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	355101	A. BUILDING _____ B. WING _____	04/17/2019

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DAKOTA ALPHA	1303 27TH STREET NW MANDAN, ND 58554

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F 000	INITIAL COMMENTS The standard Medicare/Medicaid recertification survey started on 04/15/19 and concluded on 04/17/19.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal	F 550		5/22/19

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

Electronically Signed | 05/07/2019

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F 550	Continued From page 1 from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide care in a manner that maintained or enhanced resident dignity for 1 of 4 sampled residents (Resident #6) requiring staff assistance with toileting. Failure to provide privacy during personal cares does not enhance residents' dignity. Findings include: Observation on 04/16/19 at 9:32 a.m. showed a certified nursing assistant (CNA) (#2) assisted Resident #6 to the bathroom using the stand lift. When resident finished using the restroom, the CNA assisted the resident off the toilet utilizing the stand lift. The CNA then realized there were no clean briefs in the resident's room and called another CNA for assistance. The CNA transferred the resident to his wheelchair with his pants pulled down to his knees. Resident #6 directly faced the door to the hallway. An unidentified CNA knocked on the door and opened it at the same time, exposing the unclothed resident to the hallway. After the unidentified CNA left the resident's room to get a brief, the resident attempted to pull up his pants over his front area. The CNA (#2) did not attempt to cover Resident #6 or pull his pants up.	F 550	Nurses meeting on 4/25/19 and all staff educated on dignity and privacy in regard to exposure incident of resident #6. The facility has determined that any residents have the potential to be affected. Actions taken: Nurses meeting was conducted on 4/25/19 and reeducation is scheduled for all staff meeting on 5/16/19 with videos on Residents rights and dignity. Proper procedures were addressed with staff about dignity and avoiding resident exposure. Education covering privacy during cares will be addressed by the Director of Nursing. The Director of Nursing or designee will conduct random observations of staff providing care weekly x 6 weeks, Bi Weekly x 2 months, and random monthly x 4 months to ensure staff are promoting and maintaining resident dignity in accordance with the resident□s preferences. Finding of this audit will be discussed with the QAPI committee. The audits will be reviewed at the quarterly	

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F 550	Continued From page 2 During an interview on the morning of 04/17/19, an administrative nurse (#1) agreed staff should cover residents to provide privacy.	F 550	QAPI meeting. Corrective action completion date: 5/22/2019	
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and review of the North Dakota Provider Manual Preadmission Screening and Resident Review (PASRR) and Level of Care Screening Procedures for Long Term Care Services, the facility failed to complete a status change assessment for 2 of 3 sampled residents (Resident #5 and #7) with a newly diagnosed mental illness. Failure to complete a change in status assessment may result in the delivery of	F 644	A Level 1 was completed and submitted to DDM Ascend for Resident #5 identifying bipolar disorder in his list of diagnoses on 5/2/19. Collaborating documentation was sent as requested on 5/3/19 to DDM Ascend, and we are awaiting further determination on his Level II status. A Level 1 was completed and submitted	5/22/19

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F 644	Continued From page 3 care and services that are inconsistent with residents' needs. Findings include: The North Dakota PASRR Provider Manual, page 13, stated, ". . . Change in Status Process . . . Whenever the following events occur, nursing facility staff must contact Ascend to update the Level I screen for determination of whether a first time or updated Level II evaluation must be performed. These situations suggest that a significant change in status has occurred: . . . If an individual with MI, ID, and/or RC (mental illness, intellectual disability, and conditions related to intellectual disability [referred to in regulatory language as related conditions or RC] was not identified at the Level 1 screen process, and condition later emerged to was discovered . . ." - Review of Resident #5's medical record occurred on April 15, 2019. The record showed an original PASRR completed on 02/27/2008. A progress note, dated 05/01/15, identified a new diagnosis of bipolar disorder. The medical record lacked evidence the facility completed an updated Level I screening/change in status assessment since the additional diagnosis. During an interview on 04/18/19, an administrative staff member (#4) confirmed the facility failed to submit a PASRR for Resident #5 with the change in diagnosis. - Review of Resident #7's medical record occured on all days of survey. An initial PASARR, dated 09/19/11 identified no diagnosis of major	F 644	to DDM Ascend on 5/2/19 for Resident #6 for his diagnosis of psychotic disorder. Collaborating documentation was sent as requested, on 5/3/19 and we are awaiting further determination on his Level II status. All other resident charts were audited to check for PASRR regulation conformance. To prevent further missed significant change/psychiatric diagnosis and PASRR submission, all residents who come back from appointments or have in-residence appointments need to have their appointment notes read by the coding specialist. This will assure that codes are entered into the MDS, and the ND PASRR Change in Status Process will be followed if needed. The CMA/transporter□s calendar has been synced with the MDS coordinator□s so she will be aware of all appointments. Physician visits will also trigger a chart review to check for diagnoses and changes An audit flow sheet will be developed to track appointments/coding/PASRR submission weekly x 6 weeks, biweekly x 2 months, and random monthly x 4 months. The MDS coordinator will submit it to the administrator on a monthly basis and report it to the QAPI committee on a quarterly basis for 2 quarters to establish a workable flow, and redevelop a new plan if this doesn□t accomplish the	

