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	355101	A. BUILDING _____ B. WING _____	05/04/2016

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

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F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey, started on 05/02/16 and completed on 05/04/16, the sample included 2 residents for complete review, 5 residents for focused review, and 1 closed record for review. The sample included 2 additional residents to verify specific concerns during the survey.	F 000		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) 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, and staff interview, the facility failed to complete a significant change in status assessment (SCSA) for 1 of 1 sampled resident (Resident #4) after a significant change in the resident's condition. This limited the facility's ability to accurately assess the resident's status, and identify and	F 274	1. Following the 3/7/16 MDS, the Interdisciplinary team determined that the changes in Resident #4's MDS were, according to the RAI User Manual definition, "temporary variations in the resident's status and expected to return to baseline within two weeks." The MDS coordinator did not document this team decision and therefore, a Significant	6/8/16

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

Electronically Signed | 05/20/2016

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F 274	Continued From page 1 implement appropriate care approaches. Findings include: The Long-Term Care Facility RAI User's Manual Version 3.0, October 2015, pages 2-20 and 2-23 stated, ". . . A 'significant change' is a decline or improvement in a resident's status that: 1. Will not normally resolve itself without intervention . . . (for declines only); 2. Impacts more than one area of the resident's health status; and 3. Requires interdisciplinary review and/or revision of the care plan . . . A SCSA is also appropriate if there is a consistent pattern of changes, with either two or more areas of decline or two or more areas of improvement. This may include two changes within a particular domain (e.g. [example given], two areas of ADL [activities of daily living] decline or improvement), . . ." Review of Resident #4's medical record occurred on May 02-03, 2016. Diagnoses included ataxia (lack of muscle coordination). Review of a quarterly Minimum Data Set (MDS), dated 03/07/16, identified the resident required supervision of one person with bed mobility, limited assistance of one person with transfers and dressing, and supervision with eating by one person. The previous MDS, a quarterly, dated 12/08/15, identified the resident required extensive assistance of one person with bed mobility, transfers, dressing, and eating. The medical record lacked evidence staff completed a SCSA following Resident #4's improvement in ADL's.	F 274	change should have been done. The significant change has been started and will be completed for resident #4 and transmitted to CMS and the State by 5/24/16. 2. The facility has determined that all residents have the potential to be affected. All current resident's latest MDS's will be checked for Significant change criteria and ones that trigger "Significant change" will be checked for RNAC documentation that explains why a significant change MDS is not needed (criteria not met) or the Significant change MDS that would be started within the specified 14 day time period. Any other residents who would need a Significant change MDS will have one completed and sent to CMS and the State. 3. The MDS coordinator has reviewed the Significant change criteria and printed it off for staff that covers for her when she is on vacation. A procedure has also been written up and this information will be followed before an MDS is signed off to assure this will consistently be done. The process will be explained to staff involved in completing areas of the MDS in the next Interdisciplinary team meeting on 5/25/16. 4. The MDS coordinator will start a checklist of MDS's done and Significant changes triggered (part of the Point Click care system) on a monthly basis and what was done. This will be reported to	

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F 274	Continued From page 2 During an interview on the morning of 05/04/16, a staff member (#2) confirmed a SCSA should have been done.	F 274	the Quality Assurance committee at their next meeting on July 13th, 2016. A monthly list will be reported for three quarters to assure compliance. Should there be problems with missing a Significant change, more monitoring or another system will be put in place.	
F 275 SS=D	483.20(b)(2)(iii) COMPREHENSIVE ASSESS AT LEAST EVERY 12 MONTHS A facility must conduct a comprehensive assessment of a resident not less than once every 12 months. 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 completion of an annual assessment at least every 366 days for 1 of 7 sampled residents (Resident #2). Failure to complete an annual assessment as scheduled may result in the care plan not reflecting the resident's current status and needs. Findings include: The Long Term Care Facility RAI User's Manual, Version 3.0, October 2015, page 2-19-20, stated, ". . . Annual Assessment . . . The Annual assessment is a comprehensive assessment for a resident that must be completed on an annual basis (at least every 366 days) . . . The ARD [Assessment Reference Date] . . . must be set within 366 days after the ARD of the previous	F 275	1. Resident #2 went to the hospital on 2/25/16 and returned 2/26/16. Following MDS protocol, a return MDS was done on 3/7/16 which, according to the next scheduled MDS, would have been a Quarterly. The alert system in POC failed to remind the MDS coordinator that an Annual MDS should have been due by 4/6/16. The Annual MDS was not done. After discussion with the survey team, the MDS coordinator and IDT team completed an Annual MDS for Resident #2 and it was sent to CMS and the State Health Department on 5/11/16. This did not result in any change in charges to the resident. 2. The facility determined that all residents who have resided in Dakota Alpha for a year have the potential to be affected. All other current residents who	6/6/16

