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	355052	A. BUILDING _____ B. WING _____	12/18/2014

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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 December 15, 2014 and completed on December 18, 2014, the sample included two (2) residents for complete review, seven (7) residents for focused review, and one (1) closed record for review. The sample included five (5) additional residents to verify specific concerns during the survey.	F 000		
F 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.	F 156	**F 156** 1. Residents or there legal representative will be given the proper forms for termination of services from Medicare A. Forms will be given 48 hours prior to termination of Medicare A. The appeals process will be explained and resident\legal representative will then indicate on the form if they want to appeal or not. When the form is received, staff will verify that it is complete. If it is not complete the Social Service Designee (SSD) or her designee will contact the person signing the form and verify their intent. 2. All residents receiving Medicare A benefits have the potential to be affected by this deficient practice. 3. The policy will be revised to include the reason for denials to be given in a timely manner. This will be done to ensure that the residents will have the opportunity to request a demand bill. All residents will be given notice of Medicare denial 48 hours prior to benefits changing. The SSD or someone appointed by her will issue the notice and documentation will be placed in the medical records that resident received notice of denial and has	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: K Bruce Bowersox | TITLE: CEO/Administrator | (X6) DATE: 1/14/2015

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 156	Continued From page 1 The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.	F 156	**F 156, continued** been informed of their right to appeal. Original forms will be given to the resident and copy will be placed in the chart under the Social Service section. A change of status form will be given to the Director of Nursing, MDS coordinator and Business Office. Copies of the denials will be given to the Social Service Office. 4. Date of next Medicare denial. 5. QA will be conducted for the next 6 months to document compliance and assure resident\legal representative have received and understand the appeals process. The first QA monitoring will be done at the time of the next notification of a Medicare change.	~~03/6/15~~ 01/22/15 Per T.C. with Linda Walen on 1/22/15 DON P Dunnon

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F 156	Continued From page 2 The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on review of Medicare billing records and staff interview, the facility failed to ensure the beneficiary or person acting on behalf of the beneficiary specified/marked the option for submitting to Medicare, a demand bill for 2 of 3 residents (Resident #10 and #13) reviewed who were issued a notice of termination of Medicare coverage. Failure to confirm the resident's or representative's decision regarding a request for a demand bill, limited the facility's ability to ensure residents were able to exercise their rights to a demand bill. Findings include: Review of the facility's Medicare billing records occurred on 12/16/14. The records identified Resident #10's last day of Medicare coverage as 08/13/14; and Resident #13's last day of Medicare coverage as 08/24/14. Neither resident, or their representative, indicated whether they did/did not desire a review of termination of coverage.	F 156		

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F 156	Continued From page 3 During an interview on 12/16/14 at 3:30 p.m., a staff member (#1) verified not always reviewing the notice after signed by the beneficiary or person acting on the beneficiary's behalf to determine if a demand bill should be submitted to Medicare.	F 156		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update	F 157	F157 1. The resident's infection was treated and she currently is free of infection 2. All residents have the potential to be affected. There are many different infections each with it's own signs and symptoms. Each resident will be observed for signs and symptoms that could indicate some type of infection. If there is an indication that they have an infection, their primary physician will be notified for orders. 3. The policy on physician notification has been revised. Licensed staff will be educated at a mandatory meeting 1/15/15 regarding the importance of notifying the resident's primary care provider so that treatment of a possible infection can be started as soon as possible. The DON will take a more active role in making sure that provider notifications are occurring. We are now using Point Click Care as our electronic medical record. This allows the DON the capability of accessing all resident documentation from her desk. Should any documentation be done that may indicate the need for physician notification, the DON will ensure that is done or will do so herself. 4. 01/22/15	

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F 157	Continued From page 4 the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to notify the physician in a timely manner for 1 of 1 sampled resident (Resident #2) with signs and symptoms of an infection. Failure of the facility to notify the resident's physician resulted in a delay in treatment. Findings include: Review of Resident #2's medical record occurred on all days of survey. Diagnoses included anoxic brain damage, dysphagia and a gastrostomy tube. Review of Resident #2's "Nurse's Notes" from 06/18/14 through 07/15/14 showed 10 entries that documented the condition of the skin around the percutaneous endoscopic gastrostomy (PEG) tube as red, raw and drainage noted. The Nurse's Notes showed on 07/15/14 (28 days after the first documentation,) the facility contacted the medical provided regarding odor and discharge at the PEG site. The facility received an order to culture the site. The culture showed Methicillin Resistant Staphylococcus Aureus (MRSA). On 07/21/14 Resident #2 started receiving an antibiotic for the infection. During an interview on 12/17/14 at 5:30 p.m., an administrative nurse (#2) stated staff should have notified the physician sooner.	F 157	**F 157, continued** 5. Monitoring was started 1/8/15 by the DON who reviewed nurses' progress notes that had been written the past 2 days. A QA form was developed to record that the review was done and that areas of concern were addressed. The review will be completed at least weekly for 3 months, then monthly until the end of 2015.	01/22/15

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F 157	Continued From page 5 Refer to F309	F 157		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility staff failed to provide care in a manner and environment that maintained or enhanced each resident's dignity/self-esteem for 2 of 2 sampled residents (Resident #1 and #2) observed during personal cares and/or medication administration. Failure to ensure dignity and respect during personal cares and medication administration does not recognize the individuality of each resident or enhance the quality of life for each resident. Findings include: Review of the facility "Standards of Practice" policy occurred on 12/18/14. The policy, dated 11/06/12, stated, ". . . Provide privacy during all care - pull privacy curtains, close the door, pull the drapes. . . ." - During observation on 12/17/14 at 8:15 a.m., a nursing staff (#3) assisted Resident #1 to her bed, pulled her slacks down, and pulled her undergarment upward to expose the upper thigh area, and then applied a topical patch (Lidoderm 5%) to Resident #1's right upper thigh area.	F 241	F241 1. All NCHS nursing staff passing medications will be observed doing so with the 2 residents noted in this citation. 2. All other residents have the potential to be affected by issues of dignity and privacy. Staff will be monitored using QA to ensure they are being treated appropriately. 3. Licensed staff will be educated at a mandatory meeting 1/15/15 about dignity and respect. 4. 1/22/15 5. Privacy and dignity have been added to the QA for the medication pass. All NCHS licensed staff who pass medications will be observed to ensure that this is happening. After each is observed, an additional observation will be completed each month throughout 2015. We will review the rights of all residents to be treated with dignity and respect.	01/22/15