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F 644	Continued From page 4 mental illness (MMI) and no PASARR ll needed. The facility added a diagnosis of psychotic disorder on 09/15/15. The record lacked evidence of an updated Level l screening/change in status assessment with the added diagnosis. During an interview on 4/16/19 at 4:08 p.m., an administrative staff member (#4) agreed staff failed to complete the required Level l rescreening after the diagnosis of a MMI (psychotic disorder).	F 644	intended results. The staff will be informed of the change in process at the All Staff meeting on 5/16/19. The date the corrective action will be completed will be 5/22/19.	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. 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 care and services in a manner to maintain the highest practicable well-being for 2 of 2 sampled residents (Resident #3 and #4) with daily weights per physician parameters and/or edema. Failure to implement interventions and monitor weights/edema may contribute to further complications. Findings include: Review of the facility policy titled "Vital	F 684	The order for Daily weights on resident # 3 was reviewed by Medical Director and order was discontinued on 5/1/19. Compression stockings for resident #4 regarding the documentation of TED hose will be done by nursing, 3 x daily during medication pass. TED hose Task has been added to CNA task list in Point of Care. The facility has determined that any resident could be affected.	5/22/19

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F 684	Continued From page 5 Signs/Weights" occurred on 04/16/19. This policy, revised February 2018, stated, ". . . All resident will have their weight monitored weekly prior to breakfast unless other wise specified. Weights will be obtained with residents wearing normal attire and shoes. Any variations will be documented accordingly (i.e. without shoes, after breakfast. . . ." - Review of Resident #3's medical record occurred on all days of survey. Diagnoses included heart disease with heart failure and chronic obstructive pulmonary disease. The current care plan, initiated on 02/15/19, stated, ". . . I have Congestive Heart Failure and hypertension . . . I will get Daily weights, every AM [morning] before breakfast. Nurse will notify provider of 3 lb [pound] or greater weight gain of 2 days and or 5 lbs or greater over 1 week. . . . Monitor/document/report to MD [physician] PRN [as needed] any s/sx [signs/symptoms] of Congestive Heart Failure: . . . weight gain . . . ." Review of the current Medication Review Report identified, "Daily weights every AM before breakfast. Notify provider of 3 lb or greater weight gain of 2 days and or 5 lbs or greater over 1 week. every day shift related to HEART FAILURE, UNSPECIFIED. . . . Start Date 02/01/2019. . . . Furosemide [diuretic] Tablet 40 MG [milligrams] Give 1 tablet by mouth in the morning for Peripheral edema" Review of the Weights and Vitals Summary from 02/01/19 through 04/16/19 showed the following: * 11 days with no weights recorded and no documentation regarding lack of weights * 3 pound weight gains noted on 02/12/19 (3.2 lbs); 02/18/19 (3.2 lbs); 03/10/19 (4.6 lbs) with no	F 684	Education will occur 5/16/19 at the monthly nurses meeting to all nursing and CNA staff regarding compression stockings and daily weights if ordered; the changes in Point of Care nursing will document 3 x daily during medication pass and CNA will have task added on Point of Care. The Director of Nursing or designee will complete random audits on compression stockings and daily weights if ordered weekly x 6 weeks, random biweekly x 2 months, and random monthly x 4 months of new documentation in Point of Care along with checking resident at random audit times. Finding of this audit will be discussed with the QAPI committee. The audits will be reviewed at the quarterly QAPI meeting. Corrective action Completion date: 5/22/19	

