DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355037	A. BUILDING _____ B. WING _____	08/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ALOISIUS MEDICAL CENTER NURSING HOME	325 E BREWSTER ST HARVEY, ND 58341

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F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey started on 08/05/13 and completed on 08/08/13, the sample included four (4) residents for complete review, nine (9) residents for focused review, and three (3) closed records for review. The sample included one (1) additional resident to verify specific concerns during the survey.	F 000		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a	F 278	F278 1. MDSs corrected for resident #3 on Section M on 08/19/2013 and resident #8 on section E on 08/14/2013. 2. All residents have potential for assessment error. 3. Education provided to MDS staff on August 26, 2013 regarding coding of section M0100A and M0210 and section E100 and will avoid future coding errors. 4. September 12, 2013. 5. QI monitor implemented on all MDSs with coding triggering of E0100 and M0100 and M0210 monthly times one year. MDS coordinators responsible.	9-12-13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: PRESIDENT/CEO — (X6) DATE: 9-6-2013

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

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F 278	Continued From page 1 material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual (Version 3.0), and staff interview, the facility failed to ensure the Minimum Data Sets (MDSs) accurately reflected the residents' status for 2 of 13 sampled residents (Resident #3 and #8) coded with an active pressure ulcer (Resident #3) and delusions (Resident #8) during the assessment period. Failure to code portions of the MDS correctly does not provide an accurate assessment of a resident's current status and needs. Findings include: The Long-Term Care Facility RAI User's Manual, May 2013, stated the following: * Pages M-9 and M-10, (Pressure Ulcers), stated, "Definitions: Stage 2 Pressure Ulcer: Partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, without slough. . . . Enter 0 [zero] [on the MDS] if no Stage 2 pressure ulcers are present . . ." * Pages E-1 and E-2, (Behavior), stated, "Definitions: Delusion: A fixed, false belief not shared by others that the resident holds even in the face of evidence to the contrary. . . . Steps for Assessment: . . . When a resident expresses a clearly false belief, determine if it can be readily corrected by a simple explanation of verifiable (real) facts (which may only require a simple reminder or reorientation) . . . The resident's response to the offering of a potential alternative	F 278		

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F 278	Continued From page 2	F 278		

explanation is often helpful in determining whether the false belief is held strongly enough to be considered fixed."

- Review of Resident #3's medical record occurred on all days of survey. A quarterly MDS, dated 05/27/13, identified the resident had one Stage 2 pressure ulcer during the seven day assessment period. The "Weekly Pressure Ulcer Assessment" identified Resident #3's Stage 2 pressure ulcer between the toes of his right foot as "resolved" on 05/24/13.

During an interview on 08/07/13 at 2:30 p.m., an administrative nurse (#2) confirmed Resident #3's pressure ulcer healed on 05/24/13.

- Review of Resident #8's medical record occurred on all days of survey. The annual MDS, dated 07/26/13, identified the resident had experienced delusions during the seven day assessment period.

A progress note, dated 07/26/13, stated, ". . . When I asked him and his guardian if they would like to talk to someone about the possibility of returning to the community [Resident #8] said no he can't go home he can't take care of his parents and himself . . ." The progress note failed to identify if the writer attempted to determine if his thoughts were delusional.

The Care Area Assessment (CAA), dated 07/26/13, stated, ". . . He states that he feels down and depressed daily. Then looked at me during the assessment and states you just don't understand I worry about my parents they haven't been here to see me in a long time and when you

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F 278	Continued From page 3 don't have any other family it makes you feel down and depressed . . ." The progress notes and CAA failed to identify whether facility staff attempted to correct Resident #8's false belief related to his parents.	F 278	F Tag 287 1. Death in facility MDS submitted for resident #14 on 08/17/2013. 2. All residents have potential for submission error. 3. Education provided to MDS staff on August 26, 2013 regarding need to complete and submit death in facility MDSs. 4. September 12, 2013. 5. All expirations occurring in facility will be reviewed in weekly QI by Social Service Director and/or ADON to ensure completion and submission times one quarter and then randomly times one year.	9-12-13
F 287 SS=B	483.20(f) ENCODING/TRANSMITTING RESIDENT ASSESSMENT (1) Encoding Data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. (2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. (3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i) Admission assessment. (ii) Annual assessment.	F 287		

