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	355101	A. BUILDING _____ B. WING _____	05/17/2018

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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 05/14/18 and concluded on 05/17/18.	F 000		
F 576 SS=C	Right to Forms of Communication w/ Privacy CFR(s): 483.10(g)(6)-(9) §483.10(g)(6) The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense. §483.10(g)(7) The facility must protect and facilitate that resident's right to communicate with individuals and entities within and external to the facility, including reasonable access to: (i) A telephone, including TTY and TDD services; (ii) The internet, to the extent available to the facility; and (iii) Stationery, postage, writing implements and the ability to send mail. §483.10(g)(8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to: (i) Privacy of such communications consistent with this section; and (ii) Access to stationery, postage, and writing implements at the resident's own expense. §483.10(g)(9) The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and	F 576		6/21/18

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

Electronically Signed | 06/15/2018

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F 576	Continued From page 1 video communications and for internet research. (i) If the access is available to the facility (ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident. (iii) Such use must comply with State and Federal law. This REQUIREMENT is not met as evidenced by: Based on resident group interview and staff interview, the facility failed to provide mail delivery on Saturday for 7 of 7 interviewed residents (Resident A, B, C, D, E, F, and G). Failure to provide mail delivery on Saturdays infringes on the residents' rights. Findings include: The resident group interview occurred on 05/15/18 at 1:29 p.m.. The residents stated they did not receive mail on Saturday. During an interview on 05/16/18 at 1:30 p.m., an administrative assistant (#2) verified mail is delivered to residents Monday through Friday. No mail is delivered to residents on Saturday.	F 576	Mail was currently not delivered to the facility on Saturdays as the city postal service stated that they classified us as a business, not a residential facility and we are a rural route. No business addresses at the north end of Mandan receive mail on Saturdays; therefore none of our residents receive mail on Saturdays. Upon special request, the Post office agreed to deliver mail on Saturdays to our business. All residents of Dakota Alpha will now be able to receive mail on Saturday. As long as he local post office delivers mail on Saturday, residents will be eligible to receive mail on Saturday. Residents will be able to receive their personal mail by weekend activity staff. Some guardians and POA's request that business mail that deals with matters such as medical bills, Medicaid/Medicare eligibility, insurances (or things that residents may throw away and lose eligibility for) be put in the social worker's mail box so she can open them up with the resident during business hours so their benefits can be continued	

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F 576	Continued From page 2	F 576	uninterrupted. The activity staff will have residents initial a form when they get mail on Saturday. The activity supervisor will monitor this form on Monday to see that residents are receiving mail each week to report at QAPI meetings. This form will be reviewed at the first quarterly QAPI meeting after the survey (July 11, 2018)and continue to be monitored for the first quarter. It will be continued to be monitored for the following two quarters. A PIP will be used to follow resident satisfaction with mail delivery. At the Mandatory all staff meeting on 6/21/18, the new mail delivery system will be explained.	
F 584 SS=B	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss	F 584		6/21/18

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F 584	Continued From page 3 or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on resident group interview, observation and staff interview, the facility failed to maintain an odor free environment for 4 of 9 residents who attended the group interview (Resident A, C, G, and H). Failure to prevent odors and maintain a comfortable, homelike environment, placed residents in an uncomfortable and unpleasant setting. Findings include: - During the resident group interview on 5/15/18 at 1:29 p.m., Resident G stated, "the staff sit by you and they smell like cigarette smoke and they	F 584	During the group interview, a resident who was not identified, stated that staff smelled like cigarette smoke when coming in from break. It was also stated that "they" light their cigarettes as they are going out the door and the smell comes back into the building. Staff that smoke go through two doors so the "they" that was referred to was a resident who has been discharged home. Resident smoking is no longer allowed so the problem of smoke coming back into the building from the resident patio is no longer an issue.	