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F 684	Continued From page 6 documentation regarding notification of the physician During an interview on the afternoon of 04/17/19, a supervisory staff member (3) stated staff had not followed through by completing, monitoring, and reporting weight gains to the physician. - Review of Resident #4's medical record occurred on all days of survey. Diagnoses included cerebral infarction, hemiplegia affecting left nondominant side, and peripheral edema. The current care plan stated, ". . . need assist with ADL's [activities of daily living] putting on shoes, socks . . . help me physically get started . . . dressing . . . other tasks as needed . . . verbal cues for full task completion . . . R/T [related to] Hemiplegia/Hemiparesis (muscle weakness or partial paralysis) from affects of CVA [cerebral vascular accident] . . ." Observations throughout the day on 04/15/19 showed Resident #4 with difficulty walking on his left leg. Further observation showed moderate swelling to the left leg and wearing no compression stocking. Resident #4's physicians' orders stated, ". . . compression stocking to left lower leg; on in am, off at bedtime." During an interview on 04/16/19 at 4:30 p.m., two administrative staff members (#1 and #7) stated if there is a physician order for compression stockings, staff should follow physicians orders for compression stockings.	F 684		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3)	F 692		5/22/19

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F 692	Continued From page 7 §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident and staff interviews, the facility failed to offer fluids to 2 of 2 sampled residents (Resident #6 and #15) who required staff assistance for fluid intake and are at risk for dehydration. Failure to provide assistance with fluid intake may result in dehydration, constipation, and urinary tract infections (UTIs). Findings include: Upon request the facility failed to provide a policy on hydration/fluids.	F 692	The Director of Nursing Services and Registered Dietitian reassessed the hydration status and fluid needs for Residents #6 and #15. All fluids provided on the resident tray at mealtime and at the resident□s bedside were reevaluated and preferences were reassessed. Revisions were made to the care plans to reflect hydration interventions. The revised care plans were reviewed with staff involved in the care of the resident. The facility has determined any resident has a potential to be affected.	

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F 692	Continued From page 8 - Review of Resident #15's medical record occurred on all days of survey. Diagnoses included paraplegia and dysphagia (difficulty swallowing). A quarterly Minimum Data Set (MDS), dated 01/12/19, identified total assistance from one person required for eating and coughing and/or choking during meals or when swallowing medications. Current physician orders included: * Foley catheter for neuromuscular dysfunction of bladder * 04/11/19 Push fluids * 04/15/19 Macrobid (antibiotic) 100 milligrams (mg) BID (twice a day) for 5 days and Bactrim (antibiotic) DS (double strength) BID for 5 days for UTI. Observations showed the following: * 04/15/19 at 9:50 a.m., a sign on the wall beside Resident #15's bed stated, "Offer me a glass of water whenever you can. Thanks [Resident #15's name]." * 04/15/19 at 11:50 a.m., two unidentified certified nursing assistants (CNAs) repositioned Resident #15 in the bed and checked the incontinent product. The CNAs failed to offer Resident #15 fluids during or after cares. * 04/15/19 at 4:41 p.m., two CNAs (#4 and #5) checked the resident's brief in bed and assisted the resident to the wheelchair utilizing a full body lift. The CNAs failed to offer Resident #15 fluids during or after cares. During an interview on 04/17/19 at 10:55 a.m., Resident #15 stated, "I have not been offered any water today yet. They don't give me enough water."	F 692	An in-service education program on 5/16/19 was conducted by the Director of Nursing Services and with all staff addressing the significance for accurate reporting of fluids consumed during meals, the need to encourage fluid intake after cares, and provision of sufficient intake between meals to maintain adequate hydration. The in-service also addressed the importance of reporting conditions that alter a residents fluid needs. The Director of Nursing, registered dietitian, and the Dietary Manager will review each resident with risk factors for dehydration to ensure appropriate interventions are implemented and an updated plan of care is complete. Director of Nursing or designee will complete random audits to ensure nursing staff are offering fluid intake during cares weekly audits x 6 weeks, random biweekly x 2 months, and random monthly x 4 months of new documentation in Point of Care along with checking resident at random audit times. Finding of this audit will be discussed with the QAPI committee. The audits will be reviewed at the quarterly QAPI meeting. Corrective action Completion date: 5/22/19	

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F 692	Continued From page 9 - Review of Resident #6's medical record occurred on all days of survey. Diagnoses included constipation, dementia, neuromuscular bladder dysfunction, and hemiplegia of left side. Current physician orders included: * Fiber-Lax Tablet 625 mg (Calcium Polycarbophil) Give 2 tablet orally two times a day for constipation Take with 8 ounces of water * Dulcolax Suppository 10 mg (Bisacodyl) Insert 1 suppository rectally every night shift every Tuesday, Thursday, Sunday for bowel irregularity. Observations showed the following: * 04/15/19 at 4:12 p.m., a CNA (#5) assisted the resident to the bathroom and failed to offer fluids during or after cares. * 04/16/19 at 9:32 a.m., a CNA (#2) assisted the resident to the bathroom and failed to offer fluids during or after cares. During an interview on 04/17/19 at 3:07 p.m., an administrative nurse (#1) confirmed staff are expected to offer water with cares.	F 692		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any	F 756		5/22/19

