STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355084	A. BUILDING _____ B. WING _____	09/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN SUNSET HOME	333 EASTERN AVE GRAFTON, ND 58237

(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 09/10/17 and completed on 09/13/17, the sample included 4 residents for complete review, 10 residents for focused review, and 3 closed records for review. The sample included 1 additional resident to verify specific concerns during the survey.	F 000		
F 278 SS=D	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. (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	F 278		10/18/17

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

Electronically Signed | 09/28/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355084	A. BUILDING _____ B. WING _____	09/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN SUNSET HOME	333 EASTERN AVE GRAFTON, ND 58237

(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 278	Continued From page 1 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: Based on record review, staff interview, and review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.14), the facility failed to ensure accurate coding of Minimum Data Sets (MDSs) for 1 of 14 sampled residents (Resident #11). Failure to accurately complete Section E (behaviors) of the MDS does not allow the resident's assessment to reflect her current status/needs, and has the potential to affect the accurate development of a comprehensive care plan and the care provided to the resident. Findings include: The Long-Term Care Facility RAI User's Manual, revised October 2016, Chapter 3, pages E-1 and E-3, stated, ". . . E0100: Potential Indicators of Psychosis . . . Check E0100A, hallucinations: if hallucinations were present in the last 7 days. A hallucination is the perception of the presence of something that is not actually there. It may be auditory or visual or involve smells, taste or touch. Check E0100B, delusions: if delusions were present in the last 7 days. A delusion is a fixed, false belief not shared by others that the resident holds true even in the face of evidence to the contrary. Check E0100Z, none of the above: if no hallucinations or delusions were present in the last 7 days. . . . If a belief cannot	F 278	The MDS for resident #11,ARD of 7/10/17, was corrected on 09/26/2017 to reflect no delusions/hallucinations noted in assessment period. All residents whose most recent MDS indicates hallucinations and/or delusions were present were reviewed for accuracy by the Director of Resident Services and Licensed Social Worker on 9/27/17. No modifications were indicated. Education was provided to the staff responsible for coding Section E on the MDS. Review of the RAI manual Section E was completed on 10/6/17. Behavior Management Program policy was reviewed with the licensed Social Workers and MDS Coordinator on 9/28/17. CNA's and Licensed nurses are being in-serviced on behavior management (including recognition and documentation of behaviors) on 10/10/17. Behavior monitoring has been added to the electronic treatment record,of residents recognized with behaviors, prompting nurses to interview staff at the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355084	A. BUILDING _____ B. WING _____	09/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN SUNSET HOME	333 EASTERN AVE GRAFTON, ND 58237

(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 278	Continued From page 2 be objectively shown to be false, or it is not possible to determine whether it is false, do not code it as a delusion. If a resident expresses a false belief but easily accepts a reasonable alternative explanation, do not code it as a delusion. If the resident continues to insist that the belief is correct despite an explanation or direct evidence to the contrary, code as a delusion. . . ." Review of Resident 11's medical record occurred on September 12-13, 2017. The quarterly MDS, dated 07/10/17, identified hallucinations and delusions during the 7-day look-back period. The medical record lacked evidence of hallucinations or delusions during the 7-day look-back period. During an interview on 09/13/17 at 10:35 a.m., an administrative staff member (#2) confirmed Resident #11's MDS, dated 07/10/17, should not have been coded for hallucinations or delusions and agreed the medical record lacked documentation of hallucinations or delusions during the look-back period.	F 278	end of shift and to prompt documentation if warranted for noted behaviors. QA will be completed on not less than 25% of the MDS's completed for the week, weekly x 1 month then monthly for at least 1 year, for accuracy of scoring the MDS under the direction of the Director of Resident Services or designee to assure compliance has been maintained. QA of MDS will be done prior to submission of MDS. QA findings will be reviewed by the QA committee quarterly.	
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 Quality of care	F 309		10/18/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355084	A. BUILDING _____ B. WING _____	09/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN SUNSET HOME	333 EASTERN AVE GRAFTON, ND 58237