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F 287	Continued From page 4 (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on a resident that does not have an admission assessment. (4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to electronically transmit encoded and completed Minimum Data Set (MDS) data to the Centers of Medicare and Medicaid Services (CMS) Quality Improvement Evaluation System (QIES) Assessment Submission and Processing (ASAP) system for 1 of 3 closed records (Resident #14) reviewed. Findings include: Review of the "CASPER Report [Certification and Survey Provider Enhanced Report] MDS 3.0 Resident Level Quality Measure [QM] Report" occurred on 08/05/13. This report, dated 01/29/13 through 07/29/13, identified Resident #14 as a current resident of the facility. During an interview on the evening of 08/05/13,	F 287		

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F 287	Continued From page 5 an administrative nurse (#1) stated Resident #14 passed away on 05/25/13 and facility staff failed to transmit the death in a facility tracking record MDS.	F 287		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to ensure 1 of 1 sampled resident (Resident #2) with a facility acquired Stage 2 pressure ulcer (PU) received the necessary treatment and services to promote healing. Failure to ensure the floatation of Resident #2's left heel off the bed mattress may contribute to a delay in healing of his Stage 2 PU. Findings include: Observations on 08/06/13 at 10:24 a.m. and 08/07/13 at 8:05 a.m. showed Resident #2 lying in bed with a blue wedge positioned under his knees and both heels directly resting on the mattress. Review of Resident #2's medical record occurred	F 314	F Tag 314 Pressure Sores 1. Reminder in form of picture of wedge has been placed on wall by bed for resident #2 to remind staff to properly place wedge to off load pressure of heel and of need to monitor and encourage resident's compliance. Staff is to document his refusal or removal. Education on use of wedges and documentation presented at staff meetings on September 4th and 5th. 2. All resident with pressure areas to heels could be affected. 3. All resident with pressure area to heels that have wedges for off loading will have pictures placed on wall by bed for reminders of placement. Education on the use of wedges and documentation presented on September 4th and 5th. Staff to encourage compliance. Staff to document refusal or removal.	

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F 314	Continued From page 6 on August 05-08, 2013. The facility admitted Resident #2 on 05/28/13. Diagnoses included status post hip fracture secondary to a fall (on 05/22/13) and a Stage 2 PU (identified on 06/03/13). Resident #2's admission Minimum Data Set, dated 06/10/13, identified the resident as cognitively intact, able to understand others, extensive two-person physical assistance with bed mobility and transfers, the presence of one or more unhealed PU(s) Stage 1 or higher, and skin and ulcer treatments of: pressure reducing device for chair, nutrition or hydration interventions, and ulcer care. Resident #2's current care plan identified "Potential for impaired skin integrity related to . . . impaired mobility, low hgb [hemoglobin], PVD [peripheral vascular disease], impaired skin integrity related to blister (Stage 2) to left heel and Stage 2 right heel (healed 06/24/13)" and interventions of "Accumax [a type of pressure relieving mattress], . . . Heel off wedge to foot of bed, . . . Nutritional supplements, Roho [a type of pressure relieving cushion] to electric scooter, transfer to all chairs he sits in, Skil Care boots [a type of pressure reduction product] on when up except with ambulation, treat left heel ulcer as ordered . . ." During interview on 08/08/13 at 11:00 a.m., an administrative nurse (#2) stated Resident #2 is able to reposition himself in bed and therefore facility staff did not implement a repositioning schedule. This staff member (#2) stated Resident #2 leaves the facility during the day to spend time with his spouse at their apartment. When informed of the above observations on August 6	F 314	4. September 12, 2013. 5. QI monitor placed for compliance of wedges used in treatment of heel pressure ulcers weekly for one month, then monthly for one year. DON nurse responsible.	9-12-13

