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 12/28/2016

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 complaint survey started on 12/28/16 and completed on 12/28/16, the sample included seven (7) residents for focused review and one (1) closed resident record review.	F 000		
F 157 SS=E	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the	F 157		1/30/17

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

Electronically Signed | 01/13/2017

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F 157	Continued From page 1 physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to ensure timely health care practitioner and/or family notification for 3 of 7 sampled residents (Resident #1, #3, and #7) and 1 closed resident record (Resident #8) of a change in status. Failure to promptly notify the health care practitioner and/or family of a red, swollen, and draining eye (Resident #1), low blood glucose levels (Resident #7), an elopement from the facility (Resident #3), and a medication error with adverse side effects (Resident #8) may have resulted in delayed treatment. Findings include: Review of the facility policy titled "CHANGE IN NEIGHBOR STATUS" occurred on 12/28/16. This policy, revised in 2011, stated, "OBJECTIVE:	F 157	Correction: F157 SS=E Notification of Changes (Injury/Decline/Room/Etc) The facility policy titled Change in Neighbor Status has been reviewed and is deemed appropriate. A procedure titled Blood Sugar Parameters has been developed. Res #1 Neighbor chart reviewed and no issues noted that need to be reported to MD or family. Care conference was held on 1-5-2017 and family was notified regarding eye back in June of 2016. Res #3 Neighbor chart reviewed and no issues noted that need to be reported to MD or family at the present time. Res #7 Neighbor chart reviewed and daughter was spoke to at care	

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F 157	Continued From page 2 Benedictine Living Center of Garrison (BLCG) will notify physicians, neighbors [residents] and families when there is a significant change in condition, incident or accident that occurs in the facility resulting in injury or a significant change in medications or treatments that occur in the facility. PROCEDURE: . . . 2. BLCG will notify family members unless the guest [resident] states otherwise. 3. The staff nurse/charge nurse/team leader will be responsible to inform the physician of changes that occur with the neighbor. . . ." - Review of Resident #2's medical record occurred on 12/28/16. Diagnoses included Alzheimer's disease. Resident #2's progress notes identified the following: * 07/07/16 at 2:30 a.m. - "Writer was walking the units, got to prairie rose dining room and saw neighbor outside the doors off of the prairie rose dining room. Went outside to get neighbor . . . Sat neighbor down and wanderguard put on to the left ankle . . ." During an interview on 12/28/16 at 3:40 p.m., an administrative nurse (#1) stated she would expect the facility to notify Resident #2's family regarding the elopement. Facility staff failed to notify the family about Resident #3's elopement and placement of a wanderguard. - Review of Resident #8's medical record occurred on 12/28/16. Diagnoses included	F 157	conferences on 1-5-2017 regarding neighbors blood sugars. Daughter voiced that she had been spoken to in the past about this and that she is aware that her mother has highs and lows. Res #8 □ has discharged All neighbors are potentially at risk for this and charts have been reviewed for the need to update MD and notification of family or family representative. All neighbors□ charts that reviewed, accu checks have been updated with the Blood Sugar Parameters and when to notify MD. Education was provided for all licensed nursing personnel on 1-2-2017 and 1-3-2017, to ensure understanding of the policy titled Change in Neighbor Status and procedure titled Blood Sugar Parameters that was developed. Education consisted of use of event in electronic medical record. New licensed nursing staff will receive education regarding policy and procedure listed above during new employee orientation. DON or designee will ensure and monitor compliance. 5 audits will be conducted per week x 2 weeks; then 3 audits per week x 2 weeks; then 3 audits a month x 5 months. Audits will consist of the use of all event forms and monitoring progress notes from the event to assure proper notifications have taken place. Also blood sugar audits to assure the parameters are being followed. Audits began 1-9-2017.	

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F 157	Continued From page 3 chronic pain, low back pain, stage 4 chronic kidney disease, chronic obstructive pulmonary disease, heart failure, overweight, sleep apnea, and opioid dependence. The medical record lacked evidence nursing staff notified the physician of: * hallucinations and confusion noted on 10/14/16, 10/15/16 and 10/19/16 * unusual behavior prior to a fall on 10/15/16 (walking in hall with CPAP mask on) * decrease of oxygen saturations on 10/19/16 until the following morning: "02 registered initially at 77% R/A [room air] then it was at 83%." The nurse placed the resident on two liters of oxygen by nasal cannula and "sats only up to 88% turned up to 4L [4 liters] and sats are now at 93%." * cyanosis, changes in mental status, and low oxygen saturation on the evening of 10/20/16 between 4:26 p.m. and 7:00 p.m. The medical record lacked evidence nursing staff notified Resident #8's wife, also power of attorney (POA), of a medication error. The record identified the resident with symptoms of hallucinations and confusion beginning on 10/14/16 and continuing through 10/15/16. During an interview on 12/28/16 at 3:30 p.m., an administrative staff nurse (#1) stated the procedure for notifying the family of an incident/medication error occurs by herself after she completes the investigation. She stated if there was an adverse consequence then the nursing staff are to inform the family immediately. Failure to notify the wife/POA resulted in the wife having grave concerns regarding the resident's hallucinations, confusion and her questioning of nursing staff "Did he have a stroke?"	F 157	Analysis of the observations and facility□s compliance will be presented to our Quality Assurance Team beginning 1-26-2017, who will recommend changes and on-going monitoring/auditing after analysis. Completion Date January 30, 2017	