(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 309	Continued From page 3 Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (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 observation, record review, review of facility policy, an anonymous interview, and staff interview, the facility failed to assess socially inappropriate behaviors, develop, implement, and monitor the effectiveness of individualized approaches/interventions for 1 of 11 sampled residents (Resident #13) identified with behaviors. Failure to assess, monitor and evaluate Resident #13's psychological status resulted in the lack of recognition of the resident's suicidal thoughts and addressing socially inappropriate/problematic behaviors. This limited	F 309	Resident #13 is no longer in the facility. All residents identified with behaviors, affecting self or others, on their most recent MDS were reviewed on 9/22/17. Care plans were reviewed for those residents and any needed updates were completed. CASPER Reports, identifying residents with behavior symptoms that have the potential to affect self/others, are reviewed by the interdisciplinary team monthly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355084	A. BUILDING _____ B. WING _____	09/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN SUNSET HOME	333 EASTERN AVE GRAFTON, ND 58237

(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 309	Continued From page 4 the facility's ability to ensure the resident's physical and psychological needs, and may negatively impact the overall well-being for all residents with behaviors. Findings include: Review of the following policies occurred on 09/13/17: * "Resident Behavior," revised 2003, stated, "Objective: To designate responsibilities of the interdisciplinary team in caring for residents exhibiting inappropriate and/or problematic behaviors. To address guidelines for staff interventions. . . . 2. Behavior Tracking: Use of special forms to record each problem behavior, including the frequency of occurrence, including participating factors, interventions used and resident's responses. . . . Procedure 1. Licensed personnel, in conjunction with the care plan team, are responsible for observing/monitoring resident's physical, mental, emotional and behavioral status. . . . 3. All behavioral changes will result in thorough review of diagnoses for potential causes (i.e medications). . . . 7. Individualized care plans should provide an environment that allows the resident to maximize their social, physical, and mental capabilities while preserving their personal values and dignity. . . . Behavior Intervention Guidelines 1. Differentiate "problematic" behavior, which is a sign of stress and effort to cope, from "troublesome" behavior, which may be annoying to staff, but is not potentially harmful to the resident or other residents. 2. Reducing environmental stimuli, and restructuring daily care activities for simplicity and consistency, may be effective in reducing agitation or	F 309	Policy & Procedure was developed for a Behavior Management Program on 9/26/17. Included in the policy: process to identify behaviors, care plan resident specific interventions, identify any patterns in regards to time of day or precipitating factors. Policy & Procedure was developed on 9/27/17 to evaluate risk of suicide. All licensed nursing staff were provided with education on Behavior Management Program & Suicide Policies on 9/28/17. All residents identified of having behaviors affecting self or others will be reviewed during a regularly scheduled weekly Interdisciplinary meetings to ensure that resident specific interventions continue to be appropriate. Changes to the care plan will be made as necessary. QA studies will be completed, under the direction of the Director of Resident Services or designee, on all residents newly identified with behaviors and not less then 25% of previously identified residents with behavior symptoms affecting self or others to assure Behavior Management Program and Suicide policy are being followed. QA will be completed weekly x 3 months, then monthly x 3, then quarterly for at least 1 year to assure compliance is maintained. QA studies will be reviewed by the QA committee quarterly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355084	A. BUILDING _____ B. WING _____	09/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN SUNSET HOME	333 EASTERN AVE GRAFTON, ND 58237

(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 309	Continued From page 5	F 309		

uncooperativeness. . . . 5. When dealing with persons with dementia, the key intervention is to gently guide the resident away from the situation while striving to maintain their dignity. 6. The goal in dealing with escalating, or volatile behaviors is to help the resident gain control and avoid a crisis. . . . "

* "Catastrophic Reaction," dated 07/99, stated, . . . Procedure: . . . 3. Quickly assess your knowledge of the resident. Proceed with established interventions if known. If no known interventions try to determine any causal factor and proceed as follows. . . . 7. The nurse is to document all catastrophic reactions in the medical record. Document all events prior to the reaction and events leading to its de-escalation. Document reasons the resident may give for the behavior. . . ."