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F 275	Continued From page 3 OBRA [Omnibus Budget Reconciliation Act] comprehensive assessment . . ." Resident #2's medical record, reviewed on all days of survey, identified staff completed an admission assessment for Resident #2 on 04/06/15 and quarterly assessments on 07/01/15, 10/01/15, 12/31/15, and 03/17/16. The facility failed to complete an annual assessment by 04/07/16 (366 days from the previous comprehensive assessment). During an interview, on 05/04/16 at 9:30 a.m. an administrative nurse (#2) confirmed staff did not complete the annual MDS due by 04/07/16.	F 275	have been in the facility for over a year had their MDS lists checked and all have had their Annual MDS completed within the correct time frame. 3. A service representative (Regional Account Manager) for Point Click Care was contacted by the Administrator about the problems with the accuracy of the MDS tracking system. A time was set for the MDS coordinator and other staff members who have issues with the system to teleconference to discuss the issues and what corrective action will need to be done on the Point Click Care system's part. The MDS coordinator will keep track of dates on an alternate system until the issue is fixed. 4. The MDS coordinator will check the Point Click care system with the alternative system monthly after it has been set up and report quarterly to the Q.A. committee on the findings for six months (two Q.A. meetings). If, at any time, the system is not accurate, Point Click Care will again be contacted and will be expected to fix the problem. 5. The expected date of compliance is June 6th, 2016.	
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	F 278		6/4/16

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F 278	Continued From page 4 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 by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEYS COMPLETED ON 09/02/11, 07/11/12, 05/08/13, 04/16/14, AND 04/14/15. 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 Set (MDS) accurately reflected the residents status for 2 of 7 sampled residents (Resident #3 and #4). Failure to accurately code	F 278	1. Resident #3's will have a Modified MDS submitted to CMS and to the State of his 8/15/16 MDS with the corrections made to the behavioral sections. There will be no change in charges to the resident. 2. The facility has determined that all residents with behaviors during their look-back periods have the potential to be affected. All current residents most recent MDS's were reviewed to ensure	

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F 278	Continued From page 5 sections of the MDS may result in the care plan not reflecting the residents' current status and needs. Findings include: The Long Term Care Facility RAI User's Manual, Version 3.0, October 2015, page E-5 stated, "E0200: Behavioral Symptom-Presence & Frequency . . . Steps for Assessment 1. Review the medical record for the 7-day look-back period. 2. Interview staff, across all shifts and disciplines, as well as others who had close interactions with the resident during the 7-day look-back period, including family or friends who visit frequently or have frequent contact with the resident. 3. Observe the resident in a variety of situations during the 7-day look-back period. . . . Coding Instructions: Code 0, behavior not exhibited: if the behavioral symptoms were not present in the last 7 days. Use this code if the symptom has never been exhibited or if it previously has been exhibited but has been absent in the last 7 days. . . ." Page J-32 stated, "J1900: Number of Falls Since Admission/Entry or Reentry or Prior Assessment . . . 3. Review all available sources for any fall since the last assessment, no matter whether it occurred while out in the community, in an acute hospital, or in the nursing home. . . . 4. Review nursing home incident reports and medical record (physician, nursing, therapy, and nursing assistant notes) for falls and level of injury. 5. Ask the resident, staff, and family about falls	F 278	they accurately reflected their behavior status for the identified 7 day look-back periods. Nursing and Therapy Progress notes, Nurse and CNA communication books, Incident and Accident Reports and other supporting documentation were all checked for this period and any changes resulted in modified MDS's being completed and submitted to CMS and the State. 3. The Social worker will ensure that all new MDS's being submitted will have accurate coding on Section E that reflects complete documentation regarding behavior symptoms listed in the MDS. The above sources will be used as well as reports from family when applicable. During the All Staff meeting on 5/19/16 staff members were educated on behavior coding; the definitions of verbal and physical behaviors, how and where to document them, and how to code them. 4. The Social worker will report on the accuracy of this section to the QA committee for the next 6 months beginning with the July 13th meeting for all of the residents who have had MDS's completed. 5. The expected date of compliance is June 4, 2016. 1. Resident # 4's (Section J) MDS of 3/7/16 will be modified to reflect the fall that occurred on 2/27/16 and the modified MDS will be submitted to CMS and the State. There will be no change in charges to the resident. 2. The facility has determined that all	