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F 584	Continued From page 4 light their cigarette as they are going out the door and the smell comes back into the building." Resident H, A, and C nodded their heads in agreement. - Observations on 2 of 3 days of survey noted an unidentified staff member smelled strongly of cigarette smoke when interviewed and when performing resident cares. During an interview on 5/16/18 at 1:30 p.m., an administrative nurse (#2) stated there was an issue with this in the past, but she was not aware of the current issue.	F 584	The issue of smoke odors or odor free environment has the capacity to affect all residents. Staff reported to have an odor will be asked to address the problem by washing their hands after coming in from smoking, changing clothing, washing their hair, etc. to eliminate whatever odor is the problem to maintain the comfortable, odor free environment for the residents. Staff will be reminded of the smoking area which is by the bus island and more than 20 feet from any door or opening window of Alpha. During the next staff meeting on 6/21/18, a policy addressing odor free environment will be reviewed with the staff, and smokers will be reminded to wash their hands after returning from every smoke break since the reported issue was a smoke smell. Staff will be asked to monitor each other for other issues such as strong perfume/cologne, strong food odors, etc. Residents will be asked in resident council for feedback monthly about the environment. Residents who do not regularly attend resident council and are cognitively able to answer questions will be asked for their feedback during one of their every two week sessions with the social worker so she can determine their satisfaction with the odor free environment. During our July 11, 2018 QAPI meeting and every quarter for two quarters, the social worker will report the results from the resident council meeting	

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F 584	Continued From page 5	F 584	on the odor free environment question with 100% compliance being the goal. Compliance of less than 100% will extend the monitoring. A spot check during the year will maintain compliance.	
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, group interview and staff interview, the facility failed to provide an environment free of verbal abuse for 3 of 9 residents interviewed in a group or private interview. Failure to ensure residents are free from verbal abuse, which includes disparaging and derogatory terms, may result in psychosocial harm. Findings include: Review of the facility policy titled, "Abuse Prohibition Policy" occurred on 05/17/18. This ,	F 600	We do not know all of the residents who were affected; the names were not disclosed. The CNA named by the surveyor was interviewed and she did not recall any situation with any resident that she may have used the term indicated in the resident interview. She was counseled and informed that further reports would result in disciplinary action. We have no further identification to speak directly to other staff. The Activity staff who was on duty on the morning of 5/17 was also counseled by the Activity	6/21/18

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F 600	Continued From page 6 undated policy, stated, "It is the policy of Dakota Alpha to prohibit abuse of any resident . . . Each resident has the right to be free from mistreatment, neglect . . . from facility staff . . . Verbal abuse is defined as 'the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents . . . within their hearing distance regardless of their age, ability to comprehend, or disability.' Regardless of the proximity of the family or resident, Dakota Alpha staff are discouraged from derogatory actions or talk about residents. . . . " - During a confidential group interview on the afternoon of 05/15/18 at 1:29 p.m., Resident A stated a certified nursing assistant (CNA) (#8) "has said things to me that were not very nice." Resident C stated that he/she had been called "a stupid little shit" by the CNA (#8). - During a confidential interview on 05/14/18 at 8:58 a.m., Resident A stated one of the staff members is "not nice" and has sworn at him/her. The resident stated he/she has mentioned this during a resident council meeting. The resident also stated another staff member is "gruff" with him/her and shows favoritism amongst residents. - During a confidential interview on 05/14/18 at 3:44 p.m., Resident B stated one of the staff members is verbally mean. The resident stated the staff member "acts nice all the time when [he/she] is out among others, but is mean to me when [he/she] is alone with me." - An observation of residents in the activity room on the morning of 5/17/18, showed an activity	F 600	director about the manner in which she spoke to the resident and informed that it was not appropriate (the activity director was not aware that it had happened) and that if it would be observed again, she would face further disciplinary action. All other residents have the potential to be affected. On 6/21/18, there will be a mandatory all staff meeting addressing abuse, neglect, exploitation, mistreatment, injuries of unknown source reporting, loss of property and decreased ability of residents with brain injury to process humor. Any staff member who is not able to attend will be expected to view the taped inservice and be signed off on it so they are current on the updates and refreshed on the policy enforcement. Residents are asked questions about staff abuse monthly during resident council. They also meet every other week with the social worker on an individual basis. Questions about abuse are asked every month. Resident satisfaction interviews will be conducted every quarter instead of yearly and discussed in QAPI on a quarterly basis for the next year. The first resident interview will be completed by June 20th and discussed during the July 11, 2018 QAPI meeting. Information will be used to determine if the correction is sustained and the corrective action is effective.	

