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	355052	A. BUILDING _____ B. WING _____	11/09/2016

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NELSON COUNTY HEALTH SYSTEM CARE CENTER	108 E NYHUS AVE MCVILLE, ND 58254

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F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey started on 11/07/16 and completed on 11/09/16, the sample included two (2) residents for complete review, seven (7) residents for focused review, and one (1) closed resident record for review. The sample included three (3) additional residents to verify specific concerns during the survey.	F 000		
F 160 SS=C	483.10(c)(6) CONVEYANCE OF PERSONAL FUNDS UPON DEATH Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 12/30/15 Based on record review and staff interview, the facility failed to ensure personal funds deposited with the facility were conveyed within 30 days of death for 1 of 1 supplemental resident (Resident #11). This practice has the potential to affect all residents with funds in a resident account. Findings include: Review of conveyance of funds following death occured on the morning of 11/08/16 with a business office staff member (#1). The resident trust account information identified Resident #11	F 160	1. One resident had been affected by this practice, but had been reimbursed prior to the survey occurrence. There were no other current accounts out of compliance. 2. Any resident with a Trust Account held by the facility has the potential to be affected by this practice. 3. A procedure has been implemented which includes the following information: A Change of Status form is completed by the charge nurse which includes the date and time of a resident□s death/ discharge, etc. The Hospital and Care Center office staff are included on this notification. Upon receipt of the Change	11/25/16

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

Electronically Signed | 11/23/2016

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F 160	Continued From page 1 expired on 06/09/16. The facility issued a check for the remaining balance of $46.04 on 07/28/16, 50 days later. During an interview on the morning of 11/08/16, the staff member (#1) agreed the facility failed to refund the resident's funds within 30 days of death.	F 160	of Status form, the Care Center business office will document in the area noted if a discharged/expired resident has funds in the Resident Trust Account, document the balance of that account, and send a copy to the Hospital Business office for notification and reimbursement. The Hospital Business office will provide the reimbursement to the applicable party, and inform the Care Center business office of the task completion within 7 days of the discharge date. 4. A QA monitor form has been developed and will be completed by the CFO or designee within 14 days of the resident□s discharge/death for every discharge/death since the survey exit to ensure timely reimbursement of resident funds. Monitor results will be reviewed every 15 days for every transfer/discharge/death to ensure compliance. A report of the monitoring and compliance will be provided as scheduled at the quarterly facility QA meeting.	
F 278 SS=E	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.	F 278		11/30/16

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F 278	Continued From page 2 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: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, and staff interview, the facility failed to complete Minimum Data Set (MDS) assessments which accurately reflected the resident's status for 5 of 9 sampled residents (Resident #1, #2, #4, #5, and #10). Failure to accurately code section E (Delusions) for Resident #1 and #4, section E (Physical/Verbal Behaviors) for Resident #5 and #10, and section H (Constipation) for Resident #2 does not allow the residents' assessments to reflect their current status/needs and may affect the level of care provided to the residents. Findings include:	F 278	1. The MDS assessments have been reviewed and modified for Resident□s #1, #4, and #2 to reflect their current status and verification of documentation in the medical record to validate the correct coding of the MDS. Resident□s # 5 and # 10 were discharged and had expired and as a result, were not able to interview the resident(s) and/or validate the identified concern. 2. All residents in the facility have the potential to be affected by inaccurate coding of the MDS. 3. The MDS coordinator and the Social Work Designee (SWD) will review all of the MDS assessments and coding, along with supporting documentation in the	

