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 _____	12/15/2016

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 12/12/16 and completed on 12/15/16, the sample included 2 residents for complete review, 7 residents for focused review, and 1 closed record for review. The sample included 3 additional residents to verify concerns during the survey.	F 000		
F 203 SS=D	483.15(c)(3)-(6)(8) NOTICE REQUIREMENTS BEFORE TRANSFER/DISCHARGE (c) (3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (b)(5) of this section. (c) (4) Timing of the notice. (i) Except as specified in paragraphs (b)(4)(ii) and (b)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.	F 203		1/15/17

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

Electronically Signed | 01/13/2017

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F 203	Continued From page 1 (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (b)(1)(ii)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (b)(1)(ii)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (b)(1)(ii)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (b)(1)(ii)(A) of this section; or (E) A resident has not resided in the facility for 30 days. (c) (5) Contents of the notice. The written notice specified in paragraph (b)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how	F 203		

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F 203	Continued From page 2 to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. (c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. (c)(8) Notice in advance of facility closure. In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the	F 203		

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F 203	Continued From page 3 facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE STANDARD SURVEY COMPLETED ON 01/07/16. Based on record review, review of facility policy, and staff interview, the facility failed to notify the resident and/or the 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 1 of 6 sampled residents (Resident #4) transferred to the hospital. Findings include: Review of the facility policy titled "Transfer/Discharge of a Resident" occurred on 12/15/16. This policy, revised November 2016, stated, ". . . FOR TRANSFER TO HOSPITAL OR OTHER FACILITY . . . 4. Fill out Bed Hold form & Notice of Transfer or Discharge form. Obtain needed signatures from Resident and/or family/responsible party (if appropriate). If no responsible party/family is on site, gain permission via phone call to sign forms on their behalf. . . . 8. Document on Residents chart appropriate notations including that Notice of Transfer or Discharge form and Bed Hold form were both given to Resident and handed to/mailed to family/responsible part [sic] (if appropriate). . . ."	F 203	1.)An updated written transfer form for Resident #4 will be completed and provided to the appropriate family/legal representative. 2.) All residents in DCNH have the potential to be affected by this deficient practice. 3.) All licensed staff will be educated at inservice by the LCSW/designee on proper transfer/discharge procedures and documentation. The current transfer/discharge checklist will be updated. All licensed staff will be educated at inservice by the LCSW/designee on the procedures and documentation on 01-18-17. The medical records for all residents will be reviewed by the LCSW to ensure the proper documentation for transfer/discharge has been completed. 4.) 01-15-17 5.) LCSW/designee will do a quality monitor on all residents who are transferred or discharged from DCNH. This quality monitor will be done weekly x 4 weeks, monthly x 4 months, for a total of at least 6 months. If concerns are identified immediate corrective actions will be implemented. This monitor will be reviewed by the Quality Assurance Committee at the scheduled QA Meeting.	

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F 203	Continued From page 4 - Resident #4's medical record, reviewed on all days of survey, identified the facility transferred the resident to a hospital on 06/14/16. The record lacked evidence the facility provided the resident or the resident's family with a written notice of transfer. During an interview on 12/14/16 at 9:55 a.m., an administrative nurse (#2) stated she was unable to find evidence the facility provided the above notice.	F 203		
F 225 SS=D	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS (a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a	F 225		1/19/17

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F 225	Continued From page 5 nurse aide or other facility staff. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:	F 225		

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F 225	Continued From page 6 Based on record review, review of facility policy, and staff interview, the facility failed to investigate an injury of unknown origin for 1 of 1 sampled resident (Resident #3) with a documented burn to the right thigh. Failure to investigate an injury of unknown origin placed Resident #3 and other residents at risk for mistreatment and/or abuse, and did not allow the facility to determine causative factors for the injury and implement corrective action. Findings include: Review of the facility policy titled "Abuse, Neglect and Misappropriation of Resident Property - Investigation and Reporting" occurred on 12/15/16. This policy, dated 08/25/16, stated, ". . . POLICY: . . . Abuse, neglect and misappropriation of property 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. . . . The prohibition policy and its proactive programs are implemented system wide. Each department may enhance these procedures by implementing specific programs, training, and investigation within the scope of their practice, but in all circumstances each department and/or individual must maintain and enact the minimal requirements and features of this policy and its procedures. . . . DOCUMENTATION RELATED TO POLICY . . . Nursing . . . Injuries of unknown origin reports and follow-up. . . .Reporting 1. Every employee or [nursing home initials] must make an immediate report to Administrator, DON [Director of Nursing], and the person-in-charge . . . 2. The Administrator, Director of Nursing,	F 225	1.) Resident #3 will have an investigation completed for an injury of unknown origin from 08-22-16. 2.) All residents who obtain injuries of unknown origin have the potential to be affected. 3.) The current policy on abuse, neglect and misappropriation of funds is being revised. A new incident report specific to injury of unknown origin will be implemented. The nursing staff will be inserviced on the revised policy and the new incident report on 01-19-17. 4.) 01-19-2017 5.) A quality monitor to review all incidents of injuries of unknown origin will be implemented. All incidents will be reviewed by DON/Designee weekly x 4, monthly x 4, for a total of 6 months. This quality monitor will be reviewed by the Quality Assurance Committee at the scheduled QA Meeting.	

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F 225	Continued From page 7 Director of Social Services, or Charge Nurse will make a telephone report to the State Health Department immediately. . . . Investigations: 1. Administration coordinates the facility's investigation and assigns an investigating team. Investigations will be done on a timely basis . . ." Review of Resident #3's medical record occurred December 12-15, 2016. Diagnoses included diabetes, paraplegia, and traumatic brain injury. A quarterly Minimum Data Set, dated 08/23/16 identified the resident as cognitively intact. The current care plan stated ". . . 04/30/15; Resident at risk for burns/injury to lower extremities R/T [related to] decreased sensory perception . . ." Review of Nurse's Notes showed the following: "8-22-16, 925pm. [sic] CNA [certified nurse assistant] notified nurse that resident has what looked like a burn to [right] thigh. Wound assessed [and] identified as a burn measuring 2 x [by] 4 cm [centimeters] edges intact [and] is started to blister. Res [Resident] denies knowing where burn came from. MD [medical doctor] notified. . . ." Resident #3's medical record lacked evidence of an investigation as to possible causes of the blister as well as reporting the burn. During an interview on 12/15/16 at 1:30 p.m. an administrative nurse (#1) stated an incident report should have been completed and staff would then follow the reporting/investigating procedure as per the facility abuse policy.	F 225		
F 250 SS=D	483.40(d) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE	F 250		1/19/17

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F 250	Continued From page 8 (d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review and review of facility policy, the facility failed to assess socially inappropriate behaviors, develop and implement individualized approaches/interventions, and monitor the effectiveness for 2 of 2 sampled residents (Resident #2 and #7) who exhibited sexual behaviors toward each other. Failure to adequately assess the behaviors and respond appropriately placed other residents at risk for potential harm. Findings include: Review of the facility policy titled "RESIDENT BEHAVIOR LOG and PHYSICAL AGGRESSION" occurred on 12/15/16. This policy, revised September 2013, stated, ". . . 6. If the incident is that of Physical Aggression, (actual physical contact, including inappropriate sexual contact), a Resident Grievance/Abuse Concern Form will be filled out and routed to the DON [director of nursing] office. Also, notify the Administrator and DON at the time the incident happens. . . . b) The incident will be reviewed along with the interventions and response to determine if the interventions were successful. Revisions to interventions may be necessary. . . . e) A Care Plan will be developed to reflect the intervention. . . ." - Review of Resident #2's medical record occurred on all days of survey. Diagnoses	F 250	1.) For Resident #2 and #7 the medical records were updated to identify the other resident involved during the incidents of 01/24/16 and 01/25/16. Their medical records were updated to include the incident of 06/11/16. Resident #2's care plan was updated to include her guardian's wishes. The care plans for both residents will be reviewed and updated to develop individualized interventions and monitor the effectiveness of those interventions for inappropriate behaviors. 2.) All residents have the potential to be affected by this deficient practice. 3.) The current care plan policy/procedure has been reviewed. The procedure for resident behaviors and physical aggression and the incidents reports will be reviewed. Nursing staff and the interdisciplinary care plan team will be inserviced on the care plan policy and the procedure for resident behaviors and physical aggression and the reporting and documenting of such on 01-18-17 an 01-19-17. 4.) 01-19-17 5.) See FTag 280 for the Quality Monitor on care planning. Administrator/designee will monitor behavior log to assure incident reports are completed when appropriate. DON/designee will monitor	

