinfection of Glucose Monitor: 1. After each use, wipe glucose monitor with 2 x 2 wet with bleach solution of 1 part bleach and 10 parts water." - During an interview on the afternoon of 11/19/14 in the whirlpool tub room, two certified nursing assistants (CNA) (#4 and #5) described the process to disinfect the whirlpool tub. Between resident baths, the CNAs spray and leave the disinfectant on the tub surface for about 5 minutes, scrub the tub area with a brush, fill the tub with water, run the tub's jets, empty the water from the tub, spray the disinfectant on the tub surface again and leave wet for 5 minutes, and rinse it off. The Master Care disinfectant container's directions stated, "Leave on surface wet for 10 minutes." During an interview on 11/20/14 at 9:30 a.m., an administrative nurse (#1) agreed staff should follow the policy and leave the disinfectant on the tub surface for 10 minutes. - Observation on 11/17/14 at 4:20 p.m. showed a staff nurse (#3) disinfected the glucometer with a Sani-Cloth Bleach wipe after each resident use	F 441	4.) 01-01-15 5.) DON/Designee will visually monitor the above practice's 3 times per week for 4 weeks, then weekly for 8 weeks until 100% compliance, then monthly for a total of 6 months. This quality monitor will be reviewed at the Quality Assurance Meeting.	

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F 441	Continued From page 22 and then used a paper towel to dry the glucometer. The Sani-Cloth wipe's package indicated disinfection with the wipe occurred "in 4 minutes." During an interview on 11/18/14 at 3:40 p.m., an administrative nurse (#1) agreed staff should not dry the glucometer with a paper towel after disinfecting. This action would interfere with the 4 minute disinfection time noted on the Sani-Cloth package. The nurse (#1) agreed the policy needed to be updated to reflect the current glucometer disinfecting method. - During an interview on 11/20/14 at 9:40 a.m., a CNA (#8) stated the men in the facility share electric razors. The CNAs clean the razors after each use by taking the pieces apart and wiping the parts with an alcohol prep pad. During an interview on 11/20/14 at 9:50 a.m., a nurse (#3) stated the CNAs clean the "community electric razors" with alcohol prep pads. During an interview on the afternoon of 11/20/14, an administrative nurse (#1) agreed using alcohol prep pads to clean razors is not the best practice (according to the Centers for Disease Control, semi-critical items such as electric razors, require meticulous cleaning followed by a high-level disinfection treatment using an FDA (Food and Drug Administration) approved chemo sterilizer agent, or sterilization.	F 441		