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F 157	Continued From page 4 - Review of Resident #1's medical record occurred on 12/28/16 and identified a diagnosis of traumatic brain injury. Review of Resident #1's progress notes identified the following: * 06/10/16 at 10:26 p.m.: ". . . neighbor left upper eye lid swollen, can [sic] stated there was dried drainage in corner of eye. I looked at eye and cleaned with a warm washcloth. Upper inner eye lid red in color Md [physician] notified via fax. Will continue to monitor." Review of Resident #1's event report, dated 06/10/16, showed the facility notified the physician of the resident's change in condition but not the family. During an interview on 12/28/16 at 4:00 p.m., an administrative nurse (#1) stated that she expected nursing staff to notify family of any changes in status. - Review of Resident #7's medical record occurred on 12/28/16 and identified a diagnosis of Type 2 diabetes mellitus. Review of Resident # 7's progress notes occurred 12/28/2016 and identified the following: * 06/03/16 at 10:40 a.m.; " . . . held medications in mouth, would not swallow. Would not follow commands . . . unable to grip nurses hands . . . Blood sugar 409 . . . " * 07/23/16 at 1:46 p.m.; " . . . FBS [fasting blood sugar] 54. The medical record identified that nursing staff failed to notify the provider for either occurrence.	F 157		

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F 157	Continued From page 5 During an interview on 12/28/16 at 4:00 p.m., an administrative nurse (#1) stated she expected nursing staff to notify the provider of any fasting blood sugars greater than 400 or less than 60. The nurse stated the facility currently lacks a policy or protocol on blood sugar parameters.	F 157		
F 281 SS=E	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, review of professional reference, and staff interview the facility failed to monitor administration, daily monitoring, and destruction of Fentanyl patches for 4 of 7 sampled residents (Residents #1, #4, #6, #7) and 1 closed resident record (Resident #8) prescribed and administered Fentanyl transdermal patches. Failure to ensure the five rights with medication administration of Fentanyl patches may result in negative outcomes, and failure to ensure the placement and proper destruction of Fentanyl patches has the potential for residents to not receive their prescribed medication, and drug deferral. Findings include: Berman and Snyder, "Kozier and Erb's Fundamentals of Nursing: Concepts, Process	F 281	Correction: F281 SS=E Services provided meet professional standards The facility policy titled Administering Medication has been reviewed and is deemed appropriate. A procedure titled PRN Medication has been developed. Policies titled Fentanyl Transdermal System, Fentanyl Patch removal and Disposal and Fentanyl Transdermal System Rotation have been developed. Res #1 Care plan has been reviewed by care plan team and deemed appropriate. Res #4 Care plan has been reviewed by care plan team and deemed appropriate, staff was educated regarding 9/22/16 and documentation regarding missing	1/30/17