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F 314	Continued From page 7 and 7, this staff member (#2) stated she expected facility staff members to position the wedge to ensure floatation of Resident #2's bilateral heels when the resident is in bed.	F 314		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, review of a professional reference, and staff interview, facility staff failed to implement appropriate interventions to restore/maintain adequate nutritional status for 1 of 3 sampled residents (Resident #6) identified with severe weight loss and observed to require extensive assistance with eating. Failure to ensure staff implemented measures to avoid weight loss including ensuring staff provided adequate assistance, consistent with the comprehensive assessment, resulted in Resident #6 experiencing severe weight loss. Findings include:	F 325	F Tag 325 Weight Loss 1. Nurses, CMAs and C.N.A.s were instructed to assist resident #6 with eating at all times. This was communicated through messages on the communication logs and the C.N.A. Daily Plan of Care on August 9th. On August 29th the resident was placed on the Restorative Nursing program for dining. He has been screened by OT and has an Occupational Therapy Function Maintenance program that individualizes and directs his eating program. He is placed in the Dining Room with other residents that need assistance in eating. His weight is monitored and stable. The weight management policy has been revised. In the revision, the method of charting has been revised to return the "weight clip board" for documentation of resident's	

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F 325	Continued From page 8	F 325		

The Centers for Medicare and Medicaid Services (CMS) has outlined the parameters for evaluating significance of unplanned & undesired weight loss:

Interval	Significant Loss	Severe Loss
1 month	5%	Greater than 5%
3 months	7.5%	Greater than 7.5%
6 months	10%	Greater than 10%

Review of the facility policy "Weight Management LTC [long term care]" occurred on 08/07/13. The policy, dated 01/06/13, stated:
"Policy: To manage resident body weight within a stable range, avoiding 3# [pound] fluctuation.
Procedure:
1) Upon admission all residents will be weighed weekly.
2) Post-admit weight schedule will be determined to be weekly or monthly according to weight stability or lack of stability and will be changed according to status.
3) CNAs [Certified Nursing Assistants] will weigh residents and record the present weight in the computer.
4) If there is a difference of 3# or more between the present weight and the past weight, the resident will be reweighed.
5) The type of scale will be recorded in the computer
6) Weight entries on the form will be reviewed by the Dietary Manager or the Dietician
7) Recommendations for calorie increase or decrease will be made by the Dietary Manager or Dietitian according to weight results.
8) Alterations will be made in individual meal plans according to weight result review, with snacks and or nutritional supplements added accordingly if weight loss is experienced.
9) Addition of snacks or nutritional supplements

weights rather than the recent change of C.N.A. charting directly into the electronic record. The log will provide a quick glance and visual alert to weight losses. The weights will be logged by the C.N.A., recorded in the electronic record by the Unit supervisor. The Unit supervisor will be responsible to evaluate the weights, alert Dietary as needed, reweigh as per policy and follow –up on interventions. Staff educated on policy at staff meetings on September 4th and 5th. Staff re-educated on charting of assistance needed with meals at staff meetings on September 4th and 5th.

2. All residents have the potential for weight loss.
3. The Restorative Nursing supervisor has been assigned to implement a monitoring program for residents dining/eating. A checklist has been developed along with a communication tool for all staff to use for monitoring resident's assistance needed with dining. Staff educated on