* "Behavior Intervention Plan," revised 08/17, stated, "The Behavior Intervention Plan (BIP) will be developed for residents who exhibit inappropriate and/or problematic behavior which is potentially harmful to resident and/or others. Every attempt will be made to use the least restrictive/intrusive intervention. . . . Objective: Behavior Intervention Plans will serve as a vehicle to communicate and educate staff in the specific plan of care developed for individual residents. . . . Procedure: . . . 2. BIP's will be directed at behavior prevention and de-escalation. Intervention may include structuring of the environment and consistency of approaches."

* "Behavior Charting,"revised 08/17, stated, "Policy: Behavior Charting will be used as a tool

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355084	A. BUILDING _____ B. WING _____	09/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN SUNSET HOME	333 EASTERN AVE GRAFTON, ND 58237

(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 309	Continued From page 6 for monitoring targeted behavior/mood over brief periods of time. . . . will be used in determining specific interventions to be included in the Behavior Intervention Plan (BIP) . . . Objective: Behavior Charting will provide a detailed record of the targeted behavior(s) occurrence (frequency), use of interventions, precipitating factors and resident response. . . . Procedure: 1. The assessment will be initiated in the following instances: . . . B. As a tool to determine appropriate interventions for an individualized behavior intervention plan. C. As a tool to evaluate behavioral interventions to determine effectiveness. . . . 3. Nursing or IDT [interdisciplinary team] members will document targeted behaviors(s), (frequency, precipitating factors, interventions and resident response), . . . " An observation on 09/11/17 during the late afternoon showed Resident #13 propelling her wheelchair around the Nurse's Station 3 with a magazine in hand. The resident started making meowing noises which progressed into yelling and hitting staff members walking by her with the magazine. An unidentified CNA held the resident's wheelchair to prevent her from wandering around the nurse's station. During an interview with a group of residents on 9/11/17 at 10:30 a.m., two residents (Resident A & B) complained about Resident #13 yelling during meal time. During an interview on 09/12/17 at 1:45 p.m., an anonymous person identified one of the residents will sit at Nurse's Station 3 at different times throughout the day meowing like a cat and	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355084	A. BUILDING _____ B. WING _____	09/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN SUNSET HOME	333 EASTERN AVE GRAFTON, ND 58237

(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 309	Continued From page 7 screaming out. Observation on 9/12/17 at 5:15 p.m. showed Resident #13 sitting in a wheelchair at her dining room table for the evening meal. Resident #13 displayed intermittent yelling and screaming, propelling her wheelchair back and forth. She slid the clothing protector from the table onto the floor. While attempting to pick up the clothing protector, she removed her socks and shoes. Resident #13 turned her wheelchair to face the table of residents behind her and continued with the intermittent yelling and screaming. Two of the female residents repeatedly told Resident #13 to "Shut-up . . . stop screaming . . . you don't have to scream." A male resident at a neighboring table also commented "Shut-up." At 5:25 p.m. observation showed staff maneuvered Resident #13 back to her table and offered encouragement to eat. The staff member left to deliver other residents' meal trays. Resident #13 continued to maneuver her wheelchair back and forth next to her table, and continued to yell and scream. Review of Resident #13's record occurred on September 12-13, 2017. The record identified an admission to hospice care with diagnoses of "Alzheimer's, dementia with psychosis, and weight loss" on 08/30/17. On 09/06/17, a psychiatrist diagnosed the resident with bipolar disorder. Medication orders upon admission to hospice included Morphine Concentrate for pain/dyspnea (difficulty breathing), Lorazepam (anti-anxiety medication) 0.25 milligrams (mg) as needed every fours hours for restlessness or anxiety, and on 09/06/17 Risperdal (anti-psychotic medication) 0.5 mg three times a day.	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355084	A. BUILDING _____ B. WING _____	09/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN SUNSET HOME	333 EASTERN AVE GRAFTON, ND 58237