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F 278	Continued From page 6 during the look-back period. Resident and family reports of falls should be captured here, whether or not these incidents are documented in the medical record. . . ." - Resident #3's medical record, reviewed on all days of survey, identified diagnoses including mood and impulse control disorder. Progress notes, dated 08/03/15 at 10:57 a.m., stated, "OT [Occupational Therapist] heard shouting coming from the activity room. OT entered activity room to find [Resident #3] shouting at another resident. The other resident was shouting back but stopped when asked and was easily redirected out of the room. OT observed [Resident #3] push other resident's craft activity off of table, hit her hand, and attempt to hit her further while stating 'f--- you." OT attempted to redirect [Resident #3]. He was not redirect able [sic] so OT removed other resident. . . ." An annual MDS, dated 08/06/15, identified Resident #3 had no verbal or physical behaviors during the 7 day assessment period. During an interview on 05/04/16 at 9:30 a.m. a social services staff member (#7) confirmed staff failed to code Resident #3's episode of verbal and physical behaviors which occurred on the 08/06/15 annual assessment. Failure to accurately code the verbal and physical behaviors on the comprehensive assessment resulted in the Behavior Care Area Assessment not being triggered and not assessed for the need to revise care plan interventions. - Review of Resident #4's record occurred on all days of survey. Diagnoses included ataxia (lack	F 278	residents who have had falls have the potential to be affected by this deficiency. All current residents' MDS's will be reviewed and Section J will be reconciled with the Excel spread sheet that is currently kept on Falls by the Occupational Therapist (who became in charge of this Section in April 2016). Any residents whose MDS's have been coded inaccurately will have a Modified MDS submitted to CMS and the State. 3. The Occupational therapist has developed a system for checking the Falls spreadsheet with the dates of the MDS's (current and last admission/entry or reentry or the prior assessment [OBRA or Scheduled PPS] whichever is more recent.) She will refer to this when completing Section J 1800-1900 to assure the accuracy of the falls information. In the All staff meeting on 5/19, falls were also covered as a topic and the definition of falls (regardless of where they occurred) was again explained to the staff. Those staff who were not in attendance will sign off on the meeting minutes to assure that they understand and will fill out the Accident reports accurately for any fall. 4. The Occupational therapist already reports information on falls to the Q.A. committee on an ongoing basis; she will add "Falls reported on MDS's" to her report for the next 6 months to evaluate how her reporting system is working. 5. The expected date of compliance is June 4, 2016.	

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F 278	Continued From page 7 of muscle coordination). Review of a quarterly MDS, dated 03/07/16, identified the resident experienced no falls since the prior assessment completed on 12/08/15. A progress note, dated 02/27/16 stated the resident "fell backwards and hit the back of her head on a wooden deck" while out on pass with her husband. The record stated after the nurse assessed the resident, her husband took her to a local emergency room where the resident had a computerized axial tomography (CT) of the head which "was negative and received four staples in the head." A quarterly MDS, dated 03/07/16, did not identify the type of injury from the fall. During an interview on 05/04/16 at 9:45 a.m. a supervisory staff member (#2) confirmed the facility failed to code Resident #4's fall episode which occurred outside of the facility. This failure may result in the care plan not accurately reflecting Resident #4's current status and care needs.	F 278		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: NEUROLOGICAL ASSESSMENTS 1. Based on record review, review of facility policy, and staff interview, the facility failed to complete neurological assessments according to facility policy for 1 of 6 sampled residents	F 281	A review of the policy for the completion of Neuro Checks was discussed immediately and again on 5/19/16 during the All Staff Meeting. All residents have the potential of being affected by the same deficient practice. Nurses were	6/8/16