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F 278	Continued From page 3 BEHAVIORS The Long-Term Care Facility RAI 3.0 User's Manual, October 2015, pages E-2 through E-4 stated, ". . . *Check E0100B, delusions: if delusions were present in the last 7 days. A delusion is a fixed, false belief not shared by others that the resident holds true even in the face of evidence to the contrary. *Check E0100Z, none of the above: if no hallucinations or delusions were present in the last 7 days . . . Coding Tips and Special Populations, *If a belief cannot be objectively shown to be false, or it is not possible to determine whether it is false, do not code it as a delusion. *If a resident expresses a false belief but easily accepts a reasonable alternative explanation, do not code it as a delusion. If the resident continues to insist that the belief is correct despite an explanation or direct evidence to the contrary, code as a delusion. . . . E0200: Behavioral Symptom - Presence and Frequency . . . A. Physical behavioral symptoms directed toward others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually). . . B. Verbal behavioral symptoms directed toward others (e.g. threatening others, screaming at others, cursing at others.) . . ." - Review of Resident #1's medical record occurred on all days of survey. The significant change Minimum Data Set (MDS), dated 09/01/16, identified the resident as cognitively intact and had delusions during the seven day look-back period. A progress note, dated 08/29/16, stated, ". . . Looking for a pkg. [package] she said arrived y'day [yesterday], with a jacket and slacks for	F 278	medical record in relation to behaviors (verbal ; physical; sexual) and subsequent accurate coding on the MDS. Professional nursing staff have been provided education on hallucinations, delusions and behaviors in relation to adequate documentation for accurate coding of the MDS sections. The SWD has initiated a behavior log to be completed by direct care staff on an ongoing basis. This will ensure prompt documentation and notification of all resident behaviors. The SWD□s will investigate all allegations of behaviors. If the investigation indicates an actual behavior and/or potential change in the resident□s condition, they will notify the charge nurse and Interdisciplinary Care Plan team for a review and meeting to discuss the resident□s status/actions and determine appropriate interventions, notifications and changes to be made, as applicable, to the resident□s care plan, along with notification to the provider as needed to address concerns and ensure safety of the resident, other residents, and staff. Nursing education will include a policy review in relation to behaviors and constipation, interventions to be done, and the definitions and coding requirements for behaviors and constipation. 4. The Behavior log and subsequent documentation will be monitored weekly or as often as necessary by the SWD□s to ensure documentation and investigations are present to validate any behaviors and to ensure accurate coding	

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F 278	Continued From page 4 which she paid $100. Reminded y'day was Sunday, she replied 'Yes, we were all so surprised the package came on a Sunday.' Found her looking in room and closet across the hall. Enc. [encouraged] her to not look in other's rooms. . . . Spoke with nurse who worked y'day, who states no package were rec'd [received]. Res. [resident] gently told this, shakes head in response." The facility failed to identify if Resident #1 shook her head in agreement or disagreement when presented with the facts that occurred and failed to provide documentation to support the MDS coding for delusions. - Review of Resident #4's medical record occurred on all days of survey. Diagnoses included dementia. The annual MDS, dated 07/22/16, identified the resident experienced delusions during the seven day assessment period. A progress note, dated 07/21/16, stated, ". . . Went into residents [Resident #4] room to do her MDS assessment and before we could get started she told me a story: She stated '[family member's name] is alive, they held her you know and they did bad things to her . . . I am taking care of [family member's name] 8 year old son . . .' I interrupted her and talked about her day . . . When resident was telling me her story she firmly believed that is was real . . ." The facility failed to provide documentation to support the MDS coding for delusions. During an interview on the morning of 11/09/16, the social service designee (#2) stated she did not attempt to challenge Resident #4's thought process during the above interview.	F 278	on the MDS. The Medical provider will be notified to assess and evaluate any changes. Monitoring of bowel movements and initiating interventions to prevent constipation will be done daily.The DON/designee will complete a QA monitor on the MDS coding in relation to constipation and coding accuracy, as well as a monitor on the interventions implemented by staff per facility policy and standing order to ensure compliance. Monitoring will be completed daily X 30 days, and if 100% compliance is achieved, 3 times/wk X 1 month followed by every 2 weeks X 2 months with 100% continued compliance. The interdisciplinary care plan team will meet to review, evaluate and make changes to the resident□s care plan as applicable. A monthly monitor report will be made and reported as part of the QA process. Reports will be provided to the facilities QA committee quarterly by the Don/dedsignee, SWD□s or as often as needed to address any additional concerns and ensure ongoing compliance.	