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F 281	Continued From page 6 and Practice," 10th Edition, Pearson Education, Inc., New Jersey, page 772 states, " . . . Check Three Times for Safe Medication Administration . . . Read the MAR [medication administration record] and remove the medication(s) from the client's drawer. Verify that the client's name and room number match the MAR. Compare the label of the medication against the MAR . . while preparing the medication, look at the medication label and check against the MAR . . . Recheck the label on the container against the MAR before returning to its storage place or before giving the medication to the client. . . . Document medication administration after giving it . . . If a medication is not given, follow the agency's policy for documenting the reason why . . . " Wolters Kluwer "Nursing 2015 Drug Handbook," 35th edition, pages 599 and 603, identifies "fentanyl transdermal (applied to surface of the skin) system" with indications for use include as an anesthetic, and to manage "breakthrough . . . pain in opioid-tolerant patients." In regards to the use: "Alert: Transdermal patches must be stored, used, and disposed of properly to prevent poisonings or other harm . . . A patch that has been worn for 3 days may still contain enough fentanyl to cause harm . . . Patches should only be handled by patient or patient's caregivers." - Review of Resident #8's medical record occurred on 12/28/16. Admission diagnoses included chronic pain, low back pain, and opioid dependence. Admission orders included a Fentanyl 50 micrograms (mcg) transdermal patch every three days and hydromorphone (Dilaudid - a potent	F 281	patches. Res #6 Care plan has been reviewed by care plan team and deemed appropriate. Res #7 Care plan has been reviewed by care plan team and deemed appropriate. Res #8 □ has discharged Potentially all neighbors are at risk, we have reviewed all neighbors in house to assure appropriate care plans are in place. All neighbors MARS with an order for a Fentanyl patch have been reviewed to assure that disposal is accurate. All Fentanyl patches are being checked for placement twice a day, MARS were reviewed and appropriate. Education was provided for all licensed nursing personnel on 1-2-2017 or 1-3-2017, to ensure understanding of the policy titled Fentanyl Transdermal System, Fentanyl Patch removal and Disposal and Fentanyl Transdermal System Rotation and Administering Medications and procedures titled PRN Medication. New licensed nursing staff will receive education regarding policy and procedures listed above during new employee orientation. DON or designee will ensure and monitor compliance. Audits will consist of monitoring MAR of all neighbors with Fentanyl patches for proper destruction and placement. 3 audits will be conducted per week x 2 weeks; then 2 audits per week x 2 weeks; then 3 audits	

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F 281	Continued From page 7 opioid medication) two mg (milligrams) by mouth as needed (prn) for severe pain. Progress notes and/or the medication administration record (MAR), and an event report identified the following: * 10/13/16 at 4:39 p.m., a nurse administered hydromorphone two mg by mouth. The MAR failed to identify this administration. * 10/14/16 at 6:00 p.m., an event report identified a medication error indicating the resident received a Fentanyl 75 mcg patch. The medical record nor the MAR reflected the administration of the 75 mcg dose. * 10/18/16 at 4:40 p.m., the MAR showed a nursing staff member administered hydromorphone. Neither the progress notes nor the MAR identified the result/effect of the hydromorphone. - Review of Resident #6's medical record occurred on 12/28/2016 and identified diagnoses polyosteoarthritis and chronic pain. Medications included Fentanyl 25 mcg/hour every three days, ordered on 09/16/16.. Review of Resident #6's MAR identified the following: * November 2016: Fentanyl patch scheduled for 11/21/16 and initialed (includes a signature identification) for administration/placement on 11/20/16. Scheduled Fentanyl patch for 11/29/16 initialed on 11/30/16. * September through December 2016 lacked an entry/means to identify destruction of the Fentanyl patch upon removal from the resident. - Review of Resident #7's medical record	F 281	a month x 5 month Analysis of the observations and facility□s compliance will be presented to our Quality Assurance Team beginning 1-26-2017 who will recommend changes and on-going monitoring/auditing after analysis. Completion Date: January 30, 2017	

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F 281	Continued From page 8 occurred on 12/28/2016 and identified a diagnosis of chronic pain. Medications included Fentanyl 50 mcg every three days, ordered on 03/29/16. Review of Resident #7's MAR identified the following: * August 2106: no initials for destruction of the Fentanyl patch on the 08/23/2016 and 08/29/2016. * September 2016: no initials for destruction of the Fentanyl patch on 09/25/2016. * November 2016: no initials for destruction of the Fentanyl patch on 11/27/2016. - Review of Resident #1's medical record occurred on 12/28/16. Diagnoses included traumatic brain injury and pain. Medication included Fentanyl patch 50 mcg/hr one patch every seventy-two hours. Review of Resident #1's MAR for the Fentanyl patch showed the following: * August 2016: 1. No documentation for the disposal of the Fentanyl patch during all thirty-one days. 2. A missed dose on 08/26/16. * September 2016: No documentation for the disposal of the Fentanyl patch on 09/07/16. * November 2016: No documentation for the disposal of the Fentanyl patch on 11/27/16. * December 2016: No documentation for the disposal of the Fentanyl patch on 12/27/16. - Review of Resident #4's medical record occurred on 12/28/16. Diagnoses included rheumatoid arthritis, muscle weakness, and calliopsis. Medication included Fentanyl patch 25 mcg/hr every seventy-two hours.	F 281		

