DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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Division of Health Facilities

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FORM APPROVED
OMB NO. 0938-0391

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 _____	07/11/2012

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 July 9, 2012 and completed on July 11, 2012 the sample included two (2) residents for complete review, five (5) residents for focused review, and one (1) closed record for review. The sample included two (2) additional residents to verify specific concerns during the survey.	F 000		
F 278 SS=C	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a	F 278	The DON who codes Section P of the MDS (Restraints) is in total agreement with the new definition of restraints in relation to side rails set forth in the April 2012 revision of the RAI User's Manual and will not code our quarter rails as restraints on succeeding MDS's. Upon consultation with Lucille Rostad (who was answering questions in Joan Coleman's absence the week our POC was due), since no care or payment were affected by this issue, no MDS corrections will be sent to CMS. At the next quarterly QA meeting in October, section P of all MDS's done since the survey will be reviewed to see that side rails are coded correctly. If the section is coded correctly, 10 MDS's will be reviewed in the January QA meeting to spot check to assure compliance. Sections J 1900 A and B of Resident #4's 5/25/12 MDS have been corrected in Resident #4's chart by the MDS coordinator to reflect the injury noted in the survey.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Landon Feil	VP of Brain Injury Svcs/Administrator Insp CM	8/16/12

any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 278	Continued From page 1 material and false statement. 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), April 2012, and staff interview, the facility failed to accurately complete the Minimum Data Set (MDS) assessments for 6 of 7 sampled residents (Resident #1, #3, #4, #5, #6 and #7). Failure to accurately assess and code the MDS may affect the level of care provided by staff to the residents. Findings include: - The Long-Term Care Facility RAI User's Manual (Version 3.0), April 2012, page P-1 defines a restraint as, "Any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body." The bed rails used by these residents aided the resident in repositioning, as well as assisted in transferring in and out of bed. The facility coded these devices as a physical restraint used daily, even though they failed to meet the definition of a physical restraint. Record review for Resident #1, #3, #5, #6, and #7 occurred on July 09-11, 2012 and revealed the facility staff failed to accurately code the restraint section on their MDSs. For Resident #1, #3, #5, #6, and #7 review of Section P: Restraints on the current MDSs	F 278	Accident reports are circulated to several interdisciplinary staff members and are therefore subject to delays in circulation. The date of the fall and proximity to the MDS date, therefore, sometimes has interfered with the accuracy of the coding of the MDS. The ADON and the DON have changed their fall tracking system to now include the injury (if one is sustained) in addition to the date of the fall. The DON (who completes this section of the MDS) will additionally check the Nurse's notes in case an accident report has been, for some reason, delayed for additional information before completing this section of the MDS. At each QA meeting, when the Safety committee member recaps the accident reports for the quarter, he/she will also recap the information contained in J1900 as verified in the Nurse's notes each time a resident has a fall. The DON and ADON, as directed by our Medical Director feel Resident #3 with the diagnosis of overflow incontinence does meet the criteria for a toileting/bladder training program. Resident #3 who was learning independent living skills while the survey was here was discharged from Dakota Alpha on 8/1/12.	

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F 278	Continued From page 2 identified the following: * Resident #1 - admission assessment - assessment reference date (ARD) of 05/04/12 - bed rail used daily. * Resident #6 - quarterly assessment - ARD of 05/14/12 - bed rail used daily. * Resident #3 - quarterly assessment - ARD of 06/11/12 - bed rail used less than daily. * Resident #7 - quarterly assessment - ARD of 06/11/12 - bed rail used daily. * Resident #5 - quarterly assessment - ARD of 07/01/12 - bed rail used daily. During an interview on 07/11/12 at 2:45 p.m., an administrative staff nurse (#1) stated the side rails used by these residents (Resident #1, #3, #5, #6, and #7) are not restraints, but rather assists these residents with bed mobility and transfers. - The Long-Term Care Facility RAI User's Manual (Version 3.0), April 2012, page J-31 defines an injury (except major) as, ". . . skin tears, lacerations, superficial bruises, hematomas, and sprains; or any fall-related injury that causes the resident to complain of pain." Review of Resident #4's medical record occurred on all days of survey. Review of Resident #4's progress note, dated 04/21/12, indicated Resident #4 fell in the dining room and experienced rib pain, bruising, and an abrasion to his left side. Due to the pain the resident experienced from this fall, the physician ordered an x-ray. This x-ray showed no fracture. A quarterly MDS, dated 05/25/12, indicated Resident #4 experienced one fall since the prior	F 278	Because our next QA meeting is not until October, on August 24, the DON and ADON will review all the MDS's since the date of survey for compliance in the above areas.	08/24/12

