STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355064	A. BUILDING _____ B. WING _____	C 06/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING CENTER OF GARRISON	**609 4TH AVE NE GARRISON, ND 58540**

(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 and complaint survey started on 05/31/16 and completed on 06/02/16, the sample included three (3) residents for complete review, nine (9) residents for focused review, and two (2) closed records for review. The sample included three (3) additional residents to verify specific concerns during the survey.	F 000		
F 278 SS=E	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.	F 278		7/7/16

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

Electronically Signed | 06/24/2016

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F 278	Continued From page 1 Clinical disagreement does not constitute a material and false statement. 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 (Version 1.13), and staff interview, the facility failed to ensure accuracy of the coding of Minimum Data Sets (MDSs) for 7 of 12 sampled residents (Resident #1,#2, #3, #4, #5, #8, and #12). Failure to ensure the resident interview questions were completed during the assessment period of the MDS may result in an inaccurate assessment. Findings include: The Long-Term Care Facility RAI 3.0 User's Manual, dated October 2015, pages 2-8 and 2-9 stated, ". . . Assessment Reference Date (ARD) refers to the last day of the observation (or "look back") period that the assessment covers for the resident. . . . Most of the MDS 3.0 items have a 7 day look back period. If a resident has an ARD of July 1, 2011 then all pertinent information starting at 12 AM on June 25th and ending on July 1st at 11:59 PM should be included for MDS 3.0 coding." Pages Z-6 to Z-7 stated regarding Z0400: Signatures of Persons Completing the Assessment, ". . . Coding Instructions * All staff who completed any part of the MDS must enter their signatures, titles, sections or portion(s) of sections(s) they completed, and the date completed. If a staff member cannot sign Z0400 on the same day that he or she completed a section or portion of a section, when the staff	F 278	F 278 ASSESSMENT ACCURACY 1) The interviews identified for neighbor #1, 2, 3, 4, 5, 8 and 12 were completed out of the time frame for the MDS assessment period. Section Z will not be corrected as the dates of the interviews cannot change as it is after the fact. The interviews that were completed late did not have any adverse effects on the neighbors or their care. 2) All neighbors in the facility have the potential to be affected. 3) Social Work Designee and her backup were in-serviced by SW consultant Tana Hoornaert LSW on June 14, 2016, regarding the timing requirements when completing interviews and the MDS process. Interview dates in Section Z will be double checked by the MDS coordinator prior to submission to ensure that interviews are being completed timely. 4) Date certain will be 7/7/16. 5) The MDS coordinator will monitor the dates in Section Z of SW interviews (section C and D) to ensure timing is within parameters identified in the RAI manual. Starting June 27, 2016, an audit will be completed on section Z of 2 MDS/week x2 months, then 3 MDS/month for the remainder of the year and issues	

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F 278	Continued From page 2 member signs, use the date the item originally was completed. . . . You are certifying that the information you entered on the MDS, to the best of your knowledge, most accurately reflects the resident's status. . . ." Review of the sampled residents' MDSs occurred throughout the survey. Review of Section Z0400 showed the following sections or portions of sections signed as completed after the end of the ARD: * Resident #1: ARD 04/02/16 - Section C (04/04/16), Section D (04/04/16) and ARD 07/02/15 - Section C (07/06/15), Section D (07/06/15). * Resident #2: ARD 03/04/16 - Section C (03/17/16), Section D (03/17/16) and ARD 12/11/15 - Section C (12/15/15), Section D (12/15/15). * Resident #3: ARD 02/20/16 - Section C (02/27/16), Section D (02/27/16) and ARD 11/27/15 - Section C (12/01/15), Section D (12/01/15. * Resident #4: ARD 03/14/16 - Section C (03/26/16), D (03/26/16). * Resident #5: ARD 03/11/16 - Section C (03/24/16), D (03/24/16). * Resident #8: ARD 03/18/16 - Section C (03/28/16), D (03/28/16) and ARD 06/25/15 - Section C (06/29/15), Section D (06/29/15). * Resident #12: ARD 03/08/16 - Section C (03/15/16), D (03/15/16). During an interview on the afternoon of 06/02/16, an administrative nurse (#13) stated the resident interview sections of the MDS, such as Section	F 278	brought to SW attention prior to submission. The MDS coordinator will submit a report of the monitoring results to the QA committee at each scheduled meeting.	