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F 281	Continued From page 9 Review of Resident #4's MAR for the Fentanyl patch showed the following: * August 2016: 1. A missed dose on 08/21/16. 2. No documentation for the disposal of the Fentanyl patch on 08/21/16, 08/23/16, and 08/26/16. * September 2016: 1. A wrong dose given on 09/22/16. 2. No documentation for the disposal of the Fentanyl patch on 08/22/16 and 08/25/16. * November 2016: No documentation for the disposal of the Fentanyl patch for 11/27/16. * December 2016: 1. No documentation of the Fentanyl patch on 12/09/16 and 12/15/16. 2. Documentation on 12/24/16 showed the Fentanyl patch missing from the resident and no further action taken to find or replace this patch. During an interview on 12/28/16 at 2:30 p.m., an administrative nurse (#1) confirmed nursing staff are expected to document when Fentanyl patches are removed and destroyed with two licensed nurse signatures, and document actions taken when a Fentanyl patch is missing.	F 281		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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	F 309		1/30/17

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F 309	Continued From page 10 (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: Based on record review, review of professional references, and staff interview, the facility failed to provide the appropriate care and services for 1 of 1 sampled closed resident record (Resident #8) who experienced a decline in health. Nursing staff failed to implement measures in relation to medication administered causing changes in mental status, and significant changes in oxygen saturations, affected the resident's physical, mental and psychosocial well-being. Findings include: Wolters Kluwer "Nursing 2015 Drug Handbook," 35th edition, pages 711 - 712, identifies hydromorphone hydrochloride (generic) as Dilaudid (brand) and as an opioid analgesic indicated for moderate to severe pain. The handbook specifies a typical adult dose, by mouth, of two to four milligrams (mg) every four to six hours as needed (prn). The indications for use included, "Adjust-a-dose: For elderly patients	F 309	Correction: F309 SS=D Provide Care/Services for Highest Well Being The facility polies titled Cardiovascular Conditions, Diabetic Care, Emergency and First Aid, Falls and Fall Risk, Gastrointestinal Conditions, Musculoskeletal Conditions, Pain Management, Respiratory and Pulmonary Conditions, Urinary and Renal Conditions and Change in Neighbor Status have been reviewed and deemed appropriate. Res #8 □ has discharged All neighbors who have had an increase or decrease in pain medication are at risk. All neighbors who have a Fentanyl Patch have been reviewed. All neighbors who have had a pain medication increase or decrease have been reviewed.	

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F 309	Continued From page 11 and those with renal or hepatic impairment, reduce initial starting dose." Adverse reactions identified included, "sedation, somnolence [sleepiness], clouded sensorium [difficulty with concentrating and thinking clearly], euphoria, light-headedness . . . respiratory depression . . ." Wolters Kluwer "Nursing 2015 Drug Handbook," 35th edition, pages 599-600, identifies "Fentanyl transdermal [applied to surface of the skin] system" doses available in dosages of 12.5, 25, 50, 75 and 100 micrograms (mcg) of drug administered per hour. Fentanyl as a potent opioid analgesic medication. Indications for use include as an anesthetic, and to manage "breakthrough . . . pain in opioid-tolerant patients." Adverse reactions identified included, "asthenia [abnormal physical weakness], clouded sensorium, confusion, euphoria, sedation, somnolence, seizures, anxiety, depression, dizziness, hallucinations . . . apnea, hypoventilation, respiratory depression, dyspnea . . . Transdermal drug levels peak between 24 and 72 hours after initial application and dose increases. . . ." Review of Resident #8's medical record occurred on 12/28/16. Diagnoses included chronic pain, low back pain, stage 4 chronic kidney disease, chronic obstructive pulmonary disease, heart failure, sleep apnea, and opioid dependence. The record identified his wife as the power of attorney (POA) and as one of five primary contacts. Admission orders included the continuation of the Fentanyl patch 50 mcg every three days;	F 309	Education has been provided for all licensed nursing personnel on 1/2/2017 and 1/3/2017, to ensure understanding of the policies titled Cardiovascular Conditions, Diabetic Care, Emergency and First Aid, Falls and Fall Risk, Gastrointestinal Conditions, Musculoskeletal Conditions, Pain Management, Respiratory and Pulmonary Conditions, Urinary and Renal Conditions and Change in Neighbor Status. Education also consisted of the use of event in electronic medical record. Education provided ensured licensed nursing personnel understood a complete assessment and follow through on all family concerns. Licensed staff have been observed by the DON or designee on 1/18/2017 and 1/19/2017 and 1/23/2017 to assure accuracy of assessments skills. New licensed nursing staff will receive education regarding all policies listed above during new employee orientation and will be observed during their orientation completing assessments. DON or designee will ensure and monitor compliance. 3 audits will be conducted per week x 2 weeks; then 2 audits per week x 2 weeks; then 3 audits a month x 5 month. Audits will consist of monitoring any changes in medications for all neighbors and proper follow up assessments and documentation regarding that change and documentation that neighbor representative has been notified. Audits began 1/09/2017. Analysis	