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F 756	Continued From page 10 irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the consulting pharmacist failed to identify and report drug regimen irregularities regarding as needed (PRN) psychotropic medications to the attending physician and the director of nursing for 1 of 5 sampled residents (Resident #6) reviewed. Failure to ensure the pharmacist reported the	F 756	A review of the medication regimen was conducted by Nurse Practitioner, for resident # 6 on 4/30/19. The Medical Director was notified of those irregularities and order was changed to discontinue PRN psychotropic medication after 14 days from the new order.	

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F 756	Continued From page 11 medication irregularities may result in the resident receiving unnecessary medications and experiencing adverse consequences related to the medications. Findings include: Review of Resident #6's medical record occurred on all days of survey and identified a physician's order, dated 02/11/19, for Ativan (antianxiety) 0.5 milligram (mg) orally every eight hours as needed for anxiety and sleep. The record showed staff last administered a PRN dose for Resident #6 on 04/09/19. The record lacked evidence the physician renewed the order after 14 days. During an interview on 04/17/19 at 3:10 p.m., an administrative nurse (#1) agreed the consulting pharmacist failed to identify and review Resident #6's PRN Ativan.	F 756	The facility has determined any residents using PRN psychotropic medications have potential to be affected. A Nursing protocol was developed regarding the timely review and action taken on identified medication irregularities on 4/26/19, by Director of Nursing Services. Director of Nursing Services will review new guidelines with the staff nurses on 5/16/19. Education was provided to the Pharmacist regarding missed irregularity of PRN psychotropic medications on 4/24/19. Pharmacists will be provided a copy of the nursing protocol regarding the timely review and action taken on identified medication of prn psychotropic medication by 5/16/19. The Director of Nursing or designee will address any prn psychotropic irregularities identified by the medication regimen review by pharmacy within one week of receipt of the report. Documentation will be provided of action taken for each irregularity noted. The Director of Nursing Services will review pharmacy review report and corresponding documentation for three months to ensure compliance. Finding of this audit will be discussed with the QAPI committee. The audits will be reviewed at the quarterly QAPI meeting. Corrective action completion date: 5/22/19	
F 758	Free from Unnec Psychotropic Meds/PRN Use	F 758		5/22/19

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 _____	04/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 758 SS=D	Continued From page 12 CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is	F 758		

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F 758	Continued From page 13 appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review, and staff interview the facility failed to ensure orders for as needed (PRN) psychotropic drugs were limited to 14 days for 1 of 1 sampled resident (Resident #6) receiving a PRN antianxiety medication. Failure to ensure the physician renewed the PRN order after 14 days may result in the resident receiving an unnecessary medication. Findings include: Upon request the facility failed to provide a policy on PRN psychotropic medications. Review of Resident #6's medical record occurred on all days of survey and identified a physician's order, dated 02/11/19 for Ativan 0.5 milligrams (mg) one tablet orally every eight hours as needed for anxiety and sleep. Review of Resident #6's Medication Administration Record identified staff administered the PRN Ativan on 04/09/19 after the order expired. Staff failed to discontinue the medication or obtain a new physician's order for the PRN Ativan after 14 days (February 25, 2019).	F 758	Resident #6□s PRN psychotropic medication was renewed with a 14 day stop order. The facility has determined any resident that takes PRN Psychotropic medications have the potential to be affected. A review of all PRN psychotropic medications orders and indications for use was completed on 5/2/19 by Director of Nursing. All licensed Nursing Staff will have an in-service regarding the Nursing protocol use of Psychotropic Drugs on 5/16/19. A copy of the regulations regarding PRN psychotropic drug regimen and the facility protocol use were provided to the physician as a resource. The Director of Nursing or designee will conduct random audits of all prn psychotropic medications to ensure appropriate and current order for continued use weekly x 6 weeks, Bi Weekly x 2 months, and random monthly	

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F 758	Continued From page 14 During an interview on 04/17/19 at 3:15 p.m., an administrative nurse (#1) agreed the facility failed to re-order the medication after 14 days.	F 758	x 4 months to ensure that appropriate indications for use of any PRN Psychotropic drugs are clearly documented in the medical record . Finding of this audit will be discussed with the QAPI committee. The audits will be reviewed at the quarterly QAPI meeting. Corrective action completion date: 5/22/19	