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F 278	Continued From page 3 C, D, and J, should be completed before the end of the ARD.	F 278		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation and review of manufacturer's instructions, the facility failed to follow professional standards of practice for 2 of 2 supplemental residents (Resident #15 and #16) observed receiving insulin. Failure to follow manufacturer's instructions for priming an insulin pen has the potential for residents to receive an incorrect dose of insulin. Findings include: Review of the Novolog FlexPen manufacturer's instructions, dated 2013, stated, ". . . Before each injection small amounts of air may collect in the cartridge during normal use. To avoid injecting air and to ensure proper dosing: E. Turn the dose selector to 2 units. F. Hold your FlexPen with the needle pointing up. Tap the cartridge gently with your finger a few times to make any air bubbles collect at the top of the cartridge. G. Keep the needle pointing upwards, press the push-button all the way in until the dose selector returns to 0. A drop of insulin should appear at the needle tip. . . . " - On 5/31/16 at 11:52 a.m., observation showed a licensed nurse (#1) prepared Resident #15's	F 281	F 281 INSULIN PEN PREPARATION 1) Neighbor□s #15 and 16 did not have any adverse effects as the result of staff improperly priming their insulin pen. The procedure for priming insulin pens was updated and nurse #1 was educated immediately on the deficient practice. The procedure was put in the communication book for all nurses on 5/31/16. 2) All neighbors who utilize insulin have the potential to be affected. 3) The procedure for priming insulin pens was updated immediately and will again be reviewed individually with all nurses by the DON by 7/7/16. 4) Date certain will be 7/7/16. 5) DON/RN designee will be responsible to monitor that all nurses are priming insulin pens correctly. Starting June 27, 2016, audits will be completed on the priming of three insulin pens x2 weeks, then one quarterly per licensed nurse. Nurses will be re-educated on the spot as issues are identified. The DON/RN designee will submit a report of the monitoring results to the QA Committee at	7/7/16

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F 281	Continued From page 4 insulin injection. The nurse primed the Novolog FlexPen with two units of insulin while pointing the pen horizontally. - On 5/31/16 at 11:40 a.m., observation showed a licensed nurse (#1) prepared Resident #16's insulin injection. The nurse primed the Novolog FlexPen with two units of insulin while pointing the pen horizontally. Facility staff failed to hold, tap, and prime the insulin pens in an upright position, therefore possibly giving an inaccurate dose of insulin.	F 281	each scheduled meeting.	
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, review of Material Safety Data Sheets (MSDS), and staff interview, the facility failed to ensure an environment free of accident hazards on 2 of 3 units (Dakotah Unit and Sunflower Unit). This failure placed cognitively impaired residents residing on these units at risk of an injury. Findings include: A tour of the dietary department occurred on	F 323	F323 FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES 1) No neighbors were adversely affected by the deficient chemical storage practices in Sunflower or in the dishwashing room in the Dakota neighborhood. All chemicals were locked up immediately. 2) All neighbors have potential to be affected by improper chemical storage.	7/7/16

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F 323	Continued From page 5 05/31/16 at 1:40 p.m. with a dietary staff member (#4). Observation showed a swinging door in the dishwasher room which opened to a resident dining room (Dakotah). Shelves next to the door contained an assortment of cleaning and dishwasher chemicals. Observation of the open kitchen area in the Sunflower unit (Alzheimer's unit) occurred on the afternoon of 05/31/16 and showed the following chemicals in an unlocked cabinet: * Monogram oven and grill cleaner aerosol - The MSDS stated, "Skin corrosion/irritation . . . Serious eye damage/eye irritation." * Two Virex II 256 bottles - The MSDS stated, "Danger. Corrosive. Causes eye and skin burns. Harmful if inhaled, absorbed through the skin or swallowed." * Glass/ceramic cook-top cleaner - The label stated, "Keep out of reach of children." * Windex concentrate with ammonia-D - The MSDS stated, "Harmful if swallowed." * Lime-a-way - The label stated, "Keep out of reach of children." The environmental tour of the facility occurred on 05/31/16 at 3:00 p.m. with an environmental staff member (#5). Observation of the open kitchen area in the Sunflower unit showed the above unlocked kitchen cabinet containing the same chemicals. The staff member (#5) stated he expected staff to lock the cabinet. During an interview on 05/31/16 at 5:35 p.m., the dietary staff member (#4) stated dietary staff kept the door between the Dakotah dining room and dishwashing room open during the day and locked at night.	F 323	3) A locked cabinet will be placed in the dish room in the Dakota neighborhood to ensure chemicals are secure. The Sunflower kitchen cabinet used for chemical storage will be kept locked. 4) Date certain will be 7/7/16. 5) The culinary manager will be responsible to monitor. Starting June 17, 2016, audits will be completed 3x/week x 1 month to ensure the dish room cabinet in Dakota is locked and Sunflower kitchen cabinets used for chemical storage are locked. After one month audits will be completed 1x/week x 3 months. The culinary manager will submit a report of the monitoring results to the QA Committee at each scheduled meeting.	