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F 309	Continued From page 12 hydromorphone two mg by mouth prn for severe "breakthrough pain;." CPAP/BiPAP while asleep nightly (an apparatus to force air into the lungs as treatment for sleep apnea); a neurostimulator for pain in his back (which he operated himself); and on 10/19/16 orders for oxygen two liters per nasal cannula "to keep sats [oxygen saturation] above 90%, may titrate to need once a day." The progress notes identified the resident's condition and changes in condition: * 10/11/16 and 10/12/16: Resident alert and oriented to time, person and place (times three), needed assistance of two for transfers and toileting, able to make his needs known, and no complaints of pain. Review of the medication administration record (MAR) showed nursing staff administered Fentanyl 50 mcg/hour patch on 10/11/16 at 5:00 p.m. * 10/13/16 at 4:39 p.m.: Resident complained of pain in his lower back, pain rated as an eight on a scale of one to 10, and nursing administered hydromorphone two mg by mouth, and the resident obtained relief after an hour. * 10/14/16 at 2:23 p.m. the social service designee (SSD) stated ". . . He said that he is having a lot of pain. Inquired as to whether or not he has used his neurostimulator charger . . . he struggled to get it together and placed. During the attempts to do this, he would often stop moving and stare into space. When SSD spoke, he would look and respond and continue trying to put it together. He asked several times what work is being done to the roof. He said, 'There's a tractor up there. I don't know what they're trying to do with it.' as he was looking up at the ceiling. .	F 309	of the observations and facilities compliance will be presented to our Quality Assurance Team with the first meeting on 1/26/2017 who will recommend changes and on-going monitoring/auditing after analysis. Completion Date January 30, 2017	

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F 309	Continued From page 13 . . SSD left and spoke with ADON [assistant director of nursing] about the hallucinations. ADON and SSD returned to his room. When asked about the tractor, he said he saw a forklift. ADON visited with him some more and we began to exit room. He then asked if we saw 'the owl.' ADON replied she did not and he said he saw it last night. ADON and SSD left room. . . ." The notes stated the SSD updated the charge nurse and certified nursing assistant (CNA) to push fluids and begin a three day urinary tract protocol. A staff nurse wrote the resident was put on 72 hour monitoring. The notes identified, at 3:04 p.m., nursing staff informed the resident's wife regarding the hallucinations and "asked her if he has ever done that before. She said, 'Yes he has.' She believes that it was due to medications in the past when he was having hallucinations. . . ." The MAR showed nursing placed the scheduled Fentanyl 50 mcg patch at 5:00 p.m. At 8:00 p.m., the progress note identified the resident as awake, alert, sitting on edge of the bed and "Respirations are labored as he moves around. Seemed to be falling asleep as I was talking to him. Helped him lie back down in bed. Has no complaints. Will monitor." The note lacked evidence nursing staff checked the resident's oxygen saturation with the observed labored respirations. An event report, dated 10/14/16, identified the discovery of a medication error which indicated nursing staff had administered a 75 mcg Fentanyl patch instead of the 50 mcg Fentanyl patch ordered. The report included a "Description of Event/Effect on Neighbor" and stated "May have caused hallucinations." * 10/15/16 at 12:49 a.m.: "Assisted [resident] with	F 309		

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repositioning in bed. He had sat up when nursing entered the room. He could not hold himself up. Assisted him with lying back down. He was talking about the people outside his window. The blinds on the window are closed. His breathing is labored with exertion, 02 [oxygen] sats are 93% on room air . . . Assisted him with putting on his C-PAP . . ." At 2:24 a.m., the resident got himself out of bed and into his chair. "Found him in the hallway looking for staff with his C-PAP mask on yet. He asked if we called the fire department. Had to assure him there was no fire. . . . Assisted him back into bed. . . ." At 7:33 a.m., a CNA found him on the floor lying on his right side and the assessment identified a "small 1 cm [centimeter] abrasion to right elbow" at which time the resident denied "seeing any owls or other animals in room." At 11:48 a.m., the note stated the wife visited and was informed of resident "getting himself up during the night shift and then this AM tried and fell. Abrasion top right arm. . . ." A progress note, written at 2:40 p.m., stated the wife expressed concerns about the resident's "current status. She said he would not hold fork or fork [sic] at lunch and one arm shaking. Reassured her that the staff . . . monitoring him for abnormal mental status." The note identified staff said he "is not having hallucinations" while the wife expressed concern that "he was talking to his son and when he was finished with phone call he continued to hold his hand by his ear and talk. 'Did he have a stroke?' Reassured her that staff would monitor status for any changes. This nurse then went and spoke with [resident] and he is alert and orient [sic] [to person, place, and time' and denies any discomfort. Will continue to monitor."