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F 281	Continued From page 8 (Resident #4) who experienced a fall. Failure to perform neurological assessments may result in a delay in recognizing neurological changes following a head injury. Findings include: Review of the facility policy "Neuro Checks" occurred on 05/04/16. The policy, dated 03/29/16, stated, "If there is a significant blow to the head, neurological assessment protocol is to check pupil size and reaction to light, squeezing of the nurse's hand on command, and answering orientation questions appropriate to the resident's cognitive status before the significant blow to the head. . . . A 'Neurological Assessment' form (a.k.a.[also known as] crani check form) must be used. Do not chart these on the routine vital signs sheet. Crani checks must be done initially and then: [every] 15 min [minutes] [for] 1 hour. If stable, then . . . When an accident requires physician notification, follow-up charting in the nurses notes must be done each shift for 24 hours, then daily until the injury is stabilized." Review of Resident #4's record occurred on all days of survey. Diagnoses included ataxia (lack of muscle coordination). Record review included a the following progress notes on 02/27/16: * 7:15 p.m.: "[Resident] and her husband returned back from being out all day today. They stopped at the nurses station when they came back only to show me the gash on [resident's] right posterior scalp. Her husband states about one hour prior, they were visiting some friends at their house when [resident] was walking on some	F 281	educated on the need to follow the protocol whenever a resident has had a significant blow to the head such as the incident that occurred with resident #4. 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 Neuro Check policy will be attached to the front of the nurses report book so travel nurses who do not attend our in-service are reminded to check the protocol. The DON will review every competed reportable event that included a blow to the resident□s head to insure the protocol was properly followed starting on May 20, 2016 and will continue for the following 6 months (through October 2016). At the end of October, if no errors have been found, the checks will be discontinued. If errors are found, the checks will be increased and re-education will be done with the nurses who are repeating the errors. The DON will report the error rate to the Q.A committee on a quarterly basis until compliance is reached. A review of the policy for Medication Administration including documentation and the clarification of dosages to ensure the physician□s order corresponds with the label on the medication and in the MAR was discussed immediately following survey and again on 5/19/16 during the All Staff Meeting. All residents have the potential of being affected by the	

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F 281	Continued From page 9 gravel in their yard, fell backwards and hit the back of her head on the wooden deck. . . . the cut. It appears to be a deep cut approximately one inch in length though it was hard to tell because it was still bleeding. . . . Husband thought next stop should be the Emergency Room . . ." * 10:31 p.m.: ". . . just came back from [hospital] ER. [Resident] had a CT [computerized axial tomography] done which was negative and received four staples in the head. . . . said she did have a little headache, so gave two Tylenol . . ." The ER discharge instructions stated, "You have been seen for a head injury. . . . Treatment includes observation at home . . ." The record lacked evidence nursing staff completed neuro checks as per facility policy. On 05/04/16 at 1:45 p.m., an administrative staff nurse (#1) confirmed the record lacked evidence nursing staff completed neuro checks following the significant blow to the resident's head, as per facility policy. MEDICATION ADMINISTRATION ORDERS 2. Based on observation, record review, facility policy, and staff interview, the facility failed to follow professional standards of practice for medication administration for 1 of 2 supplemental residents (Resident #11) observed during medication pass. Failure to clarify physician's orders for the right dose of medication has the potential to result in adverse consequences related to medication administration. Findings include:	F 281	same deficient practice. Nurses were educated on the need to follow the protocol at all times. Re-education included the incidents that occurred with resident #5, #6, and #11. 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 front of the nurses report book so travel nurses who do not attend our in-service are reminded to check the protocol. The DON will spot check both the completion of documentation on MAR and also the comparison of medication labels to physician orders and MAR two times per week starting the first full week after the All Staff Meeting on May 19, 2016. By June 8, 2016 6 checks will be done. If spot checks result in no errors, the DON will reduce the number of spot checks to one per month for the following six months (through October 2016). At the end of October, 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 the errors. The DON will report the error rate to the Q.A committee on a quarterly basis for the remainder of the year or until compliance is reached.	

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F 281	Continued From page 10 Review of the facility policy "MEDICATION ADMINISTRATION" occurred on 05/04/16. The policy, dated 03/29/16, stated, "Medication administration frequency is indicated on the MAR [medication administration record], and the 'Physician's Order Renewal' sheet in the chart. Follow the steps outlined below before each medication pass. . . . Check the MAR and the Rx [medication] bottle/card to ensure that the dosage . . . are correct. Correct all errors. . . ." During observation of medication pass on 05/03/16 at 7:45 a.m. the nurse (#3) obtained two different eye drops for administration for Resident #11. The medications included Systane ultra eye drops to both eyes, and Maxitrol drops to the left eye. The MAR and the medication label identified to administer one drop of each medication. Review of the original physician's order and "PHYSICIAN'S ORDERS-Renewal" sheet did not specify the dosage/number of drops for administration. During the above observation, Resident #11's MAR included an entry for Miralax (laxative) 17 grams daily which the nurse (#3) administered. Review of the physician's order and the "PHYSICIAN'S ORDERS-Renewal" record did not specify the dosage for administration. Nursing staff failed to clarify the number of eye drops for administration and the dose of Miralax, and ensure the physician's order corresponded with the label on the medication. MEDICATION ADMINISTRATION/DOCUMENTATION	F 281		