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F 241	Continued From page 6 During this time the staff left the window blinds to the outdoors open. - During observation on 12/17/14 at 9:30 a.m., a nursing staff (#3) administrated medications through Resident #2's feeding tube. During this observation, the nurse (#3) left the privacy curtain open between the resident and her roommate. Leaving the privacy curtain open allowed the resident's roommate full visual view of Resident #2. - On 12/17/14 at 10:00 a.m., a nurse (#3) administered a breathing treatment to Resident #2. Observation showed drooling from the left side of the resident's mouth and draining onto the resident's anterior neck area. The nurse failed to wipe the drool off the resident's face and neck and moved the resident by wheelchair to a TV/lounge area with other residents present. During interview on 12/17/14 at 5:00 p.m. two administrative staff (#2 and #4) stated the blinds and/or privacy curtain should be pulled when cares are provided. Both staff members agreed the nurse should have wiped the drool off Resident #2 before removing the resident from his/her room.	F 241		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.	F 278	**F- 278** 1. This item addresses conversations with Residents regarding the MDS section D-PHQ-9 mood disorder question. If resident states that they have thoughts that they would be better off dead or are thinking of hurting themselves, the policy and procedure for suicidal precautions will be implemented. A training video for	

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F 278	Continued From page 7 A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual (Version 3.0) and staff interview, the facility failed to ensure the Minimum Data Sets (MDSs) accurately reflected the residents' status for 2 of 10 sampled residents (Resident #2 and #5) coded incorrectly on the MDS. Failure to accurately assess the residents and code the MDS correctly may affect the level of care provided to residents. Findings include: The Long-Term Care Facility RAI User's Manual, October 2014, stated the following:	F 278	**F 278, continued** the MDS section D will be viewed by the Social Service Designee and MDS coordinator for proper coding of section D by 1-22-2015. 2. All residents of the facility have the potential to be affected by this deficient practice. 3. Suicide assessment and precautions policy has been revised and will be implemented. It will be followed by the Social Service Designee that conducts the MDS section D interviews. If a "yes" answer is obtained on question I of the PHQ-9 and a "yes" answer is generated on D0350 proper notification will be conducted as per revised policy. 4. 1-22-2015 5. QA will be conducted for the next 3 months to monitor compliance with revised policy. Staff will then assess and decide if further monitoring is needed.	

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F 278	Continued From page 8 Page D-10, D0350 Safety Notification - Complete only if D0200I1=1 indicating possibility of resident self harm? Was responsible staff or provider informed that there is a potential for resident self harm? This item documents if appropriate clinical staff and/or mental health provider were informed that the resident expressed that he or she had thoughts of being better off dead, or hurting him or herself in some way. - Review of Resident #2's medical record occurred on all days of survey and identified a history of depression. The Resident Mood Interview section of the significant change MDS, dated 04/26/14, identified potential for self harm and the responsible staff or provider informed. Resident #2's medical record lacked evidence the facility notified the responsible staff or provider. - Review of Resident #5 medical record occurred on all days of survey and identified a diagnosis of depression. The Resident Mood Interview section of the quarterly MDS, dated 07/27/14, identified potential for self harm and the responsible staff or provider informed. Resident #5's medical record lacked evidence the facility notified the responsible staff or provider. During an interview on 12/17/14 at 11:30 a.m., a social services staff member (#1), verified the responsible staff or provider was not notified.	F 278		
F 281	483.20(k)(3)(i) SERVICES PROVIDED MEET	F 281		

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F 281 SS=D	Continued From page 9 PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, review of professional reference, and staff interview, the facility failed to ensure the services of medication administration met professional standards of practice for 2 of 7 sampled residents (Resident #2 and #12), observed during medication administration. Failure to clarify physician's orders, prepare medications from clearly labeled bottles, reconcile medication administration records with physician's orders, prepare liquid medications using aseptic technique, ensure proper placement of a feeding tube prior to medication administration, and ensure notification of the physician of unavailable medications has the potential to cause negative outcomes to residents. Findings include: Review of the facility policy titled "Medication Administration" occurred on 12/18/14. This policy, revised February 2014, stated, ". . . The services provided or arranged by the facility must meet professional standards of quality . . . Policy . . . General Considerations . . . All medication directions from the original order to the MAR [medication administration record] to the pharmacy label on the medication should correlate. . . . Medications should not be given from an unlabeled bottle or card. . . . 3. Procedure . . . The '6 Rights' must always be checked before	F 281	F281 1. Corrective action for the resident with the PEG tube will be accomplished through the education of the nurses and QA that will be completed. Verifying placement of the PEG tube by comparing the length of the external tube to what is on the care plan was added to the MAR to ensure completion. Corrective action for the resident whose medication was not available will be through the measure listed in the answer to F 281, #3 below. 2. Any resident who has a PEG tube has the potential to be affected in the same way as the resident above. Any resident has the potential to be affected by unavailable medication. We will identify them by the use of the form that has been developed. 3. The policy for medication administration will be reviewed at a mandatory meeting for licensed staff on 1/15/15. At that meeting, the citation particulars will be reviewed including the necessity for having the MAR available to clarify orders as medication is dished; that all medications, excluding stock medications, need to be labeled; that liquid medications need to be dished using aseptic technique and that the physician must be notified of medications that are not available. The policy on G-tubes will also be reviewed to reinforce the importance of checking proper	

