STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355078	A. BUILDING _____ B. WING _____	08/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVENTIDE JAMESTOWN	1300 2ND PL NE JAMESTOWN, ND 58401

(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 MDS 3.0/Staffing Focused Survey started on 08/25/15 and completed on 08/26/15, the sample included 10 residents for focused review.	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 material and false statement. This REQUIREMENT is not met as evidenced	F 278	F278 Assessment Accuracy/Coordination/Certified 1. Resident #2, #4, and #8 MDS Assessments were modified to reflect the correct medication and diagnoses information. 2. All residents have the potential to be affected. 3. All staff who complete the MDS Assessments have been educated on proper coding of the MDS Assessment Tool from nursing documentation. 4. The Director of Nursing or designee will be responsible to monitor the MDS Assessment Process to accurately reflect the condition of the resident. QA Monitoring was implemented on 9/28/15. The DON or designee will monitor weekly for a month, monthly for three months and random audits as needed per QA committee recommendations. Results will be immediately reported to the Executive Director. If concerns are identified, immediate corrective action will be implemented. The DON or designee will submit a report of the monitoring results to the QA Committee at each scheduled meeting. 5. Date of Correction: 9th October 2015	

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Executive Director — 9/24/15

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 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 3 of 10 sampled residents (Resident #2, #4, and #8). Failure to accurately complete portions of the MDS, Section N (Medications) (Resident #2, #4, and #8), Section I (Active Diagnosis) (Resident #2), does not allow each resident's assessment to reflect 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 2014, page N-5 stated, ". . . N0410: Medication 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 . . . N0410A, Antipsychotic . . . N0410E, Anticoagulant . . . N0410G, Diuretic . . ." - Review of Resident #2's medical record occurred on 08/26/15 and diagnoses included Huntington's Chorea and dementia with behaviors. The physician orders and Medication Administration Records (MARs) identified the resident received quetiapine fumarate (Seroquel) (an antipsychotic medication) twice daily since 05/03/15. A quarterly MDS, dated 08/03/15, failed to identify Resident #2 received an antipsychotic	F 278		

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F 278	Continued From page 2 medication each day of the 7-day look-back period. - Review of Resident #4's medical record occurred on 08/26/15 and diagnoses included dementia, depression, and anxiety. The physician orders and MARs identified the resident received Geodon (an antipsychotic medication) twice daily since 04/01/14. A quarterly MDS, dated 07/01/15, failed to identify Resident #4 received an antipsychotic medication each day of the 7-day look-back period. - Review of Resident #8's medical record occurred on 08/26/15. The physician orders and MARs identified the resident received Pradaxa (an anticoagulant medication) twice daily since 06/24/15 and Valsartan-Hydrochlorothiazide (a diuretic medication) once daily since 06/24/15. A Medicare 14 day MDS, dated 07/08/15, failed to identify Resident #8 received an anticoagulant medication and a diuretic medication each day of the 7-day look-back period. The Long-Term Care Facility RAI Manual, revised October 2014, page I-3 stated, "I: Active Diagnoses in the Last 7 days . . . This section identifies active diseases and infections that drive the current plan of care . . . 1. Identify diagnoses: The disease conditions in this section require a physician-documented diagnosis (or by a nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state license laws) in the last 60 days . . . 2. Determine whether diagnoses are active: Once a diagnosis is identified, it must be determined if the diagnosis is active. Active diagnoses are diagnoses that have a direct relationship to the resident's current functional, cognitive, or mood or behavior status,	F 278		

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F 278	Continued From page 3 medical treatments, nursing monitoring, or risk of death during the 7-day look-back period. Do not include conditions that have been resolved, do not affect the resident's current status, or do not drive the resident's plan of care during the 7-day look-back period, as these would be considered inactive diagnoses . . ." - Review of Resident #2's medical record occurred on 08/26/15 and identified staff discovered a Stage I pressure ulcer to Resident #2's left ankle on 06/16/15. A nursing progress note, dated 06/20/15, stated, "No redness or breakdown noted on left outer ankle." A quarterly MDS, dated 08/03/15, incorrectly identified a Stage I pressure ulcer to the ankle as an "active diagnosis" during the 7-day look-back period.	F 278		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format.	F 356		