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F 323	Continued From page 6 Failure to secure chemicals in the dishwashing room during the day increased the risk of a wandering resident to those chemicals with potential for injury.	F 323		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to provide pharmaceutical services to meet the needs of each resident for 1 of 1 sampled resident (Resident #5) who did not receive a scheduled inhaler. Failure to ensure the availability of Resident #5's inhaler may result in	F 425	F425 PHARMACEUTICAL SERVICES □ ACCURATE PROCEDURES 1) Neighbor #5, who□s Dulera inhaler was not available for two months did not have any episodes of exacerbation of	7/7/16

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F 425	Continued From page 7 an exacerbation of respiratory symptoms. Findings include: Review of Resident #5's medical record occurred on all days of survey. Diagnoses included chronic obstructive pulmonary disease (COPD) and pulmonary coccidioidomycosis (an infection of the lungs cause by a fungus). Physician's orders included Dulera (an inhaled medication to prevent asthma symptoms) twice a day (discontinued on 05/26/16). Resident #5's medication administration records (MARs), dated 03/01/16 through 05/26/16, identified the last administration Dulera as 03/21/16. From 03/22/16 to 05/26/16, the MAR identified the medication as not available. Review of the "Pharmacy Communication Sheets," dated 03/20/16 and 03/21/16, showed the facility faxed the pharmacy requesting a refill for Resident #5's Dulera. The record lacked evidence the facility followed up with the pharmacy. A progress note, dated 05/26/16, stated, "Dulera is discontinued today, as neighbor [Resident #5] has not been utilizing . . ." The medical record however, identified Dulera as not available for the resident to utilize. During an interview on 06/02/16 at 10:00 a.m., an administrative nurse (#7) was unable to provide evidence the facility had notified the physician the medication was unavailable for over two months.	F 425	respiratory symptoms due to dx COPD. The Dulera inhaler was discontinued on 5/26/16 as it was deemed not necessary. 2) All neighbors who receive a prescription medication would be considered at risk. 3) A procedure for unavailable medications was created. All licensed nurses and CMA□s will be in-serviced regarding new procedure on 6/28/16 and 7/6/16. 4) Date certain will be 7/7/16. 5) Nurse designee will monitor to ensure that procedure for unavailable medication is being followed. Starting June 27, 2016, all neighbors in the facility will be audited monthly to ensure all of their medications were available in a timely manner x3 months. If any issues are discovered, the length of the audit time will be extended. The DON will be notified of any missing medications over 3 days. The DON will submit a report of the monitoring results to the QA Committee at each scheduled meeting.	
F 441	483.65 INFECTION CONTROL, PREVENT	F 441		7/7/16

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F 441 SS=E	Continued From page 8 SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441		