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F 600	Continued From page 7 staff member (#7) slammed his/her hand down on the table in front of a resident, pointing his/her finger in the resident's face, and in a harsh tone stated, "Don't start with me!" During an interview on 05/16/18 at 1:30 p.m., an administrative nurse (#2) stated it is inappropriate and unacceptable for staff to use derogatory terms to the residents.	F 600		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the	F 609		6/21/18

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F 609	Continued From page 8 incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, and staff interview, the facility failed to identify and immediately, but no later than 2 hours, report 1 of 1 potential incident of neglect with injury of unknown source (unwitnessed) involving (Resident #1) to the State Survey Agency and report the results of the investigation within five working days. Failure to identify and report all alleged violations of neglect with injury placed all residents at risk of neglect and subsequent injury. Findings include: Review of the facility policy titled, "ABUSE PROHIBITION POLICY" occurred on 5/16/18. This undated policy, stated, ". . . Neglect means [the failure of the facility, its employees or service provider to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress] . . . Upon hire and at least yearly, all employees will have training in resident rights and the prevention of abuse and neglect . . . Individuals must report immediately, but no later than 2 hours after forming the suspicion if the events that cause the suspicion results in serious bodily injury. . . ." Review of Resident #1's medical record occurred on all days of survey. Diagnoses included impulse disorder and repeated falls. The current care plan stated, " ELOPEMENT I am impulsive and may leave the facility without notifying staff or without a set destination in mind. I have left in	F 609	The deadline has passed to be able to report the incident to the State Survey agency for the resident identified in the sample. Any resident who has a violation of F609 would have the potential to be affected by this regulation. We have revised our procedures to state specifically whose responsibility it is to report an incident of neglect or abuse to the State Health Department and listed the contact information for the on call nurses and for the nursing staff. If an incident happens, others have the information to call the State survey agency in the event that the Administrator or administrative staff cannot be contacted within the specified time frame. The specific definitions of abuse, neglect, exploitation and mistreatment, injuries of unknown source and misappropriation of resident property will be explained in detail and the reporting information details will be given to all staff again during the inservice of June 21, 2018. Staff who miss the inservice will need to view the recording of it and the definitions will be put into their mailbox at the facility. All elopements in which residents do not	

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F 609	Continued From page 9 the past, sometimes without being dressed for the weather, and cannot find my way back. I need to stay within the building or courtyard for my safety . . . I eloped on 1/29 which caused me injuries that took me to the ER and a stay overnight in the hospital for observation. . . ." A resident elopement report assessment, dated 1/28/18, identified, ". . . there was physical injury to the resident upon return . . . a 4 centimeter [cm] laceration with stitches to his supraorbital left forehead area. Had 2 small open areas to the dorsum of his right hand . . . medical treatment was received resident taken to the Sanford ED [emergency department] via ambulance and was admitted overnight.. . ." A nursing note dated 1/29/18 at 8:50 p.m., stated, ". . . Late entry for 1/28/18: I received a telephone call from a certified nursing assistant [CNA] at Dakota Alpha about 20:54 stating that [Resident #1]. . . had left the building. She stated that [nurses name] was currently talking to a police officer who reported that an ambulance was working on [Resident #1] and would be transporting him to the hospital. . . ." During an interview on 5/16/18 at 1:30 p.m., the administrator (#1) and an administrative nurse (#2) confirmed the facility did not contact the state agency to report Resident #1's elopement with injury.	F 609	have permission of their guardians to be outside of the facility, leave the grounds without staff knowing they are leaving, or sustain bodily injury must be reported to the State Survey agency. All incidents will be reviewed by the DON and incident team weekly to assure that the proper determination has been made and followed. At the quarterly QAPI meeting in July, the DON will report on all incidents and the administrator will report on all elopements to assure that proper reporting has been done and determination of procedure has been done. This reporting will be a permanent part of QAPI so continuous performance improvement will be made in this area.	
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:	F 610		6/21/18

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F 610	Continued From page 10 §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to properly educate staff to prevent further neglect from occurring, and take appropriate corrective action for 1 of 1 resident (Resident #1) who repeatedly eloped from the facility. Failure to educate staff regarding elopements placed Resident #1 and other residents at risk for possible neglect and/or injury. Findings include: Review of the facility policy titled "ELOPEMENT POLICY" occurred on 05/17/18. This undated policy, stated, ". . . staff will be given an in-service of the Elopement Policy during orientation to the facility and yearly thereafter . . . The facility's quality assurance [QA] committee will review elopement reports in each quarterly meeting. . . ." Review of Resident #1's medical record occurred	F 610	Before the surveyors left the grounds all staff were in the process of going through reorientation to the locked door security process for both Resident #1 and any other residents that may elope from the facility. All current employees have completed the re-training. Family with key fobs and visitors/vendors were also re-oriented. New vendors are watched/reminded as they come in that this is a secure building,they need to watch as they leave that the doors lock behind them and residents cannot go out unless staff accompany them. Orientation of new students/instructors/travel staff includes instructions about closing the door behind themselves, waiting for the lock to engage, waiting either longer than 5 seconds or pulling on it to check that it is secure before the outside door is opened.	