(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 309	Continued From page 8	F 309		

Review of Resident #13's annual Minimum Data Set (MDS), dated 07/12/17, identified impaired vision, severely impaired cognition, present and fluctuating behaviors of inattention and disorganized thinking, half or more of the days feeling down, depressed, or hopeless, feeling tired or having little energy, and trouble concentrating on things, such as reading the newspaper or watching television, physical and other behaviors occurred 1-3 days, verbal behaviors occurred 4-6 days, but less than daily, behaviors impacted the resident's participation in activities or social interactions, behaviors significantly intrude on the privacy or activity of others, and behaviors disrupt care or living environment of others. The annual MDSs, completed on 07/12/17 and 07/21/16, showed no indication of weight loss in the past year.

The current care plan identified the following problems and interventions:
* "Visual Function . . . has impaired vision prefers large print to read. . . ." The interventions lacked how to address the problem for Resident #13, but rather included measures for staff to utilize due to the impaired vision (cleaning and maintaining glasses, eye exams, supplements and eye drops).
* "Communication . . . may have difficulty hearing others in some enviornments (sic) that are noisy or if the speaker is speaking softly. She does not wear a hearing aid . . . [on 08/02/17] Ability to effectively communicate has changed. Increased difficulty noted in making self understood. Speech maybe [sic] non-sensical."
* "Behavior Problem: [Resident] may refuse to take her bath, or be uncooperative with cares.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355084	A. BUILDING _____ B. WING _____	09/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN SUNSET HOME	333 EASTERN AVE GRAFTON, ND 58237

(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 309	Continued From page 9 When re-approached will usually cooperate. 8/2/17 confusion, wandering-see BIP. 8/2/17 attention seeking behaviors/loud noises-see BIP, 8/2/17: verbal/physical aggression-see BIP. . . If being uncooperative approach at a later time. Assess for unmet needs. . . ." * "Alteration in comfort . . . Analgesics as ordered . . . Steroid treatment as ordered . . . Non-pharmacy interventions: distraction, repositioning, warm blankets" * "8-30-17 Admitted to Hospice and anticipate declines. . . ." which addressed activity of daily living needs only * "Mood State: [Resident] has dx of anxiety disorder . . . she made comments of not wanting to live past 92 but stated life is worth living, stating 'I'll be ready when it is my time'. . . . 08/30/17 Potential for paranoia: with interventions of: "SS [social services] visit PRN[as needed]. Offer activities and opportunities to keep busy. . . . Antianxiety medications as ordered . . . Risperdal as ordered by MD [medical doctor] . . ." * "Poor eyesight, but can still get around. Asset: very out going and loves to visit. Interested in our Activities. 4/13/17 Comes to things, can be disruptive and leaves early most of the time." with interventions of "Remind and assist with direction to get things. Her interests are: Cards - Pinochle, Bingo, Music - Old Time - loves to sing, exercise - loves to walk, shopping, TV [television], news on the TV, outdoors, cooking, baking and likes I Love Lucy and Little House on the Prairie. . . ." * "Cognitive Loss/Dementia . . . dx [diagnosis] of Dementia . . . severe impairment . . ." with interventions of ". . . Establish a predictable daily routine. Orient to time, person and place as needed, Provide cues and reminders regarding	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355084	A. BUILDING _____ B. WING _____	09/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN SUNSET HOME	333 EASTERN AVE GRAFTON, ND 58237

(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 309	Continued From page 10	F 309		

daily schedule and upcoming appointments." Reality orientation (orientation to person, place and time) is generally ineffective for confused residents with severe cognitive abilities, and may, in fact, create behaviors. An alternative, validation therapy, would acknowledge the person's feelings behind the behavior or statements, and allows the person to talk about the reality they are in.