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F 281	Continued From page 10 administering any medication . . . 2. Right dose . . . h. If a medication is unavailable, call the physician for a substitute or get an order for a 'HOLD' until the right medication is available. . . . 4. Documentation a. Sign initials on the MAR for each medication after the medication has been given. . . ." Review of the facility policy titled "Enteral Tube Feeding" occurred on 12/18/14. This policy, dated November 2012, stated, ". . . Procedure . . . Confirm the correct placement of the feeding tube. . . . b. Other [other than nasogastric] tubes - Measure the external length of the tube and compare to the length documented in the nursing care plan. . . ." Kozier & Erb's "Fundamentals of Nursing, Concepts, Process and Practice," 9th Edition, dated 2012, pages 860 and 868 states, ". . . Nurses who administer medications are responsible for [to] . . . Call the person who prescribed the medication for clarification. . . . Use only medications that are in a clearly labeled container. . . . Compare the label of the medication container or unit-dose package against the order on the MAR or computer printout. Rationale: This is a safety check to ensure that the right medication is given. . . . Prepare the medication. . . . Prepare the correct amount of medication for the required dose, without contaminating the medication . . . Aseptic technique maintains drug cleanliness. While preparing the medication, recheck each prepared drug and container with the MAR again. Rationale: This second safety check reduces the chance of error. . . ." - During observation of medication preparation on	F 281	**F 281, continued** placement of the tube prior to medication administration. We will also go over the new form for notification of unavailable medications. 4. 1/22/15 5. All NCHS licensed staff who pass medications will be observed during a medication pass that will include the 2 residents who were affected by this citation. The QA used will include all of the concerns in the citation. The form that will serve as notification and QA for the DON to monitor medications that are not available will be completed each time a medication is not available and will be ongoing.	01/22/15

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F 281	Continued From page 11 12/17/14 at 9:30 a.m., a licensed nurse (#3) entered the medication room to obtain refrigerated liquid medications for Resident #2. The nurse proceeded to obtain the medications without the MAR to verify the orders. Upon request from the surveyor, the nurse exited the med room and returned with the MAR. Observation showed the nurse (#3): * poured liquid omeperazole (Prilosec) from the bottle into a medication cup, withdrew six milliliter (ml) from the medication cup for administration, returned the excess into the medication bottle, rinsed out the syringe with water, and placed the syringe (for reuse) into the medication refrigerator. The syringe lacked a date to determine how long this syringe had been used. * poured both liquid acetaminophen and Keppra into separate medication cups and poured the excess liquid back into the original bottle. - On 12/17/14 at 9:30 a.m., observation showed a licensed nurse (#3) prepared liquid medications for Resident #2. The medication administration record (MAR) showed an order for omeperazole (Prilosec) 20 milligrams (mg). The label on the bottle identified the medication as omeperazole, but lacked a label with the resident's name and instructions for administration. The manufacturer's label lacked the amount of drug per ml of liquid. The nurse poured 10 ml into a medication cup. When asked regarding the dose, the nurse stated the dose was 10 ml. The nurse failed to confirm the proper dose of liquid medication to administer. - During the observation of medication administration through a feeding/gastrostomy tube for Resident #2 on the morning of 12/17/14, the nurse (#3) failed to ensure placement of the	F 281		

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F 281	Continued From page 12 tube, including comparing it to the length documented in the nursing care plan. - Following the observation on the morning of 12/17/14 of medication administration for Resident #2 by the nurse (#3), the nurse returned to the MAR and signed off the medications administered. The nurse signed off a 10:00 p.m. medication and when questioned by the surveyor, the nurse crossed a line through it. - During observation of medication administration on the morning of 12/16/14, Resident #12's MAR included an order for the antibiotic trimethoprim (Bactrim) for a three times weekly dosing, on Monday, Wednesday and Friday. The MAR showed nursing staff identified the medication not available beginning on 12/03/14 resulting in five missed doses through 12/15/14. The MAR and/or medical record lacked evidence nursing staff notified the physician of the unavailable medication for a substitute or a hold order until the medication became available. During interview on 12/17/14 at 5:00 p.m., two administrative staff (#2 and #4) agreed unused liquid medications should not be poured back into the bottle and stated feeding tube placement is determined by measurement of the tube.	F 281		
F 309 SS=D	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	309 1. The resident's infection was treated and she is currently free of infection. 2. All residents have the potential to be affected. There are many different infections each with it's own signs and symptoms. Each resident will be observed for signs and symptoms that could indicate some type of infection. If ~~there is an indication that they have an~~	

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F 309	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to respond to the development of an infection and provide the necessary care and services for 1 of 1 sampled resident (Resident #2) diagnosed with an infection. The facility's failure to recognize and notify the physician of the change in the condition at the site of the resident's percutaneous endoscopic gastrostomy (PEG) tube lead to a delay in diagnosis and treatment for an infection. Findings include: Review of Resident #2's medical record occurred on all days of survey. Diagnoses included a gastrostomy tube. Review of Resident #2's nurses notes' showed the following: *6/18/14 at 7:00 a.m., "Skin around tube site reddened. Moderate amount of thick tan drainage on dressing noted. Area cleansed [with] safe cleanse, Lantiseptic [a barrier cream] applied to reddened area . . . " *6/19/14 at 1:00 p.m., "Small amt [amount] bldy [bloody] & [and] tan drge [drainage] cleansed from peg site . . . " *6/19/14 at 10:30 p.m., "Moderate amount of odorous tan, green drainage noted from PEG tube site at this time [with] cares. Site is red and raw area cleansed and dried and new dressing applied. Lanoseptic [sic] applied to area. Resident denies pain. Will monitor." *6/20/14 at 10:00 p.m., "Noted medium amount of	F 309	**F 309, continued** infection their primary provider will be notified for orders. 3. The policy on provider notification has been revised. Licensed staff will be educated at a mandatory meeting 1/15/15 regarding the importance of notifying the resident's primary care provider so that treatment of a possible infection can be started as soon as possible. The DON will take a more active role in making sure that provider notifications are occurring. We are now using Point Click Care as our electronic medical record. This allows the DON the capability of accessing all resident documentation from her desk. Should any documentation be done that may indicate the need for physician notification, the DON will ensure that is done or will do so herself. 4. 1/22/15 5. Monitoring was started 1/8/15 by the DON who reviewed nurses' progress notes that had been written the past 2 days. A QA for was developed to record that the review was done and that areas of concern were addressed. The review will be completed at least weekly for 3 months, then monthly until the end of 2015.	01/22/15