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F 250	Continued From page 9 included dementia. The quarterly Minimum Data Set (MDS), dated 11/04/16, identified severe cognitive impairment. The current care plan stated, "Problem: Resident has potential to be abused by others: touching, verbal expressions of sex, offensive with misunderstood gestures r/t [related to] progression of her dementia and inability to know what is inappropriate. . . . Approach: Staff to monitor whereabouts frequently. Staff to redirect her to safe area if indicated. Staff to allow her to express her feelings. Staff to approach her in a calm respectful manner. Notify provider and guardian if needed. . . ." Review of Resident #2's social service progress notes showed the following: * 01/25/16 at 11:00 a.m.: "Phone call placed to Res [resident] guardian informing him of other Res placing his hand on Res back, under Res. shirt. Informed Guardian we are conducting an investigation. Guardian had no questions or concerns. Informed guardian to call with any questions." * 01/25/16 at 12:30 p.m.: "Phone call placed to Dunseith City Sheriff to make a report regarding incident between Res & other Res. . . ." * 01/25/16 at 2:00 p.m.: "Ombudsman on site. Ombudsman informed of incident between Res & fellow Res. . . ." Review of the "RESIDENT GRIEVANCE/ABUSE CONCERN FORM" (a form used as part of the investigation and not in the medical record), dated 01/24/16, stated, ". . . Description of Incident . . . (Dietary Aide) came up to the nurses station and stated, '[Resident #7] had his hand down the back of [Resident #2's] shirt.'	F 250	all incidents reports on behavior/physical aggression to ensure proper documentation, reporting and care planning. This monitor will be weekly x 4, biweekly x 4, monthly for a total of 1 year. These monitors will be reported to the QA Committee at the Quality Assurance Meeting.	

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F 250	Continued From page 10 Discussed with [Resident #7] this behavior was not appropriate. . . . Department Response Summary: Reviewed incident on camera. Viewed resident touching other resident on back. Could not verify by camera if [Resident #7] if [sic] hand was under shirt. Started DOH [Department of Health] investigation. . . . Will visit with resident regarding inappropriate behaviors and careplan as such. Notified [Resident #2's] guardian of resident involved. He expressed no concerns." Resident #2's medical record failed to identify who the other resident involved was during the incident on 01/24/16. Review of the "RESIDENT GRIEVANCE/ABUSE CONCERN FORM" (a form used as part of the investigation and not in the medical record), dated 06/11/16, stated, ". . . Description of Incident: At around 4:15 pm 6-11-16, [Resident #2] was visiting in [Resident #7's] room. . . . (roommate of [Resident #7]) yelled out to . . . CNA [certified nurse assistant] 'hey, [Resident #2] is in here flirting' as she walked by. [CNA] stopped to check on [Resident #2] & witnessed her fondling [Resident #7] private area over his pants. [CNA] removed [Resident #2] from room & took her to dining room. . . . Department Response Summary: [Resident #2] is not to be allowed to visit [Resident #7] in any private area per her son . . . She may visit him in public areas. . . . informed [Resident #7] of the son's request. Will review this behavior at next empowerment meeting. . . ." Resident #2's medical record failed to identify the incident on 06/11/16 and facility staff failed to update Resident #2's care plan to reflect her	F 250		

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F 250	Continued From page 11 guardian's wishes. Review of Resident #2's undated empowerment meeting minutes, stated, ". . . She had some inappropriate behavior with another male resident, that resident has now left the facility [Resident #7 discharged from the facility on 09/20/16 and readmitted on 11/16/16]. . . ." - Review of Resident #7's medical record occurred on December 14-15, 2016. Diagnoses included psychosis and dementia with behaviors. The admission MDS, dated 11/22/16, identified moderately impaired cognition. The care plan, dated 06/11/16, and the current care plan, stated, "Problem: Resident has history of inappropriate sexual behavior with another female resident. . . . Approach: Resident will not visit female resident in any private areas per her guardian. May visit in public areas in view of staff. . . ." A nurse's progress note, dated 01/24/16 at 4:15 p.m., stated, "Dietary Aide came up to nurses station and informed nurse that client had his hand up another female clients shirt. Talked to client and told client this was not appropriate. This happened after dinner. Told client this was not appropriate in a public place. Client told me 'He could do what the [expletive word] he wants.' Left client to express himself in his room." Review of Resident #7's social services progress notes identified the following: * 01/26/16 at 11:30 a.m.: ". . . spoke with Res reminding him to only touch other Res in appropriate ways. Expressed our concern for all Res. safety." * 01/26/16 at 1:30 p.m.: "Statement regarding	F 250		

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F 250	Continued From page 12	F 250		

incident between Res & a fellow Res given to Dunseith police department given by this writer."

Review of Resident #7's undated empowerment meeting minutes, stated, ". . . There is questionable incident of concern at the dining room where he probably just patted an elderly demented resident on the back, but there was concern about something more than that. This has been thoroughly reviewed by the nursing home administration and social services. Video tape was reviewed and there was no obvious behaviors of concern. . . ."

Resident #7's medical record failed to identify who the other resident involved was during the incident on 01/24/16.

Review of the "RESIDENT GRIEVANCE/ABUSE CONCERN FORM" (a form used as part of the investigation and not in the medical record), dated 06/11/16, stated, ". . . Description of Incident: At around 4:15 pm 6-11-16, [Resident #2] was visiting in [Resident #7's] room. . . . (roommate of [Resident #7]) yelled out to . . . CNA [certified nurse assistant] 'hey, [Resident #2] is in here flirting' as she walked by. [CNA] stopped to check on [Resident #2] & witnessed her fondling [Resident #7] private area over his pants. [CNA] removed [Resident #2] from room & took her to dining room. . . . Department Response Summary: [Resident #2] is not to be allowed to visit [Resident #7] in any private area per her son . . . She may visit him in public areas. . . . informed [Resident #7] of the son's request. Will review this behavior at next empowerment meeting. . . ."

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F 250	Continued From page 13 A social services progress note, dated 06/13/16 at 11:00 a.m., stated, "[Administrator] and this writer spoke with Res regarding the wishes of [Resident #2's] guardian that [Resident #2] cannot be alone with him in private areas of DCNH [Dunseith Community Nursing Home]." Resident #7's medical record failed to address the incident on 06/11/16. Resident #2's social services notes, dated 01/25/16, failed to identify what the incident was and who the other resident involved was. The progress notes failed to address an incident between Resident #2 and #7 on 06/11/16. Resident #2's care plan failed to include her guardian's wish to keep Resident #2 and #7 in public areas. The facility failed to assess the socially inappropriate behaviors between Resident #2 and #7; failed to develop and implement individualized interventions; and monitor the effectiveness of those interventions.	F 250		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE (b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and	F 274		1/20/17

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F 274	Continued From page 14 requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, and staff interview, the facility failed to complete a significant change in status assessment (SCSA) for 1 of 9 sampled residents (Resident #5) reviewed. Failure to determine the need for and complete a SCSA assessment in response to the resident's decline limited the facility's ability to accurately assess the resident's status, and identify and implement appropriate interventions. Findings include: The Long-Term Care Facility RAI 3.0 User's Manual (Version 1.13), dated October 2015, page 2-20 stated, ". . . A "significant change" is a decline or improvement in a resident's status that: 1. Will not normally resolve itself without staff intervention . . . 2. Impacts more than one area of the resident's health status; and 3. Requires interdisciplinary review and/or revision of the care plan. . . ." and page 2-23 stated, "A SCSA is appropriate if there are either two or more areas of decline or two or more areas of improvement. . . . [such as] increase in the number of areas where behavioral symptoms are coded as being present and/or frequency of a symptom increases . . . Any decline in an ADL [activity of daily living] physical functioning area where a resident is newly coded as Extensive assistance . . . Emergence of unplanned weight loss problem . . . "	F 274	1.) Resident #5's MDS will be accurately coded to reflect his current status. 2.) All residents have the potential to be affected by this deficient practice. 3.) 01-20-17 4.) The definition and procedure for significant change in status assessment will be reviewed at inservice on 01-19-17 by all staff involved in the MDS process. 5.) DON/Designee will do a quality monitor to assure the procedure is followed. This monitor will be weekly until all residents have been audited. Then a random audit of 2 MDSs per month for a total of 1 year. This will be reviewed by the Quality Assurance Committee at the scheduled QA meeting.	