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F 610	Continued From page 11 on all days of the survey. Elopement reports showed the resident eloped from the facility on 01/28/18 at approximately 8:25 p.m. resulting in a serious injury which required stitches and hospitalization. Elopement reports showed the following: * 08/29/17 at 3:04 p.m.,Resident #1 followed a nursing student out through the locked front door - out of facility for 3 minutes. * 12/08/17 at 6:30 a.m., Resident #1 found half way up the courtyard fence in cold temperatures - missing 15-30 minutes. * 01/28/18 at 8:25 p.m., Resident #1 found by police in the street, unknown route of elopement - required hospitalization. * 03/07/18 at 10:23 a.m., Resident #1 followed activity staff out through the locked front door - out of facility for 2 minutes. * 05/01/18 at 3:00 p.m., resident climbed over the courtyard fence - missing 40 minutes. Review of the QA meeting minutes showed staff reviewed elopement reports on 10/18/17, 01/10/18 and 04/11/18, but lacked evidence of staff education regarding Resident #1's repeated elopements. During an interview on 05/16/18 at 3:40 p.m., an administrative nurse (#2) stated staff were educated after each front door elopement, to wait until the front doors are completely closed/locked/secured when arriving and leaving the facility. She was unable to provide an agenda or staff education roster showing that staff were educated/re-educated on front door safety since 2016.	F 610	Security for other doors in the facility was also checked; the interior garage door had a metal place cover installed over the door jamb and the lock to prevent insertion of objects to "jimmy" that door on 5/29. The administrative assistant at the front desk monitors people coming in and out; she is available to give feedback to people to check the door and to keep residents from going out the door before it closes securely when she is here. We have cameras in our hallways for security monitoring. To check compliance when she is not here, the administrative assistant has pulled up camera footage for random evening and week-end dates the week of May 20-26th, May 27-June 2, June 5th and she will continue weekly random checks through June 16th. The May and June camera footage findings will be discussed at our June 21, 2018 mandatory staff meeting and at our QAPI meeting on July 11, 2018. Further action with staff will be discussed if a problem is discovered. Beginning in July, she or the administrator will pull up random evening and week end camera hours to watch every other week the week of July 1st through 7th, July 15th through 21st and the weeks of August 5th through August 11th and August 19th through August 25th. (a change in every other week dates may occur if the need is found in our July QAPI meeting or through watching the camera in our every other week viewing).	

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F 610	Continued From page 12	F 610	The plan and the changes made to the outside wall, doors, monitoring of Resident A's and other residents who have eloped and solicitation of further staff feedback about elopements will be discussed with the staff at our June 21 Mandatory staff meeting. A yearly training of staff in elopement prevention, which residents are at elopement risk, and what needs to be reported in regard to elopements will be held.	
F 623 SS=E	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.	F 623		6/21/18

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F 623	Continued From page 13 (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for	F 623		

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F 623	Continued From page 14 the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to provide the resident and/or the resident's family/legal representative and the Office of the State Long Term Care (LTC)Ombudsman a written notice of transfer, including the destination, the reason for transfer,	F 623	Although the correct notices of transfer were not sent to all the parties for Resident #116 and #166, they both returned from the hospital and were re-admitted without problems as planned. When the ombudsman was called and	

