STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355101	A. BUILDING _____ B. WING _____	03/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DAKOTA ALPHA	1303 27TH STREET NW MANDAN, ND 58554

(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 03/27/17 and completed on 03/29/17, the sample included two (2) residents for complete review, five (5) residents for focused review, and one (1) closed record for review. The sample included one (1) additional resident to verify specific concerns during the survey.	F 000		
F 156 SS=D	483.10(d)(3)(g)(1)(4)(5)(13)(16)-(18) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES (d)(3) The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care. §483.10(g) Information and Communication. (1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility. (g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including: (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes - (A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section; (B) A description of the requirements and procedures for establishing eligibility for	F 156		4/24/17

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

Electronically Signed | 04/18/2017

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F 156	Continued From page 1 Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act. (C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and (D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.)	F 156		

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F 156	Continued From page 2 [§483.10(g)(4)(ii) will be implemented beginning November 28, 2017 (Phase 2)] (iii) Information regarding Medicare and Medicaid eligibility and coverage; [§483.10(g)(4)(iii) will be implemented beginning November 28, 2017 (Phase 2)] (iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program; [§483.10(g)(4)(iv) will be implemented beginning November 28, 2017 (Phase 2)] (v) Contact information for the Medicaid Fraud Control Unit; and [§483.10(g)(4)(v) will be implemented beginning November 28, 2017 (Phase 2)] (vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives: (i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office,	F 156		

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F 156	Continued From page 3 adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and (ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community. (g)(13) The facility must display in the facility written information, and provide to residents and applicants for admission, oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. (g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay. (i) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. (ii) The facility must also provide the resident with	F 156		

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F 156	Continued From page 4 the State-developed notice of Medicaid rights and obligations, if any. (iii) Receipt of such information, and any amendments to it, must be acknowledged in writing; (g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in paragraphs (g)(17)(i)(A) and (B) of this section. (g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the	F 156		

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F 156	Continued From page 5 Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on review of the facility's Medicare billing notices, Medicare billing records, and staff interview, the facility failed to confirm whether a resident or their responsible party requested a demand bill for 1 of 1 resident (Resident #10) issued a notice of non-coverage of Medicare services. Failure to confirm a resident or their responsible party requested a demand bill is a	F 156	Resident #10 was called via telephone and notified that the fax would be re-sent for him to check option #1 or 2 to have his father's charges submitted to Medicare (demand bill). He checked the box he wished, faxed his back and it was received at Dakota Alpha on 04/3/2017.	

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F 156	Continued From page 6 violation of resident rights. Findings include: Review of the facility's Medicare billing records occurred on 03/29/17 and showed the facility mailed Resident #10's responsible party the notice of non-coverage of Medicare services and the request for a demand bill for services ending on 03/13/17. The resident's responsible party signed the notice and returned it to the facility but failed to identify, by checking a box, whether they requested a demand bill. During an interview on the morning of 03/29/17, an administrative staff member (#1) stated the facility should have confirmed whether the responsible party wanted Resident #10's bill for services submitted for review.	F 156	The facility determined that this practice has the potential to affect all future recipients. Going forward, when a "Demand Bill" notification form is given or sent to a Medicare recipient, or to their legal representative to end Medicare services, and after all questions are answered and signatures are obtained, the staff will assure that one of the options boxes is checked before the form is filed in the resident's chart. The MDS coordinator will audit each Medicare chart for one year to ensure that residents and/or their guardians have checked one of the two option boxes pertaining to the demand bill as required. This will be reported to QA/QAPI and will be monitored until such time consistent substantial compliance has been met.	
F 157 SS=D	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical,	F 157		5/3/17

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F 157	Continued From page 7 mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on record review, facility policy review, and staff interview, the facility failed to ensure	F 157	1. a review of the "Notification of Changes" and "Harm to Self or Others"	

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F 157	Continued From page 8 timely notification of a health care provider for 2 of 7 sampled residents (Resident #1 and #2) and 1 closed resident record (Resident #8) who experienced a change in medical/mental health status. Failure to promptly notify the resident's health care provider of thoughts of suicide (Resident #1), worsening of a surgical wound (Resident #2) and repeated refusal of a scheduled medication (Resident #8) may have resulted in further decline. Findings include: Review of the facility policy titled "Physician Notification" occurred on 03/29/17. This policy, dated 03/24/17, stated, ". . . Circumstances requiring notification include: . . . 2. Significant change in the resident's physical, mental or psychosocial condition such as deterioration in health, metal or psychosocial status. . . . 3. Circumstances that require a need to alter treatment. . . ." - Review of Resident #2's medical record occurred on all days of survey. Current diagnoses included right above the knee amputation (AKA), peripheral vascular disease, vascular dementia, dysphasia, and hemiparesis (weakness) of the right side. Review of Resident #2's progress notes identified the following: * 12/28/16 at 3:01 p.m.: ". . . discharge from medical center post right below the knee amputation (BKA). . ." * 12/30/16-01/25/17 progress notes identified deterioration in Resident #2's surgical wound of the right BKA, concerns with the resident	F 157	policy was discussed with nursing staff immediately following survey and will again be reviewed on 4/27/17 during the All Staff Meeting. All residents have the potential to be affected by the same practice. Nurses were educated on circumstances that require notification of residents' physicians whenever there is a significant change in mental/medical health status; such as the changes that occurred with residents #1, #2, and #8. Along with this, if at any time there is an indication of risk of harm to self or others, the LSW, DON or on-call staff (after hours, weekends, holidays) must be notified immediately and then from their a mental health professional. If the letter in I in Section D of the MDS is marked 'yes' during the resident interview the LSW will make nursing staff aware and together will contact the mental health professional for further instructions. All nurses, including those who are unable to attend, will sign off on the In-Service minutes. A memo to 'travel nurses' to review the "Notification of Changes" policy will be attached to the nurses report binder so travel nurses who do not attend our In-Service are reminded to check the protocol. The psychiatrist was notified that Resident #1 expressed thoughts of self-harm during his 3/23/17 MDS interview and she instructed to continue with the plan of care. During Resident's #1 MDS on 4/8/17, he answered no to question I in section D. We will continue	