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F 274	Continued From page 15 Review of Resident #5's medical record occurred on all days of survey. The admission Minimum Data Set (MDS), dated 02/28/16, identified limited assistance with bed mobility, independence with personal hygiene, and a weight of 186 pounds (#). The quarterly MDS, dated 06/02/16, identified a new behavior of rejection of care, extensive assistance (decline) with bed mobility and personal hygiene, and weight of 154# (a significant loss of 17.2% in three months). During an interview on the morning of 12/15/16, when asked about Resident #5's changes in condition on the 06/02/16 MDS, two administrative nurses (#1 and #2) stated "[Name of Resident #5] never was independent with personal hygiene and [prior MDS Coordinator] was terminated last summer."	F 274		
F 278 SS=F	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.	F 278		1/24/17

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F 278	Continued From page 16 (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT CITATION FROM THE SURVEY CONDUCTED ON 01/07/16 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 accurate coding of Minimum Data Sets (MDSs) for 9 of 9 sampled residents (Resident #1, #2, #3, #4, #5, #6, #7, #8, and #9). Failure to accurately complete portions of the MDS does not allow each resident's assessment to reflect their current status/needs and may result in the inaccuracy of the facility's Resident Level Quality Measure Reports. Findings include:	F 278	1.) The MDS for residents #1,2,3,4,5,6,7,8, and 9 will be accurately coded and the CAA documentation will be properly documented. 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 and properly document the CAA for residents #1,2,3,4,5,6,7,8, and 9. b.) All resident's current MDS' and CAAs will be reviewed for accuracy. c.) All staff involved in the MDS process will follow the current RAI Users Manual for guidance to accurately code assessments and document CAAs. d.) The current procedure for the RAI process will be reviewed and revised if indicated.	

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F 278	Continued From page 17 BEHAVIOR The Long-Term Care Facility RAI User's Manual, revised October 2015, Chapter 3 pages E-4, E-7, E-13, and E-17-18, stated, "E0200: Behavioral Symptom - Presence and Frequency . . . A. Physical behavioral symptoms directed toward others (e.g., hitting, kicking, pushing. scratching, grabbing. abusing others sexually). B. Verbal behavioral symptoms directed toward others (e.g. threatening others, screaming at others cursing at others) . . . E0500: Impact on Resident . . . Coding Instructions for E0500C. Did Any of the Identified Symptom(s) Significantly Interfere with the Resident's Participation in Activities or Social Interactions? . . . Code 1, yes: if any of the identified behavioral symptom(s) interfered with the resident's participation in activities or social interactions. . . . E0800: Rejection of Care-Presence & Frequency . . . Did the resident reject evaluation or care (e.g. bloodwork, taking medications, ADL assistance) that is necessary to achieve the resident's goals for health and well-being? Do not include behaviors that have already been addressed (e.g., by discussion or care planning with the resident or family), and determined to be consistent with resident values, preferences, or goals. . . . E0900: Wandering-Presence & Frequency . . . Steps for Assessment 1. Review the medical record and interview staff to determine whether wandering occurred during the 7-day look-back period. Wandering is the act of moving (walking or locomotion in a wheelchair) from place to place with or without a specified course or known	F 278	e.) All staff involved in the RAI process will be inserviced on the current procedure on 01-18-17 and 01-19-17. 4.) 01-24-17 5.) DON/Designee will do a quality monitor to audit the accuracy of the MDS assessments and CAA documentation. This monitor will be done weekly until each resident's MDS/CAA has been audited. Then a random audit of 2 resident MDS' will be done monthly for one year. If concerns are identified, immediate corrective action will be implemented. This quality monitor will be reviewed by the Quality Assurance Committee at the scheduled QA Meeting.	

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F 278	Continued From page 18 direction. Wandering may or may not be aimless. The wandering resident may be oblivious to his or her physical or safety needs. . . . E1000: Wandering-Impact . . . Coding Instructions for E1000A. Does the Wandering Place the Resident at Significant Risk of Getting to a Potentially Dangerous Place? Code 1, yes: if the wandering places the resident at significant risk of getting to a dangerous place (e.g. wandering outside the facility where there is heavy traffic) or encountering a dangerous situation (e.g. wandering into the room of another resident with dementia who is known to become physically aggressive toward intruders). . . ." - Review of Resident #2's medical record occurred on all days of survey. A quarterly MDS, dated 11/04/16, identified rejection of care and wandering occurred daily. An annual MDS, dated 05/05/16, identified wandering occurred one to three days and placed the resident at significant risk of getting to a potentially dangerous place. The medical record lacked evidence of Resident #2's rejection of care and wandering during the look-back periods. - Review of Resident #7's medical record occurred on December 14-15, 2016. An admission MDS, dated 11/22/16, identified physical and verbal behaviors occurred one to three days during the look back period and interfered with the resident's participation in activities or social interactions and disrupted care or living environment for other residents. The medical record lacked documentation to support the coding of Resident #7's behaviors. PAIN	F 278		

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The Long-Term Care Facility RAI User's Manual, revised October 2015, pages J-2 to J-3, stated, "Coding Instructions for J0100A-C, Determine all interventions for pain provided to the resident during the 5-day look-back period. Answer these items even if the resident currently denies pain. . . . Coding Instructions for J0100C, Received Non-medication Intervention for Pain. Code 0, no: if the medical record does not contain documentation that a non-medication pain intervention was received. Code 1, yes: if the medical record contains documentation that a non-medication pain intervention was scheduled as part of the care plan and it is documented that the intervention was actually received and assessed for efficacy."

- Review of Resident #1's medical record occurred on December 12-15, 2016. A quarterly MDS, dated 10/01/16, identified Resident #1 received non-pharmacological interventions for pain. Resident #1's record lacked evidence staff documented the non-pharmacological interventions that controlled the resident's pain during the look-back period.

- Review of Resident #2's medical record occurred on all days of survey. A quarterly MDS, dated 11/04/16, identified Resident #2 received non-pharmacological interventions for pain. Resident #2's record lacked evidence staff provided non-pharmacological interventions for pain during the look-back period.

- Review of Resident #3's medical record occurred on December 12-15, 2016. An annual MDS, dated 11/23/16, identified Resident #3

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received non-pharmacological interventions for pain. Resident #3's record lacked evidence staff documented the non-pharmacological interventions that controlled the resident's pain during the look-back period.

- Review of Resident #4's medical record occurred on all days of survey. A quarterly MDS, dated 09/17/16, identified Resident #4 received non-pharmacological interventions for pain. The medical record lacked evidence staff provided non-pharmacological interventions for pain during the look-back period.

SKIN CONDITIONS

The Long-Term Care Facility RAI User's Manual, revised October 2015, pages M-36 to M-39, stated "M1200: Skin and Ulcer Treatments . . . Coding Tips . . . M1200D Nutrition or Hydration Intervention to Manage Skin Problems, The determination as to whether or not one should receive nutritional or hydration interventions for skin problems should be based on an individualized nutritional assessment. . . . If it is determined that nutritional supplementation, i.e. [that is] adding additional protein, calories, or nutrients is warranted, the facility should document the nutrition or hydration factors that are influencing skin problems and /or wound healing and 'tailor nutritional supplementation to the individual's intake, degree of under-nutrition, and relative impact of nutrition as a factor overall; and obtain dietary consultation as needed,' . . ."

- Review of Resident #1's medical record occurred on December 12-15, 2016. A quarterly MDS, dated 10/01/16 identified Resident #1 as

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having stage 2 pressure ulcers and nutritional interventions in place for the pressure ulcers. Resident #1's record lacked evidence staff documented the nutrition factors that influenced wound healing or the need for high-protein supplementation to aid wound healing during the look-back period.

- Review of Resident #3's medical record occurred on December 12-15, 2016. A quarterly MDS, dated 10/01/16 identified Resident #1 as having moisture associated skin damage and nutritional interventions in place for treatment. Resident #3's record lacked evidence staff documented the nutrition factors that influenced wound healing or the need for high-protein supplementation to aid wound healing during the look-back period.

- Review of Resident #5's medical record occurred on all days of survey. The quarterly MDS, dated 11/26/16, identified M1200 D - nutrition or hydration intervention to manage skin problems. Resident #5's Skin Wound/Ulcer Records, dated 08/13/16 - 12/10/16, identified wounds to the left and right lateral feet. The medical record lacked evidence of nutritional interventions used specifically for skin issues during the 7-day look-back period.