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F 623	Continued From page 15 and the resident's right to appeal the action for 2 of 2 residents (Resident #116 and #166) transferred to the hospital. Failure to provide a notice of transfer or discharge does not allow the resident and/or the family/legal representative to make an informed choice regarding their rights and to keep the Ombudsman informed of all transfers/discharges. Findings include: - Review of Resident #166's medical record occurred on all days of survey. Progress notes identified Resident #166 was hospitalized from April 7-13, 2018, April 21-22, 2018, and April 29-May 4, 2018. The record lacked evidence the facility provided the resident and/or the family/legal representative and State LTC Ombudsman written notice of transfer for these hospitalizations. - Review of Resident #116's medical record occurred on all days of survey. Progress notes showed Resident #116 was hospitalized from April 25-May 1, 2018. The record lacked evidence the facility provided the resident and/or the family/legal representative and State LTC Ombudsman written notice of transfer for this hospitalization. During an interview on the afternoon of 5/16/18, an administrative staff member (#2) stated the facility does not provide written notice to the resident/resident's representative or the ombudsman when a resident is transferred to the hospital.	F 623	asked about sending notices at this date, she stated that the 30 day date of appeal had passed and since the residents had returned to the facility after hospitalization, the purpose of the notice would no longer be fulfilled. Notices, therefore, will not be sent. Family had also been notified. In the case of these residents being sent to the hospital again, protocol will be followed. The notice of transfer/discharge not being sent correctly could have affected all residents. New notices of transfer/discharge have been sent from the Ombudsman office and received. Copies were made and all nursing and social work staff will be informed of the correct protocols at the mandatory June 21 all staff meeting. Nurses that are on call staff will be given copies that they have access to when they are off duty so if they receive calls, they could "walk through" staff who may admit residents to the hospital when they are on call. The nursing policy book will be updated so they can refer "travel staff" to the correct procedure. Transfers/discharges to home and other facilities that are not of an emergency nature are coordinated by the interdisciplinary team and residents, families, and community agencies involved according to resident needs. Discharge for most residents is a goal planned since admission.	

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F 623	Continued From page 16	F 623	When a resident is discharged or transferred, copies of the notice will be given to the resident, family or guardian (unless the resident is their own guardian and does not wish family to be notified)and ombudsman to meet the standard. All transfers and discharges will be reviewed at the quarterly QAPI meeting for 6 months beginning with the July 11, 2018 meeting and followed up at the October 2018 meeting by the MDS coordinator to review compliance. If it is achieved, a spot check will be done once yearly.	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.	F 657		6/21/18

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F 657	Continued From page 17 (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy and staff interview, the facility failed to review and revise the comprehensive care plan to reflect the current status for 1 of 15 sampled residents (Resident #4). Failure to revise the care plan limits the ability of staff to communicate care needs and ensure continuity of care for the resident. Findings include: Review of the policy titled "Resident Care Plan" occurred on 05/17/18. This undated policy stated, " . . . Individualized care plans will be developed within 7 days of the date of the Minimum Data Set (MDS) assessment and revised as needed. . . ." Review of Resident #4's quarterly MDS, dated 04/17/18, identified the resident as having frequent pain that limits daily activities and is rated as 6/10 on the numeric rating scale (0-10). Review of Resident #4's current care plan occurred on 05/16/18. The care plan failed to address Resident #4's pain. During an interview on 05/16/18 at 1:30 p.m., an administrative assistant (#2) agreed the care plan	F 657	Resident #4's care plan was updated to include the PRN medication and therapy that he had been receiving for his chronic back pain. All other residents had the potential to be affected. Staff who complete sections of the MDS will be reminded at the June 20th weekly interdisciplinary meeting to address issues they may find when completing the MDS, unless it is a one time issue that is resolved, in the care plan that follows the MDS. The MDS coordinator will check all MDS's completed for two quarters and 5 MDS's for the quarter following and report compliance at the July and October QAPI meetings. If compliance is at 100%,a yearly spot check will be done to maintain compliance. If it is not, further checks will be scheduled.	

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F 657	Continued From page 18 failed to address Resident #4's pain.	F 657		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to provide assistance with activities of daily living (ADLs) for 1 of 2 residents (Resident #2) dependent on staff for care. Failure to assist a resident who cannot perform the task independently may result in decreased quality of life. Findings include: Review of Resident #2's medical record occurred on all days of survey. Diagnoses included traumatic brain injury, hemiplegia, hemiparesis, and contracture's. The resident's current quarterly Minimum Data Set (MDS), dated 02/16/18, identified extensive assistance from one person for personal hygiene. The current care plan stated, ". . . I need assistance in performing my ADL's due to hemiparesis and my left hand contracture's. . . ." A nursing note, dated 5/13/18 at 10:44 p.m., stated, ". . . Got a sunburn on day shift on face, arms and chest. aloe applied times 2. Stayed inside on pm shift. . . ." A current physician's order, dated 11/16/17, stated, ". . . sunscreen lotion apply to skin topically as needed for sun protection, apply to skin prior to outdoor activities. . . ."	F 677	It is procedure to apply sunscreen for residents who are going outside to sit on the patio. Resident #2 will have sunscreen applied to his face, neck and any exposed skin before going outside. As sometimes he refuses because he wants to have a dark tan, any refusals will be charted and he will be reminded again for the need to have sunscreen to avoid sunburn after a short interval. Exposure to sun during the hottest parts of the day will be discouraged by offering other indoor activities he enjoys and he will be encouraged to sit under the "shade sail" if he is out for longer periods. He is able to maneuver his wheelchair by himself for short distances so he can move from one spot to another if he is inside or outside, ring the doorbell to let the staff know that he wants to come in or hit the electric door button to come in or out independently. All residents may be affected by this practice for our few days of sunshine in North Dakota. Nursing staff will offer and document the	6/21/18