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F 441	Continued From page 9 This REQUIREMENT is not met as evidenced by: WHIRLPOOL BATHTUB CLEANING 1. Based on observation, review of facility policy, review of the manufacturer's label, and staff interview, the facility failed to follow accepted infection control practices for 1 of 1 resident whirlpool bathtub. Failure to follow accepted infection control practices when disinfecting the whirlpool bathtub between residents has the potential to spread infection within the facility. Findings include: Review of the facility instruction sheet titled "Bath Disinfecting Process" occurred on 05/31/16. This undated instruction sheet stated, " . . . Use the disinfecting solution to scrub the tub, chair and underneath seat bottom. Leave wet for 10 minutes. . ." Observation on 05/31/16 at 11:20 a.m. showed a certified nursing assistant(CNA) (#2) in the tub room. The CNA explained she disinfects the bathtub between residents by using the disinfectant and scrubs the entire bath tub, leaving the disinfectant solution on for five minutes. The CNA (#2) stated she cleans the shower chair by spraying the chair and the handrails with Virex II and wiping it with a cloth. She stated she leaves the solution on for 2-3 minutes. On 06/01/16 at 8:00 a.m., an administrative staff member (#5) showed the surveyors a bottle of Virex II. The label stated, ". . . Contact Time: All	F 441	F 441 INFECTION CONTROL PART 1 □ WHIRLPOOL TUB CLEANING 1) No adverse effects resulted to any neighbors in the facility as the result of improper whirlpool disinfection. Staff #2 and #5 were educated immediately on the deficient practice and a copy of the whirlpool cleaning instructions was posted in the spa area. 2) All neighbors who use the whirlpool tub have the potential to be affected. 3) The whirlpool disinfecting process will be reviewed with all nursing staff at in-services on 6/28/16 and 7/6/16. 4) Date certain will be 7/7/16. 5) Nurse designee will be responsible for auditing the whirlpool disinfection process. Starting June 27, 2016, an audit will be completed weekly x3 months. If any issues are discovered within the audit, the length of the time will be extended. The Infection Control nurse will submit a report of the monitoring results to the QA Committee at each scheduled meeting. PART 2 □ MEDICATION PASS 1) Neighbor #17 did not have any adverse effects from improper infection control practices demonstrated during a medication pass. The bottle that the aspirin was returned to was discarded and staff member #3 was educated immediately on the deficient practice.	

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F 441	Continued From page 10 surface to remain wet for 1 minute to kill HIV-1, 5 minutes to kill HBV and HCV, and for 10 minutes to kill all other organisms cited on the label." The label listed multiple organisms. MEDICATION PASS 2. Based on observation and review of professional reference, the facility failed to follow infection control practices for 1 of 1 supplemental resident (Resident #17) observed receiving medications. Failure to follow infection control practices during medication administration has the potential to spread infection to other residents. Findings include: Saxton and Clark, "Geriatric Medication Handbook," 7th edition, Med-Pass, Inc., OH, 2005, page 146, stated, ". . . Tablets and capsules should not be poured in the nurse's hand or touched during the medicine pass. The nurse should wear gloves when cutting tablets in half or touching them for any other reason. . . ." Observation of medication administration on 05/31/16 at 12:13 p.m. showed a certified medication assistant (CMA) (#3) dished up Resident #17's medications into a paper medication cup, including a chewable baby aspirin. The CMA (#3) stated it was the wrong aspirin, removed the tablet with her bare hand, and returned it to the bottle of chewable aspirin. During this medication pass, the CMA (#3) dropped Resident #17's hydrocodone tablet onto the medication cart. Using her bare hand, the CMA (#3) picked the tablet up and placed it into	F 441	2) All neighbors who receive medications are at risk. 3) The medication administration policy was reviewed and revised. All nurses and CMA□s will be in-serviced on either 6/28/16 or 7/6/16 regarding the updated policy. 4) Date certain will be 7/7/16. 5) Nurse designee will be responsible for auditing medication passes. Starting June 27, 2016, an audit will be completed weekly x1 month, then every quarter there after x1 year. The Infection Control nurse will submit a report of the monitoring results to the QA Committee at each scheduled meeting.	

