| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 355040 | A. BUILDING _____ B. WING _____ | 08/13/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LUTHER MEMORIAL HOME | 750 MAIN ST E MAYVILLE, ND 58257 |

| (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 |
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| F 000 | INITIAL COMMENTS<br><br>For the standard Medicare/Medicaid recertification survey started on August 10, 2015 and completed on August 13, 2015, the sample included four (4) residents for complete review, twelve (12) residents for focused review, and three (3) closed records for review. The sample included two (2) additional residents to verify specific concerns during the survey. | F 000 | | |
| F 278 | 483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED<br><br>The assessment must accurately reflect the resident's status.<br><br>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.<br><br>A registered nurse must sign and certify that the assessment is completed.<br><br>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.<br><br>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.<br><br>Clinical disagreement does not constitute a | F 278 | | 9/8/15 |

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

Electronically Signed | 08/26/2015

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| F 278 | Continued From page 1<br>material and false statement.<br><br>This REQUIREMENT is not met as evidenced by:<br>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 complete Minimum Data Set (MDS) assessments which accurately reflected the resident's status for 1 of 16 sampled residents (Resident #11) coded on the MDS for a bowel toileting program. Failure to accurately assess and code the MDS may affect the level of care provided to residents.<br><br>Findings include:<br><br>The Long-Term Care Facility RAI User's Manual: version 3.0, October 2014, page H-12 stated, "implementation of an individualized, resident-specific bowel toileting program based on an assessment of the resident's unique bowel pattern. . . "<br><br>- Review of Resident #11's medical record occurred on August 10-13, 2015. MDS assessments, dated 05/30/15 (quarterly), 02/28/15 (quarterly), 09/11/14 (significant change), and 06/28/14 (quarterly) identified Resident #11 as on a bowel toileting program.<br><br>The current care plan for activities of daily living self care deficit stated, "Toilet/Check/Change 3x/shift [three times per shift] & [and] prn [as needed] . . . Bowel Incontinence: Frequently incontinence [sic]. . . ." The record failed to identify an individualized bowel toileting program. | F 278 | F278<br>1. Corrective action occurred by modifying the 5/30/15 quarterly assessment (see attachment 4). Corrective action was also accomplished by meeting 1 on 1 with the RNs who complete the MDS assessments (see attachments 1 and 2). Counseling statements were also given to nurses involved in the inaccurate coding (see attachment #3a,b,c,d).<br>2. All residents have the potential to be affected by it.<br>3. The facility put the following measure into place: a) Mandatory meeting on August 24, 2015 (see attachments 1 and 2).<br>4. The facility (QA coordinator or designated staff member) will monitor using a QA check 1x/week for 4 weeks then 1x/month for 2 months (see attachment #6).<br>5. Corrective action will be accomplished by September 8, 2015. | |

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| F 278 | Continued From page 2<br>During a staff interview on 08/12/15 at 1:35 p.m., an administrative nurse (#1) identified staff should not have coded Resident #11 for a bowel training program. | F 278 | | |
| F 431 | 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS<br><br>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.<br><br>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.<br><br>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.<br><br>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. | F 431 | | 9/8/15 |

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| F 431 | Continued From page 3<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and review of facility policy, the facility failed to provide locked and secure storage of medications for 1 of 2 medication carts in the dining room. Failure to lock medication carts may result in accidental ingestion of medications by residents.<br><br>Findings include:<br><br>Review of the facility policy titled "Medication Pass Procedure" occurred on 8/13/15. This policy, dated February 2013, stated, "B.1. . . . Medication cart in the dining room. . . . Keep it within direct line of vision at all times, unless it is locked. 3. . . . Place all medications back into the cart before approaching resident. If it becomes necessary for you to be visually away from the medication cart, it should be locked. . . ."<br><br>Observation in the dining room on 08/12/15 at 8:15 a.m. showed an unlocked medication cart without a nurse present or in sight of the cart. Observation showed several medications lying on top of the cart with residents and kitchen staff members present in the dining room. | F 431 | F431<br>1. Corrective action will be accomplished by counseling the CMA involved (see attachment #5). It will also be accomplished by having a mandatory CMA, LPN, RN meeting on August 24, 2015 (see attachments 1 and 2).<br>2. All residents on C/D wing have the potential to be affected by this.<br>3. The facility put the following into place: a) Mandatory CMA, LPN, RN meeting August 24, 2015 (see attachments 1 and 2).<br>4. The facility (QA coordinator or designated staff member) will monitor a QA check randomly 3x/week for 1 month and weekly x2 months (see attachment #7).<br>5. Corrective action will be accomplished by September 8, 2015. | |