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F 325	Continued From page 9 will be determined after study of residents food and beverage preferences, review of meal intake and general nutritional status. . . . " - Review of Resident #6's medical record occurred on all days of survey. The facility admitted Resident #6 in September 2012 with diagnoses including severe dementia and major depressive disorder. The record identified the resident as being on a regular diabetic diet and varying nutritional supplements (see weight records). Review of Resident #6's Minimum Data Set (MDS) assessments, completed since admission identified the resident's cognitive function and feeding assistance ability as: * Admission MDS, dated 09/25/12, identified the resident sometimes understood, is sometimes able to understand others, severe impairment in cognitive function (BIMS - Brief Interview of Mental Status-score of 3), and independent with set-up only with eating * Significant change MDS, dated 12/19/12, identified the resident with the same cognitive function as above, and supervision of one person with eating * Quarterly MDS, dated 06/18/13, identified the same cognitive function and required limited assistance of one person with eating Review of Resident #6's MDSs, completed since admission, identified the resident experienced the following: * Admission - 09/25/12: Weight 204 pounds (lbs). A dietary progress note stated, " . . . Diet Regular Weight 204 # BMI [basil metabolic index] 31.94, above BMI range. . . . " * Significant change - 12/19/12: Weight 186 lbs (a	F 325	this plan at staff meetings on September 4th and 5th. The weight management policy has been revised to return to the "weight clip board" for documentation of resident's weights. The log will provide a quick glance and visual alert to weight losses. The weights will be logged by the C.N.A., charted in the electronic recod by the Unit supervisors. The Unit supervisors will be responsible to evaluate the weights, alert dietary as needed, reweigh as per policy and follow-up on interventions. In addition to other interventions, the LRD will bring a list of residents who have experienced a negative weight loss to the multidisciplinary Quality Assurance staff meetings held three times a week. Staff educated on revised weight management policy at staff meetings on September 4th and 5th. The policy and minutes posted. Staff re-educated on charting of assistance needed with meals at staff meetings on September 4th and 5th, minutes	

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F 325	Continued From page 10 severe weight loss over 3 months). A dietary progress note addressed this weight and stated "Resident requires from limited to exrensive [sic] assist in dining. He has had 8.7% (18#) weight loss since admission . . . decline in eating . . ." A second note by Licensed Registered Dietician, (LRD) on the same day stated, ". . . his meal intake has decreased, averaging 43%, previous intake 83% . . . recommends 3 oz [ounces] Plus 2 [nutritional supplement] BID [twice a day] per med [medication] pass, monitor." * Quarterly - 03/19/13: Weight 176 lbs (a severe weight loss). A dietary progress note stated, "Weight 176 # BMI 27.56 Diet ADA . . . average meal intake during assessment was 71% . . . 14.6% weight loss in past 6 months, he is provided Plus 2 BID, weight stable past 30 days, weight remains above BMI. . . ." On 03/21/13, the LRD recommended decreasing Plus 2 to daily "due to resident eating better. Resident had a favorable weight loss, BMI remains slightly elevated at 27.56, monitor." A nutritional assessment, dated 03/20/13, identified the resident required one person limited assist during the assessment. On 05/15/13, a dietary note stated, ". . . weight continues to decrease, meal intake stable at 71%, good intake of 4 oz Plus 2 daily at 100%, LRD recommends increasing Plus 2 to BID per med pass, monitor." * Quarterly - 06/18/13: Weight 164 lbs (a severe weight loss). A nutritional assessment, dated 06/19/13 identified the resident required limited assistance of one person. A dietary progress note on 06/20/13 stated, ". . . LRD recommends continuing with supplements as ordered, receives 4 oz Plus 2 BID per med pass . . . weight has stabilized out within the last 30 days, remains slightly above BMI, LRD encourages weight maintenance, continue with supplements as	F 325	posted. 4. Date completed 09/12/2013. 5a. LRD will QI monitor all residents that have had a three pound weight gain or loss between the present and past weekly weights, that they have been reweighed within the last three days. 5b. LRD will QI monitor all residents with a 5% weight loss within the last 30 days and 10% weight loss within the last six months, monthly times one year.	9-12-13

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F 325	Continued From page 11	F 325		

ordered and encourage adequate meal and fluid intake, current meal intake average 67% . . . monitor." A dietary progress note on 08/05/13 acknowledged a weight of 155.5 lbs on 07/30/13, and stated "14# loss within last month, current meal intake stable at 65% . . . 4 oz Plus 2 BID per med pass, increase 4 oz Plus 2 to TID [three times a day] per med pass, monitor."