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F 677	Continued From page 19 - Observation on 5/14/18 at 9:34 a.m. showed a certified nursing assistant (CNA) (#9) transferred Resident #2 from his wheel chair (WC) to the toilet in his room using a sit to stand lift. The CNA commented to the resident on the sunburn to his arms and left leg. The CNA (#9) asked the resident if he would like her to put lotion on the sunburn, and the resident nodded yes. The CNA applied lotion. Observation showed a sunburn on the resident's right and left arm and on his upper left thigh. During an interview on 5/16/18 at 3:45 p.m., an administrative nurse (#2) stated she expected staff to apply sunscreen to residents before taking them outside.	F 677	response of all residents concerning sunscreen and chart if residents refuse. All staff will be reminded about the application of sunscreen and when to reapply according to the package instructions at the Mandatory all staff meeting on 6/21/2018. Sunscreen is a standing order for all residents, unless they are allergic to the ingredients, then another product is ordered. The DON will review all incident reports for the months of May through September for incidents of sunburn and sunscreen usage (and charting) and report it to QAPI in July and October. July reporting and incidents may require further planning and a change in procedure.	
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. 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 the adequate supervision and necessary interventions to ensure the safety of 1 of 1 sampled resident (Resident #1) identified at risk for elopement and who exited the facility unsupervised. Failure to ensure and maintain	F 689	Resident #1 has left the facility by climbing over the 6 1/2 foot fence in the patio area. After he demonstrated this to the previous administrator on 5/1/18, his and other resident's access to the patio was curtailed by a locked door. The fence and the surrounding wall has now	6/21/18

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F 689	Continued From page 20 resident safety by providing adequate supervision, implementing effective interventions, and monitoring and re-evaluating those interventions resulted in Resident #1 eloping from the facility on five occasions in the past eight months with one elopement resulting in injury/hospitalization. Findings include: Review of the facility policy titled, "ELOPEMENT POLICY" occurred on 05/17/18. This undated policy stated, ". . . Elopement: When a resident walks away, runs away, or otherwise leaves the facility or environment unsupervised . . . the management team will develop a plan of care to attempt to prevent elopement specific for each resident at risk . . . If, at any time, a resident is in the care of [facility] and cannot be located on the grounds . . . and the staff does not know their whereabouts, the Elopement Response Plan will be immediately implemented. . . . " Review of Resident #1's medical record occurred on all days of the survey. A quarterly Minimum Data Set, dated 03/05/18, identified the resident as independent in locomotion on and off the unit. The current care plan stated, ". . . ELOPEMENT I am impulsive and may leave the facility without notifying staff or without a set destination in mind. I have left in the past, sometimes without being dressed for the weather, and cannot find my way back. I need to stay within the building or courtyard for my safety . . . I eloped on 1/29 which caused me injuries that took me to the ER and a stay overnight in the hospital for observation. . . ."	F 689	been reinforced with steel panels so the resident is no longer able to climb over the fence. When staff knows this resident is outside in the courtyard, he is to be kept within eyesight. The fence was finished by 5/31 due to delays in receiving materials. It was in process before the surveyors came to the facility. Other areas in the patio/grounds area that he has not tried to go over have been reinforced as well as a preventive measure. All other residents who are an elopement risk have the potential to be affected. Before the surveyors left the grounds, all staff were in the process of going through reorientation to the locked door security process. All current employees have completed the re-training. Family with key fobs and visitors/vendors were also re-oriented. New vendors are watched/reminded as they come in that this is a secure building, they need to watch as they leave that the doors are locked behind them and residents cannot go out unless staff accompany them. Orientation of new students/instructors, new resident's families and travel staff includes directions about closing the door behind themselves, waiting for the lock to engage, and either waiting 5 seconds after the lock engages or pulling on the door to check that it is locked before the outside door is opened. Security for other doors in the facility was	