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F 441	Continued From page 11 the medication cup. Failure to protect the resident's medications from possible contamination by bare-hand contact placed the resident at increased risk of developing an infection.	F 441		
F 495 SS=F	483.75(e)(4) NURSE AIDE WORK < 4 MO - TRAINING/COMPETENCY A facility must not use any individual who has worked less than 4 months as a nurse aide in that facility unless the individual is a full-time employee in a State-approved training and competency evaluation program; has demonstrated competence through satisfactory participation in a State-approved nurse aide training and competency evaluation program or competency evaluation program; or has been deemed or determined competent as provided in §§483.150(a) and (b). This REQUIREMENT is not met as evidenced by: Based on review of facility personnel records and staff interview, the facility failed to ensure 5 of 6 staff members (staff members #8, #9, #10, #11, and #12), hired within the past five months, were enrolled in a State-approved nurse aide training program (NATP) or passed a State-approved nurse aide competency test before providing hands-on care to residents. Failure to ensure training and/or competency of caregivers has the potential to affect resident care. Findings include:	F 495	F495 NURSE AIDE WORK <4 MO TRAINING/COMPETENCY 1) No neighbors had adverse effects or were injured due to care received from staff hired at BLC who did not complete a state-approved nurse aide training program or pass a state-approved nurse aide competency test before providing hands-on care. All uncertified staff were immediately pulled off the schedule. 2) All neighbors who received care from nurse aide (NA) staff would be considered at risk.	7/7/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355064	A. BUILDING _____ B. WING _____	C 06/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING CENTER OF GARRISON	**609 4TH AVE NE GARRISON, ND 58540**

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F 495	Continued From page 12 Review of facility personnel records occurred on June 01-02, 2016 and identified the following: * Staff #8, hired on 02/11/16 as a nurse aide (NA) - Worked four days providing hands-on care for residents before enrolling in a nurse aide training program on 03/01/16. Staff #8 passed the written test, but failed the skills test of the NATP on 05/25/16. * Staff #9, hired on 04/29/16 as a NA - Worked for 16 days providing hands-on care for residents. Staff #9's certified nurse aide certification expired on 05/06/13 and he/she would need to retake a NATP class or pass a State-approved competency test before caring for residents. Staff #9 competency tested on 06/01/16 and passed. * Staff #10, hired on 04/19/16 as a NA - Worked 10 days providing hands-on care for residents before passing a State-approved competency test on 06/01/16. * Staff #11, hired on 04/19/16 as a NA - Worked 16 days providing hands-on care for residents. Staff #11 had not enrolled in a State-approved NATP nor had he/she passed a State-approved competency test. * Staff #12, hired 03/30/16 as a NA - Worked 18 days providing hands-on care for residents before completing a nurse aide training program on 05/13/16. The facility failed to ensure the staff hired (Staff #8, #9, #10, #11, and #12) were enrolled in a State-approved NATP, or passed a State-approved competency-testing program prior to being allowed to provide direct hands-on care to residents. For those staff members (Staff #8 and #12) in a State-approved NATP, the facility failed to monitor the training to ensure the	F 495	3) No nurse aide will provide hands on care until they have met state requirements for CNA training. 4) Date certain will be 7/7/16. 5) Starting June 27, 2016, the DON will monitor to ensure that all nurse aides have met the state requirements prior to providing hands on care. The DON will submit a report of the monitoring results to the QA Committee at each scheduled meeting.	

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F 495	Continued From page 13	F 495		

staff were deemed competent to provide hands-on care and whether the care provided needed to be under direct or indirect supervision of a licensed nurse.

During an interview on 05/31/16 at 2:40 p.m., a NA (#11) reported she is doing on-the-job training. She was trained by the facility's employed CNAs and performs perineal care for residents if another CNA is with her. (Only a licensed nurse is allowed to provide training/supervision to a nurse aide). She stated another facility staff member trained her how to feed residents (Only licensed or certified staff may feed a resident, unless they have completed a State-approved paid feeding assistant program). She also reported she can check blood pressures and pulses as she knew how to do this before working at the facility.

During an interview on 05/31/16 at 6:15 p.m., a NA (#11) stated she is doing a CNA self-study course. (A self-study course in not an acceptable method of NA training.) The NA could not provide a skills checklist identifying the areas he/she had been deemed competent in.

An interview occurred on 05/31/16 at 5:00 p.m. with the health unit coordinator (#6). This staff member stated when a NA is hired they are provided with a CNA training book. The NAs study on their own, and the health unit coordinator (#6) schedules them to work with a facility employed CNA. The facility's CNAs oversee the NAs, as the NAs work hands-on. (The NA must be enrolled in or completed a State-approved nurse aide training program and a licensed nurse is required to train and

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F 495	Continued From page 14 supervise (directly or indirectly) all NAs).	F 495		