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F 281	Continued From page 11 3. Based on record review, review of facility policy, and staff interview, nursing staff failed to ensure the administration of medications occurred as ordered for 2 of 7 sampled residents (Resident #5 and #6) reviewed. Failure to administer medications or identify the reason for not administering medications ordered has the potential to result in adverse consequences related to medication administration or documentation. Findings include: Review of the facility policy "MEDICATION ADMINISTRATION" occurred on 05/04/16. The policy, dated 03/29/16, stated, ". . . If a medication is not administered (i.e. ill, refused) initial MAR as usual & circle your initials. Complete a 'Medication Variance Form' to explain why the medication(s) weren't taken as prescribed. . . . If a resident is on pass use 'P'; if in the hospital use 'H' or if a medication is to be held write 'hold' in place of your initials." Review of Resident #5's medical record occurred on all days of survey. Diagnoses included a neurogenic bowel. Resident #5's MARS for the months February through April 2016 identified nursing staff failed to administer: * Lorazepam (used for anxiety) scheduled twice daily at 7:00 a.m. and 12:00 p.m.: missed/undocumented doses at 7:00 a.m. on February 25; at 12 p.m. on March 23, 25, 26 and 27; and at 12:00 p.m. on April 06, 08, 09, 10, 11, 16 and 17. The record failed to identify why the resident did not receive the prescribed medication.	F 281		

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F 281	Continued From page 12 * Glycerin suppository (laxative) scheduled once daily on Tuesday, Thursday and Saturday, including results: missed doses on February 06, 09, 11, 16, 18, 20, 25 and 27; on March 10, 12 and 17; and on April 09, 19 and 30. The record failed to identify why the resident did not receive the prescribed medication. - Review of Resident #6's medical record occurred on May 03-04, 2016. Diagnoses included spastic hemiplegia. Resident #6's MARS for March 2016 identified an order for scheduled Dulcolax suppository (laxative) on Monday, Wednesday and Friday of each week. The MAR showed nursing staff failed to administer or did not document the scheduled doses on March 18, 23, 25, 28 and 30. During an interview on the afternoon of 05/04/16, an administrative staff member (#1) agreed nursing staff should administer prescribed medications or document the reason the resident did not receive the medication.	F 281		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that -- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration	F 322		6/8/16

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F 322	Continued From page 13 pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEYS COMPLETED ON 05/08/13, 04/16/14, AND 04/14/15. Based on observation and review of facility policy, the facility failed to provide the appropriate treatment and services (checking for placement and residual) for 2 of 2 sampled residents (Resident #2 and #3) observed receiving bolus feedings (instilled rapidly by gravity) through a gastrostomy tube. Failure to check for residual gastric contents and for correct placement of the tube prior to administration of medications and feedings may result in harm to the resident. Findings include: Review of the facility policy titled "PEG (Percutaneous Endoscopic Gastrostomy) TUBES" occurred on 05/04/16. The policy, dated 03/29/16, stated, ". . . Gravity/Bolus PEG Tube Feeding: . . . 1. Glove and check feeding tube placement for predetermined mark. 2. Remove the port plug from the tubing. 3. Insert syringe into PEG port. Aspirate stomach contents to check residual. NOTE: Residual checks are done	F 322	A review of the protocol for tube feeding including checking placement and residual to reduce discomfort and/or complications related to the feedings was discussed immediately following survey and was again discussed on 5/19/16 during the All Staff Meeting. Nurses were educated on the need to follow the protocol and also physician orders when feeding/administering contents to all residents receiving treatments including residents #2 and #3. 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 tube feeding protocol will be attached to the front of the nurses report book so travel nurses who do not attend our in-service are reminded to check the protocol. The DON will “spot check” nurses performing tube feeding/medications administration on random resident’s who receive peg tube treatments two times per week starting the first full week after the All Staff Meeting on May 19, 2016. The	