Review of Resident #6's weight records identified the following:
* 06/11/13: 173 lbs
* 06/18/13: 163.5 lbs, a loss of 9.5 lbs. The MDS for 06/18/13 reflected a weight of 164 and triggered for weight loss. A reweigh three days later recorded a weight of 171 lbs.
* 07/02/13: 169.8 lbs
* 07/09/13: 162.9 lbs, a loss of 6.9 lbs. The next recorded weight occurred one week later.
*07/23/13: 160 lbs
* 07/30/13: 155.5 lbs, a loss of 4.5 lbs. The next recorded weight occurred one week later.
* 08/06/13: 166.0 lbs., a gain of 9.5 lbs. No reweigh occurred within the next two days while survey occurring.

Review of Resident #6's current care plan identified: "Focus: Alteration in nutrition related to . . . Receives a therapeutic diet . . . Leaves 25% or more uneaten at the majority of meals served. Above BMI."Approaches included a supplement three times a day (initiated 08/05/13); and "Provide Extensive assist with meals."

Review of Resident #6's Nutritional Status Care Area Assessments (CAA), dated 12/20/12, identified the resident with inability to perform ADLs (activities of daily living) without significant physical assistance, requiring limited to extensive

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355037	A. BUILDING _____ B. WING _____	08/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ALOISIUS MEDICAL CENTER NURSING HOME	325 E BREWSTER ST HARVEY, ND 58341

(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 325	Continued From page 12	F 325		

assistance of one person for meals, and as having a pattern of leaving food uneaten. The pattern of leaving food uneaten was not identified in the previous CAA, dated 10/01/12. The 12/20/12 CAA identified a change of the resident's cognitive status interfering with his eating, including resisting cares.

The following observations of Resident #6's dining occurred on all days of survey and identified the following:
* On 08/06/13: At 11:45 a.m., Resident #6 sat in a wheelchair in the dining room. Observation showed Resident #6 confused and incoherent. At noon, upon receiving his lunch tray, a CNA prompted him to drink his juice, gave him his pudding and prompted him to eat that, and cut up the resident's meat. Resident #6 began eating on his own. CNA charting identified the resident received extensive assistance and ate 76-100% of the meal.
At 5:15 p.m., Resident #6 sat at the dining table in a wheel chair. The resident displayed confusion. While waiting for his supper tray, three drinks (one cup of coffee, one cup of hot chocolate and a glass of water) sat on the table in front of him, out of his reach. At 5:20 p.m., the resident received his meal which included a noodle hot dish, beets, and a glass of juice. The resident made no attempt to feed himself. Eight minutes later a staff member was observed provided Resident #6 assistance with the meal. By 5:52 p.m., 32 minutes after the resident received the meal, the resident had eaten 25% of the hot dish. CNA charting identified the resident ate with supervision and ate 0-25% of the meal.
* On 08/07/13: At 7:45 a.m., observation showed a CNA in Resident #6's room. The CNA prompted Resident #6 to eat his breakfast and then left the

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	355037	A. BUILDING _____ B. WING _____	08/08/2013

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F 325	Continued From page 13	F 325		

room. The meal consisted of cold cereal, juice, milk, one slice of toast, a fruit cup and a hot drink. Observation showed Resident #6 distracted and confused. Within 5 minutes, a nurse (#12) entered the room and Resident #6 removed a (dental) bridge from his mouth and the nurse offered to wash them. The resident placed them back into his mouth. The resident drank 100% of his juice independently, dipped half of his toast into his coffee and the nurse assisted with the other half of toast. The nurse then gave Resident #6 a fruit cup which he ate. Upon completion of the meal, Resident #6 consumed 100% of the meal. CNA charting identified the resident received extensive assistance with the meal and ate 76-100% of the meal.

At 5:25 p.m., Resident #6 sat in his wheelchair in the dining room. At 5:27 p.m., Resident #6 received his meal tray, a CNA placed a clothing protector on the resident and left the resident. Resident #6 proceeded to reach for a drink sitting on the table. At 5:30 p.m. a nurse stopped by and asked Resident #6 if he would like to eat, however provided no feeding assistance. At 5:42 p.m., the resident drank two thirds of a glass of juice. At 5:45 p.m. (18 minutes after Resident #6 received his meal), a nurse sat next to Resident #6. By 5:55 p.m., the resident drank the rest of the juice, a few sips of coffee, a few bites of the main course and the jello. CNA charting identified the resident ate with supervision and ate 0-25% of the meal.