Review of facility the Behavior Intervention plan (BIP) for Resident #13 occurred on September 12-13, 2017, and included:
* a BIP, implemented on 09/06/16, and currently in effect, stated "Targeted Behavior: Makes rude, mean, hurtful comments to staff and other residents. Also making comments of wanting to die, then states how great life is. Interventions prior to behavior (Prevention); 1. [Resident name] enjoys talking about her life, talk about joyful memories. 2. Talk with her about her children, to try and keep her mind off of hurtful comments. Interventions while behavior is occurring (De-Escalation): 1. Remind [Resident #13] that these comments are hurtful to others. 2. Offer her to calm on her own, if her comments are hurtful to other residents help to remove other residents as they wish. 3. If comments are made towards other staff, do not take personally. Try reproaching later when mood is more calm. 4. Remind [Resident #13] to take deep breaths to calm down if she is upset."

* a BIP, implemented on 08/02/17, and currently in effect, stated "Targeted Behavior: Attention seeking behaviors, such as making loud noises, . . . Interventions prior to behavior (Prevention): 1. Establish predictable routine. 2. Greet [Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355084	A. BUILDING _____ B. WING _____	09/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN SUNSET HOME	333 EASTERN AVE GRAFTON, ND 58237

(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 309	Continued From page 11	F 309		

name] in passing. Make positive comments to her, such as "you look very nice in that shirt." 3. Encourage [Resident name] to participate in activities. Interventions while behavior is occurring (De-Escalation): . . . 3. Ignore attention-seeking behavior as able. If the behavior is bothersome to others in the common area, attempt to re-direct [Resident name] to her room. 4. If [resident name] is disruptive, re-direct [resident name] to her room or engage her in an activity. 5. Offer [resident name] a one to one visit and/or offer her coffee."

* a BIP, implemented on 08/23/17, and currently in effect, stated "Target Behavior: Potential for confusion, wandering - not exit seeking. Interventions prior to behavior (Prevention): 1. Establish a predictable routine 2. Encourage participation in activities or other preferred tasks. 3. Visit with [Resident name] as time allows. Interventions while behavior is occurring (De-Escalation): 1. Assess for potential unmet needs such as hunger, thirst, boredom, troublesome environmental stimuli or the need for sleep/nap. Provide corresponding intervention to meet need if possible. 2. Redirect [Resident name] to another area."

Neither the care plan nor the BIPs identified what Resident #13's "predictable" routines are, define what preferred as well as available/accessible activities staff can utilize, how staff are to ensure they have time to visit ("as allows"), what typical unmet needs the resident communicates (verbal or non-verbal), and what REDIRECTION staff should implement besides moving her to her room (including assessing for effectiveness). Greeting Resident #13 "in passing" is not an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355084	A. BUILDING _____ B. WING _____	09/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN SUNSET HOME	333 EASTERN AVE GRAFTON, ND 58237

(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 309	Continued From page 12 individualized activity, and would/should be applicable for all residents. Review of Resident #13's progress notes from August 1 - September 13, 2017 identified the following behaviors: * 14 incidents documented wishing she was dead * 64 incidents documented yelling/hollering/screaming out * 11 incidents documented verbal comments * 13 incidents documented hitting/kicking/pulling/scratching staff * 4 incidents documented spitting/refusing medication * 2 incidents documented throwing foods/drinks on floor In addition, the progress notes identified instances that staff either created a behavior or failed to prevent a behavior from occurring: * 08/25/17 at 5:45 a.m., staff toileting and checking the resident's orthostatic blood pressures and "screamed through the entire procedure." * 08/26/17 at 5:28 a.m., ". . . slept majority of night. . . . anytime she is disturbed, she starts in with high pitched conversation that does not make sense . . . Took scheduled AM meds without difficulty et [and] was encouraged to try to go back to sleep. . . ." * 08/28/17 at 5:00 p.m., "Activities staff has repeatly asked [resident] to various activities, she refuses them stateing [sic] she dos'nt [sic] want to leave her chair by the station. . . . When approached for activities she states 'I'm staying here.'" * 08/31/17 at 2:24 p.m., "Noted only a few times today that resident would holler out when loud	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355084	A. BUILDING _____ B. WING _____	09/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN SUNSET HOME	333 EASTERN AVE GRAFTON, ND 58237