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F 689	Continued From page 21 An Elopement Risk Assessment, completed on 11/21/17, identified Resident #1 scored a 9. A score of 7 and above on this assessment indicated the resident is at risk for elopement. Nurse's notes identified the following: * 05/01/18 at 4:08 p.m. "[Resident #1] was found to be missing roughly at 3pm. After checking the security video footage, it appears that [Resident #1] went out the western door at 3:18 pm. elopement procedures were initiated, including calling the guardians and police. A full scale search took place and a number of staff when [sic] looking in their vehicles. I found [Resident #1] sitting on a hill adjacent to the Wal-Mart holding a few items. I went up to him and asked if he was ok. He stated that he was not hurt. I assisted [Resident #1] into my car and drove him back to Dakota Alpha. When we arrived, the police where there asking questions. We took inventory of the items that he had in his possession. The police noted that they will be taking the items back since they were not paid for. From the best of our knowledge, [Resident #1] took the items through the self-check out. The back door will be locked until further notice per my instructions. . . ." * 05/01/18 at 4:27 p.m. "Staff began search [3:30 p.m.] and call placed to [resident's mother] at 1538. . . Call placed to [local] police and notified of missing person at 1545. Aware that he was located by staff at [4:00 p.m.] and called police department [PD], called mother. . . At 1605 [Resident #1] is out in courtyard talking with [administrative staff] and [Resident #1] went to room with writer for assessment. Bruising and abrasion on left forearm is unchanged, no abrasions or bruising to lower legs and [Resident	F 689	also checked; the inside garage door had a metal plate cover installed over the door jamb and lock to prevent insertion of objects to "jimmy" that lock on 5/29. The administrative assistant at the front desk monitors people coming in and out; she is available to give feedback to people to check the door and keep residents from going out the door before it closes securely she is here. We have cameras in our hallways for security monitoring. To check compliance when she is not here, the administrative assistant has pulled up camera footage of random evening and weekend dates the week of May 20th through 26th, May 27th through June 2nd, June 5th, and she will continue weekly random checks through June 16th. These audit sheets have been checked by the administrator weekly. The May and June findings from the audit sheet will be discussed at our QAPI meeting on July 11th and further action will be discussed if problems are found. Beginning in July, she or the administrator will pull up camera footage or random evening and week end camera hours to watch every other week the week of July 1st through 7th, July 15th through July 21st, August 5th through 11th and August 19th through 25th. Again, the audit sheets will be checked by the administrator weekly or bi-weekly to let staff or family know if there is a problem so they can change behaviors that may lead to resident elopement. (A change in every other week dates may occur if the	

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	355101	A. BUILDING _____ B. WING _____	05/17/2018

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F 689	Continued From page 22 #1] denies falling. [Resident #1] denies pain. When asked why he left, he tells me that he wanted "some pop". Half hour checks initiated for safety. . . ." * 03/07/18 at 10:23 a.m. "At 10:25 a.m. [Resident #1] was let in the building after he was ringing the bell to the front door. After reviewing the camera in the front lobby it is found that [Resident #1] followed Activities personnel out the door at 10:23 a.m. and stayed in the space between the doors when he turned around and pressed the button to come back in. . . ." * 01/29/18 at 8:50 a.m. " . . . Late entry for 1/28/18: I received a telephone call from [name of staff member] CNA, at Dakota Alpha about 8:54 PM stating that [Resident #1], resident of Dakota Alpha had left the building. She stated that [name of nurse], the licensed practical nurse [LPN] was currently talking to a police officer who reported that an ambulance was working on [Resident #1] and would be transporting him to the hospital but was wondering which hospital they should transport him to. I informed her that his hospital of choice was [name of local hospital]. When [name of staff member] was finished with the police officer, I spoke to her and she stated that the officer informed her that [Resident #1] was found injured off the grounds of Dakota Alpha and was being transported to the hospital. The staff did not know he was missing; the last time they had seen him was when meds were given at [8:20 p.m.] in the dining room. . . . the nurse was going to notify his mother of his going to the hospitalized and I told her I would notify the guardian. I went to the hospital to check on [Resident #1's] condition and [name of staff member] faxed his med list to the hospital to the number she was given . . . I reported his	F 689	information in the July QAPI meeting or every week findings warrants it). The plan and changes made to the outside wall, doors, viewing of the door security process will be discussed with the staff at our June 21 mandatory staff meeting.	