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F 157	Continued From page 9 dangling the stump over the side of the bed, and increased pain at the surgical site. The record lacked evidence the facility notified Resident #2's medical provider regarding the significant changes to his right BKA surgical wound site. * 02/03/17 at 1:45 p.m., stated, ". . . returned from the hospital following a revision of his BKA [below knee amputation] to an AKA. . . ." - Review of Resident #8's medical record occurred on 03/29/17. Diagnoses included right cerebral infarct, unspecified mental disorder, major depression, and anxiety. Medications included Seroquel (an antipsychotic) 25 mg (milligrams) 1/2 tablet (12.5 mg) by mouth at bedtime, started on 10/14/16. Review of Resident #8's medication record identified the resident refused his Seroquel as follows: * October 2016: refused 5 of 20 days. * November 2016: refused 26 of 30 days. * December 2016: refused 10 of 13 days and 3 days lacked documentation. Review of Resident #8's progress notes identified the ordering provider was not notified of Resident #8's refusal of his Seroquel until his psychiatric visit on 12/14/16, at which time the provider changed the Seroquel to as needed and started Ativan (an antianxiety) 0.25 mg at bedtime daily. Review of the facility policy titled "Harm to Self or Others" occurred on 03/29/17. This policy, dated 03/29/16, stated, ". . . Any indication of risk of	F 157	to monitor and contact the physician if needed. Resident #2 has a healed surgical wound and is medically stable. It is not appropriate to contact the physician at this time, however, the staff will continue to monitor for any medical changes and notify the physician if necessary. Resident#8 was discharged from the facility on 2/9/17 and corrective action can no longer be addressed. The DON will conduct a random audit of 3 residents weekly for 4 consecutive weeks starting the week of April 3, 2017. If random checks result in no errors, the DON will reduce the number of checks to 1 resident per month for the following 6 months (through September 2017), These residents will be newly assessed to ensure any significant changes in medical health status have been identified, evaluated and communicated with the physician. At the end of September, if no errors have been found the checks will be discontinued. If errors are found, the number of checks will be increased and re-education will be done with the nurses repeating errors. the DON will report the error rate at the QA meeting until compliance has been met. The LSW will monitor Section D on a continuous basis for any significant changes in mental health status for all residents. If question I in Section D is marked 'yes', the LSW and nursing staff will contact the mental health professional for further instructions and document the	

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F 157	Continued From page 10 harm to self or others must be immediately reported to the LSW [licensed social worker], or the DON [director of nursing]. . . . If staff determine that a resident could harm himself or others, staff should: 1. Contact the LSW. The LSW will contact the mental health professional. . . ." - Review of Resident #1's medical record occurred on all days of survey. Diagnoses included Intracranial injury, right hemiplegia, major depression, and intermittent explosive disorder. The quarterly Minimum Data Set (MDS) dated 09/25/16 identified Resident #1 had 2-6 days of thinking better off dead/wishes for death. Medications included Nortriptyline (antidepressant) 75 mg daily at bedtime for depression started 12/14/16. Review of Resident #1's progress notes identified the following: * 11/07/16 at 4:26 p.m.: LSW note, ". . . expressing thoughts about suicide today. . . . stated he has thoughts "off and on", but would "probably never do anything." . . . [Resident] showed that he's wearing a large watch on his wrist, and this would make it difficult for him to bite wrist, which is how he said he'd hurt himself if actually planned to. . . . [Resident] agreed that if he actually planned to harm himself, he would speak to a [facility name] staff first. This has been a reoccurring pattern for [resident]. He verbally contracted for safety . . ." The record lacked evidence that staff notified the mental health professional. * 11/10/16 at 11:30 a.m.: "He [resident] did indicate that he tried biting his wrist this morning to try and hurt himself but wasn't able to follow	F 157	outcome. Also, if at anytime there is an indication of risk or harm to self or others, the LSW and nursing staff will contact the mental health professional for further instructions and document the outcome There is no end date for monitoring as this will be completed on an on going basis. The LSW will report the error rate at the QA meeting through September 2017	