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F 309	Continued From page 14 tan, green drainage from PEG site [with]cares. Site is red, raw and irritated. Resident denies pain. area cleaned dried, Lanoseptic [sic] and new dressing applied." *6/25/14 at 9:00 p.m., "Noted small amount of yellow, green drainage from PEG tube site. Area is also red, raw and irritated. Area cleansed lanoseptic [sic] applied [with] new dressing." *6/26/14 at 10:00 p.m., "Noted small amount of brown, green drainage [with] PEG site cares area around tube insection [sic] site is red, raw and irritated. Res [resident] denies pain. Area cleansed lanoseptic [sic] applied new dressing applied." *7/1/14 at 1:00 p.m., "Res peg site remains reddened small amt [amount] tan/brown drge no c/o [complaints of] pain [with] cleaning." *7/01/14 at 10:30 p.m., "Noted that resident's PEG site remains reddened and raw. Small amount of tan/brown drainage noted [with] odor noted . . . " *7/2/14 at 10:15 p.m., "Noted PEG site remains raw, red and irritated, small amount of green brownish drainage noted [with] cares. No odor noted. No pain noted." *7/3/14 at 6:00 a.m., "PEG tube site cleansed skin slightly red. Had bloody grn [green] drng [drainage] [with] slight odor." *7/15/14 at 2:30 p.m., "[medical providers name] informed of peg site odor & discharge orders rec'd [received] to culture site." *7/16/14 at 8:00 a.m., "Culture obtained et [and] sent to lab." *7/21/14 at 1:00 p.m., ". . . C&S [culture and sensitivity] of peg site culture R/T [related to] [sic] [with] New orders rec'd from NP [nurse practitioner]" The record lacked assessment or documentation of the site from 7/4/14 until 7/15/14.	F 309		

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F 309	Continued From page 15 Review of a culture report dated 07/20/14 showed Methicillin Resistant Staphylococcus Aureus (MRSA). On 07/21/14 Resident #2 received an order for Septra DS (an antibiotic) twice a day for 10 days. A medical provider's progress note dated 07/22/14, stated, ". . . seen on routine rounds. She has been having increased drainage around her tube and this was cultured as MRSA. Has just started tx [treatment] with Septra . . . " During an interview on 12/17/14 at 5:30 p.m., an administrative nurse (#2) stated staff should have notified the physician sooner. The facility's staff failed to recognize the infection and act in a timely manner in regard to the signs and symptoms. The facility contacted the medical provider regarding odor and discharge at the PEG site on 07/15/14, 28 days after staff first documented an abnormality with the PEG site. This failure to notify the medical provider placed the resident at risk of complications and caused a delay in treatment of an infection.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS 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:	F 312	**F312** 1. The resident who was listed in this deficiency will have oral care listed as a part of the tasks in Point of Care that the CNAs' are responsible for documenting. They will be asked if they completed oral care. This will confirm that it has been completed AM and PM. It will be a visual reminder that oral care needs to be completed.	

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F 312	Continued From page 16 Based on observation, record review, review of professional reference, review of facility policy, and staff interview, the facility failed to provide the necessary care and services to maintain good oral hygiene for 1 of 1 sampled resident (Resident #2) who was NPO (nothing by mouth) and dependent on staff for oral hygiene. Failure to perform oral hygiene has the potential to negatively affect the resident's oral health. Findings include: Berman and Snyder, "Kozier & Erb's Fundamentals of Nursing: concepts, process, and practice", 9th edition, Pearson, Boston, page 774, states ". . . Certain clients are prone to oral problem because of an inability to maintain oral hygiene. Among these are clients who are seriously ill, confused, comatose, depressed, or dehydrated. . . . Mouth care should be performed every 2 hours on these clients. . . . people with nasogastric tubes or who are receiving oxygen are likely to develop dry oral mucous membranes, especially if they breathe through their mouths. . . ." Review of the facility policy titled "Routine Care" occurred on 12/18/2014. This policy, revised 11/06/12, stated, ". . . Each of the following is a part of the routine care provided by caregivers, unless otherwise directed. . . . Daily Morning Care Standards: . . . Provide oral care-brush teeth and/or dentures. Cleanse the oral cavity of those without teeth or dentures using a toothette. . . ." Review of Resident #2's medical record occurred on all days of survey. Diagnoses included anoxic brain damage, dysphagia, and aphasia. The quarterly Minimum Data Set (MDS), dated	F 312	**F 312, continued** 2. All residents have the potential to be affected by this. 3. On 1/14/15, an in-service on oral care will be presented by the ND Department of Health - Oral Health Division. Many staff may not be aware of the negative repercussions that can occur when oral care is not completed. NCHS staff are being required to attend a mandatory in-service that will show them the importance of oral care and what it can mean for the health of their residents._We will initiate the QA process to monitor that oral care is being completed. 4. 1/22/15 5. Each NCHS CNA will be monitored using an oral care QA. Once each has been monitored, they will again be monitored after 3 months. Oral care is a part of their annual CNA skills and will again be monitored as each comes up for their annual evaluation. This will be an ongoing QA.	01/22/15