* On 08/08/13 at 8:20 a.m., a nurse (#11) present in Resident #6's room stated the resident ate toast only for breakfast and a staff member assisted the resident with breakfast. CNA charting identified the resident ate independently and ate 0-25% of the meal.

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	355037	A. BUILDING _____ B. WING _____	08/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 325	Continued From page 14 Review of CNA charting for the months of June and July 2013 identified varying levels of assistance (independent, supervision, limited, and extensive) provided during meal time; and various meal percentages eaten dependent on the level of assistance received. The charting identified Resident #6 received extensive assistance six times in those two months. Failure to provide/assist and monitor the assistance or lack of assistance, including accurate charting may have contributed to Resident #6's weight loss. During interview on 08/07/13 at 11:25 a.m., a supervisory dietary staff member (#8) stated nursing staff and dietary staff monitor if residents are receiving the assistance needed with meals. The staff member said if a resident is assessed as requiring extensive assistance with meals, she would expect staff to assist the resident once the meal was served.	F 325		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review and review facility policy, the facility failed to ensure the safe administration of medications for 1 of 1 sampled resident (Resident #10) who received medication prescribed for another resident. Failure to administer medications to the correct resident has the potential for residents to experience adverse drug events which may negatively impact their health.	F 333	F Tag 333 Significant Med Error 1. Resident #10 staff involved have had a Personal Improvement Plan developed and completed in the Medication Administration module with the Nurse Education Director and assessed competency. Root cause analysis was established. The employee has had no further errors. Date August 9, 2013.	

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	355037	A. BUILDING _____ B. WING _____	08/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ALOISIUS MEDICAL CENTER NURSING HOME	325 E BREWSTER ST HARVEY, ND 58341

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F 333	Continued From page 15 Findings include: Review of the facility policy titled "Medication Administration" occurred on 08/08/13. This policy, dated 05/06/13, stated, "PROCEDURE: 1. Check Medication Administration Record [MAR] for order - read label and check against eMar [electronic MAR] - Six Rights: a. Right medication b. Right dose c. Right resident . . ." Review of Resident #10's medical record occurred on all days of survey. A communication note, dated 04/21/13 at 1:00 p.m. stated, ". . . Dr. [name] notified of resident inadvertently taking another resident's noon medications . . . ORDERS RECEIVED: Neuro [neurological] checks every 2 hours for 6 hours . . ." The "Neuro Checks" assessment identified facility nurses conducted neuro checks on 04/21/13 at 1:00 p.m., 3:15 p.m., and 5:30 p.m. The neuro checks conducted at 1:00 p.m. identified Resident #10's pupils as "sluggish," and "Resident drowsy." The neuro checks conducted at 3:15 p.m. identified "states that he [Resident #10] is not feeling well, H/A [headache], stomach upset, tired." The facility provided a form titled "Medication Event Report," used to report medication errors, dated 04/21/13. The form stated Resident #10 received his roommate's noon medications. The medications included Celexa (antidepressant) 20 milligrams (mg), lorazepam (antianxiety) 0.5 mg, Seroquel (antipsychotic) 50 mg, and a multivitamin. The causes of the error stated "Monitoring inadequate/lacking" and "System safeguards inadequate." The factors that contributed to the error stated "Distractions." The form identified on 04/22/13 an administrative	F 333	2. All residents receiving medication have the potential to be affected. 3. A Nurse Education Director position has been developed. The Medication Event policy has been changed to include; all nurses or CMAs noted to have made medication error will have a Personal Improvement Plan developed. The Medication Event policy was updated to include establishing a root cause analysis to the event. The Medication Administration policy has been revised to eliminate #6 last sentence; "the medication that is refused or held for a period of time may be stored in the medication cart with the resident's name or initials placed on the medication cup that the medication is stored in. Staff educated at meetings on September 4th and 5th, on updated policy and minutes posted. 4. Completed by September 12, 2013. 5. QI monitor placed for all medication events that policy	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355037	A. BUILDING _____ B. WING _____	08/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 333	Continued From page 16 nurse (#3) reviewed the medication error and the medication administration policy with the staff member involved. The facility failed to thoroughly investigate the contributing factors which resulted in the medication error, such as where it occurred (i.e. Resident #10's room or the dining room); if the staff member left the medications for the resident to self-administer; or if the staff member had method to identify the resident prior to administering the medication.	F 333	was followed monthly times one year. DON is responsible.	9-12-13
F 363 SS=E	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. This REQUIREMENT is not met as evidenced by: Based on observation, review of residents' tray cards, review of daily menus, and staff interview, the facility failed to meet the nutritional needs of the residents by serving incorrect portion sizes during 3 of 3 observations of tray line (noon meal on 08/06/13, evening meal on 08/06/13, and evening meal on 08/07/13). Failure to follow recommended portion sizes as outlined in the facility's menus may result in weight loss and inadequate nutritional intake. Findings include:	F 363	F Tag 363 Menus meet resident's needs/prep in advance/followed. 1. Correct portion sizes will be served to all residents. 2. All residents eating in the facility have the potential to be affected. 3. LRD will inform all Dietary serving staff of correct portion sizes according to the menu. The Diet Clerk on duty will supervise and assure that the correct serving utensils will be used to serve the meal according to the menu portion sizes. 4. September 12, 2013. 5a The Diet Clerk on duty will supervise and assure that the correct serving utensils will be used to serve the meal according to the menu portion sizes.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355037	A. BUILDING _____ B. WING _____	08/08/2013