MEDICATIONS

The Long-Term Care Facility RAI User's Manual, revised October 2015, pages N-4 to N-6, stated "N0410: Medications Received . . . N0410B, Antianxiety: Record the number of days an anxiolytic medication was received by the resident at any time during the 7-day look-back

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F 278	Continued From page 22 period . . . Coding Tips and Special Populations, Code medications in Item N0410 according to the medication's therapeutic category and/or pharmacological classification, not how it is used. . . ." - Review of Resident #5's medical record occurred on all days of survey. The quarterly Minimum Data Set (MDS), dated 11/26/16, identified the following: * N0410 C - antidepressant, coded received "7" days * N0410 D - hypnotic, coded received "0" days Resident #5's Medication Administration Record (MAR) showed the number of days the resident received the following during the 7-day look-back period from November 20-26, 2016: * duloxetine 30 milligrams (antidepressant) - 2 days * zolpidem 5 mg (hypnotic) - 1 day - Review of Resident #6's medical record occurred on all days of survey. The quarterly MDS, dated 11/18/16, identified the following: * N0410 B - antianxiety, coded received "0" days * N0410 D - hypnotic, coded received "7" days Resident #6's MAR showed the number of days the resident received the following during the 7-day look-back period from November 12-18, 2016: * clonazepam 0.5 mg (antianxiety) - 7 days * hypnotic - none ordered or administered SPECIAL TREATMENTS, PROCEDURES, AND PROGRAMS	F 278		

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F 278	Continued From page 23 The Long-Term Care Facility RAI User's Manual, revised October 2015, pages O-36 to O-37, stated " O0500: Restorative Nursing Programs . . . Steps for Assessment . . . 2. For the 7-day look-back period, enter the number of days on which the technique, training or skill practice was performed for a total of at least 15 minutes during the 24-hour period. . . . Coding Instructions . . . The time provided for items O0500A-J must be coded separately, in time blocks of 15 minutes or more. . . . 15-minute time increments cannot be obtained by combining 5 minutes of Technique-Range of Motion [Passive] item O0500A, 5 minutes of Technique-Range of Motion [Active] item O0500B, and 5 minutes of Splint or Brace Assistance item O500C, over 2 days in the last 7 days. . . ." - Review of Resident #1's medical record occurred on December 12-15, 2016. A quarterly MDS, dated 10/01/16, identified Resident #1 received restorative nursing programs of passive range of motion (PROM) and active range of motion (AROM) for five days each. Resident #1's record identified 10 minutes of combined AROM and PROM during the look-back period. The record lacked evidence Resident #1 completed 15 minutes each of AROM and PROM during the look-back period. - Review of Resident #3's medical record occurred on December 12-15, 2016. An annual MDS, dated 11/23/16, identified Resident #3 received restorative nursing programs of PROM and AROM for three days each. Resident #3's record identified four days and 15 minutes of combined AROM and PROM during the look-back period. The record lacked evidence	F 278		

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F 278	Continued From page 24 Resident #3 completed 15 minutes each of AROM and PROM during the look-back period. - Review of Resident #5's medical record occurred on all days of survey. The quarterly Minimum Data Set (MDS), dated 11/26/16, identified O0500 B - AROM, coded performed "4" days. Resident #5's Rehabilitation/Restorative Service Delivery Record showed the resident performed range of motion, strengthening, and ambulation on three days of the look-back period. The record identified the resident spent 15 minutes on the combination of activities, but did not state the number of minutes spent on each individual activity. The record failed to provide evidence the resident performed a minimum of 15 minutes of AROM on each of four days during the look-back period. - Review of Resident #6's medical record occurred on all days of survey. The quarterly MDS, dated 11/18/16, identified O0500 A - PROM, coded performed "5" days. Resident #6's Rehabilitation/Restorative Service Delivery Record showed the resident performed PROM and AROM on five days of the look-back period. The record identified the resident spent 15 minutes on the combination of activities, but did not state the number of minutes spent on each individual activity. The record failed to provide evidence the resident performed a minimum of 15 minutes of PROM on each of five days during the look-back period. - Review of Resident #8's medical record occurred on December 14-15, 2016. A quarterly MDS, dated 10/05/16, identified Resident #8 received restorative nursing programs of AROM	F 278		

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and walking for five days each. Resident #8's medical record identified Resident #8 received two days of AROM completed for 15 minutes and three days of walking completed for 20 minutes. The record lacked evidence Resident #8 completed five days each of AROM and walking.

During an interview on 12/14/16 at 5:20 p.m., an administrative nurse (#1) verified staff documented the restorative therapy minutes incorrectly, by entering the total time versus the time for each therapy area.

CARE AREA ASSESSMENT (CAA) SUMMARY

The Long-Term Care Facility RAI User's Manual, revised October 2015, page V-5, stated, "Items V0200A 01 through 20 document which triggered care areas require further assessment, decision as to whether or not a triggered care area is addressed in the resident care plan, and the location and date of CAA documentation. The CAA summary documents the interdisciplinary team's and the resident, resident's family, or representative's final decision(s) on which triggered care areas will be addressed in the care plan. . . . For each triggered care area, indicate the date and location of the CAA documentation in the "Location and Date of CAA Documentation" column. . . . Coding Instructions for V0200B, Signature of RN [Registered Nurse] Coordinator for CAA Process and Date Signed, V0200B1, Signature, Signature of the RN coordinating the CAA process. . . ."

- Review of Resident #1's medical record occurred on December 12-15, 2016. An annual MDS, dated 07/01/16, failed to identify the dates

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F 278	Continued From page 26 for all areas of the CAA documentation. - Review of Resident #3's medical record occurred on December 12-15,2016. An annual MDS, dated 11/23/16, failed to identify the dates of the CAA documentation in two areas, and failed to identify a specific assessment, stating "Chart," "Clients chart," or "see Clients chart" with the date "11/29/16" for seven areas. - Review of Resident #7's medical record occurred on December 14-15, 2016. An admission MDS, dated 11/22/16, failed to identify the dates for all areas of the CAA documentation and V0200B1 lacked a signature from the RN Assessment Coordinator. - Review of Resident #9's medical record occurred on December 14-15, 2016. An admission MDS, dated 09/21/16, failed to identify the dates for all areas of the CAA documentation. CODING SECTION Z 2. Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual (Version 3.0), the Centers for Medicare Medicaid Services (CMS) Submission Reports, and staff interview, the facility failed to ensure accurate coding of Section Z of the Minimum Data Sets (MDSs) for 7 of 9 sampled residents (Resident #1, #2, #3, #6, #7, #8, and #9). Failure of the registered nurse assessment coordinator to verify the completion of the MDSs signing at Z0500A and to assure completion all sections of the MDS at Z0400 before signing it off as complete may result in an inaccurate assessment.	F 278		

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F 278	Continued From page 27 Findings include: The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, revised October 2015, pages Z-6 to Z-8 stated, "Z0400: Signatures of Persons Completing the Assessment or Entry/Death Reporting . . . 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. . . . Z0500: Signature of RN [Registered Nurse] Assessment Coordinator Verifying Assessment Completion . . . Z0500A. Signature . . . Federal regulation requires the RN assessment coordinator to sign and thereby certify that the assessment is complete. . . . Coding Instructions * 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 . . ." Review of Resident #1's medical record occurred on December 12-15, 2016. A quarterly MDS, dated 10/01/16 identified the following: * Z0400 - the latest date signed by staff to verify completion of their assigned section was "10/04/16" * Z0500A - lacked a signature from the RN Assessment Coordinator. * Z0500B - date the RN Assessment Coordinator should have signed the MDS assessment as complete was entered as "10/03/16" - Review of Resident #2's medical record occurred on all days of survey. A quarterly MDS, dated 11/04/16, identified the following:	F 278		

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F 278	Continued From page 28 * Z0400 - the latest date staff signed Z0400 to verify completion of their assigned section was "11/08/16" * Z0500B - date the RN Assessment Coordinator signed the MDS assessment as complete was "11/06/16" Review of Resident #3's medical record occurred on December 12-15, 2016. An annual MDS, dated 11/23/16 identified the following: * Z0400 - the latest date signed by staff to verify completion of their assigned section was "11/29/16" * Z0500B - date the RN Assessment Coordinator signed the MDS assessment as complete was "11/25/16" - Review of Resident #6's medical record occurred on all days of survey. The quarterly MDS, dated 11/18/16, identified the following: * Z0400 - the latest date staff signed Z0400 to verify completion of their assigned section was "11/22/16" * Z0500B - date the RN Assessment Coordinator signed the MDS assessment as complete was "11/20/16" - Review of Resident #7's medical record occurred on December 14-15, 2016. An admission MDS, dated 11/22/16, identified the following: * Z0400 - the latest date staff signed Z0400 to verify completion of their assigned section was "11/29/16" * Z0500B - date the RN Assessment Coordinator signed the MDS assessment as complete was "11/24/16"	F 278		

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F 278	Continued From page 29 - Review of Resident #8's medical record occurred on December 14-15, 2016. A quarterly MDS, dated 10/05/16, identified the following: * Z0500A - lacked a signature from the RN Assessment Coordinator - Review of Resident #9's medical record occurred on December 14-15, 2016. An admission MDS, dated 09/21/16, identified the following: * Z0400 - the latest date signed by staff to verify completion of their assigned section was "09/28/16" * Z0500B - date the RN Assessment Coordinator signed the MDS assessment as complete was "09/27/16" During an interview on 12/15/16 at 10:45 a.m., an administrative nurse (#1) stated the facility established guidelines for the MDS Coordinator to sign section Z0500 within two days of the Assessment Reference Date (ARD) [the last day of the observation or look-back period that the assessment covers for the resident]. This nurse agreed section Z0500 should not be completed before section Z0400.	F 278		
F 280 SS=E	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request	F 280		1/20/17