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F 322	Continued From page 14 before medication administration if medications are scheduled at the same time as the feeding. Feedings are delayed for two hours if residual is > [greater than] 150 cc [cubic centimeters]. . . ." - Observation on 05/02/16 at 12:40 p.m. showed a licensed nurse (#3) entered Resident #2's room to administer bolus tube feedings. The nurse donned gloves, connected a syringe to the feeding tube, and immediately instilled a water flush followed by bolus feedings of Ensure Clear (a nutritional supplement), Promod (a protein supplement), and Fibersource (a type of tube feeding). The nurse failed to check placement of the tube or check for residual prior to instilling the bolus tube feedings. - Observation on 05/03/16 at 11:45 a.m. showed a licensed nurse (#3) entered Resident #3's room to administer medications and a bolus tube feeding. The nurse donned gloves, connected a syringe to the feeding tube, and immediately instilled a water flush followed by four medications, boluses of Promod and Ensure Clear, and another water flush. The nurse then connected the feeding pump and started a feeding of Nutren (a type of tube feeding) via the pump. The nurse failed to check placement of the tube or check for residual prior to instilling the bolus tube feedings and starting the feeding pump. Failure to check for placement of the tube and for residual gastric contents may result in the resident experiencing discomfort and/or complications related to the feedings.	F 322	DON will make sure to address all residents including resident #2 and #3 with peg tubes treatments during checks. By June 8, 2016 6 checks will be done. If spot checks result in no errors, the DON will reduce the number of “spot checks” to one per month for the following six months (through October 2016). At the end of October, 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 the errors. The DON will report the error rate to the Q.A committee on a quarterly basis for the remainder of the year or until compliance is reached.	
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323		6/8/16

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F 323	Continued From page 15 The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: GAIT BELT AND MECHANICAL LIFT TRANSFERS 1. Based on observation, record review, review of manufacturer's recommendations, review of facility policy, review of a professional reference, and staff interview, the facility failed to provide adequate supervision and assistive devices during transfers for 2 of 3 sampled residents (Resident #5 and #7) and one supplemental resident (Resident #10) observed during transfers. Failure to ensure proper use of gait belts (Resident #5 and #10), and safe stand lift transfers (Resident #7) has the potential for residents to experience unnecessary falls, injury, and pain. Findings include: Review of the manufacturer's instructions for the use of the EZ stand lift occurred on 05/04/16. The instructions regarding * "Transferring the patient, Attach harness 1) Position the harness around the upper body of the patient so the sides of the harness are between the patient's torso and arm, resting 2-3	F 323	A review of the protocol for use of gait belts and PAL lift harnesses including being securely fastened and properly placed was discussed immediately after survey and again on 5/19/16 during the All Staff Meeting. Staff was educated on the need to follow the protocol when working with residents who require transfers with gait belts and/or PAL lifts. The “EZ Stand Manufacturer Transfer Instructions” were also gone over with staff immediately after survey and again at the All Staff Meeting. All staff including those who are unable to attend will sign off on the in-service minutes. A memo to travel nurses to review the protocol for use of gait belts and PAL lift harnesses will be attached to the front of the nurses report book so travel nurses who do not attend our in-service are reminded to check the protocol. Administration is also looking into buying a different type of sling that is more supportive for the resident. The DON will “spot check” staff performing both transfers with gait belts	

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F 323	Continued From page 16 inches below the underarm . . . 2) For the safety of the patient, securely fasten the safety strap around the patient's torso. 3) Secure the buckle and pull the strap to tighten. . . ." and * Raising the patient ". . . simultaneously tighten the safety strap buckled around their torso. Stop lifting when the patient is in a standing position. . . ." Review of the policy for "Standing Lift Transfer," dated 03/29/16, failed to include the procedure and/or instructions for the placement of the harness. Review of the policy "Gait Belts" occurred on 05/04/16. The policy, dated 03/29/16, stated, "It is the policy of this facility to use gait belts with residents that cannot independently ambulate or transfer for the purpose of safety. . . . Failure to use gait belt properly may result in disciplinary action." Berman, Snyder, Frandsen, "Kozier & Erb's Fundamentals of Nursing Concepts, Process and Practice," 10th Edition, Pearson Education, New Jersey, page 1054 states regarding assisting a client/patient/resident to ambulate with a gait belt, ". . . Make sure the belt is pulled snugly around the client's waist and fastened securely. Grasp the belt at the client's back, and walk behind and slightly to one side of the client." - Review of Resident #7's record occurred on all days of survey. Diagnoses included history of an intracranial injury, and abnormality of gait and mobility. Observation on 05/04/16 at 10:30 a.m., showed a	F 323	and PAL lifts on random resident's who receive these types of transfers. This includes gait belt transfers on residents #5 and #10 and stand lift transfers on resident #7 two times per week starting the first full week after the All Staff Meeting on May 19, 2016. By June 8, 2016, 6 checks will be done. If spot checks result in no errors, the DON will reduce the number of "spot checks" to one per month for the following six months (through October 2016). At the end of October, 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 staff repeating the errors. The DON will report the error rate to the Q.A committee on a quarterly basis for the remainder of the year or until compliance is reached. A review of the abuse and neglect policy and incident reports including follow up and investigation was discussed immediately after survey and again at the All Staff Meeting on May 19, 2016. Staff was educated on the need to follow the policy and how the investigation is completed when an incident occurs that has a negative mental or physical outcome on the resident. An example that was given to staff was the incident that occurred with resident #4 and how it should have been handled differently. All staff including those who are unable to attend will sign off on the in-service	