(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 309	Continued From page 13	F 309		

noises going by or group of people interacting."
* 08/31/17 at "approx. [approximately] 5:30 AM. Able to arouse resident for scheduled meds, but is lethargic et [and] writer had to call her name several times et massage her arms. Then when fully awake became angry et states "What the hell are you doing now? . . . Task completed et resident returned to sleep."

During an interview on 09/13/17 at 8 a.m. a nurse manager (#1) and a social worker (#7) indicated the following regarding Resident #13's behaviors:
* the nurse manager (#1) stated she asked staff how to communicate with Resident #13 just the other day; have to ask basic questions to communicate with her, and look for cues and this does not always work; the resident may approach although staff do not always understand what the resident wants. Both staff agreed Resident #13's communication is non-sensical
* the assessment of the resident's unmet needs includes staff asking if she would like a snack, needs to use toilet, and so forth. The manager stated yesterday the resident "seemed distressed" and was "going around in circles" so she asked the resident what she needed, and stated she doesn't always tell us what she needs
* regarding how staff know if the resident has pain, the manager stated they would ask her. Again the manager stated she is non-sensical so staff often have to ask several questions to determine her unmet need
* have not noticed any consistency in her behaviors
* do not track Resident #13's behaviors
* no daily routine has been established including, for example, when she arises in the morning and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355084	A. BUILDING _____ B. WING _____	09/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN SUNSET HOME	333 EASTERN AVE GRAFTON, ND 58237

(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 309	Continued From page 14 goes to bed at night, and/or sleep habits * her own mail may not be large print; she may pick up a magazine, we would "offer" her large print material * it is her choice to participate in activities; staff may access the activity department after hours to obtain materials for her activities; staff attempt to include her in activities, but she had a poor attention span. * predictable daily routines are now varied, and stated it changes; stated it was "pretty predictable" before going on hospice; trying to work on a predictable routine, but the resident has a choice * her behaviors have not changed since admitted to hospice services on 08/30/17. The facility failed to assess, including track, Resident' #13's behaviors, including suicidal thoughts, distressing symptoms, and socially inappropriate behaviors. This resulted in a failure to develop and implement interventions, and evaluate those interventions for effectiveness, to improve Resident #13's physical, mental, emotional and behavioral needs.	F 309		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use	F 323		10/18/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355084	A. BUILDING _____ B. WING _____	09/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN SUNSET HOME	333 EASTERN AVE GRAFTON, ND 58237

(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 323	Continued From page 15 appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of policy and procedure, and staff interview, the facility failed to provide adequate supervision and assistive devices necessary to prevent accidents for 3 of 6 sampled residents (Resident #3, #10, and #12) who required assistance with transfers using a gait belt. Failure to utilize gait belts for assisted transfers, including proper use, during transfers placed the residents at risk of accidents and injury. Findings include: Review of the "Gaitbelts For Transfers" policy and procedure occurred on 09/13/17. The policy and procedure stated, ". . . PURPOSE: Gaitbelts are provided to assist staff to safely transfer or ambulate residents. PROCEDURE: . . . 3. Apply belt around resident waist. . . . D. Ensure belt is snug . . ."	F 323	Residents #3,#10, & #12 current mode of transfer was reviewed, care plans were observed to reflect current needed assistance with transfers and direct care staff were educated regarding specific transfer ability on those residents. All residents who require assist with transfers have the potential to be affected. Newly admitted residents, residents who evidence functional changes, and those returning from a hospitalization are evaluated by the Rehab Manager, a licensed nurse or professional therapies (as ordered by MD) for transfer assistance needed and this information is communicated to the direct care staff and licensed nursing staff. Our Gait Belt policy was reviewed on	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355084	A. BUILDING _____ B. WING _____	09/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN SUNSET HOME	333 EASTERN AVE GRAFTON, ND 58237