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F 280	Continued From page 30 revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that	F 280		

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F 280	Continued From page 31 includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to review and revise the comprehensive care plan to reflect the residents' current status for 5 of 9 sampled residents (Resident #2, #4, #5, #6, and #8). Failure to revise the care plans limited staff's ability to communicate care needs and ensure continuity of care for each resident.	F 280	1.) The care plans for residents #2, #5, #6 and #8 have been updated to reflect their current status. Resident #4 was discharged from DCNH. 2.) All residents have the potential to be affected by this deficient practice. 3.) The current policy for care planning has been reviewed. The nursing staff will	

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F 280	Continued From page 32 Findings include: Review of the facility policy titled "Care Plans - Individualized Resident" occurred on 12/15/16. This policy, revised August 2006, stated, ". . . Policy . . . Care plans will be updated on a PRN [as needed] basis and quarterly after the initial care planning conference. . . . How to Keep the Care Plans Up to Date: 1. Any resident care plan, if it is to be useful for the resident, must be kept up to date at specific times. This is usually done daily if a new difficulty for that resident occurs, or at least quarterly at their care conference. . . ." - Review of Resident #2's medical record occurred on all days of survey. The "POST FALL ASSESSMENT," dated 04/19/16, stated, "What falls prevention strategies have been added? (See Falls Prevention Care Plan): Make sure bed is in the lowest position . . ." The current care plan stated, "Problem: Potential for falls. . . . Approach: Encourage resident to keep door to room open at all times. Encourage use of her walker if/when she may leave the facility for long distances or if feeling weak/tired/unsteady. Frequent check on resident while visiting other residents. Keep call light within reach of resident while in her room. Encourage and remind resident to use call light for when she needs assistance with anything. Assess residents foot wear for proper fit and non skid soles. Frequent checks on resident at night. Remind resident to rise slowly from sitting position. Use wheelchair for ambulation if weak and unsteady. . . ."	F 280	be educated at inservice on following the current policy on 01-19-17. The interdisciplinary team will also review the policy at the next care conference meeting on 01-18-17. All residents care plans will be reviewed and updated as needed by the care plan coordinator/designee to assure that the plan reflects the residents current care needs. 4.) 01-20-17 5.) A quality monitor to review care plans for completeness will be implemented. The monitor will be done weekly x 12,then a random audit of 2 care plans per month for a total of 1 year will be done. The quality monitor will be reviewed at the Quality Assurance Meeting.	

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During an interview on 12/13/16 at 12:28 p.m., an administrative nurse (#1) confirmed Resident #2's care plan lacked the low bed intervention.

- Review of Resident #4's medical record occurred on all days of survey. A nutritional progress note, dated 12/09/16, stated, ". . . With planned wt [weight] loss over the past 6 months. Team reviewed at meeting today. . . ." Review of Resident #4's weights showed approximately 60 pound weight loss in one year.

The current care plan stated, "Problem: Morbidly [sic]. Takes fluids well. Approaches: Offer fluids . . . Problem: Needs assistance with eating dependent. Approaches: Staff sets up table. Staff will help as required. Have dietitian visit with her about the goals utilizing an educational approach. . . ."

During an interview on 12/14/16 at 11:24 a.m., the dietary manager (#5) confirmed Resident #4's care plan lacked the planned weight loss.

Review of the social services progress notes showed the following:
* 09/08/16 - "Res [resident] & Res daughter requested a referral for admission be sent to [a different skilled nursing facility]. This was completed."
* 10/06/16 - "Res attended her Care Plan meeting today. Res expressed desire to transfer to a Facility in Fargo where her son & daughter live. This writer has been trying to make contact with the Social Workers at [a different skilled nursing facility]. Multiple messages left. . . ."
* 12/13/16 - "Spoke with Res about transfer tomorrow. . . ."

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The current care plan stated, "Problem: Resident is long term. She is her own guardian. She wants her sister . . . to help and be involved with her health and finances. . . . Approaches: Staff will keep resident up to date with all cares and also keep family informed on resident health and cares. . . ." The care plan failed to address Resident #4's discharge plans.

The current care plan stated, "Problem: Potential for falls Approaches . . . Hoyer lift with two or three assist for all transfers. . . . Problem: ADL [activities of daily living] function/resident is dependent on one or two staff to complete her ADL's Approaches: Hoyer lift with 3 assist for all transfers. . . ."

During an interview on 12/14/16 at 9:55 a.m., an administrative nurse (#2) stated Resident #4 is transferred with a Hoyer lift and 2-3 staff. The care plan failed to address that a nurse must assess Resident #4 prior to transfers to determine whether 2 or 3 staff were required.

- Review of Resident #5's medical record occurred on all days of survey.
Review of the facility's Weight Change/Nutrition Risk monthly meeting notes, from March - December 2016, identified Resident #5 had significant weight loss and the interventions trialed or currently used. The interventions included liberal diabetic diet, dialysis with no diet restrictions, regular diet, increased protein, protein bars, supplements all snacks, lunches sent along to kidney dialysis unit, increased calories, large portions, milk shake, supplements left in room, and double portions. The notes

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identified resident refusal of interventions, refusal of many meals, a healed sacral ulcer, and right/left foot ulcers.

Resident #5's Skin Wound/Ulcer Records identified areas as "Rt [right] & [and] Lt [left] Lateral Foot" with date first observed "08/13/16." A physician order, dated 08/24/16, stated "Silvadene to Right Foot [word blotted out] and wrap with Kerlix."

A physician order, dated 09/29/16, stated, "Ambien 5 mg [milligrams] q [every] HS [bedtime] PRN for insomnia. DC [discontinue] if staying in room all day napping." Resident #5's Medication Administration Records (MARs) from 11/01/16 through 12/14/16 identified the resident received Ambien 13 times.

Resident #5's care plan included the following problems:
* 02/22/16, "Nutritional Status: Receives Kidney Dialysis, Potential weight loss. . . . Approaches: Dietary to work with his dialysis unit by following their recommendations . . . Review effectiveness of interventions to help maintain/gain weight at monthly weight loss meetings . . ." The care plan failed to address the resident's actual weight loss and interventions being followed.
* 03/31/16, "Pressure Ulcer: Resident has pressure/arterial ulcer to rt [right] foot r/t [related to] arterial insufficiency to lower extremities. . . . Approaches: . . . 08/23/16: Dressing change per MD order: Apply silvadine [sic] to rt foot ulcers than apply kerlix daily. . . ." The care plan failed to specify the original ulcer healed and the emergence of new ulcers to the left and right lateral feet.

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F 280	Continued From page 36 * The current care plan lacked a problem and interventions related to insomnia and the use of Ambien. - Review of Resident #6's medical record occurred on all days of survey. A physician order, dated 03/20/14, stated, "Clonazepam [antianxiety medication] 0.5 mg 1 tab [tablet] PO [orally] at bedtime." When asked the reason Resident #6 was prescribed clonazepam, an administrative nurse (#1) provided Empowerment committee notes, dated 01/06/10, and signed by the physician, which stated, ". . . He will be started on Klonopin (clonazepam) to see if that helps control tremors . . ." Observation throughout the survey showed Resident #6 utilized a geri-chair when out of bed. Observation failed to show the use of a pressure reducing cushion. Resident #6's current care plan included the following problems: * "Psychotropic Drug Use . . ." The care plan listed an antidepressant and antiemetic, but failed to include the antianxiety medication clonazepam. * Lacked a problem and interventions related to seizures/tremors and the use of clonazepam. * "Falls: . . . Resident slides down in w/c [wheelchair] . . . Approach: . . . Staff to assist resident to reposition in w/c if he slides down . . . " The facility failed to update the care plan to reflect the use of a geri-chair versus a wheelchair. * "Pressure Ulcer: Resident is at risk for pressure ulcers due to sitting in W.C. [wheelchair]. . . .	F 280		

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F 280	Continued From page 37 Approach: . . . Pressure relieving cushion in w/c. . . . Pressure relieving device in w.c. . . ." The facility failed to update the care plan to reflect the use of a geri-chair and no cushion. During an interview on 12/15/16 at 10:45 a.m., two administrative nurses (#1 and #2) stated Resident #6 used a geri-chair for at least three years and did not have an extra cushion in the geri-chair. - Review of Resident #8's medical record occurred on December 14-15, 2016. A nutritional progress note, dated 12/09/16, stated, "Dialysis continues . . . Wt [weight] = 193.6 # [pounds] which is a favorable increase from admit. Wt appears to have stabilized without further increase this month. Team discussed nutrition at meeting today." Review of Resident #8's weight from 01/06/16 (admission to facility) to 12/12/16 showed a gain of 59.2 pounds. The current care plan stated, "Problem: Nutritional Status/Receives Dialysis. Potential for weight loss. Goal: Resident will maintain weight through next review. Approach . . . Weight is monitor 3x's/week. . . . Review effectiveness of interventions to help maintain/gain weight at monthly weight loss meetings . . ." During an interview on 12/15/16 at 11:45 a.m., the dietary manager (#5) confirmed Resident #8's care plan lacked the planned weight gain.	F 280		
F 309 SS=E	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309		1/18/17