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F 356	Continued From page 4 o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to post accurate nursing staffing data on 2 of 2 days of survey (August 25-26, 2015). Failure to post accurate nurse staffing data denied residents and visitors the opportunity to be informed regarding the staffing levels. Findings include: During the initial staffing tour on 08/25/15 at 9:23 a.m., observation showed two registered nurses (RNs) and two licensed practical nurses (LPNs) working on the floor. Review of the daily nurse staffing information posted showed one RN and three LPNs working the day shift. During an interview on 08/25/15 at 11:00 a.m., an administrative nurse (#1) stated there were staffing changes and the daily nurse staffing information should be updated. During the afternoon staffing tour on 08/25/15 at 3:15 p.m., observation showed one RN working	F 356	F356 Posted Nurse Staffing Information 1. Not Applicable 2. All Residents have the potential to be affected. 3. Staffing Secretary and Nursing Staff have been educated on the posting of accurate nurse staff data. 4. The Director of Nursing or designee will monitor the posting of Nurse Staff Information. The audit process was implemented on 9/28/15. The DON or designee will monitor weekly for a month, monthly for three months and random audits as needed per QA committee recommendations. Results will be immediately reported to the Executive Director. If concerns are identified, immediate corrective action will be implemented. The DON or designee will submit a report of the monitoring results to the QA Committee at each scheduled meeting. 5. Date of Correction: 9th October 2015	

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F 356	Continued From page 5 until 7:00 p.m., three LPNs working until 10:30 p.m., and two LPNs working until 7:00 p.m. Review of the daily nurse staffing information posted showed one RN working until 7:00 p.m., three LPNs working until 10:30 p.m., and three LPNs working until 7:00 p.m. The daily nurse staffing information posted showed one extra LPN working until 7:00 p.m. During the morning staffing tour on 08/26/15 at 8:25 a.m., observation showed four LPNs working the day shift. One LPN (#7) stated she was called into work and would work until 11:00 a.m. The daily nurse staffing information posted showed three LPNs working until 3:00 p.m. and one LPN working until 2:30 p.m. During an interview on 08/26/15 at 9:47 a.m., the staffing coordinator (#3) confirmed the nurse staffing data sheets were not completed accurately.	F 356		
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	F 441		

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F 441	Continued From page 6 actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to follow standard infection control practices for 1 of 4 sampled residents (Resident #7) observed during perineal care and for 1 of 1 sampled resident (Resident #3) observed during ostomy care. Failure to follow infection control practices related to hand hygiene has the potential to cause or spread infection within the facility. Findings include: Review of the facility policy titled "Hand Hygiene" occurred on 08/26/15. This policy, revised	F 441	F 441 Infection Control, Prevent Spread, Linens 1. Resident 7 & 3 were reassessed for proper peri and ostomy care. 2. All residents who require dressing changes and peri-cares have the potential to be affected. 3. All nursing staff have been re-educated on the proper infection control process related to hand hygiene with dressing changes and peri-cares. 4. The Director of Nursing or designee will be responsible to monitor hand hygiene with dressing changes and peri-cares. QA auditing was implemented on 9/28/15. The DON or designee will monitor weekly for one month, monthly for three months, and random audits as needed. Information will be immediately reported to the Executive Director. If concerns are brought forward, immediate corrective action will be implemented. The DON or designee will submit a report of the monitoring results to the QA Committee at each scheduled meeting. 5. Date of Correction: 9th October 2015	

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November 2013, stated, ". . . Hand hygiene will be done:
A. Before and after resident contact (before you leave the room)
B. Before every clean procedure
C. After every dirty procedure
D. As needed . . .
Hand Hygiene is a general term that applies to either hand washing or antiseptic hand rub. The purpose is to prevent the spread of infection . . ."

Review of the facility policy titled "Ostomy Management" occurred on 08/26/15. This policy, revised May 2013, stated, ". . . Policy: Ostomies will be managed by a nurse according to approved procedure . . . Procedure: Refer to Perry & Potter Clinical Nursing Skills & Techniques . . ." The referenced Perry & Potter Clinical Nursing Skills & Techniques stated ". . . Implementation . . . 3. Perform hand hygiene and apply clean gloves . . . 5. . . . remove used pouch and skin barrier gently by pushing skin away from barrier. Use an adhesive remover to facilitate removal of skin barrier . . . 6. Clean peristomal skin gently with warm tap water using washcloth . . . 7. Measure stoma . . . 8. Trace pattern of stoma measurement on pouch backing or skin barrier . . . 9. Cut opening on backing or skin barrier wafer . . . 10. Remove protective backing from adhesive . . . 11. Apply pouch over stoma . . . Press firmly into place around stoma and outside edges . . . 12. Close end of pouch with clip . . . 13. Remove gloves. Perform hand hygiene . . ."