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F 278	Continued From page 5 - Review of Resident #5's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease. The quarterly MDS, dated 09/11/16, identified physical behaviors during the seven day assessment period. Review of Resident #5's behavioral log, dated September 02-10, 2016, identified "sexually inappropriate" on 09/07/16. The nurses notes and behavioral log failed to identify the physical behavior pertaining to the resident's "sexually inappropriate" behavior. The facility failed to provide documentation to support the MDS coding for physical behaviors. During an interview on the morning of 11/09/16, the social service designee (#2) stated Resident #5 grabbed at a certified nursing assistant's (CNA's) breasts on 09/07/16, but could not find the supporting documentation. - Review of Resident #10's medical record occurred on November 08-09, 2016. The quarterly MDS, dated 04/27/16, identified physical and verbal behaviors during the seven day assessment period. Review of Resident #10's progress notes, dated April 20-27, 2016, identified "refusing to stay at the meal table" on 04/24/16. The nurses notes failed to identify the physical and verbal behavior pertaining to the resident's "refusing to stay at the meal table" behavior. The facility failed to provide documentation to support the MDS coding for physical and verbal behaviors.	F 278		

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F 278	Continued From page 6 CONSTIPATION The Long-Term Care Facility RAI 3.0 User's Manual (Version 1.13), October 2015, pages H-12 and H-13 stated, ". . . H0600 Bowel Patterns . . . Definition CONSTIPATION, If the resident has two or fewer bowel movements during the 7-day look-back period or if for most bowel movements their stool is hard and difficult for them to pass (no matter what the frequency of bowel movements). . . . Coding Instructions . . . Code 0, no: if the resident shows no signs of constipation during the 7-day look-back period. . . . Code 1, yes: if the resident shows signs of constipation during the 7-day look-back period. . . ." - Review of Resident #2's medical record occurred on all days of survey. Diagnoses included constipation. The annual MDS, dated 07/08/16, identified the resident did not experience constipation. The resident's bowel movement charting showed Resident #2 did not have a bowel movement from July 01-05, 2016, a total of five days. The facility failed to identify Resident #2's constipation during the seven day look back period and code the MDS for constipation.	F 278		
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309		11/30/16

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F 309	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, review of the facility's standing orders, and staff interview, the facility failed to follow their standing orders to promote regular bowel elimination for 5 of 9 sampled residents (Resident #1, #2, #3, #5, and #9) with bowel elimination exceeding the recommended three days without receiving as needed (PRN) bowel medications. Failure to follow the facility policy and the facility standing orders may have contributed to residents experiencing constipation and discomfort due to delayed bowel elimination. Findings include: Review of the facility policy titled "Bowel Assistance Policy" occurred on 11/09/16. This policy, dated October 2016, stated, ". . . 2 Unless otherwise indicated, on the third consecutive day a PRN laxative should be considered as ordered by the physician and standing orders. . . . 5. On day four of no BM [bowel movement], a stronger laxative should be considered per physician or standing order. . . ." Review of the facility's Physician's Standing Orders occurred on 11/09/16. These undated orders stated, ". . . Constipation a. If no stool after 3 days, give MOM [milk of magnesia] (for constipation) 30 cc [cubic centimeter]PRN. b. If no stool after 4 days, give a Bisacodyl Suppository (rectal) (for constipation) PRN. c. If the Bisacodyl Suppository is ineffective, give a Fleets enema PRN. . . ."	F 309	1. Resident□s #1, #2, #3 and #9 have been compliant with the Bowel program since completion of the survey. Documentation of Bowel movements have occurred with no need for any prn medications. No plan of corrective action is possible for Resident #5 as they expired. 2. All residents have the potential to be affected by this practice. 3. Nursing staff were informed of the survey findings along with a review of the facilities standing orders. The Medical Provider will review the standing orders on his next visit (11/28/16) to determine if any changes should be made in the standing orders protocol per the current policies and procedures. Education of the professional nursing staff (with the exception of two who will be educated on their next scheduled day of work) was done on 11/16/16. Education will include facility policies, interventions to be provided in relation to Bowel management, follow-up documentation and the resident□s right to refuse medications. The 24 hour report includes the BM list for nursing and aides to follow. 4. Nurse aide documentation of ADL□s , including Bowel movements will be monitored on a daily basis by the Day and Night charge nurses to ensure compliance. A QA monitor has been developed and is located on the back of	