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F 323	Continued From page 17 certified nursing assistant (CNA) (#6) placed the stand lift harness across the resident's upper back, clipped the belt across the anterior chest placing that belt across the resident's upper chest, and raised the resident to a near standing position. The stand lift harness sling slid up into the resident's axilla (armpits) of both arms. This caused both of the resident's elbows to extend outwards and marginally cleared the width of the bathroom door during the transfer. This occurred while the CNA (#6) transferred the resident from the wheelchair to the bathroom and with the return transfer from the bathroom to the wheelchair. - Review of Resident #5's record occurred on all days of survey. Diagnoses included impulsive disorder, hemiplegia (paralysis) affecting the resident's right side, and epilepsy. Observation on 05/02/16 at 4:45 p.m. showed a CNA (#4) transferred Resident #5 from a recliner to a wheelchair with a gait belt applied loosely around Resident #5's waist. After providing personal cares, the CNA transferred the resident from the wheelchair to a recliner again with the gait belt loose and twisted. - Observation on 05/03/16 at 8:35 a.m. a random staff member assisted Resident #10 to ambulate with a walker and a gait belt applied loosely around the resident's waist. During an interview on the afternoon of 05/04/16, an administrative staff member (#1) stated gait belts should be secured when used. She also stated with the harness sliding into Resident #5's axilla area, an evaluation of the use of a lift for	F 323	minutes. A memo to travel nurses to review the abuse and neglect policy and incident reports including follow up and investigation will be attached to the front of the nurses report book so travel nurses who do not attend our in-service are reminded to check this policy. The DON will review every completed incident that has a negative physical or mental outcome on the resident is investigated starting on May 19, 2016 and will continue for the following 6 months (through October 2016). If an investigation is needed follow up documentation and completion of investigation will be documented. Also, if there is equipment that cannot be used at the time of the investigation for the safety of the residents, management will place a “Do Not Operate” tag on equipment to alert staff of situation. At the end of October, 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 staff repeating the errors. The DON will report the error rate to the Q.A committee on a quarterly basis for the remainder of the year or until compliance is reached.	

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F 323	Continued From page 18 transfers needs to be done. WHIRLPOOL TUB TRANSFER 2. Based on observation, record review, and staff interview, the facility failed to ensure the safety of 1 of 1 sampled resident (Resident #4) who obtained an injury while receiving assistance with bathing. Failure to implement measures promptly placed this resident and all other residents transferred into the whirlpool at risk of injury. Findings include: Review of Resident #4's record occurred on all days of survey. Diagnoses included ataxia (lack of muscle coordination). The progress note, dated 01/26/16, stated: * 6:45 a.m.: "[resident] was getting into the whirlpool this morning and the CNA [certified nursing assistant] was helping her and she leaned forward and hit the spout of the whirlpool. She did not hit her head, though she does have bruising on her left chest. I asked her if it hurt and she said a little bit. . . ." * 08:20 a.m.: "[resident's first name] vomited in the dinning [sic] room during breakfast and was assisted back to her room for clean [sic]. While helping clean her, staff noted severe swelling and bruising to left chest/breast area from the accident earlier. [Resident] complain [sic] of pain and tender to touch. . . . NP [nurse practitioner] was notified of incident and she ordered to transfer her to ER [emergency room] for evaluation and treatment. Her husband [name] was notified as well and will be updated on her ER visit. . . ."	F 323		