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F 363	Continued From page 17 - Observation of tray line occurred on 08/06/13 during the noon meal. Observation showed the following inconsistencies between portion sizes listed on the facility's menus and the actual amount served to residents: *Ground meat served with a unmarked tablespoon (the menu identified 3 ounces [oz]) *Dumplings served with a large unmarked serving spoon (the menu identified 1 cup of chicken and dumplings) During an interview on 08/06/13 at 12:25 p.m., a dietary staff member (#10) stated she used a tablespoon to serve approximately one half cup of ground meat and the scoop she should have used was in the mashed potatoes (a 4 oz scoop). The staff member stated the large serving spoon held approximately one half to three fourths cup of dumplings. The menu identified one cup of chicken and dumplings to be served. - Observation of tray line occurred on 08/06/13 during the evening meal (approximately 5:15 p.m.). Observation showed the following inconsistencies between portion sizes listed on the facility's menus and the actual amount served to residents: *Mashed potatoes served with a 2 oz scoop (the menu identified 4 oz) *Sliced carrots served with a 2 oz scoop (the menu identified 4 oz) *Diced beets served with a 3 oz scoop (the menu identified 4 oz) *Ham fettucini served with a 4 oz scoop (the menu identified 8 oz) - Observation of tray line occurred on 08/07/13 during the evening meal (approximately 5:15 p.m.). The menu identified 4 oz of green beans. A	F 363	b. A QI monitor on the use of correct serving utensils according to the menu portion sizes will be evaluated monthly times one year by the LRD and the results will be reported quarterly to the QI Committee at the regularly scheduled meeting.	9-12-13

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	355037	A. BUILDING _____ B. WING _____	08/08/2013

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F 363	Continued From page 18 dietary aide (#9) served the green beans with a silver serving spoon (no portion size identified). Observation showed eight residents received green beans. During an interview on the morning of 08/08/13, a supervisory dietary staff member (#8) stated the staff member should not have used an unmarked serving spoons.	F 363		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their	F 441	F Tag 441 Insulin in garbage can: 1. Reviewed with nurse the policy of proper disposal of sharps on August 9, 2013. 2. All resident's receiving injections have potential of having the sharp disposed of improperly. 3. All staff educated on proper sharps disposal at staff meetings on September 4th and 5th, policy and minutes posted. 4. Completed September 12, 2013. 5. QI monitor placed for observation of random injections weekly times one month then monthly times one year. DON is responsible.	9-12-13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 441	Continued From page 19	F 441		

hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:
Based on observation, facility policy review, and staff interview, the facility failed to follow infection control standards regarding hazardous medical waste disposal during 1 of 1 observation of insulin administration on 08/07/13. Failure to dispose of used needles properly may result in needlestick injuries and exposure to bloodborne pathogens.