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F 309	Continued From page 8 - Review of Resident #1's medical record occurred on all days of survey. Diagnoses included constipation. Medication to aide in bowel elimination included Bisacodyl suppository as needed if no BM after 4 days, Milk of Magnesia every twenty-four hours as needed, and Senokot S (laxative and stool softener) twice a day. Review of Resident #1's BM documentation, dated August 17, 2016 through August 24, 2016, showed no BM for 8 days and the electronic medication administration record (eMAR) showed no PRN medications administered. - Review of Resident #2's medical record occurred on all days of survey. Diagnoses included constipation. Medication to aide in bowel elimination included Milk of Magnesia every 24 hours PRN and Senokot S twice a day PRN. Review of Resident #2's bowel elimination records, dated July 01, 2016 through November 09, 2016 showed the following: *July 2016: No BM for 5 days on one occasion and no BM for three days on two occasions. *August 2016: No BM for 3 days on two occasions and no BM for 4 days on another occasion. *September 2016: No BM for 3 days on one occasion, no BM for 4 days on one occasion, and no BM for 5 days on another occasion. *October 2016: No BM for 4 days on one occasion and no BM for 5 days on another occasion. *November 2016: No BM for 3 days on one occasion.	F 309	the 24 hour Daily worksheet to ensure protocols and standing orders are followed and reported. The Administrator/RN or DON /Designee will monitor this report as well as documentation, residents with decreased fluid intake, those on pain medications, and decreased physical activity and correct any concerns on a daily basis until 100% compliance is achieved and maintained for 60 consecutive days.If compliant, weekly monitors X 4, biweekly X 2 and monthly monitors X 1. If compliance remains, random monitoring will be completed as directed by the DON□s, to ensure compliance remains as part of the QAPI process. Any identified non-compliance will be addressed immediately.	

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F 309	Continued From page 9 Resident #2's eMAR showed no PRN bowel medications administered on those dates. - Review of Resident #3's medical record occurred on all days of survey. Diagnoses included constipation. Medication to aide in bowel elimination included Senna plus twice a day. Review of Resident #3's BM documentation, dated July 17, 2016 through October 10, 2016 showed the following: * July 2016: No BM for 4 days on one occasion. * August 2016: No BM for 3 days on one occasion. * October 2016: No BM for 3 days on one occasion. Resident #3's eMAR showed no PRN bowel medications administered on those dates. - Review of Resident #5's medical record occurred on all days of survey. Medication to aide in bowel elimination included Senokot S (laxative and stool softener) twice a day, MOM PRN, and a Dulcolax suppository PRN. Review of Resident #5's bowel elimination records, dated 07/01/16 through 11/07/16, showed the following: * No BM from 08/05/16 to 08/08/16 (4 days). MOM administered on 08/09/16 with results * No BM from 08/14/16 to 08/18/16 (5 days). MOM administered on 08/18/16 with results * No BM from 08/23/16 to 08/26/16 (4 days). MOM administered on 08/26/16 without results * No BM from 08/29/16 to 09/03/16 (5 days).	F 309		