(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 323	Continued From page 16 - Review of Resident #3's record occurred on all days of survey. Diagnoses included dementia with behavioral disturbances. During observation on 09/11/17 at 11:20 a.m., a certified nursing assistant (CNA) #3 transferred Resident #3 from his bed to a wheelchair at the bedside. The CNA placed a gait belt loosely around the resident's waist which slid up into the resident's axillary area during the transfer and the resident complained of pain. During interview on 09/13/17 at 10:05 a.m., a nursing management staff member (#2) agreed the gait belt should not slide up the resident's chest during a transfer. - Review of Resident #10's record occurred on all days of survey. Diagnoses included unspecified dementia without behavioral disturbances, weakness, and history of falls. - Review of Resident #12's medical record occurred on September 13-14, 2017. Diagnoses included Parkinson's disease, generalized muscle weakness, and osteoarthritis. The resident's current care plan stated, ". . . Self care deficit with mobility related to Parkinson's Disease and Dementia. Care may vary day-to-day depending on gait, balance, and cognition. . . . Extensive assist of 1 for transfers. . . . Extensive assist of 1 for ambulation with FWW [front-wheeled walker]. . . ." Observation on 09/12/17 at 4:03 p.m. showed a CNA (#6) brought Resident #12 to the bathroom in her wheelchair. The CNA did not apply a gait belt and encouraged the resident to stand/pivot	F 323	9/22/17 and no changes have been made. The current gait belt policy was reviewed with all C.N.A's on 9/28/17 during a mandatory in-service on safe transfers. Education provided included: information on what a gait belt is, how to properly apply and use the gait belt. A skills validation checklist was completed with all C.N.A's to ensure proper understanding of education provided. QA studies will be conducted to monitor for proper application and use of gait belts weekly on each shift x 1 month then monthly x 3 months then quarterly for 1 year by the Director of Resident Services or designee conducted to assure compliance has been maintained. QA results will be reviewed quarterly by the QA committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355084	A. BUILDING _____ B. WING _____	09/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN SUNSET HOME	333 EASTERN AVE GRAFTON, ND 58237

(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 323	Continued From page 17 to and from the toilet using the grab bars. The CNA then brought Resident #12 into her room, applied a gait belt, and assisted the resident to stand/pivot to a recliner. During an interview on 09/13/17 at 10:07, a supervisory nurse (#2) identified staff should have used a gait belt in the bathroom. An observation on 09/11/17 at 4:17 p.m. showed two CNA's (#4 and #5) transferred Resident #10 from her bed to a wheelchair at the bedside without the use of a gait belt. Both CNA's lifted underneath Resident #10's arms.	F 323		
F 431 SS=E	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) 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) Procedures. 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. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient	F 431		10/18/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355084	A. BUILDING _____ B. WING _____	09/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN SUNSET HOME	333 EASTERN AVE GRAFTON, ND 58237

(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 431	Continued From page 18 detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to secure or count controlled medications prior to disposal for 1 of 2 medication storage areas (Station 2). Failure to ensure controlled medications are secure and accounted for prior to disposal may	F 431	All controlled medications found to be in locked storage cabinets in the nurses station were transferred and logged into drawer for destruction in the station 2 med room by the Director of Resident Services on 9/13/17.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355084	A. BUILDING _____ B. WING _____	09/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN SUNSET HOME	333 EASTERN AVE GRAFTON, ND 58237