- Review of Resident #7's medical record occurred on 08/26/15 and identified a diagnosis of "blood in stools."

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F 441	Continued From page 8 Observation on 08/25/15 at 3:30 p.m. identified two certified nursing assistants (CNAs) (#5 and #6) transferred Resident #7 from her recliner to her bed using a full-body mechanical lift. The CNAs donned gloves and washed and dried the resident's skin folds with soap and water. A CNA (#6) proceeded to complete perineal cares. Observation showed the resident incontinent of a large amount of thick, soft, black stool. After performing perineal cares, the CNA (#6) removed her gloves and placed a new brief and draw sheet (stool present on the one in use prior). Without performing hand hygiene, the CNAs (#5 and #6) positioned the resident's clothing, placed the mechanical lift sling, and transferred the resident back to her recliner. Once the resident was in her recliner, both CNAs (#5 and #6) covered the resident with a blanket, elevated her feet, and placed her belongings and call light within reach. The CNAs failed to perform hand hygiene after completing perineal cares, prior to completing other tasks, and prior to exiting the resident's room. During this same observation, a nurse (#4) donned gloves, assessed Resident #7's buttocks and applied Calmoseptine cream. The nurse removed her gloves and without performing hand hygiene, emptied and cleaned the wash basin and wiped off the mechanical lift. The nurse (#4) gathered the soiled linen used during cares and exited the resident's room. The nurse (#4) failed to perform hand hygiene after applying cream to the resident's buttocks, prior to performing other tasks, and prior to exiting the resident's room. - Observation on 08/25/15 at 3:50 p.m. identified a nurse (#4) entered Resident #3's room, donned gloves, palpated the resident's colostomy and fistula drainage bags, observed fluid leaking around the sites, removed her gloves and exited	F 441		

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the resident's room without performing hand hygiene. At 4:00 p.m. the nurse (#4) reentered the resident's room, and without performing hand hygiene, donned gloves, removed the colostomy bag and used a moistened cloth to wipe the stool from the stoma and surrounding skin. The nurse changed her gloves, removed the drainage bag from the resident's fistula site and used a moistened cloth to wipe away mucous from the fistula and surrounding skin. The nurse used a gloved hand and applied pressure to manipulate the fistula back into the resident's abdominal cavity. The nurse changed gloves and cut the skin barrier wafer to fit around the fistula site and adhered it to the skin with an adhesive paste. The nurse changed her gloves, cut the skin barrier wafer to fit around the colostomy stoma and then adhered it to the skin with an adhesive paste. The nurse then applied the drainage bags to each site. The nurse removed her gloves, put away the supplies, administered Resident #3 his scheduled nebulizer treatment, and then washed her hands prior to exiting the resident's room. The nurse failed to perform hand hygiene upon entering the resident's room, when transitioning from the colostomy to the fistula site, when changing her gloves, and prior to administering the resident's nebulizer treatment.

- Observation on 08/25/15 at 4:20 p.m. showed two CNAs (#5 and #6) entered Resident #3's room and donned gloves. A CNA (#6) repositioned the resident's pillows, wiped off his bedside table, tidied his room, and applied lotion to his skin below his colostomy and fistula sites. Upon removing her gloves, the CNA (#6) exited the room without washing her hands. During this observation, another CNA (#5) emptied the resident's urostomy drainage bag, wiped off the

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F 441	Continued From page 10 spout of the bag with an alcohol pad, and emptied the urine into the toilet. After rinsing and drying the measuring cylinder, the CNA (#5) bagged the resident's garbage and exited the room without washing her hands. During an interview on 08/26/15 at 12:20 p.m., an administrative nurse (#1) stated she expected staff to perform hand hygiene in the resident's room immediately after completing perineal cares, after applying cream to a resident's buttocks, after emptying urostomy drainage bags, after removing or changing gloves, and when transitioning between different ostomy sites.	F 441		