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F 309	Continued From page 15 * 10/16/16, 10/17/16, 10/18/16: The progress notes identified the resident alert and oriented, able to make needs known, no hallucinations, and no prn pain medication given. On 10/17/16, the MAR showed nursing staff administered the scheduled 50 mcg Fentanyl patch at 5:00 p.m. and on 10/18/16 a dose of prn hydromorphone (Dilaudid) at 4:40 p.m. * 10/19/16 at 12:26 p.m.: The resident's wife visited with the SSD and director of nurses (DON) expressing concerns of the resident "confused today." The "DON shared that he was given a dosage of Dilaudid yesterday evening. . . . DON and SSD suggested that perhaps the confusion and hallucinations are due to the Dilaudid." The note stated the DON and SSD questioned the wife regarding the home medications the resident received and whether Dilaudid was included in those. The wife stated she had brought in his "home medication list," and the SSD wrote "Will review home med list." The progress note at 3:16 p.m. stated "Nurse called to . . . room, his wife . . . present. Is noted that [resident] is continuing to have periods of confusion, and some hallucination were noted . . . he was seeing leaves all over the floor. Upon nurse's assessment [resident] is alert, his 02 registered initially at 77% R/A [room air] then it was at 83%." The nurse placed the resident on two liters of oxygen by nasal cannula and "sats only up to 88% turned up to 4L [4 liters] and sats are now at 93%. Wife has a lot of questions and concerns about . . . confusion. . . . will have [resident] seen tomorrow on rounds." The nursing staff failed to inform the physician at this time of the resident's drop in O2 saturation, the need to place oxygen concentration and change	F 309		

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F 309	Continued From page 16 from two to four liters per nasal cannula, and the continuing periods of confusion and hallucinations. * 10/20/16: noted at 8:29 a.m., the physician saw the resident and discontinued the Dilaudid "as the increased confusion and hallucinations were noticed after the doses of dilaudid had been given. . . ." The physician ordered blood work. The physician progress note on this date, stated: "Reason for visit . . . recertification. Patient . . . with a history of chronic pain on an implanted pain pump. Apparently there is a situation that arose when a 75 mCg [sic] Fentanyl patch was placed on the patient. . . ." *10/20/16 at 4:25 p.m. nursing noted the resident alert and oriented, able to make needs known and respirations even and unlabored. At 7:00 p.m., the nurse noted his fingers and toe nails "bluish in color. Was slow to respond to nursing. Checked 02 saturation. Was 73%. Repositioned him. Still unable to get saturation up. Applied mask at 5 LPM [liters per minute] . . . P [pulse] 45 . . . After about 20 minutes his saturation level came up to 93%, Pulse 61. Is talking to nurse now. Will monitor." Nursing administered the Fentanyl 50 mcg patch at 5:00 p.m. At 10:10 p.m. the nurse charted "Will leave oxygen mask on for the night and monitor." The record lacked evidence nursing notified the physician of the cyanosis, change in mental status, and low oxygen saturations. * 10/21/16: a critical lab report identified the resident with a serum potassium level of 5.9 milliequivalents per liter (normally 3.6 to 5.2), BUN (blood urea nitrogen) of greater than 140	F 309		

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mg per deciliter (dL) (normal BUN levels generally range from 7 to 20), and creatinine of 9.2 mg per dL (normal levels in blood are approximately 0.6 to 1.2 in adult males), all indicators of serious kidney disease. The medical record showed the resident transferred by ambulance to an acute care hospital an hour after the critical lab notification.

During an interview on 12/28/16 at 3:30 p.m. an administrative staff nurse (#1) stated after the first dose of hydromorphone the physician thought the confusion and hallucinations occurred due to the combination of the Fentanyl. Review of an "event report," dated 10/14/16, identified the medication error. The report identified the physician notification, and the physician's response to monitor the resident "for problems." The investigation report stated "No harm came to neighbor. He did have a fall with no injury on the early morning of 10/15/2016. It was found that he had confusion on October 15, 2016. He had received a prn pain medication prior to this. His confusion seemed to clear on October 16, 2016. No other prn medication given to this point."