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F 309	Continued From page 38 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. 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, consistent with the resident's comprehensive assessment and plan of care. 483.25 (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: WOUND ASSESSMENT 1. Based on record review, review of facility policy, and staff interview, the facility failed to provide care and services to maintain the highest practicable physical well-being for 3 of 3 sampled residents (Resident #1, #3, and #5) with ulcers or a history of ulcers. Failure to consistently assess the wounds has the potential to delay the healing process and may result in further skin breakdown.	F 309	1.)a.) Resident #1, #3 and #5 wounds will be assessed weekly. Their care plans will be updated to include the current wounds and the current plan of treatment. b.) Resident #5 and #8 will have an arrangement between the dialysis provider and DCNH to coordinate care and services. Their care plans will be updated to include their dialysis access, the care of the site, signs of infection and any necessary interventions needed to	

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F 309	Continued From page 39 Findings Include: Review of the facility policy/procedure titled "Skin Care Program" occurred on 12/15/16. This policy, dated 10/29/07, stated, ". . . Protocol for injury/impairment of skin integrity . . . Document at least every 7 days. . . ." - Review of Resident #1's medical record occurred December 12-15, 2016. Diagnoses included paraplegia and non-pressure chronic ulcer of lower legs. The current care plan, stated, "Problem . . . Skin integrity. Resident has a Lt. [left] thigh decubitus (on admission). Has ulcer on right side also. . . . Approaches . . . Dressing changes as ordered by MD [medical doctor] monitor condition of ulcer and keep MD informed. . . ." Review of wound assessments from February to December 2016 showed the facility failed to measure and assess the wounds at least weekly on 10 occasions ranging from 9-22 days between assessments. - Review of Resident #3's medical record occurred December 12-15, 2016. Diagnoses included paraplegia and healed wound to left upper posterior thigh. The current care plan showed a resolved wound stating "Problem . . . Posterior thigh pinched in sling - blood blister broke open, healed . . . Approaches . . . use proper sling [and] dress [with] mepilex. . . ." Review of wound assessments from March until November 26, 2016 when the ulcer healed showed the facility failed to measure and assess	F 309	care for the needs of a dialysis patient. Signs have been placed above their beds to indicate what arm to not take a blood pressure on. 2.) All residents with wounds or on dialysis have the potential to be affected by this deficient practice. 3.) 01-18-17 4.) a.) A new procedure for wound assessment is being developed. A specific wound nurse will be identified and responsible for the weekly assessment. b.) An agreement has been developed and will be implemented between the dialysis center and DCNH for the residents who receive dialysis to coordinate their care and services. c.) Nursing staff will be inserviced on the wound assessment procedure and the agreement for dialysis residents on 01-19-17. 5.) DON/designee will do a quality monitor to ensure the agreement for dialysis residents is in place, signed and in their medical record. This quality monitor will be complete when the agreements have been signed and placed in their medical records. This will be reviewed by the Quality Assurance Committee at the scheduled QA meeting. DON/designee will do a quality monitor for timely wound assessment weekly x 8, Biweekly x 8 and then monthly for a total of 1 year. If concerns are identified, immediate corrective action will be implemented. This monitor will be reviewed by the Quality Assurance Committee at the scheduled QA meeting.	

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F 309	Continued From page 40 the wounds at least weekly on eight occasions ranging from 14-38 days between assessments. - Review of Resident #5's medical record occurred on all days of survey. The care plan, dated 03/31/16 for the problem of pressure ulcers, stated, "Resident has pressure/arterial ulcer to rt [right] foot r/t [related to] arterial insufficiency to lower extremities. . . . Approach: . . . Assess the ulcer for stage, size (length, width, and depth), exudate, necrotic tissue, presence/absence of granulation tissue and epithelization, and condition of surrounding skin during weekly skin assessments. . . ." See F280 for failure to update the care plan with the current ulcers. Resident #5's skin wound/ulcer records for the right and left lateral feet, dated 08/13/16 through 12/10/16, showed the facility failed to measure and assess the ulcers on 6 of the 18 weeks. During an interview on the afternoon of 12/14/16, an administrative nurse (#2) identified wound charting is to be completed on Saturday or Sunday, depending on which day the staff have time. DIALYSIS 2. Based on record review, review of professional literature, and staff interview, the facility failed to provide the necessary care and services to attain the highest practicable physical, mental, and psychosocial well-being for 2 of 2 sampled residents (Resident #5 and #8) who received dialysis at another location. Failure to obtain an agreement with the dialysis provider which included all aspects of how the resident's care	F 309		

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should be managed, may result in complications related to the residents' health and decrease their quality of life and well-being.

Findings include:

The American Nephrology Nurses' Association (ANNA) "Vascular Access Fact Sheet," dated 2013, stated:
". . . Caring for a Fistula or Graft [dialysis access site]: Good fistula or graft care will help maintain the patency of the vascular access. There are measures that can be taken to prevent clotting or infection to the access. Feel the 'thrill' or vibration of blood through the access, or use a stethoscope to listen to the 'bruit' or 'whoosh' of blood through the access and site rotation. The access should be kept clean and free of injury. Inspect the access for signs of infection, including pain, tenderness, swelling, and redness to the area. . . . The access needs to be protected from injury or restriction to prevent clotting of the access. *Avoid tight clothing, jewelry, or pressure on the access area. . . . *Avoid lying on the access site when sleeping. *Do not allow blood to be drawn from the access arm. *Do not allow blood pressure to be taken in the access arm. . . ."

- Review of Resident #5's medical record occurred on all days of survey. Diagnoses included end stage renal disease. The record failed to include an agreement or arrangement between the facility and the dialysis provider to ensure the coordination of safe care and services for Resident #5.

The current care plan stated, "Problem: Resident

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F 309	Continued From page 42 requires dialysis per physician orders. . . . Approach: Monitor and report signs of localized infection . . . Monitor and report signs of systemic infection . . . Problem: Resident requires dialysis, Fistula inserted. . . . Approach . . . Kidneys [sic] Dialysis Unit will do frequent assessments on shunt during KDU [kidney dialysis unit] visits per Doctors orders. . . ." The care plan failed to include the location of Resident #5's fistula, how to assess the fistula for abnormalities (thrill and bruit), and to not obtain blood pressures or blood draws on the same arm as the fistula. During an interview the morning of 12/15/16, an administrative nurse (#1) stated staff were educated to not take blood pressures on Resident #5's left arm where the fistula is located, and agreed the site of the fistula and precautions should be care planned. During an interview on 12/15/16 at 10:58 a.m., two administrative staff members (#1 and #2) verified the care plan developed by the facility does not include the necessary interventions to care for Resident #5's dialysis fistula. - Review of Resident #8's medical record occurred on December 14-15, 2016. Diagnoses included end stage renal disease. The current care plan stated, "Problem: Resident currently attending dialysis 3x's [three times] per week per physicians recommendations. Goal: Resident will not exhibit signs or symptoms of infection at access site. Approach: Monitor and report signs of localized infection . . . Monitor and report signs of systemic infection . . ."	F 309		

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F 309	Continued From page 43 The record failed to include an agreement or arrangement between the facility and the dialysis provider to ensure the coordination of safe care and services for Resident #8.	F 309		
F 333 SS=E	483.45(f)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS (f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of professional literature, review of facility policy, and staff interview, the facility failed to ensure residents remained free from significant medication errors for 8 of 9 sampled residents (Resident #1, #2, #3, #4, #5, #6, #8, and #9) and 2 supplemental residents (Resident #11 and #12). Failure to administer medications as ordered (Resident #1, #2, #3, #4, #5, #6, #8, and #9), ensure proper medication administration via a gastrostomy tube (G-tube) (Resident #11), and failure to ensure accurate transcription of physician's orders to the recertification sheet and medication administration record (MAR) (Resident #1, #11 and #12) placed the residents at risk for adverse health effects, adverse drug reactions, and may result in a negative outcome. Findings include: COMPLETION OF MEDICATION ADMINISTRATION RECORD Review of the facility policy titled "Dunseith Community Nursing Home Pharmaceutical Service" occurred on 12/15/16. This policy, dated	F 333	1.)a.) Residents #1, #2, #4, #5, #^, #8 and # 9's MARS for October, November and December 2016 will be reviewed and the nurse or MA II responsible for medications on the days that were not administered and/or recorded were complete the appropriate documentation. b.) Resident #11 will receive medications by proper administration via his G-tube. c.) Resident #1, #11 and #12 Recertification Sheets and MARs have all been reviewed and double checked to ensure accurate transcription of the provider's orders to ensure proper medication administration. 2.) All residents who receive medications have the potential to be affected by this deficient practice. 3.) The current policy/procedure for Medication Administration is being reviewed and revised. A new policy for medication administration per G-tube has been developed. The current policy/procedure for Transcription of Orders/Verification of Recertification	1/20/17