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F 323	Continued From page 19 * 10:52 a.m.: "[Resident] return from ER diagnose with Hematoma and instructions on how to manage pain and swelling. . . ." * 4:42 p.m.: "[Resident] complain [sic] of pain 4/5 to her left chest/breast area from the accident earlier. she was medicated at 1 pm with ibuprofen [by mouth] with some relief. Her left breast is red/purple in color, 3+ [on scale of 1-4], warm, hard and sensitive to touch. . . ." A "REPORTABLE EVENT" (incident report), dated 01/26/16, written by a staff nurse, described the event as "Staff was helping [resident] in to the tub. She was fiddling with the belt on the tub chair. She tried to stand up when the chair was still in the air. due to fiddling with the belt it had loosened to the point it allowed [resident] hit her upper body/left breast on tub faucet. Nurse notified and assessed." The event report investigation, dated 01/27/16, stated: "Accident reviewed in incident committee and re-education done with staff on monitoring [resident] to make sure she doesn't loosen strap while using tub. Nurse will monitor next whirlpool tub bath to make sure nothing can be implemented to prevent future injury. Injury from accident caused hematoma and resident sent to ER." The report showed the director of nurses, administrator, social worker, and assistant administrator signed the final results of the investigation. The report lacked the outcome of observing the next whirlpool tub bath. During interview on the afternoon of 05/04/16, an administrative staff member (#10) provided a purchase order, dated 02/01/16, for a new belt for the whirlpool tub. The staff member stated installment of the belt occurred on that day, and	F 323		

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F 323	Continued From page 20 did not know if staff continued to utilize the tub until the replacement of the belt. The facility failed to implement preventive measures to prevent reoccurrences including: identifying the outcome of observing the next whirlpool tub bath for Resident #4; and ensuring staff did not utilize the whirlpool tub until replacement of the belt.	F 323		
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		6/8/16

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F 441	Continued From page 21 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 and facility policy review, the facility failed to follow infection control practices for 2 of 5 sampled residents (Resident #5 and #7) observed during toileting/incontinence cares. Failure to follow infection control practices related to hand hygiene/perineal cares and disinfecting of equipment has the potential to spread infection to other residents, staff, and visitors. Findings include: Review of the policy "Handwashing/Hand Hygiene Protocol" occurred on 05/04/16. The policy, dated 03/29/16, stated, "When to Wash Hands . . . When to Use Alcohol-Based Hand Rub . . . Before moving from a contaminated body site to a clean body site during resident care . . . Use of Gloves: The use of gloves does not replace hand washing/hand hygiene." - Observation on 05/02/16 at 4:45 p.m., showed a certified nursing assistant (CNA) (#4) provided incontinence cares for Resident #5 while the resident stood at the bedside. During the cares,	F 441	A review of the protocol for hand washing including when to perform hand hygiene and offering the resident hand hygiene after cares was discussed immediately and again on 5/19/16 during the All Staff Meeting. Nursing staff were educated on the need to follow the protocol during cares for every resident including resident number #5 and #7. Staff was given examples of the situations that occurred with these particular residents and were educated on how to correct this. All nursing staff including those who are unable to attend will sign off on the in-service minutes. A memo to travel nursing staff to review the hand washing protocol will be attached to the front of the nurses report book so travel nurses who do not attend our in-service are reminded to check the protocol. The DON will “spot check” nursing staff performing cares and hand hygiene on random resident’s including resident’s #5 and #7 two times per week starting the	

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 _____	05/04/2016

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 441	Continued From page 22 Resident #5 touched his frontal peri area. The CNA failed to offer/provide the resident hand hygiene following the incontinence care and prior to leaving the room. Observation on 05/03/16 at 11:30 a.m., showed a CNA (#5) provided incontinence cares for Resident #5 while laying in bed. During the care, Resident #5 touched his frontal peri area. The CNA failed to offer/provide the resident hand hygiene following the incontinence care and prior to leaving the room. - Observation on 05/04/16 at 10:30 a.m., showed a CNA (#6) transferred Resident #7 utilizing a stand lift into the bathroom. After the resident had a bowel movement, the CNA donned gloves, provided pericares, removed the gloves, donned a new pair of gloves, placed a new brief, and pulled the resident's pants up. The CNA then transferred the resident to a wheelchair in the resident's room. After ensuring the resident's safety, the CNA continued with cares with the same pair of gloves on. Those cares included removing the leg straps, removing the lift harness, and moving the lift into the resident's bathroom. The CNA removed the gloves, completed hand hygiene, transferred the resident out of the room, returned to the bathroom, and moved the stand lift to the tub room across the hall without disinfecting the lift including the handles.	F 441	first full week after the All Staff Meeting on May 19, 2016. By June 8, 2016, 6 checks will be done. If spot checks result in no errors, the DON will reduce the number of “spot checks” to one per month for the following six months (through October 2016). At the end of October, 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 staff member or members repeating the errors. The DON will report the error rate to the Q.A committee on a quarterly basis for the remainder of the year or until compliance is reached.	