Findings include:

Review of the facility policy titled "Injections" occurred on 08/08/13. This policy, dated 01/14/05, stated, ". . . After the medication is given, you must activate the safety device and dispose of the contaminated sharp into the contaminated needle box. The contaminated needle box will be on the med [medication] cart or on the injection tray. . . ."

Observation on 08/07/13 at 9:22 a.m. showed a licensed nurse (#4) administered an insulin injection via insulin pen to Resident #8. The nurse then removed the needle (equipped with a spring-loaded safety device) from the pen, wrapped it in her glove, and threw the needle in the garbage.

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	355037	A. BUILDING _____ B. WING _____	08/08/2013

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F 441	Continued From page 20 On 08/07/13 at 4:15 p.m., a licensed nurse (#5) identified a sharps container located in the bottom drawer of the medication cart. She stated staff were expected to dispose of insulin needles in the sharps container.	F 441	F Tag 494 Nurse Aide Qualification Travel 1. Individual A no longer works in facility. Facility shall validate all travel staff certification along with employees. 2. All ~~C.N.A.s~~ residents have potential to be affected. Per Phone call 9/10/13 to DON K.Beechie 3. All travel C.N.A.s will be validated for current certification before working in our facility. We use one agency. The agency is submitting by fax all required certification to the facility before the staff is scheduled to work. The Administrative Secretary will double check the registry before C.N.A. will work. 4. September 12, 2013. 5. QI monitor placed for all travel staff maintaining required	
F 494 SS=D	483.75(e)(2)-(3) NURSE AIDE WORK > 4 MO - TRAINING/COMPETENCY A facility must not use any individual working in the facility as a nurse aide for more than 4 months, on a full-time basis, unless that individual is competent to provide nursing and nursing related services; and that individual has completed a training and competency evaluation program, or a competency evaluation program approved by the State as meeting the requirements of §§483.151-483.154 of this part; or that individual has been deemed or determined competent as provided in §483.150(a) and (b). A facility must not use on a temporary, per diem, leased, or any basis other than a permanent employee any individual who does not meet the requirements in paragraphs (e)(2)(i) and (ii) of this section. Nurse aides do not include those individuals who furnish services to residents only as paid feeding assistants as defined in §488.301 of this chapter. This REQUIREMENT is not met as evidenced by: Based on information from the nurse aide	F 494		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355037	A. BUILDING _____ B. WING _____	08/08/2013

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ST ALOISIUS MEDICAL CENTER NURSING HOME	325 E BREWSTER ST HARVEY, ND 58341

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F 494	Continued From page 21 registry, personnel files, and staff interview, the facility failed to ensure 1 of 1 direct care staff (Individual A) who provided resident care maintained a current certification. Failure to ensure certification of caregivers placed residents at risk of receiving care from unqualified staff. Findings include: Information from the North Dakota nurse aide registery identified Individual A's certification expired on 10/09/12. On the morning of 08/07/13, an administrative staff member (#7) provided the hours worked without certification by Individual A. Review of the hours identified Individual A worked six shifts from October 2012 to January 2013 for a total of 55 hours with an expired certification. During an interview on the morning of 08/07/13, an administrative nurse (#3) confirmed Individual A worked at the facility without a valid certification.	F 494	qualifications monthly for one year. Administrative Secretary is responsible. This Plan of Correction constitutes St. Aloisius Medical Center's written allegation of compliance for the deficiencies cited. However submission of the Plan of Correction is <u>not</u> an admission that a deficiency exists or that one was cited correctly. This plan of Correction is submitted to meet requirements established by state and federal law.	9-12-13