Facility nursing staff failed to monitor Resident #8 for adverse effects from the increased dose of Fentanyl, related to the medication error, peak drug levels, and the combined effect of another potent opioid medication. The nursing staff failed to notify the physician of the resident's changes in mental status, hallucinations and low O2 saturation. The nursing staff dismissed/negated the wife's concerns/observations of the resident's unusual behaviors. Each of these failures placed Resident #8 at risk for delayed treatment and

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F 309	Continued From page 18 significant adverse effects.	F 309		
F 315 SS=D	483.25(e)(1)-(3) NO CATHETER, PREVENT UTI, RESTORE BLADDER (e) Incontinence. (1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. (2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. (3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much	F 315		1/30/17

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F 315	Continued From page 19 normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to provide appropriate treatment and services for 3 of 7 sampled residents (Resident #1, #2, and #4) treated for a urinary tract infection (UTI). Failure to ensure prompt diagnosis and treatment of a UTI may result in unnecessary discomfort, behaviors, and/or sepsis. Findings include: Review of the facility policy titled "Urinary Tract Infections/Bacteriuria - Clinical Protocol" occurred on 12/28/16. This policy, dated 2012, stated, "Assessment and Recognition: 1. As part of the initial assessment, the physician will help identify individuals who have a history of symptomatic urinary tract infections, and those who have risk factors (for example, an indwelling urinary catheter, . . .) for UTI. 2. The staff and practitioner will identify individuals with signs and symptoms suggesting a possible UTI. a. Nurses should observe, document, and report signs and symptoms (for example fever or hematuria) in detail and avoid premature diagnostic conclusions. . . . c. . . . three of the following symptoms must be present to make an empirical diagnosis of UTI in a long term care resident who does not have an indwelling catheter: . . ." The policy did not state to document signs and symptoms for three days after suspecting a resident may have a UTI. - Review of Resident #2's medical record	F 315	Correction: F315 SS=D No Catheter, Prevent UTI, Restore Bladder The facility polies titled Urinary Incontinence, Urinary Tract infections/Bacteriuria, Urinary Continence and Incontinence Assessment and Management, Change in Neighbor status have been reviewed and deemed appropriate. A procedure titled Urinary Tract Evaluation has been developed. Res #1 A review of neighbor chart shows no present signs/symptoms of UTI Res #2 A review of neighbor chart shows no present signs/symptoms of UTI Res #4 A review of neighbor chart shows no present signs/symptoms of UTI All neighbors are at risk for this and have been reviewed for the need to update MD and notification of family or family representative. Any neighbor identified with symptoms has been monitored with the Urinary Tract Evaluation Form. Education has been provided for all licensed nursing personnel on 1/2/2017 and 1/3/2017, to ensure understanding of the policies titled Urinary Incontinence, Urinary Tract Infections/Bacteriuria, Urinary Continence and Incontinence Assessment and Management, and Change in Neighbor Status and the	

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F 315	Continued From page 20 occurred on 12/28/16. Diagnoses included dementia and urinary retention. Orders included a indwelling Foley catheter. Resident #2's progress notes identified the following: * 11/13/16 at 5:16 p.m. - "Neighbor [Resident #2] is with retained urinary catheter, intact. she has a dark yellow amount of urine drained in her bag less than 500 [milliliters (ml)] for the 12 hour shift, her fluid intake is not sufficient enough . . . not febrile [no fever] . . . does not complain of flank pain. . . . She has foul smelling odor of urine but her catheter is intact. Will [follow] up on her tomorrow." * 11/17/16 at 3:59 a.m. - "Resident incontinent of urine at this time. Attempted to irrigate catheter without success. Foley catheter changed . . . 50 ml dark yellow, odorous urine returned . . ." * 11/23/16 at 1:57 p.m. - "Catheter changed today . . . sample saved for urinalysis and sent to lab." * 11/23/16 at 2:30 p.m. - ". . . foul smelling urine . . . urine is very concentrate and strong . . ." * 11/24/16 at 5:49 p.m. - "UA [urinalysis] obtained 11/23/16, results still pending . . ." * 11/26/16 at 3:53 p.m. - "UA result with CS [culture and sensitivity] came today. Result to be relayed on Monday." * 11/28/16 at 12:49 p.m. - "Urine CS result was relayed to Dr. . . . To start antibiotic . . ." During an interview on 12/28/16 at 3:40 p.m., an administrative nurse (#1) stated she expected facility staff to document signs and symptoms for three days after suspecting a resident may have a UTI. This nurse also stated there is always a provider on call for the facility and she would	F 315	procedure for Urinary Tract Evaluation that was developed. Education provided ensured licensed nursing personnel understand a complete assessment, when and how to notify MD and family notification. New licensed nursing staff will receive education regarding policy and procedures listed above during new employee orientation. DON or designee will ensure and monitor compliance. Audits will consist of the use of all Urinary Tract Evaluation forms to assure completion and outcome. 3 audits will be conducted per week x 2 weeks; then 2 audits per week x 2 weeks; then 3 audits a month x 5 month to ensure sustainability. Audits began on 1/10/2017. Analysis of the observations and facilities compliance will be presented to our Quality Assurance Team with the first meeting on 1/26/2017, who will recommend changes and on-going monitoring/auditing after analysis. Completion Date: January 30, 2017	

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have expected nursing staff to notify the provider of the urine culture results on 11/26/16.