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F 333	Continued From page 44 January 2016, stated, ". . . Each dose of medication administered to a resident shall be recorded in the resident's medication record (MAR) at the time the medication is given. . . ." - Review of Resident #1's medical record occurred December 12-15, 2016. Review of the MAR for the months of October, November, and December 2016 showed the following medications not administered and/or recorded: * 10/06/16 at 11:30 p.m. - hydrocodone/APAP (narcotic pain reliever), and at 12:00 p.m. ferrous sulfate (iron supplement). * 10/09/16 at 8:00 p.m. - artificial tears (for comfort); baclofen (prevent muscle spasms); metformin (antidiabetic); metoprolol tartrate (antihypertensive); and Tylenol (pain relief). * 10/12/16 at 11:30 p.m. - hydrocodone/APAP * 11/08/16 at 8:00 p.m. - metformin and metoprolol tartrate * 11/20/16 and 11/28/16 at 11:30 p.m. - hydrocodone/APAP * 12/06/16 at 11:30 p.m. - hydrocodone/APAP and Tylenol - Review of Resident #2's medical record occurred on all days of survey. Review of the October through December 14, 2016 MAR showed the following medications not administered and/or recorded: * 10/05/16 at 8:00 p.m. - simvastatin (lowers cholesterol) * 10/09/16 at 8:00 p.m. - simvastatin, Warfarin (blood thinner), Atenolol (lowers blood pressure), Diltiazem (lowers blood pressure), and Quetiapine (antipsychotic) * 10/21/16 at 8:00 a.m. - Potassium Chloride * 11/18/16 at 8:00 p.m. - Warfarin	F 333	Sheet is being reviewed and revised. The policies will be reviewed by nursing staff at inservice on 01-19-17. 4.) 01-20-17 5.) DON/Designee will do a quality monitor on the MARs to ensure medications are properly administered and/or recorded. The monitor will be weekly x 4, biweekly x 4, then monthly for a total of 1 year. DON/Designee will do a quality monitor to observe medications administered per G-tube to ensure proper administration. This monitor will be 2 x week for 4 weeks, weekly x 8 weeks and monthly for a total of 6 months. If concerns are identified, immediate corrective action will be implemented. DON/Designee will do a quality monitor to assure that the Transcription of Orders and the verification of the recertification sheets is accurate with the providers orders. This monitor will be completed on all recertification sheets initially then weekly x 4, biweekly x 4 and monthly for a total of 1 year. If concerns are identified, immediate corrective action will be implemented. All of these quality monitors will be reported to the Quality Assurance Committee at the scheduled QA Meetings.	

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F 333	Continued From page 45 * 12/02/16 at 8:00 p.m. - simvastatin * 12/09/16 at 8:00 p.m. - Tylenol - Review of Resident #3's medical record occurred December 12-15, 2016. Review of the MAR for the months of October, November, and December 2016 showed the following medications not administered and/or recorded: * 10/07/16 at 8:00 p.m. - levothyroxine (thyroid hormone replacement) * 10/09/16 at 6:00 p.m. - hydrocodone/APAP; at 8:00 p.m. - metformin, morphine sulfate (narcotic pain reliever), senna (laxative), and vitamin C; and at 9:00 p.m. - baclofen, docusate sodium (laxative), and gabapentin (anticonvulsant) * 10/10/16, 10/11/16, and 10/13/16 at 12:00 a.m. - gabapentin * 10/19/16 at 3:00 p.m. - baclofen * 10/23/16 at 8:00 p.m. - metformin, morphine sulfate, senna, Requip (antiparkinsonian), and vitamin C; and at 9:00 p.m. - baclofen, docusate sodium, and gabapentin * 10/24/16 at 12:00 a.m. - hydrocodone/APAP * 10/30/16 at 9:00 p.m. - gabapentin * 11/03/16 and 11/30/16 at 8:00 a.m. - Zyrtec (antihistamine) * 11/11/16 at 8:00 p.m. - levothyroxine a 200 and a 50 mcg (micrograms) tablet, metformin, morphine sulfate, ropinirole (Requip), and vitamin C; and at 9:00 p.m. - baclofen, docusate sodium, polyethylene glycol (laxative) and gabapentin * 12/05/16 at 8:00 p.m. - metformin, senna, and vitamin C; and at 9:00 p.m. baclofen, docusate sodium, and gabapentin - Review of Resident #4's medical record occurred on all days of survey. Review of the October through December 14, 2016 MAR	F 333		

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F 333	Continued From page 46 showed the following medications not administered and/or recorded: * 10/06/16 at 10:00 p.m. - Labetalol (lowers blood pressure) * 10/09/16 at 6:00 p.m. - Hydrocodone/Acetaminophen, Furosemide (diuretic), Pantoprazole (for gastroesophageal reflux disease), and Tylenol * 10/09/16 at 10:00 p.m. - Bisacodyl (laxative), Poly-Iron, Sertraline (for depression), and Labetalol * 10/27/16 at 6:00 p.m. - Furosemide and Pantoprazole * 10/28/16 at 10:00 p.m. - Labetalol, Poly-Iron, and Sertraline * 12/02/16 at 2:00 p.m. - Hydrocodone/Acetaminophen * 12/06/16 at 12:00 p.m. - Labetalol, Poly-Iron, Potassium Chloride * 12/13/16 at 12:00 a.m. - Tylenol - Review of Resident #5's medical record occurred on all days of survey. Review of the MAR for the months of October - December, 2016 showed the following medications not administered and/or recorded: * 10/09/16 at 7:00 p.m. - quetiapine (antipsychotic); and at 8:00 p.m. - metoprolol, morphine sulfate, and Renvela (phosphate binder) * 10/21/16 at 8:00 a.m. - aspirin (blood thinner) * 10/23/16 at 7:00 p.m. - quetiapine; and at 8:00 p.m. - metoprolol, morphine sulfate, and Renvela * 10/28/16 at 12:00 p.m. - duloxetine (antidepressant) * 11/04/16 at 12:00 p.m. - duloxetine * 11/06/16 at 8:00 p.m. - Renvela * 11/11/16 at 12:00 p.m. - duloxetine; and at 8:00	F 333		

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F 333	Continued From page 47 p.m. - quetiapine, Renvela, and metoprolol tartrate * 11/17/16 at 8:00 a.m. - furosemide -Review of Resident #6's medical record occurred on all days of survey. Review of the MAR for the months of October - December, 2016 showed the following medications not administered and/or documented: * 10/09/16 at 7:00 p.m. - baclofen and divalproex (anticonvulsant); and at 8:00 p.m. - clonazepam (anticonvulsant) and glycopyrrolate (anticholinergic) * 10/20/16 at 8:00 p.m. - clonazepam * 11/17/16 at 7:00 a.m. - potassium chloride - Review of Resident #8's medical record occurred December 14-15, 2016. Review of the October through December 14, 2016 MAR showed the following medications not administered and/or recorded: * 10/05/16 at 12:00 p.m. - Lorazepam (for anxiety) * 10/09/16 at 6:00 p.m. - Renvela (phosphate binder) * 10/09/16 at 8:00 p.m. - Colace (stool softener), Diltiazem, Latanoprost (eye drop for glaucoma), Mirtazapine (for depression), Tamsulosin (for urinary retention), Tylenol, and Quetiapine * 10/27/16 at 8:00 p.m. - Diltiazem * 11/01/16 at 7:00 a.m. - Aspirin * 11/02/16 at 7:00 a.m. - Aspirin * 11/22/16 at 7:00 a.m. - Aspirin - Review of Resident #9's medical record occurred December 14-15, 2016. Review of the MAR for the months of October, November, and December 2016 showed the following	F 333		

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F 333	Continued From page 48 medications not administered and/or recorded: * 10/09/16 at 8:00 p.m. - labetalol (antihypertensive), Extra Strength Tylenol, and Colace (laxative) GASTROSTOMY TUBE MEDICATION ADMINISTRATION Review of the facility policy titled "CARE OF GASTROJEJUNOSTOMY TUBE (G/J TUBE) / Gastrostomy Tube (G-tube)" occurred on 12/15/16. This policy, revised August 2012, stated, ". . . 8. Note: Before and after each tube feeding or medication to be given, flush feeding port tube with water. . . ." Kozier & Erb's "Fundamentals of Nursing: Concepts, Process, and Practice," 10th ed., Pearson Education, Inc., New Jersey, page 780, states, ". . . Administering Medications by Nasogastric or Gastrostomy Tube . . . When administering the medication(s) . . . If you are giving several medications, administer each one separately and flush with at least 15 to 30 mL [milliliters] . . . of tap water between each medication. . . ." Observation during medication pass on 12/13/16 at 11:08 a.m. showed a nurse (#3) administered Resident #11's colace (stool softener) and gabapentin (anti-epileptic) together through the resident's G-tube. The nurse failed to administer the medications separately and flush the G-tube between the medications resulting in a medication error. TRANSCRIPTION OF MEDICATION ORDERS	F 333		

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Review of the facility policy titled "Transcription of Orders/Verification of Recertification Sheet" occurred on 12/15/16. 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 . . . 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. . . . D. Recopying the Recertification Sheet (Recert Sheet) . . . 2. The Recert Sheet must be checked for accuracy against the MAR. Upon verification, it is to be initialed and dated in the upper right hand corner of the new Recert Sheet. 3. A second verification will be done by a different nurse. This nurse will also verify by comparing the Recert Sheet against the MAR. Upon verification, it is to be initialed and dated in the upper left hand corner of the new Recert Sheet. . . ."