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F 312	Continued From page 17 11/11/14, identified extensive assistance of one person for personal hygiene. Resident #2 received gastrostomy tube feedings and nothing by mouth (NPO) and receives oxygen per nasal cannula. Resident #2's current care plan stated, ". . . Focus: Resident has full set of dentures . . . Interventions: Provide good oral cares . . . Focus: The resident has an ADL [activities of daily living] self-care performance deficit . . . Interventions: Personal Hygiene/Oral Care: The resident is totally dependent on 1X [one] staff for personal hygiene and oral care. . . ." Observations of Resident #2 occurred on 12/16/14 at the following times: * 8:30 a.m., resident resting in bed * 8:45 a.m., nurse providing treatments * 9:30 a.m., certified nurse aides (CNAs) preformed morning cares, with no oral cares observed * 10:00 a.m., resident attended activities * 11:30 a.m., CNA preformed restorative exercises * 12:00 p.m., CNAs transferred Resident #2 from wheelchair into bed, and provided incontinence cares * 1:45 p.m., resident in bed * 2:10 p.m., CNAs checked, changed and provided incontinence cares * 4:30 p.m., CNAs provided personal hygiene cares and changed the resident's clothes Observations from 8:30 a.m. to 4:30 p.m. on 12/16/14 (8 hours) showed facility staff failed to provide oral cares for Resident #2. During an interview on 12/17/14 at 5:30 p.m., an	F 312		

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F 312	Continued From page 18 administrative nurse (#2) stated she would expect oral cares to be done in the "AM and PM."	F 312		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to ensure the safety of 2 of 2 sampled residents (Resident #4 and #7) who wandered and exited the facility. Failure to ensure and maintain resident safety by providing adequate supervision, implementing effective interventions, and monitoring/reevaluating interventions resulted in Resident #4 and Resident #7 eloping from the facility on multiple occasions. Findings include: Review of the facility policy titled "MISSING RESIDENT (ELOPEMENT)" occurred on 12/18/14. This policy, revised 11/15/12, stated, "Policy: Safety is of primary importance for our residents. We will attempt to determine which residents are at the greatest risk for wandering when they are admitted. In the event that a resident is missing or has eloped, every effort will be made to find them as soon as possible. . . .	F 323	~~F323~~ 333 per T.C. with Linda Walen, DON on 1/22/15 1. Each resident, as part of their rights as a resident, is entitled to choose which pharmacy they will use to provide their medications. The residents are now receiving their ordered medications and future interruptions in administration will be addressed timely to prevent adverse occurrences. 2. Any resident has the potential to be affected by unavailable medication. We will identify them by the use of the form that has been developed. 3. A form has been developed as a notification to the DON when medications are not available. It will enable the DON to monitor and ensure that unavailable medication notification to the provider is timely. The provider will be asked if a different medication can be given or if they will provide a hold order for the unavailable medication until it is received. Licensed staff will be educated regarding the use of this form at a mandatory meeting 1/15/15. 4. 1/22/15 5. The form that will serve as notification and QA for the DON to monitor medications not available will be completed each time a medication is not available and will be ongoing.	01/22/15

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F 323	Continued From page 19 Procedure: Elopement Prevention: . . . 3. The potential risk for elopement should be addressed in the care plan. . . ." Review of the facility policy titled "Magnetic Alarm System Use" occurred on 12/18/14. This policy, dated 07/17/14, stated, " . . . Policy: The safety of the residents who reside at the Care Center is a priority. Being aware of the location of our residents and preventing elopement is a big part of keeping them safe. Until such a time when an electronic door monitoring system can be installed and on an as needed basis thereafter, magnetic alarms will be used on doors leading to the outside. . . . Procedure: . . . 3. If an alarm is being used on the front (south) door . . . it will be deactivated during the days when there are more staff members present to monitor the residents. The alarms will be activated by the charge nurse at approximately 6:00 PM or earlier if wandering residents are about. . . ." - Review of Resident #4's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease. Resident #4's quarterly Minimum Data Set (MDS), dated 10/15/14, identified severely impaired cognition and wandered on 1-3 days of the 7-day assessment period. The current care plan stated, ". . . Focus: The resident is an elopement risk . . . Interventions/Tasks: Distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book. Door Alarms to be active and utilized. See policy in regards to this. Encourage walking with staff, Follow elopement protocol as required . . ." An observation on 12/16/14 at 4:20 p.m. showed	F 323		

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F 323	Continued From page 20 Resident #4 walked through the first main entrance door and a staff member (#1) saw Resident #4 from her office and stopped the resident from going outside. Review of Resident #4's nurses' notes identified the following: * 03/15/14 at 4:30 p.m. - "Res [resident] pushed another w/c [wheelchair] bound res outside, neither wearing jackets. Res let go of w/c on sloping concrete et [and] w/c rolled away from her. CNA [certified nurse aide] called out to res & [and] did not stop walking. Res did stop [after] CNA caught up. CNA had to 'talk res into coming back inside.'" * 06/03/14 at 5:00 p.m. - "Res. ambulated out front door et out to street on sidewalk [without] any staff assist - res. approached by staff et asked her to wait so they could walk [with] her, but res. kept right on going - staff caught up et res. related she knew her way around as she walks around Devils Lake all the time. Reminded res. she is not in D. [Devils] Lake - res. then realized in McVille et [after] completing block, she returned [without] any further problems - family et MD [medical doctor] informed." * 06/08/14 at 8:30 p.m. - "[name of doctor] notified of incident on 6/7/14 of leaving facility. . . ." During an interview on 12/18/14 at 10:46 a.m., an administrative nurse (#2) confirmed the medical record lacked information regarding the 06/07/14 elopement and she was unable to provide additional information. * 06/15/14 at 4:00 p.m. - "Res. found walking into building thru [through] front entrance [with] roommate . . . writer approached them et res. said to writer 'see, I made my way back, I didn't	F 323		