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F 309	Continued From page 10 MOM administered on 08/26/16 without results and administered again on 09/04/16 with results * No BM from 10/03/16 to 10/06/16 (4 days). Dulcolax suppository administered on 10/07/16 with results * No BM from 10/28/16 to 11/01/16 (5 days). MOM administered on 11/01/16 without results and a Dulcolax suppository administered on 11/02/16 with results - Review of Resident #9's medical record occurred on November 08-09, 2016. Diagnoses included constipation. Medication to aide in bowel elimination included Bisacodyl suppository as needed if no stool after 4 days and Milk of Magnesia every twenty-four hours as needed. Review of Resident #9's BM documentation for October 2016 showed no BM for 3 days on one occasion with no PRN medication documented for treatment. During an interview on 11/09/16 at 10:05 a.m., an administrative nurse (#3) stated he expected the facility to administer PRN bowel medications on day three as stated in the facility policy and physician standing orders.	F 309		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a	F 325		11/30/16

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F 325	Continued From page 11 nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to implement appropriate interventions to restore/maintain adequate nutritional status for 1 of 2 sampled residents (Resident #6) with weight loss. Failure to implement interventions resulted in Resident #6 experiencing weight loss. Findings include: Review of Resident #6's medical record occurred on all days of survey. Diagnoses included dementia and depression. The current care plan stated, "Resident will maintain good nutrition. . . . Low Fat, Mech [mechanical] Soft with cut meats . . . EATING: The resident is able to eat independently with set-up. Depending on her daily health functions she may have to be assisted to eat . . ." Observation on 11/08/16 at 8:00 a.m. (morning meal) and 11:40 a.m. (noon meal) showed Resident #4 seated at a supervised table and eating independently. Review of Resident #6's weights showed the following: * 05/06/16 - 163 pounds (lbs) * 06/10/16 - 162 lbs * 07/08/16 - 164 lbs * 08/05/16 - 160 lbs	F 325	1. The Dietary Manager visited with Resident # 6 re: the weight loss concerns. Monitoring of intakes is done for all meals. Resident indicates she is satisfied with her meals, indicated she is not hungry, and could not give any ideas re: foods or preferences that could improve her eating pattern. The family is aware of the weight loss and resident decline and have no suggestions to offer.; Family does participate in care conferences. The Resident was referred to the LRD for further consultation and clear supplements of choice will be initiated daily. The Resident will continue to be monitored daily for intakes and preferences, with continued review of her status. 2. All residents have the potential to be affected by weight loss. 3. A significant weight loss policy was developed by the LRD. On a monthly basis, the LRD, CDM, and the Care Team will review a monthly printout of weights, make adjustments to any resident□s nutritional care plan and document in their progress notes any nutritional concerns with an update/revision of their Care Plan, as applicable. The LRD will be informed of any potential or actual concerns identified and review the resident□s	

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F 325	Continued From page 12 * 09/02/16 - 159 lbs * 10/07/16 - 152.5 lbs * 10/14/16 - 154 lbs * 10/28/16 - 153 lbs * 11/04/16 - 151 lbs May 2016 to November 2016 represents a 12 pound weight loss in 6 months (7.4 percent (%)). Resident #6's nutrition progress notes stated the following: * 05/09/16 - "Wt [weight]: 163, BMI [body mass index]: 27. Diet order: Low fat, intake at meals ~ [about] 75%. Resident ~ nutritionally stable, continue current nutrition care plan." * 10/17/16 - "Wt: 152, BMI: 25.2. Diet order: Regular, added fiber, intake at meals ~ 75%. Estimated calorie needs ~ 1700 to 1800, estimated protein needs ~ 69 to 75 grams . . . Continue current nutrition care plan." During an interview on 11/09/16 at 9:15 a.m., the dietary manager (#7) confirmed Resident #6's gradual weight loss over six months.	F 325	intake and chart on her next weekly visit. 4. The CDM will monitor weights on a monthly basis prior to the Monthly Nutrition meeting and complete a weight change form for discussion at the meeting. The CDM will printout the Weight exception report from our EMR (Point Click Care) to also discuss at the monthly meeting. The CDM will add results of weight monitoring and weight loss to the QAPI monthly meeting. All residents will continue to be monitored for any weight loss.	
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to ensure the safe administration of medications for 1 of 1 sampled resident (Resident #6) who received medication prescribed for another resident.	F 333	1. Resident #1 was monitored for side effects and adverse reactions while hospitalized and for 72 hours upon return to the Care Center. The family was immediately notified and visited with the	11/17/16