Facility staff recognized dark, foul smelling urine on 11/13/16. The progress notes showed facility staff failed to document follow up on the Resident #2's signs and symptoms of a UTI until 11/17/16 (four days later) when they changed her Foley catheter. Facility staff changed the resident's catheter again on 11/23/16 and observed strong, concentrated, and foul smelling urine (10 days after the initial documentation). At this time, nursing staff obtained a urine specimen. On 11/28/16, five days after obtaining the urine specimen and 15 days after the initial documentation, Resident #2 started antibiotics for a UTI.

- Review of Resident #1's medical record occurred on 12/28/16. Diagnoses included traumatic brain injury, pain, and urinary tract infection.

Resident #1's progress notes identified the following:
* 07/21/16 at 4:04 p.m.: "Neighbor seen by . . . FNP [family nurse practitioner] for recertification. Orders received to cath [catheter] for UA [urinalysis] as neighbor smells strongly of foul urine."
* 07/26/16 at 12:15 p.m.: ". . . Received final U/C [urine culture]. Orders received . . . for Cipro 500 mg [milligrams] per peg BID [twice a day] x 7 days."

Review of the lab results showed a urinalysis obtained on 07/22/16, one day after nursing received the order. The record showed positive

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urine culture results completed at 8:45 a.m. on 07/25/16. The medical record identified the facility received the results on the afternoon of 07/26/16 at 12:15 p.m., 27 hours later.

During an interview on 12/28/16, an administrative nurse (#1) stated she expected staff to obtain urine samples for cultures and analysis when ordered unless contradicted by the resident, then the reason should be documented.

The facility failed to obtain the results of the urine culture report on the day of completion (07/25/16) which resulted in a delayed treatment of the UTI, and failed to document signs and symptoms for three days after suspecting a UTI.

- Review of Resident #4's medical record occurred on 12/28/16. Diagnoses included urinary tract infection.

Resident #4's progress notes identified the following:
* 11/19/16 at 3:09 p.m. "Neighbor's daughter [name of daughter] phoned facility today with concerns regarding [name of resident], she states that . . . has had more and more confusion the last couple weeks and would like her to have a UA done. Will obtain UA per standing orders . . ." The clinical protocol for UTIs does not include nursing staff to obtain a UA per standing orders.
* 11/20/16 1:27 p.m.: "Neighbor has been increasingly confused today, at approximately [10:00 a.m.], facility received a phone call from McClean county sheriff's dept. [department]. They had stated they had received a 911 call from this neighbor, they stated she seemed extremely confused and not making any sense,

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 12/28/2016

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 315	Continued From page 23 stated she was looking for her children and needed to find them. . . . advised her she cannot be calling 911 unless it is emergent, she became agitated and frustrated stating 'this IS an emergency my children are missing'. . . ." * 11/24/16 4:57 p.m.: "Obtained UA from neighbor, in refrigerator. Will send to lab in morning." * 11/26/16 11:49 a.m.: "Urinalysis result relayed to [doctor name] on call. prescribed antibiotics for the neighbor. . . . Also ordered to send Urine [culture]." * 11/26/16 at 9:51 p.m.: "Neighbor started on ABT [antibiotic] for UTI." * 11/27/16 at 3:47 p.m.: "At [2:10 p.m.], neighbor was found on the floor inside her room. . . ." * 11/28/16 at 12:45 p.m.: "Urine CS result was relayed to [name of physician] growth of E. coli. Bactrim DS [double strength] changed to Nitrofurantioin 2x [two times] a day for 10 days. . . ." The facility failed to document signs and symptoms for three days after suspecting a UTI on 11/19/16. A urinalysis was sent to the lab on 11/25/16, six days later.	F 315		
F9999	FINAL OBSERVATIONS Based on record review, review of facility policy and procedure, review of professional references, and staff interview, the concerns of one of the complainants regarding physician/family notification; monitoring of medications administrated including for adverse effects, particularly of opioid medications (Fentanyl and hydromorphone); and the provision of care and services for a resident with a significant change in condition were validated.	F9999		

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F9999	Continued From page 24 Based on record review, the concerns of one of the complainants regarding staffing concerns related to falls, catheter cares, elopement, toileting, skin irritations from inadequate incontinence cares, assistance with activities of daily living, and medication administration could not be validated.	F9999		