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F 278	Continued From page 3 assessment with no injury. - The Long-Term Care Facility RAI User's Manual (Version 3.0), April 2012, page H-6 states, ". . . Toileting (or trial toileting) programs refer to a specific approach that is organized, planned, documented, monitored, and evaluated that is consistent with the nursing home's policies and procedures and current standards of practice. A toileting program does not refer to: * simply tracking continence status, * changing pads or wet garments, and * random assistance with toileting or hygiene . . ." Review of Resident #3's medical record occurred on all days of survey. Resident #3's medical diagnoses include spinal cord injury at T (thoracic) 6, paraplegia, and neurogenic bowel and bladder. Resident #3's quarterly MDS, dated 06/11/12, identified the use of intermittent catheterization, on a current urinary toileting program, and occasionally incontinent of urine. Review of Resident #3's record identified the resident (or with the assistance of facility staff) completed self catheterization four-six times a day with urine output ranging from 300-500 cubic centimeters (cc). The completion of self catheterization on a routine basis by the resident and/or with the assistance of facility staff does not meet the criteria of a scheduled toileting program according to the definition listed in the current Long-Term Care Facility RAI User's Manual.	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.	F 281		

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F 281	Continued From page 4 This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 09/21/11. Based on observation, record review, review of professional reference, review of facility policy, and staff interview, the facility failed to ensure the insulin label for 2 of 2 residents observed receiving insulin injections (Resident #4 and #10) and 1 of 2 sampled residents (Resident #2) observed receiving an oral medication on July 09-10, 2012 accurately identified the amount (of units) and dosage (in milligrams) to be administered. Failure to ensure the label on each insulin pen and medication card correlates with the resident's current physician order could result in the incorrect administration of insulin dosages and oral medications. Findings include: The Centers for Medicare and Medicaid Services (CMS) has outlined current acceptable labeling requirements of medications and biological to include at a minimum "the medication name (generic and/or brand) and strength, the expiration date when applicable, and typically the resident's name, route of administration, and appropriate instructions and precautions (such as shake well, with meals, do not crush, special storage instructions). The facility ensures that medication labeling in response to order changes is accurate and consistent with applicable state requirements."	F 281	A review of the medication card for Resident #2 shows that the strength of the Triphocaps is shown on the medication card. The card states 1 mg. When the dispensing pharmacy (Thrifty White in Mandan) and the Consulting Pharmacist (Curt McGarvey) were asked, they stated that Trophocaps is dispensed as a generic and there is no dose-it contains so many ingredients that a dosage is not possible. We will take off the Trophocap strength on the med card. We will also have Dr. Eggert change it to 1 cap or 1 tab on the medication order to eliminate confusion. For other drugs: Upon receiving a medication order, the nurse will question the prescriber of any drug that does not list a strength and if he/she cannot give us the information, will ask the consultant pharmacist or filling pharmacy for that information. The full information will then be listed on the MAR for all pharmaceuticals that have strengths listed (we have been informed that some will not). Until our MARS are printed by our new pharmacy on October 1, 2012 the ADON and charge nurse will review all MARS to be sure that the information is listed as	

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F 281	Continued From page 5 Berman, Snyder, Kozier, and Erb, "Fundamentals of Nursing, Concepts, Process and Practice," 9th edition, Pearson - Prentice Hall, New Jersey, page 852 stated, ". . . Essential Part of a Drug Order: . . . The dosage of the drug includes the amount, the times or frequency of administration, and in many instances the strength . . . The nurse should always question the primary care provider about any order that is ambiguous, unusual . . . ." Review of the facility policy titled "Physicians Orders" occurred on 07/11/12. This undated policy stated, ". . . Medications: . . . and other medication orders will be completely written out . . . including . . . dosage of the medication, frequency of administration and route of administration. Any physician order that is not clear or does not include essential components, the nurse receiving or transcribing the order will call the physician for clarification and completeness of the the order; it will be rewritten/clarified as a telephone order . . . ." Observation of medication administration on 07/09/12 showed: * At 4:00 p.m., a licensed nurse (#2) administered an oral medication of Triphrocaps one capsule to Resident #2. Review of the Triphrocap medication card failed to identify the dosage of this medication. *At 4:50 p.m. a licensed nurse (#2) performed a blood glucose test for Resident #10 with results of 132 milligrams per deciliter (mg/dl). The licensed nurse (#2) then administered 1 unit of sliding scale NovoLog insulin via an insulin pen to Resident #10. Review of the NovoLog insulin pen label stated "Administer 1-11 units BID and 1-5	F 281	mandated. After October 1, 2012, all MARS will be printed by our new pharmacy. We have informed the pharmacy of this requirement. New prescriptions that may need to be added by nurses until the pharmacy prints up a new MAR must also follow this format. The ADON conducts mandatory monthly nursing meetings. In her monthly nursing meeting in August, she will review the information needed to meet this standard and keep a copy of the minutes for the revisit. All nurses must attend the meeting or sign off that they have reviewed the minutes of the meeting. The DON and the ADON will review all of the MARS and labeled medications for the months of August and September 2012 to check compliance and October 2012 when the new MARS from the new pharmacy to check if our standard is met. If it is met, they will check four residents MARS and labeled medications every other month for six months to monitor ongoing compliance. If compliance is not reached, we will resume every other month checks until we are at total compliance. We will inform the QA team of our findings.	