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F 333	Continued From page 13 Failure to administer medication to the correct resident resulted in hospitalization for Resident #6. Findings include: Review of the facility policy titled "MEDICATION ADMINISTRATION" occurred on 11/09/10. This policy, revised October 2016, stated, ". . . 3. Procedure: a. Review the EMAR [electronic medication administration record] to determine which residents need to receive medication . . . e. The '6 Rights' must always be checked before administering any medication: . . . 5. Right resident - If unsure, a photo of each resident is on the MAR . . ." Review of Resident #6's medical record occurred on all days of survey. Diagnoses included dementia and macular degeneration. The annual Minimum Data Set (MDS), dated 10/13/16, identified moderately impaired cognition. A nursing progress note, dated 07/11/16 at 12:07 a.m., stated, "Resident [Resident #6] was given the wrong medication along with Insulin at HS [hour of sleep] on 7-10-16. Resident given a jello in which she ate 100% along with 3/4 can grape juice. HCP [healthcare provider] on call notified at 2120 [9:20 p.m.] with verbal orders received to transfer resident via ambulance to hospital for further evaluation. Blood sugar obtained at 2045 [8:45 p.m.]-190 . . . 2145 [9:25 p.m.]-Ambulance called. 2155 [9:55 p.m.]-Blood sugar obtained prior to leaving facility-216. 2155-Resident left via ambulance for further evaluation. 2225 [10:25 p.m.]-Son, [name of son] notified by phone regarding this incident. . . ."	F 333	nursing staff and SWD re: the error. The DON visited with the nurse involved and reviewed the medication administration policies, monitored her medication administration X 3 and she was spoken to by the Medical Staff re: the error, what was learned, and what actions she will now take to prevent any further errors. Education was provided to all staff re: interruptions while administering medications and steps to take to verify correct medication administration. The staff nurse has not experienced any additional medication errors. 2. All residents have the potential to be affected by this deficient practice. 3. Staff were informed of the error and medication administration policies and procedures were reviewed again at the nursing education meeting on 11/16/16. Skills verification was completed for the nurse involved and will be completed on all nurses on an ongoing basis to very their compliance with medication administration. Nurse observation during the survey process revealed no errors in the medication pass. Reporting of any errors and noncompliance will continue to be reported with appropriate notifications to the DON and medical staff. There have been no medication errors committed since that event. The professional nursing staff and Travel nurse orientation program was reviewed with no revisions made. 4. Observation of nursing staff during medication passes, review of the Medication Administration records, and medication supply variances will be	

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F 333	Continued From page 14 A nursing progress note identified Resident #6 returned from the hospital on 07/13/16, two days after receiving the wrong medication. Review of the information provided by an administrative nurse (#3) on the morning of 11/09/16 identified Resident #6 erroneously received another resident's medication. The medications included Seroquel (an antipsychotic medication) 125 milligrams (mg), Ramipril (a medication to treat high blood pressure) 10 mg, and Lantus insulin 36 units. The nurse failed to follow the facility's policy and procedure to ensure the right resident received the right medication. This resulted in a two day hospitalization for Resident #6.	F 333	monitored as per occurrence. Completion and documentation for the medication error will follow the facility policy. Any variances will be reported to the Medical provider& DON and immediately reviewed. The pharmacy consultant will be notified, as applicable, to provide additional education and medication reviews to ensure continued compliance. Staff who make a medication error will be monitored and observed to ensure the safe medication administration for all residents to ensure complete compliance. Reports will be completed and reported on a quarterly basis if a medication error occurs along with the investigation completed as part of the QAPI process. Additional disciplinary processes, reviews, and reporting by the DON will be completed as required and applicable to professional agencies.	
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census.	F 356		11/30/16