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F 323	Continued From page 21 get lost!' Writer reminded res. that if she goes outside she needs to have staff [with] her - res. just smiled et walked away - MD et family informed of elopement." * 07/03/14 at 2:00 p.m. - "Activity personal [sic] reported that they have taken resident out for walks x3 [three times]. Has noted resident going out on own but not on street. Staff notices resident walks around to see were [sic] staff are & then will go outside. Did talk to resident & resident stated 'no one around' when explained the need to ask someone to take her. Explained she needs to find staff & wait & agreed to do so." * 07/08/14 at 6:45 p.m. - "Found outside [with] roommate . . . amb [ambulating] in grass near east door et AL [assisted living] sidewalk driveway - assisted back inside - did come in easily but was sarcastic about have [sic] to come in - then shortly after her et roommate came in they both went out front door again then when stopped by nurse they became upset at nurse. . . ." * 07/13/14 at 10:40 a.m. - "Found resident outside of care center by vegetable garden [with] roommate. Redirected inside and encouraged to stay indoors today as it is breezy & cold." * 07/14/14 at 12:15 p.m. - "Res. got out of facility [with] room-mate and was by end of parking lot heading west. . . . (maintenance employee) witnessed them and alerted staff. Res. was directed back to facility by activity employee . . ." * 07/22/14 at 6:30 p.m. - "Resident eloped out the front door of the facility at this time during staff shift, med count, door hadn't been alarmed at this time and staff followed after resident and redirected her back into the facility and turned the alarm on." * 08/10/14 at 6:45 p.m. - "Out front door [with] roommate - then CNA went out et they went for a walk around the block."	F 323		

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F 323	Continued From page 22 * 10/15/14 - ". . . She likes to walk et makes many trips up et down the halls of the care ctr. [center] et sometimes outside as well. She requires accompany by staff for outdoor walks, but does forget sometimes et needs reminders. She is an elopement risk et door alarms provide a way for staff to be informed of her exiting. She often goes [with] her roommate, who also has dementia, et so for safety require [sic] guidance. . . ." * 11/10/14 at 3:30 p.m. - "Resident went outdoors x2 [two times] today & was brought back in by CNA. Stated she was out looking for her mom." * 11/17/14 at 1:30 p.m. - "Went outdoors [with] another [female] resident, brought right back in by staff." * 12/03/14 at 11:25 a.m. - "Went outdoors briefly." Review of Resident #4's social service notes identified the following: * 06/10/14 at 3:48 p.m. - ". . . Although since last assessment resident has had a couple of instances of leaving the building 'to go for a walk' and she will take her room mate with her. . . . She has returned without difficulty. Resident is reminded that she needs to have someone with her when she goes out for a walk and resident stated 'That's why she (pointing to roommate) comes with'. Resident likes to be outside and staff are going to attempt to take her out on a regular basis. . . ." * 08/27/14 at 3:57 p.m. - ". . . She likes to go outside and look at the garden on the front patio. She has been reminded several times to ask someone to go with her, but instead of staff she will ask her room mate to go outside with her and her comment will be 'I am not alone, she is with me'. Resident has a very short term memory, she needs reminders and direction from staff. . . ."	F 323		

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F 323	Continued From page 23 - Review of Resident #7's medical record occurred on December 17-18, 2014. Current diagnoses included Alzheimer's disease. The current care plan stated, ". . . Focus: [Resident #7] has cognitive impairment due to the diagnosis of Dementia non Alzheimer's type. . . . Interventions: Ask yes/no questions in order to determine the resident's needs. Cue, reorient and supervise as needed. Keep the her [sic] routine consistent and try to provide consistent care givers as much as possible in order to decrease confusion. . . ." The care plan failed to address Resident #7's risk for elopement. Review of Resident #7's nurses' notes identified the following: * 06/08/14 at 8:30 p.m. - "[Name of doctor] notified of 6/7/14 Res walking out of facility . . ." During an interview on 12/18/14 at 10:46 a.m., an administrative nurse (#2) confirmed the medical record lacked information regarding the 06/07/14 elopement and she was unable to provide additional information. * 06/15/14 at 4:00 p.m. - "Res. et roommate found coming up the front sidewalk - Entered building et told writer 'I'm tired!, we went around the whole block!, my butt hurts now.' Res. carrying a leaf et leaning to the R) [right] - reminded that she shouldn't go outside [without] a staff member along - res. stated 'she said we could go' pointing @ [at] roommate . . . MD et family informed of res. elopement." * 07/08/14 at 6:45 p.m. - "Found [with] roommate . . . ambulating in grass near east door et AL sidewalk driveway - assisted back inside - was picking up pinecones in grass - wants to make a wreath so CNA brought them in for her et left in activity room - did come back in building easily - then went out front door again [with] roommate . .	F 323		