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F 689	Continued From page 23 condition to [name] and that [Resident #1] would be staying overnight . . .She had also stated that [Resident #1's] Prothrombin time/international normalized ratio [PT/INR] [a lab test used when a resident is on a blood thinner] from the last time he had lab work were "pretty high"; and that was part of the concern to keep him overnight to re-check for bleeding (with the repeat [computerized tomography [CAT] scan in the morning) after his hitting his head. [Resident #1] had 6-7 stitches above his left eyebrow and a circular "punch type" the size of an eraser tip on his left hand from an unknown cause which was not bleeding. . . ." * 12/08/17 at 4:39 p.m. ". . .[Resident #1] was caught trying to leaving the building via the fence this morning. Reports pain to his knee and legs. Felt tired and noted sleeping at AM meal. No bruises noted except left leg still swollen and painful. He is on antibiotics. Afebrile with a temperature of 97.6. . . ." * 08/29/17 at 3:03 p.m., ". . .[Resident #1] left via the front door following behind a nursing student. He came back in right away and was found standing between the doors. No injury . He was redirected to his room . . . No concerns at this time. . . ." On 05/16/18 at 3:25 p.m., the survey team was accompanied by an administrative nurse (#2) to the facility courtyard that contained the fence Resident #1 had eloped over. The administrative nurse (#2) stated the facility is in the process of installing steel mesh to the landscape rocks and fence as a preventative measure to deter residents from climbing the wall. Observation showed the project appeared half way completed starting at the most accessible area to residents	F 689		

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F 689	Continued From page 24 and working toward the higher area. During an interview on 05/17/18 at 8:10 a.m. with an environmental services staff member (#3), this staff member stated the existing plan is to complete installing the steel mesh on half the length of the wall, (the wall gains height as it moves to the west). He did not have a project completion date. The facility failed to ensure and maintain resident safety by providing adequate supervision, implementing effective interventions, and monitoring and re-evaluating those interventions. This failure resulted in Resident #1 eloping from the facility on five occasions in the past eight months with one elopement resulting in injury/hospitalization.	F 689		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, review of manufacturer's instructions, and staff interview, the facility failed to ensure a medication error rate less than five percent for 2 of 3 residents (#12 and #14) observed receiving insulin. Two medication errors occurred during administration of 26 medications, resulting in a 7% error rate. Failure to administer medications correctly may alter the therapeutic effect and/or result in adverse side effects.	F 759	Neither resident who did not prime their insulin pen the day of the survey had any ill effects according to their medical record. They were learning how to give their own insulin as part of their self-medication program, and the nursing staff has been vigilant in assuring that they are given instruction in priming their insulin pens and charting if they do not want to include that step since the day of	6/21/18

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F 759	Continued From page 25 Findings include: Review of NovoLog FlexPen manufacturer's instructions, dated May 2016, on the afternoon of 05/17/18 indicated preparation of the pen included three steps ". . . remove the cap . . . attach a new needle . . . and prime your pen . . ." - Observation on 05/16/18 at 7:45 a.m. showed a registered nurse (#5) observing self administration of Resident #12's NovoLog FlexPen insulin injection. The nurse (#5) failed to prompt Resident #12 to prime the insulin pen when the resident omitted this step. - Observation on 05/16/18 at 8:01 a.m. showed a registered nurse (#5) observing self administration of Resident #14's NovoLog FlexPen insulin injection. The nurse (#5) failed to prompt Resident #14 to prime the insulin pen when the resident omitted this step. During an interview on the morning of 05/16/18, a registered nurse (#5) confirmed staff should prompt residents who are self administering medications if they are not correctly administering medications. This would include prompting residents to prime the NovoLog FlexPen prior to injection. During an interview on 05/17/18 at 11:00 a.m., an administrative staff member (#2) reported the facility did not have a policy regarding NovoLog FlexPen insulin administration, and they expect staff to follow manufacturer's instructions.	F 759	the survey. All residents receiving insulin have the potential to be affected by this practice if they are giving their own insulin. They do receive instruction about the advisability of doing it for accuracy of receiving the total dose drawn up. The step of signing off for priming insulin pens has been added into the Treatment administration for residents using them. During the mandatory staff meeting on June 21, nurses will be updated about the added charting requirement. The DON will review the Treatment records (TAR) for residents receiving insulin using the insulin pens monthly through December 2018 and report staff compliance in priming the insulin pens at QAPI meetings for the next 3 cycles. The first QAPI meeting that the reports will be discussed will be July 11, 2018. If nurses have been compliant, monitoring will be random every other month until June 2019.	