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F 281	Continued From page 6 units at bedtime per SS [sliding scale]." *At 5:00 p.m., Resident #4 performed his own blood glucose test and showed a result of 150 mg/dl. A licensed nurse (#2) administered 1 unit of sliding scale NovoLog insulin and 9 units of scheduled/routine NovoLog insulin via an insulin pen to the resident. Review of the NovoLog insulin pen label stated "Administer 8 units before breakfast, 6 units before lunch and supper." *Observation on 07/10/12 at 7:45 a.m., Resident #4 performed his own blood glucose test and showed a result of 272 mg/dl. A licensed nurse (#3) administered 3 units of sliding scale NovoLog insulin and 10 units of scheduled/routine NovoLog insulin via an insulin pen along with scheduled/routine 10 units of Levemir insulin via insulin pens. - Review of Resident #2's current physician orders and July medication administration record (MAR) stated "Nephrocap 1 mg [milligram] po [oral] daily after dialysis at 4 p.m.." - Resident #10's current physician order dated, 06/12/12, and July MAR identified staff should perform blood glucose monitoring (BGM) twice a day (before breakfast and supper) and administer sliding scale NovoLog insulin of 1 unit for BGM results of 130-159 mg/dl. During interview on 07/09/12 at 4:55 p.m., a licensed nurse (#2) stated Resident #10's BGM is completed before breakfast and supper, and the resident does not receive any bedtime insulin injections. This nurse confirmed the current label on Resident #10's NovoLog insulin pen is	F 281	At the present time, Resident #4's label on his Novolog and Levimir insulins are correct according to the physician's orders. Resident #10 was discharged from the facility on 7/31/12, before we received the deficiency statement. Our filling pharmacy will be changed October 1, 2012. Our new pharmacist stated when there is a dosage change for insulin pens, they will send a "baggie" with the correct label affixed to it when the nurse calls or faxes the order to them. This new baggie, new label will be sent by the end of the day of the notification. The nurse, then, will put the insulin pen into the baggie with the correct label and destroy the baggie with the incorrect label. She, therefore, will not be relabeling the insulin pens which is a practice not currently allowed for nurses to do under North Dakota law. The pens will not leave the facility and will be available for the resident's needs. The ADON will contact our current pharmacy and educate them regarding this "baggie"/label system and implement this system until September 30, 2012.	

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F 281	Continued From page 7 incorrect. - Review of Resident #4 July MAR identified staff should perform BGM four times a day (before all meals and at bedtime) and administer sliding scale NovoLog insulin as needed for BGM results before meals of 1 unit for BGM results of 150-199 mg/dl and 3 units for BGM results of 250-299 mg/dl. Resident #4's scheduled/routine insulin requirements include: NovoLog insulin 10 units (order changed on 03/20/12) and Levemir insulin 10 units before breakfast. NovoLog insulin 7 units before lunch. NovoLog insulin 9 units before supper (order changed on 06/20/12). Levemir insulin 12 units before 8 p.m. snack. During interview on 07/10/12 at 8:30 a.m., a licensed nurse (#3) stated Resident #4's insulin orders change frequently and confirmed the current label on the NovoLog insulin pen is incorrect. This licensed nurse stated as far as she knows, the facility failed to inform the pharmacy of the need for a new label when the provider changed Resident #4's NovoLog insulin dosage in June 2012 (one month ago).	F 281	The ADON conducts mandatory monthly nursing meetings. In her monthly nursing meeting in August, she will review the procedure for dosage changes, having complete dose information, and getting new labels for medication changes with specific emphasis for insulin. The staff will also be informed of the proposed changed in pharmacies to take place on October 1, 2012 and that they will be supplying the MARS. We will inform them of changes in medication handling in this and in the September meetings. A copy of the minutes will be kept for the revisit. All nurses must attend the meeting or sign off that they have reviewed the minutes of the meeting. The DON will check with the charge nurse monthly to see if any insulin changes have occurred and how the system of changed the baggies/labels is working. The charge nurse will report to the QA committee quarterly for two quarters on this deficiency and if it does not reoccur, no more monitoring will need to be done. The DON and ADON will review all resident's MARS for July and August and all insulin changes on August 24, 2012 to see that all are in compliance.	08/24/12