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F 323	Continued From page 24 . when stopped at front door by nurse both became upset - has been sitting in dayroom - then said something about going to bed but then caught by CNA going out front door again - then she went for a walk around the block with them . . ." * 07/13/14 at 10:40 a.m. - "Found resident outside by vegetable garden area [with] roommate . . . checking on vegetables. Redirected back inside and encouraged to stay indoors today as it is cool & breezy." * 07/14/14 at 12:15 p.m. - "Res. left facility w/ [with] room-mate res. was looking for country club because she was 'going golfing'. . . . (maintenance employee) saw residents & notified staff. Activity employee [name of employee] assisted res. back into facility. No harm - to residents, family called. . . ." * 07/22/14 at 6:30 p.m. - "Resident eloped out front door of facility at this time during medication count shift change the door alarm was not alarmed at this time. Staff followed resident out the door and redirected her inside at this time and alarm was turned on after the incident. No behaviors noted [with] redirection." * 08/04/14 - ". . . She is also an elopement risk R/T [related to] Independent ambulation et Dementia; therefore she is a member of the code green [missing resident protocol] et those guidelines are followed along [with] alarms on exits to alert staff of res. exiting. . . ." * 11/03/14 - ". . . She remains an elopement risk et guidelines are in place, however, [with] the cooler weather she has not been as interested in going out as before." * 11/17/14 at 1:30 p.m. - "Went outdoors [with] another [female] resident, brought right back in by staff."	F 323		

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F 323	Continued From page 25 Review of Resident #7's social service notes identified the following: * 09/09/14 at 4:34 p.m. - ". . . Resident and room mate have left the building to go on a 'walk' but return easily. Resident follows her room mate outside. . . ." During an interview on 12/18/14 at 10:15 a.m., an administrative nurse (#2) provided no additional information for either Resident #4 or Resident #7. The failure to provide adequate supervision and effective interventions to prevent Residents #4 and #7 from eloping from the facility may result in injuries to both residents.	F 323		
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 observation, record review, facility policy, and staff interview, the facility failed to ensure residents were free of any significant medication errors for 2 of 2 sampled residents (Resident #7 and #12) identified who did not receive a scheduled medication for multiple days. Failure to ensure the administration of Resident #7's Namenda (medication for Alzheimer's disease) and Resident #12's Trimethoprim (antibiotic for urinary tract infection) and failure to inform the physician regarding the unavailability of the medications has the potential to result in negative outcomes for Resident #7 and #12.	F 333	F ~~333~~ 323 p/T.C. with Linda Walen, DON, on 1/22/15 1. A new wandering management system is being installed. Both of the residents listed in this deficiency will have tag bracelets applied that go along with the new system. They continue to be a part of our 'Code Green' manual which has information and pictures of all residents who are in danger of elopement. The elopement risk that was not care planned for ~~the~~ one resident has now been added to the care plan. 2. Every resident admitted to the facility is assessed using the Wandering Risk Scale. By this means, we can potentially identify whether or not they will wander. Residents found to be at risk will have a tag applied. They will also be added to our 'Code Green' manual. 3. The facility has purchased an Accutech Resident Guard LC1200 Wandering Protection system that has been installed on the front door, maintenance hall door	RDumas

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F 333	Continued From page 26 Findings include: Review of the facility policy titled "Medication Administration" occurred on 12/18/14. This policy, revised February 2014, stated, ". . . The services provided or arranged by the facility must meet professional standards of quality . . . Policy . . . General Considerations . . . If a medication is unavailable, call the physician for a substitute or get an order for a 'HOLD' until the right medication is available. . . . 4. Documentation a. Sign initials on the MAR for each medication after the medication has been given. . . ." - Review of Resident #7's medical record occurred on December 17-18, 2014. Diagnoses included Alzheimer's disease. Review of Resident #7's progress notes identified the following: * 05/13/14 at 1:00 p.m. - "Namenda not available as script is needing refill - MD [medical doctor] informed from pharmacy; then will send in mail." * 05/16/14 at 2:00 p.m. - "MD contacted again regarding need of res. [resident] scripts to be signed & [and] sent to phx [pharmacy] - res. now has been [without] some meds. [medications] several days." The May 13-17, 2014 medication administration record (MAR) showed nursing staff administered two doses of Namenda, even though they identified the medication not available for seven doses. The facility failed to ensure Resident #7 received her prescribed medication for 7 doses, and consistently over five days. - During observation of medication administration	F 333	**F 333, continued** and Assisted Living door. The exterior east and west doors have been locked to bar entrance. People can go out the doors, though. The magnetic alarms that were previously on the inside have been moved to the inside of the outer door. They will be on at all times. The old push button alarm will be left in place so, in-effect, the doors have a double alarm. 4. Date certain: 1/22/15 5. Incident reports will serve as a basis for our QA. Licensed staff will complete a report whenever the alarm is triggered by the residents who are wearing the tags. Licensed staff will be informed of this at the mandatory RN\LPN meeting that is being held 1/15/15. That information will be transferred to a QA form that addresses wandering\elopement. This will be completed with every incident for the next 3 months. After that time, we will assess to see if it is necessary to continue.	01/22/15

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F 333	Continued From page 27 on the morning of 12/16/14, Resident #12's MAR included an order for the antibiotic Trimethoprim for a three times weekly dosing, on Monday, Wednesday, and Friday. The order identified the indication for use for Resident #12 as chronic urinary tract infections. The MAR showed nursing staff identified the medication not available beginning on 12/03/14 resulting in five missed doses through 12/15/14. During the observation, a nurse (#7) stated the reason for the missed doses was due to not receiving the medication from the pharmacy. During an interview on 12/17/14, an administrative staff member (#2) stated the reason for the missed doses was because the Trimethoprim was delivered in a bottle verses a punch (unit dose) card. The facility failed to ensure Resident #7 received her prescribed medication for 7 doses, and Resident #12 received her prescribed medication for 5 doses.	F 333		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS 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. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the	F 431	**F431** 1. Resident who receives the liquid Prilosec did not have 2 equal sized bottles of Prilosec in the box. The 2 bottles come as part of a kit. One bottle contains the Prilosec powder, the other contains the diluent for the powder. The medication comes from Thrifty White. The DON called Thrifty White. They made a note saying that a prescription label needs to be placed on the box that contains the 2 bottles of the kit. There also needs to be a on the 1 bottle that contains the powder, which will be the bottle from which the	