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F 356	Continued From page 15 The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to post accurate nurse staffing data on 3 of 3 days of survey [November 7-9, 2016]. Failure to post accurate nurse staffing data denied residents and visitors the opportunity to be informed regarding the staffing levels. Findings include: Observations throughout the survey identified the following: *11/07/16 at 1:50 p.m., all shifts: morning, evening, and nights were posted for 11/07/16. *11/08/16 at 9:30 a.m., all shifts: morning, evening, and nights were posted for 11/08/16. *11/09/16 at 8:00 a.m., all shifts: morning, evening, and nights were posted for 11/09/16. During interviews on the afternoon of 11/08/16,	F 356	1. The policy/procedure and posting form for the nurse staffing and census information was changed to include reporting of the information for both shifts (6 am and 6 pm), as well as reporting any changes as they occur in the staffing numbers and the resident census. No other items were changed in the policy/procedure. 2. All patients, family members and visitors could be affected by this deficient practice. 3. The form was changed to reflect the current staffing level and census at the start of the shift. An area was added to the lower portion to indicate any changes in the staffing hours, the resident census, and the time of change. Nursing staff were educated re: the change and the	

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F 356	Continued From page 16 two nurse managers (#3 and #4) identified the night shift nurse is responsible for posting staffing information and no one updates staff changes.	F 356	revised form and policy procedure on 11/16/15. No other changes were made. 4. Monitoring of the form will be done by the DON□s, SWD, and/or Resident Care coordinator to ensure accurate documentation and posting of staffing and resident census. A review of the medical records for transfers, discharges, out on leave, bed holds etc. will be compared to the census sheets to ensure ongoing accuracy. Checks will be done daily X 2 weeks for both shifts until 100% compliance is achieved by all nursing staff. If 100% compliance is achieved, random checks of both shifts will be completed a minimum of 2-3 times a week, including weekends/holidays, until 100 % compliance is maintained X 2 weeks, and random checks will be incorporated into the DON and SWD□s monthly QAPI monitor to verify continuing compliance for at least 2 calendar quarters.	
F 373 SS=F	483.35(h) FEEDING ASST - TRAINING/SUPERVISION/RESIDENT A facility may use a paid feeding assistant, as defined in §488.301 of this chapter, if the feeding assistant has successfully completed a State-approved training course that meets the requirements of §483.160 before feeding residents; and the use of feeding assistants is consistent with State law. A feeding assistant must work under the supervision of a registered nurse (RN) or licensed practical nurse (LPN).	F 373		11/30/16

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F 373	Continued From page 17 In an emergency, a feeding assistant must call a supervisory nurse for help on the resident call system. A facility must ensure that a feeding assistant feeds only residents who have no complicated feeding problems. Complicated feeding problems include, but are not limited to, difficulty swallowing, recurrent lung aspirations, and tube or parenteral/IV feedings. The facility must base resident selection on the charge nurse's assessment and the resident's latest assessment and plan of care. NOTE: One of the specific features of the regulatory requirement for this tag is that paid feeding assistants must complete a training program with the following minimum content as specified at §483.160: o A State-approved training course for paid feeding assistants must include, at a minimum, 8 hours of training in the following: Feeding techniques. Assistance with feeding and hydration. Communication and interpersonal skills. Appropriate responses to resident behavior. Safety and emergency procedures, including the Heimlich maneuver. Infection control. Resident rights. Recognizing changes in residents that are inconsistent with their normal behavior and the importance of reporting those changes to the supervisory nurse. A facility must maintain a record of all individuals	F 373		