- Observation of medication pass occurred on 12/12/16 at 4:00 p.m. A nurse (#3) administered Resident #12's Combivent inhaler. The MAR stated, "COMBIVANT [sic] . . . INHALE 1 PUFF BY MOUTH FOUR TIMES A DAY." The current "PHYSICIAN ORDERS/RECERTIFICATION" sheet signed by the medical provider on 12/01/16 failed to include Resident #12's Combivent inhaler. The prior "PHYSICIAN ORDERS/RECERTIFICATION" sheet signed by the medical provider on 10/27/16 stated, "Combivent 4 gm [grams] one puff QID [four

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	355080	A. BUILDING _____ B. WING _____	12/15/2016

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

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times a day]." The facility staff failed to transcribe the physician order to the current Recert Sheet, failed to complete a second verification check per their policy, and administered medication without a physician's order.

- Observation of medication pass occurred on 12/13/16 at 11:08 a.m. A nurse (#3) administered Resident #11's gabapentin. The MAR stated, "GABAPENTIN TAB [tablet] 600 MG [milligrams] TAKE 1 TABLET PER G TUBE THREE TIMES A DAY." The current "PHYSICIAN ORDERS/RECERTIFICATION" sheet signed by the medical provider on 10/27/16 stated "Gabapentin 600mg Per G-Tube BID [twice daily]." The prior "PHYSICIAN ORDERS/RECERTIFICATION" sheet signed by the medical provider on 08/25/16 stated, "Gabapentin 600 mg TID per G-tube." The facility staff failed to accurately transcribe the physician order to the Recert Sheet, failed to complete the first and second verification checks per their policy, and scheduled the medication at a different frequency from the most current recertification period.

- Review of Resident #1's medical record occurred December 12-15, 2015. Review of the MAR for December 2016 showed an order for "Tums chewable 1-2 tabs [tablets] p.o. [by mouth] prn [as needed] heartburn or gas." Review of the "Physician Orders/Recertification" failed to identify a physician's order for Tums.

During an interview on 12/15/16 at 1:28 p.m. an administrative nurse (#1) confirmed staff failed to obtain a physician order for Resident #1 to have Tums.

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F 428 SS=F	483.45(c)(1)(3)-(5) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON c) Drug Regimen Review (1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. (3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. (4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any,	F 428		1/24/17

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F 428	Continued From page 52 action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. (5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review, policy review, and staff interview, the consulting pharmacist failed to identify and report medication regimen irregularities in a timely and concise manner to the attending physician and the director of nursing for 9 of 9 sampled residents (Resident #1, #2, #3, #4, #5, #6, #7, #8, and #9) and 1 supplemental resident (Resident #13). Failure to complete the medication regimen review (MRR) in a timely and concise manner, including documentation of irregularities on a separate, written report, that lists the resident's name, the relevant medication, and the irregularity the pharmacist identified has the potential for the resident to receive unnecessary medication and experience adverse consequences related to the medication. Findings include: Review of the facility policy titled "Dunseith Community Nursing Home Pharmaceutical Service" occurred on 12/15/16. This policy, dated January 2016, stated, ". . . The consulting	F 428	1.) Resident #6, #7, and #8 have had medication reviews completed. Resident #4 has been discharged. Resident #1, #2, #3, #5, #9 and #13 will have a medication review completed by the consulting pharmacist. 2.) All residents who receive medications have the potential to be affected by this deficient practice. 3.)a.) The current policy on Pharmaceutical Service will be revised. The process for the medication regimen review will be updated to include time frames and steps to be taken when irregularities in medications are identified. b.) DON/Designee will meet with the consulting pharmacist to revise the policy and devise a method to assure there are steps in place to identify and address any medication irregularities in a timely and concise manner on 01-16-17. 4.) 01-24-17 5.) DON/Designee will do a quality monitor to assure that the method	

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F 428	Continued From page 53 Pharmacist will review all medical charts every month for drug irregularities . . . A form will be utilized for communication between the consulting Pharmacist and the provider. If recommendations are made it will be forwarded to the provider for a response. . . ." Review of the monthly consultant pharmacist reports from February through October 2016 showed the pharmacist provided the report to the facility from 42 to 77 days after the end of the month reviewed. The report stated: "Recommendations: 1. Labs, Review, monitor, adjust meds prn [as needed] 2. [listed multiple resident names with various lab values, but rarely a statement of the irregularity or a recommendation regarding the irregularity] 3. Information Corner [listed information such as management of high triglyceride levels or diabetes] Missing Signatures: [listed medications of each resident that staff failed to initial in the date/time column of the Medication Administration Record (MAR), indicating staff either failed to document they administered the medication or staff did not administer the medication.]" Review of the MRR, dated 08/01/16 to 08/31/16, included the following irregularities: * Resident #2, "labs 24th, glucose 116h [high], unable to locate lipid panel or a1c [hemoglobin A1c - indicator of blood glucose control], kidney dx [diagnosis]" * Resident #4, "labs 7/21 [07/21/16] glucose 286, a1c 9.4" *Resident #13, "metabolic panel due." The MRR was received by the facility	F 428	developed and the federal regulation for Drug Regimen Review is followed. This monitor will be monthly x 1 year. If concerns are identified, immediate corrective action will be implemented. The monitor will be reviewed by the Quality Assurance Committee at the scheduled QA Meeting.	

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F 428	Continued From page 54 approximately two months later on 11/03/16. During an interview on 12/15/16 at 10:20 a.m., two administrative nurses (#1 and #2) stated the pharmacist completed the MRR for the month of October on 11/29/16, and the facility received the results on 12/12/16. The nurse (#1) stated recommendations related to the October information was not received until over a month later, and prior months have been up to two months later. The nurses (#1 and #2) stated at times they were uncertain if the MRR information was a recommendation based on how the pharmacist worded the results, or was informative only. The nurses faxed the MRR to the physician once the facility received it. Failure to complete the MRR in a timely manner and provide concise recommendations may result in unsafe medication practices.	F 428		
F 520 SS=D	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and	F 520		1/24/17

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F 520	Continued From page 55 (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on review of the North Dakota Department of Health, Division of Health Facilities provider files and record review, the facility failed to maintain a Quality Assurance (QA) process, which identified and addressed quality issues; and failed to develop and implement appropriate plans of action to correct deficient practice to ensure compliance with federal requirements. Findings include:	F 520	1.) N/A 2.) DCNH failed to utilize Quality Assurance effectively. This deficient practice could put DCNH at risk for noncompliance of federal requirements. 3.) The current procedure/policy for Quality Assurance is being reviewed and will be revised if indicated. The Quality Assurance Committee will be inserviced on the policy. The quality monitor for FTag 203 and FTag 278 will be reviewed and revised to	

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F 520	Continued From page 56 Refer to F 203 and F 278 for specific findings. Failure to effectively utilize QA resulted in the facility not maintaining compliance in the following: * F 203 - providing residents with a transfer notice at time of transfer to the hospital. * F 278 - accuracy of Minimum Data Set Assessments and accuracy of completeing Section Z. During an interview on 12/15/16, at 1:30 p.m., an administrative nurse (#1) identified lapses in the QA system based on the findings of the current survey.	F 520	ensure the monitor is thorough and complete to ensure DCNH is effectively utilizing our quality assurance process. The Quality Assurance Committee will be inserviced on the quality monitor. 4.) 01-24-17 5.) DON/Designee will do a quality monitor to assure that the quality monitors in place are thorough, accurate and addressing quality issues. This monitor will be done monthly x 6 months and bimonthly x 6 months. Results will be reported to the Quality Assurance Committee at the scheduled QA Meeting.	