

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

PRINTED: 08/22/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355037		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/28/2016	
NAME OF PROVIDER OR SUPPLIER ST ALOISIUS MEDICAL CENTER NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 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 000	INITIAL COMMENTS			F 000			
F 278 SS=E	For the MDS 3.0/Staffing Focused Survey started on 07/27/16 and completed on 07/28/16, the sample included 10 residents for focused review. 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 material and false statement. This REQUIREMENT is not met as evidenced			F 278			8/15/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

08/12/2016

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.

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

PRINTED: 08/22/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355037		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/28/2016	
NAME OF PROVIDER OR SUPPLIER ST ALOISIUS MEDICAL CENTER NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 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 278	Continued From page 1 by: Based on record review and review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual (Version 3.0), the facility failed to ensure accurate coding of Minimum Data Sets (MDSs) for 4 of 10 sampled residents (Resident #1, #3, #5, and #7). Failure to accurately complete portions of the MDS, Section J (Health Conditions) (Resident #3 and #5) and Section N (Medications) (Resident #1 and #7) does not allow each resident's assessment to reflect the their current status/needs and may result in the inaccuracy of the facility's Resident Level Quality Measure Reports. Findings include: The Long-Term Care Facility RAI Manual, revised October 2015, pages J-1 - J-2 stated, ". . . J0100: Pain Management (5-Day Look Back) . . . Pain Medication Regimen, Pharmacological agent(s) prescribed to relieve or prevent the recurrence of pain. Include all medications used for pain management by any route and any frequency during the look-back period. Include oral, transcutaneous, subcutaneous, intramuscular, rectal, intravenous injections or intraspinal delivery. This item does not include medications that primarily target treatment of the underlying condition, such as chemotherapy or steroids, although such treatments may lead to pain reduction . . . 1. Review medical record to determine if a pain regimen exists. 2. Review the medical record and interview staff and direct caregivers to determine what, if any, pain management interventions the resident received during the 5-day look-back period. Include			F 278	1. Residents #3 and #5 with errors relating to MDS coding on section J0100 were corrected on 8/5/2016 and residents #1 and #7 with errors on section N0410 A-G were corrected on 8/5/2016 and submitted. 2. All residents have the potential to be effected. 3. The MDS nurses who complete sections J and N had education on proper coding by ADON at a meeting on August 11, 2016. 4. QI monitor for accuracy of MDS will be completed by MDS nurses weekly times four weeks, then if in compliance, monthly times three months, then quarterly times three quarters. Findings will be reported to QAPI committee for further recommendations. 5. Completion date of 8/15/2016		

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

PRINTED: 08/22/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355037	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/28/2016
NAME OF PROVIDER OR SUPPLIER ST ALOISIUS MEDICAL CENTER NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 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 278	Continued From page 2 information from all disciplines . . . J0100A, Been on a Scheduled Pain Medication Regimen . . . J0100B, Received PRN [as needed] Pain Medication . . ." - Review of Resident #3's medical record occurred on 07/27/16 and diagnoses included a neuromuscular disease. The annual MDS, dated 07/04/16, identified the resident received PRN pain medication during the 5-day look-back period. The Medication Administration Records (MARS) identified the resident last received a PRN medication on 06/27/16 (greater than 5 days from the assessment reference date). - Review of Resident #5's medical record occurred on 07/28/16 and diagnoses included rheumatoid arthritis. The physician orders and MARs identified the resident received gabapentin twice daily for rheumatoid arthritis since 08/26/15. A quarterly MDS, dated 05/26/16, failed to identify Resident #5 received scheduled pain medications during the 5-day look-back period. The Long-Term Care Facility RAI Manual, revised October 2015, page N-5 stated, ". . . N0410: Medications Received . . . 1. Review the resident's medical record for documentation that any of these medications were received by the resident during the 7-day look-back period (or since admission/entry or reentry if less than 7 days). 2. Review documentation from other health care settings where the resident may have received any of these medications while a resident of the nursing home . . . N0410C, Antidepressant . . . N0410E, Anticoagulant . . ." - Review of Resident #1's medical record	F 278			

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

PRINTED: 08/22/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355037		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/28/2016	
NAME OF PROVIDER OR SUPPLIER ST ALOISIUS MEDICAL CENTER NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 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 278	Continued From page 3 occurred on 07/27/16 and diagnoses included depression. The physician orders and MARs identified the resident received Zoloft (an antidepressant medication) daily since 03/25/16. A quarterly MDS, dated 04/27/16, failed to identify Resident #1 received an antidepressant medication each day of the 7-day look-back period. - Review of Resident #7's medical record occurred on 07/28/16 and diagnoses included coronary artery disease. The physician orders and MARs identified the resident received Eliquis (an anticoagulant medication) twice daily since 06/16/16. A discharge return anticipated MDS, dated 07/09/16, failed to identify Resident #7 received an anticoagulation medication each day of the 7-day look-back period.			F 278			