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F 431	Continued From page 28 appropriate accessory and cautionary instructions, and the expiration date when applicable. 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. 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. This REQUIREMENT is not met as evidenced by: MEDICATION ORDERS 1. Based on observation, record review, policy review, and staff interview, the facility failed to ensure labeling of a medication and verification of a medication order for 1 for 1 sampled resident (Resident #2) observed administered liquid medications, and failed to ensure the availability of medications for 2 of 2 sampled residents (Resident #7 and #12), identified with medications not available for administration. Failure to verify a medication order, failure to ensure all medications included a pharmacy label, and failure to ensure timely availability of prescribed medications has the potential for the	F 431	**F431, continued** liquid medication is dispensed. The residents who had medications that were not available are now receiving them and future interruptions in administration will be addressed timely to prevent adverse occurrences. 2. Any resident has the potential to be affected by unavailable medication. We will identify them by the use of the form that has been developed. 3. A form has been developed as a notification to the DON when medications are not available. It will enable the DON to monitor and ensure that unavailable medication notification to the Provider is timely. This will ensure so that a different medication is given or a hold order for the unavailable medication is received. Licensed staff will be educated on the use of this form at a mandatory meeting to be held 1/15/15. Regarding the unlocked medication cart, a new cart has been ordered that has an electronic locking mechanism. The cart will be set to lock after one minute of inactivity 4. 1/22/15 5. All NCHS licensed nurses will be observed passing medications using a Medication Pass QA. Until we receive the automatic locking medication cart, nurses will be monitored to ensure they are locking the cart when it is out of view.	

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F 431	Continued From page 29 residents to receive an incorrect dose of medication, and resulted in multiple missed doses of medication for Resident #7 and #12. Findings include: Review of the facility policy titled "Medication Administration" occurred on 12/18/14. This policy, revised February 2014, stated, " . . . o. All medication directions from the original order to the MAR [medication administration record] to the pharmacy label on the medication should correlate. . . . Medications should not be given from an unlabeled bottle or card. . . . h. If a medication is unavailable, call the physician for a substitute or get an order for a 'HOLD' until the right medication is available. . . ." - On 12/17/14 at 9:30 a.m., observation showed a licensed nurse (#3) prepared liquid medications for Resident #2. The liquid medication Prilosec, lacked a medication label with the resident's name, instructions for administration, and an expiration date. During interview on 12/17/14 at 11:15 a.m., a nurse (#5) showed the surveyor the label for the Prilosec liquid on the outside of the box rather than on the bottle. The box contained two equal sized bottles of Prilosec. The nurse agreed the bottle itself lacked a label and stated pharmacy was notified to obtain a label. - During observation of medication administration on the morning of 12/16/14, Resident #12's MAR included an order for the antibiotic Trimethoprim for a three times weekly dosing, on Monday, Wednesday and Friday. The MAR showed nursing staff identified the medication not	F 431	**F431, continued** The form that will serve as notification and QA for the DON to monitor medications that are not available will be completed each time a medication is not available and will be ongoing.	01/22/15

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F 431	Continued From page 30 available beginning on 12/03/14 resulting in five missed doses through 12/15/14. During the observation, a nurse (#7) stated the reason for the missed doses was due to not receiving the medication from the pharmacy. - Review of Resident #7's progress notes identified the following: * 05/13/14 at 1:00 p.m. - "Namenda not available as script is needing refill - MD [medical doctor] informed from pharmacy; then will send in mail." * 05/16/14 at 2:00 p.m. - "MD contacted again regarding need of res. [resident] scripts to be signed & [and] sent to phx [pharmacy] - res. now has been [without] some meds. several days." The May 13-17, 2014 MAR showed nursing staff administered two doses of Namenda and identified the medication not available for seven doses. The facility failed to ensure labeling of multiple bottles of liquid medication, failed to verify provider instructions to provide the proper dose of medication, and failed to ensure timely availability of medications prescribed for residents. SECURE STORAGE/LIMITED ACCESS OF MEDICATIONS 2. Based on observation, facility policy, record review and staff interview, the facility failed to ensure safe and secure storage of 1 of 1 medication cart to only authorized personnel. This practice may allow unauthorized access to medications and pose a hazard to residents who may access an unattended cart. Findings include:	F 431		

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F 431	Continued From page 31 Review of the facility policy titled "Medication Administration" occurred on 12/18/14. This policy, revised February 2014, stated, ". . . Policy . . . General Considerations . . . 2. Safety a. The medication cart should be locked when left unattended. . . . d. If the nurse or CMA [certified medication aide] is in the resident room and the medication cart is not locked, it has to be in an area where the nurse or CMA can see it. . . ." During 2 of 2 days of observations of medication pass, two nursing staff members (#3 and #8) left the medication cart unlocked and unattended or in an area where the nurse could not see it. The observations included the following: * 12/16/14 at 11:30 a.m., the nurse (#8) walked away from the medication cart while entering the dining room to administer medications. The nurse was unable to visably see the cart while in the dining room. * 12/17/14 at 8:15 a.m., the nurse (#3) provided medications to a resident who sat on the opposite end of the dining room with visual access of the cart blocked by a brick wall. * On the morning of 12/17/14 the nurse (#3) left the cart unlocked while taking medications into a resident rooms on two occasions. The nurse (#3) removed her ink pen from the top of the cart prior to leaving the cart as she stated a resident within the facility likes to take her pens from the cart. Review of Resident #7's medical record occurred on December 17-18, 2014. Current diagnoses included Alzheimer's disease. A progress note, dated 07/25/14 at 1:00 p.m., stated, "Res. [resident] wandering around 'collecting' pens. Res. had pocket full of pens/took all pens from med. cart . . ."	F 431		

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F 431	Continued From page 32 During interview on 12/17/14 at 5:00 p.m. two administrative staff (#2 and #4) agreed the medication cart should be locked when not in full view.	F 431		