STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355080	A. BUILDING _____ B. WING _____	11/07/2012

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 November 5, 2012 and completed on November 7, 2012, the sample included 2 residents for complete review, 7 residents for focused review, and 1 closed record for review.	F 000		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by:	F 329	F-Tag 329 #1. Resident #3 will not be given antipsychotic/pschotropic PRN drugs for agitation and insomnia unless non-pharmacologic interventions have been attempted prior and assessed that these interventions have not been effective. Resident #3 will also only be given one psychotropic medication (if necessary to receive one) at a time and be assessed that this intervention was not effective before given another. #2. All residents who have psychotropic medications ordered PRN have the potential to be affected by this deficient practice. #3. All Nurses will be inserviced regarding attempting: a) Non-pharmacologic interventions before administering psychotropic medications. b) Administration of only one psychotropic medication at a time and assessing effectiveness of one before giving another psychotropic	

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

Jerrold L. Brenno, Nursing Home Administrator 11/26/2012

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

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F 329	Continued From page 1 Based on record review, review of professional reference, and staff interview, the facility failed to ensure a drug regimen free from unnecessary medications for 1 of 3 sampled residents (Resident #3) receiving psychotropic medications on an as needed (prn) basis. Failure to adequately assess Resident #3's behavior and attempt non-pharmacological interventions, as well as the administration of two psychotropic medications (Haldol, trazodone) simultaneously may have resulted in Resident #3 receiving unnecessary medications and experiencing adverse drug reactions related to their use. Findings include: The 2011 Nursing Drug Handbook, page 663-664, identified Haldol as an antipsychotic and listed adverse reactions of sedation, drowsiness, and lethargy; and on page 616, listed trazodone as an antidepressant with drowsiness as a common adverse reaction. Review of Resident #3's medical record occurred on all days of survey. Diagnoses included persistent mental disorder, delirium, and depression. The current care plan stated, ". . . Resident has trouble sleeping . . . Approaches . . . Administer sleep/pain medications as ordered. Offer him a snack if unable to sleep. Visit and reminicse [sic] with him to help him sleep. . . ." A physician's order, dated 10/11/12, stated, ". . . Trial basis: Haldol 2.5 mg [milligrams] - 5 mg po [by mouth] hs [bedtime] prn for [increased] agitation. Trazodone 50 mg - 100 mg po hs prn for insomnia/restlessness. Tylenol p.m. [one] tab [tablet] hs prn - insomnia-restlessness . . ."	F 329	F-Tag 329 - continued #4. This deficiency will be corrected by December 11, 2012. #5. The DON or designee will: a) Review daily (M-F) x 2 weeks or until 100% compliant all MARS of those residents who were given PRN psychotropics the day before, checking that there is documentation of non-pharmacologic interventions attempted first and assessed adequately for its effectiveness before giving another psychotropic. b) When above is compliant, this will be reviewed 2x/week or until 100% compliant, then weekly X 2 weeks or until 100% compliancy is reached. These monitors will be given to the NH Administrator for review and will be reviewed at our regularly scheduled QA Meetings. c) When above is compliant, this will be reviewed monthly x 5 months. per telephone 12/3/12 - 2 PM - dtl - Lorraine Haas, DON & Terry Brenno, Admn.	

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F 329	Continued From page 2 Nurses' notes identified the following: *10/14/12: "Res [resident] [increased] yelling [increased] agitation. 2.5 [mg] Haldol po given @ 11 p.m. [with] 100 mg trazodone po given for [complaints of] insomnia. Resident resting @ 0100 [1:00 a.m.] . . ." *10/15/12: "[Resident #3] is again sleeping most of the shift. Will recommend [decreasing] trazodone tonight. . . ." *10/18/12: ". . . 8 p.m. Res yelling et [and] [increased] agitation. Haldol 2.5 mg po given @ this time. Res c/o insomnia trazodone 50 mg [2 tabs] given @ 8 p.m. Res sleeping @ 2200 [10:00 p.m.]. . . ." *10/31/12: ". . . [Resident #3] is restless and calling out for tylenol for shoulder pain. Gave him a tylenol [and] tylenol p.m. for rest. Will try not to give any other prn's as he is sleeping too much during the day. . . ." Resident #3's medication administration records (MARs) from October 11 through November 6, 2012 identified 17 occasions when staff administered trazodone and Haldol simultaneously for symptoms such as increased agitation, restlessness, and increased anxiety. Staff failed to first assess the effectiveness of each medication individually, which may have avoided the use of multiple psychotropics. Staff also failed to monitor the effectiveness of the medications on four occasions. On 10/13/12 at 7 p.m., the MAR showed staff administered Haldol for yelling and agitation, and Tylenol p.m. as a sleep aid. Staff evaluated these medications as "effective;" however, at 8:00 p.m., staff also administered trazodone for anxiety and as a sleep aid.	F 329		

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F 329	Continued From page 3 During an interview on 11/07/12 at 2:00 p.m., a supervisory nursing staff member (#2) agreed it was not a good practice to administer two prn psychotropics at the same time without monitoring the resident to see if one medication would be effective. Staff failed to adequately assess Resident #3 for unmet needs, attempt non-pharmacological interventions, and evaluate the effectiveness of prn medications individually before administering additional psychotropic medications. These failures may have resulted in unnecessary medications, adverse drug effects, and a decreased quality of life.	F 329		
F 465 SS=F	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide safety equipment to prevent backflow of contaminated water into the potable (drinking) water system of the facility in 1 of 1 beauty and barber shop room. The lack of safety devices has the potential to affect the water supply for the entire facility. Findings include: A tour of the environment occurred on 11/06/12 at 4:15 p.m. with an environmental staff member	F 465	F 465 #1. No specific residents identified. #2. All residents are potentially affected by this deficient practice. #3. A back flow device has been ordered and will be installed for the sink in the beauty and barber shop. #4. Once the backflow device is installed, no monitoring or quality assurance will be needed. #5. This deficiency will be corrected by December 9, 2012.	

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F 465	Continued From page 4 (#1). Observation in the beauty and barber shop identified a sink with a hose used for washing hair. Observation showed the hose could extend into the bottom of the sink. Observation showed the faucet lacked a back flow device. During an interview on 11/07/12 at 12:45 p.m., an environmental staff member (#1) confirmed the faucet had no backflow device.	F 465		