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F 157	Continued From page 11 through. . . ." The staff failed to notify the LSW or mental health provider. * 12/11/16 at 6:34 a.m.: ". . . At about 4:00 [a.m.], he [resident] put his call light on to report that he was having "bad thoughts' but did not elaborate. About 2 minutes later he reported that he was trying to chew through his wrists. Small red area to the inner side of his L [left] wrist is noted. Skin is not broken open. He talks freely about feelings of depression and not having a reason to live. . . ." The staff failed to notify the LSW or mental health provider. During an interview on 03/29/17 at 3:33 p.m., an administrative staff member (#3) confirmed that the provider or LSW should be notified when residents express thoughts or make attempts of hurting themselves.	F 157		
F 281 SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide services to meet professional standards of practice for 1 of 7 sampled residents (Resident #5) and 1 of 1 supplemental resident (Resident #9). Failure to document a medication administered to Resident #5 on the MAR or administration of an inaccurate medication	F 281	A review of the policy for the Medication Administration including documentation and reconciliation of medication cards with the MAR was discussed immediately following survey and will be again reviewed on 4/27/17 during the mandatory nurses meeting. All residents have the potential of being affected by the	5/3/17

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F 281	Continued From page 12 dosage for Resident #9 may result in adverse side effects. Findings include: Review of the facility policy titled "MEDICATION ADMINISTRATION" occurred on 03/29/17. This policy, dated 03/24/17, stated, ". . . Follow the steps outlined below before each medication pass . . . Check the MAR [medication administration record] and Rx [prescription] bottle/card to ensure that the dosage, time and route are correct. If there is a discrepancy, check the physician's orders . . . to find the correct order. Correct all errors. . . . Initial the MAR when you see that the resident has taken his/her medications . . ." - Review of Resident #5's medical record occurred on all days of survey. Diagnoses included a traumatic brain injury and a mood disorder. Medications included Ativan (for anxiety) 0.5 milligrams (mg) every six hours as needed (PRN). Review of Resident #5's progress notes identified the following: * 01/28/17 - ". . . given PRN Ativan for anxiety . . ." * 02/09/17 - "Offered Ativan to help sleep . . ." The resident accepted and stated, "It might help." Review of Resident #5's January and February MARs showed facility staff failed to document the administration of Ativan on 01/28/17 and 02/09/17. During an interview on 03/28/17 at 4:45 p.m., an	F 281	same practice. Nurses were educated on completing documentation on the "PRN Antipsychotic Sheet" that was newly implemented as a result of this survey. Re-education also included the deficiencies that involved resident #5 and #9. All nurses including those who are unable to attend will sign off on the In-Service minutes. A memo to 'travel nurses' to review the Medication Administration policy will be attached to the nurses report binder so travel nurses who do not attend or in-service are reminded to check the protocol. Education was provided to the nurses that specifically forgot to initial the administration of Ativan for resident#5. After this was completed, the MARS were initialed appropriately and corrective action was completed. The DON will conduct a random audit of both the completion of documentation on MAR and reconciliation of medication cards with MAR two times per week for 4 consecutive weeks starting the week of April 3, 2017. If random checks result in no errors, the DON will reduce the number of checks to 1 per month for the following 6 months (through September 2017). At the end of September, if no errors have been found the checks will be discontinued. If errors are found, the number of checks will be increased and re-education will be done with the nurses	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355101	A. BUILDING _____ B. WING _____	03/29/2017

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F 281	Continued From page 13 administrative nurse (#2) stated she expected facility staff to document on the MAR when medications are administered to a resident. Failure to document the administration of Ativan on the MAR has the potential for Resident #5 to receive another dose of Ativan too soon. - During observation of medication pass on 03/29/17 at 7:50 a.m., Resident #9's MAR identified Amlodipine 5 mg, give 2 tabs. Resident #9's medication card label stated Amlodipine 5 mg, take 2 tabs. Resident #9's punch packet contained only 1 pill in the daily dose pocket. The medication card identified that doses for 3/26/17-3/28/17 had been dispensed, verifying Resident #9 may have received the incorrect dose of the Amlodipine for those 3 days. The staff nurse (#4), did identify the discrepancy between the label on the card and number of pills in each punch packet. The staff nurse (#4) pulled the Amlodipine card from the medication cart and stated he would call the pharmacist to clarify the medication card before administering it, and did not administer the medication at this time. During an interview on 03/29/17 at 10:00 a.m., an administrative nurse (#2) stated she took the medication card to the pharmacist for clarification. The pharmacist stated the Amlopidine dose of each pill in Resident #9's medication card was 5 mg and that each punch out dose should contain two 5 mg pills. The medication card was corrected and returned with the administrative nurse. The administrative nurse (#2) stated she expected the staff nurses to reconcile the medication cards with the MAR when they are brought from pharmacy.	F 281	repeating the errors. The DON will report error rate to the QA meeting until compliance has been met.	

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