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F 373	Continued From page 18 used by the facility as feeding assistants, who have successfully completed the training course for paid feeding assistants. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to ensure a registered nurse (RN) assessed the residents' ability to be fed by a paid feeding assistant (PFA) for 2 of 2 residents (Resident #12 and #13) fed by a PFA. Findings include: Observation during the dinner meal on 11/08/16 at 5:28 p.m., showed a PFA (#5) assisting Resident #12 to eat. - Review of Resident #12's medical record occurred on 11/08/16. The quarterly Minimum Data Set (MDS), dated 09/05/16, identified a swallow disorder with loss of liquids/solids from mouth when eating or drinking, holding food in mouth/cheeks or residual food in mouth after meals, and needing a mechanically altered diet. The resident's current care plan stated, ". . . Feeding assistance may help feed resident PRN [as needed]. . ." The facility failed to complete a PFA assessment for Resident #12. - Review of Resident #13's medical record occurred on 11/08/16. The quarterly MDS, dated 08/13/16, identified a swallow disorder with loss of liquids/solids from mouth when eating or drinking and holding food in mouth/cheeks or residual food in mouth after meals, and needing	F 373	1). An assessment form has been developed for any resident to be completed by a licensed nurse to determine if the resident may be fed by a paid feeding assistant. This will be completed on all applicable residents prior to the utilization of a feeding assistant during their meals. The assessment was completed by a licensed nurse for Resident # 12 and # 13. The assessment indicates Resident # 12 and # 13 may be fed by a feeding assistant. The Feeding Assistant Policy was reviewed and revised to include the feeding assistant will verify with the charge nurse regarding her feeding assignment prior to each meal to ensure there has been no change in the resident□s status. The Feeding Assistant was informed of the need to verify the status of each resident assigned with the charge nurse prior to each meal to ensure the resident(s) have not had a change of status and can be fed by the feeding assistant. The nursing care plan for Resident # 12 and #13 was reviewed to indicate completion of the assessment by the charge nurse and the intervention added for the feeding assistant to verify each resident □s status with the charge	

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F 373	Continued From page 19 a mechanically altered diet. The resident's current care plan stated, ". . . Feeding assistance may help feed resident PRN . . . Mechanical Soft Diet . . ." The facility failed to complete a PFA assessment for Resident #13. During an interview on 11/09/16 at 10:08 a.m., an administrative nurse (#6) confirmed staff failed to complete a PFA assessment for Resident #12 and #13.	F 373	nurse prior each meal assigned. The Feeding assistant verified her understanding of same and the Charge nurse verified the feeding assistant did report prior to the meals she was assigned to assist at, and inquired re: the status of each resident and if there were any changes she needed to be aware of prior to feeding Resident # 12 and # 13. 2). All residents have the potential to be affected by this practice. 3).The completion and implementation of the revised assessment form and verification by the feeding assistant of her feeding assignment prior to each meal should ensure this practice will not recur. Feeding assistants will have a skills assessment completed least annually to ensure their continued competency and compliance with verification of feeding assignments. Assessments will be ongoing and completed as often as needed to reflect a resident□s change of status and eligibility for utilizing a feeding assistant. The resident□s care plan will include the Feeding assistant assignment along with interventions to take if a change in status occurs. 4). Facility staff will monitor any changes of the eligibility of any resident being considered or currently receiving assistance in eating by a feeding assistant and document same in the resident□s medical record. An assessment of the resident will be completed prior to the assignment of a feeding assistant. Observation of the feeding assistant, skills observation	

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F 373	Continued From page 20	F 373	annually or as often as needed, verification by the feeding assistant prior to each feeding assignment, and verification of the completion of the assessment prior to using a feeding assistant will be included and documented in the resident□s care plan. A reassessment and resident review as a result of any change in status for each resident will also be completed as needed. The DON□s /designee will monitor completion of those tasks, observation of the feeding assistant, and if the assessment accurately reflects the resident status initially X 1 week and if 100% compliance is obtained, continue monitoring to ensure 100 % compliance is maintained, as well as initiate monitoring if a resident□s status changes and a reassessment is needed.	