(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 431	Continued From page 19 result in unauthorized access to medications and/or drug diversion. Findings include: The facility policy titled "CONTROLLED MEDICATION DISPOSAL" occurred on 09/13/17. This policy, revised 10/22/08, stated, ". . . 2. Schedule medications (CII-V) remaining in the facility after a resident has been discharged, or the order discontinued, are: a. Counted by two licensed/certified nursing staff. Both staff members are to sign the tenants' 'Controlled Med [Medication] Count Sheet". . . ." Observation/inspection on 09/13/17 at 10:00 a.m., of Station 2's medication room showed a locked cabinet used to store discontinued controlled medications prior to disposal and identified: * Alprazolam 25 milligrams (mg) blister pack with four tablets remaining. No Controlled Med Count Sheet attached. * Temazepam 15 mg blister pack with 12 capsules remaining. No Controlled Med Count Sheet attached. * Hydrocodone (Norco) 10/325 mg as needed blister pack with nine tablets remaining. No Controlled Med Count Sheet attached. * Lorazepam 0.5 mg blister packs with 53 tablets remaining. No Controlled Med Count Sheet attached. * Ambien 5 mg as needed blister pack with 30 tablets remaining. No Controlled Med Count Sheet attached. * A Controlled Med Count Sheet for Roxanol 20 mg/milliliter (ml) discontinued on 08/04/17 with 32.25 ml remaining. No medication bottle	F 431	On 9/21/17 the policy for Controlled Medication Disposal was reviewed and updated to reflect controlled medications will remain in the medication carts and continue to be counted after being discontinued or following a resident death until the medications are picked up by the Director of Resident Services or Nurse Manager and logged into the drawer for disposal. The Director of Resident Services and the 2 Nurse Managers are the only staff with the keys to access this drawer. This policy change was reviewed with licensed nursing staff on 9/21/17 and again on 9/28/17. QA studies will be conducted under the direction of the Director of Resident Services or designee weekly x 3 months then monthly x 1 year to assure compliance is maintained. QA studies will be reviewed by the QA committee quarterly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355084	A. BUILDING _____ B. WING _____	09/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN SUNSET HOME	333 EASTERN AVE GRAFTON, ND 58237

(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 431	Continued From page 20 attached. * A Controlled Med Count Sheet for olanzapine 10 mg vial for injection discontinued on 02/22/17 with five vials remaining. No vials attached. During an interview on 09/13/17 at 10:20 a.m., a nurse manager (#1) had no knowledge of the missing Controlled Med Count Sheets and/or medications. The facility failed to properly secure and/or account for controlled medications stored prior to disposal.	F 431		
F 502 SS=B	483.50(a)(1) ADMINISTRATION (a) Laboratory Services (1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on observation and professional reference review, the facility failed to ensure laboratory supplies stored in 1 of 1 medication rooms containing lab supplies were not expired. The use of expired Culture Swabs and Vacutainers (a urine specimen collection tube) may affect the integrity of the sample and impact the lab result. Findings include: The BD Vacutainer Evacuated Blood Collection System reference material, revised September 2012, stated, ". . . Storage . . . Do not use tubes after their expiration date. Tubes expire on the	F 502	Expired laboratory supplies were disposed of on 9/13/17. All laboratory supplies have been moved to a central nursing location. No supplies will be kept in the individual nursing stations. Nursing staff were informed to look at expiration dates on lab supplies at nurse's meeting on 9/21/17. Transfer staff were educated on looking at expiration dates supplies obtained on 9/13/17. Lab supplies are obtained from local hospital. Hospital lab director was informed that	10/18/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355084	A. BUILDING _____ B. WING _____	09/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN SUNSET HOME	333 EASTERN AVE GRAFTON, ND 58237

(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 502	Continued From page 21 last day of the month and year indicated. . . . " Inspection of Station 2's medication room occurred on 09/13/17 at 10:00 a.m. Observation revealed the following: * 8 Culture Swabs expired June 2017 * 5 Culture Swabs expired April 2017 * 13 BD Vacutainers with urinary analysis (UA) preservative expired August 2017	F 502	they are holding expired lab materials. QA will be performed by the Director of Resident Services or designee monthly x 1 year on current laboratory supplies to ensure that all expired supplies are removed. QA studies will be reviewed quarterly by the QA committee.	