STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355094	A. BUILDING _____ B. WING _____	06/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MOHALL	602 E MAIN ST MOHALL, ND 58761

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F 000	INITIAL COMMENTS The standard Medicare/Medicaid survey started on 06/04/18 and concluded on 06/07/18.	F 000		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 04/05/17. Based on record review, staff interview, and review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, the facility failed to complete a significant change in status assessment (SCSA) for 1 of 14 residents (Resident #12) who experienced a significant change in status. Failure to determine the need for and complete a SCSA in response to a resident's decline limited the facility's ability to accurately assess the resident's status, and identity and implement appropriate care approaches. Findings include:	F 637	1. For Resident #12 a Significant Change in Status Assessment (SCSA) was done with ARD 6/7/2018 due to a decline in ADL's and on Comfort Cares. 2. All residents who have a significant decline or improvement in their status and meet the definition of a SCSA have the potential to be affected. Reviewed all residents for a SCSA. 3. A) The Long Term Care Facility Resident Assessment Instrument (RAI) User's Manual procedure and information involving SCSA (page 2-22 to 2-28) will be reviewed by the Unit Manager/MDS Coordinator including guidelines for	7/4/18

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

Electronically Signed | 06/29/2018

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F 637	Continued From page 1 The Long-Term Care Facility RAI 3.0 User's Manual (Version 1.15), dated October 2017, stated, ". . . A 'significant change' is a major decline or improvement in a resident's status that . . . Will not normally resolve itself without staff intervention . . . Impacts more than one area of the resident's health status . . . Requires interdisciplinary review and/or revision of the care plan . . . A SCSA is appropriate if there are either two or more areas of decline or two or more areas of improvement. . . . This may include two changes within a particular domain (e.g., [for example] two areas of ADL [Activities of Daily Living] decline or improvement. . . ." - Review of Resident #12's medical record occurred on all days of survey. An annual Minimum Data Set (MDS), dated 12/16/17, identified Resident #12 required extensive assist with bed mobility, transfers, dressing, eating, toilet use and personal hygiene. The medical record showed she was placed on comfort cares on 02/21/18. A quarterly MDS, dated 03/17/18, identified Resident #12 was totally dependent on staff for bed mobility, transfers, dressing, toilet use and personal hygiene. The facility failed to complete a SCSA after Resident #12's was placed on comfort cares and declined in health status. During an interview on 06/06/18 at 4:05 p.m., an administrative staff nurse (#1) stated she was unable to locate any information that would identify why a significant change MDS had not been completed on Resident #12 after she declined in health status.	F 637	determining SCSA for residents with Terminal illness b/w 6/26-6/29/18. B) The Charge nurses will be in-serviced b/w 6/25-6/30/18 regarding what triggers a significant change so they can communicate changes to the Unit Managers. C) The MDS Coordinator will review the High Risk Progress notes and Resident 24 hr. Communication Report Kardex to identify a resident exhibiting a significant change according to the RAI definition. D) MDS Coordinator/Social Services will review Comfort Care, ADLs, mood, and behavior status when completing interviews prior to scheduled assessments. The MDS will be refreshed and current ADL score or new RUG Rate will be compared to prior MDS to monitor for Significant Changes that may have occurred. 4. A) The MDS Coordinators will develop an audit to monitor for possible significant changes on MDS Assessments every week x 4, and then monthly x 3, and then quarterly x 2, following the with PRN audits as needed. B) The MDS Coordinators will submit audit reports starting 6/30/18 to the DON, who will then report to the Quality Assurance Performance Improvement (QAPI) Committee monthly for compliance, trends to make recommendation as needed. If concerns are identified, immediate corrective action will be implemented. The QAPI will use the Model for Improvement for any	

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F 637	Continued From page 2	F 637	opportunities for improvement identified.	
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review, review of the North Dakota Provider Manual for Preadmission Screening and Resident Review (PASARR) and Level of Care Screening Procedures For Long Term Care Services, and staff interview, the facility failed to complete a status change assessment for 1 of 5 sampled residents (Resident #8) with a newly diagnosed mental illness. Failure to complete a change in status assessment may result in the delivery of care and services that are inconsistent with residents' needs.	F 644	1. For resident #8, PASRR Level II request was submitted to Ascend on 6-22 -18. When results are received, facility will proceed with any recommendations and update resident's care plan as indicated. 2. All residents with a mental illness diagnosis have the potential to be affected by this deficient practice. Director of Social Services and HIM Director audited medical record for all current residents with mental health diagnosis for PASRR Level II completion. No other current resident was affected by	7/4/18

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F 644	Continued From page 3 Findings include: The North Dakota PASARR Provider Manual page 13 states, ". . . Change in Status Process . . . Whenever the following events occur, nursing facility staff must contact Ascend [contracted service provider for screening process] to update the Level I screen for determination of whether a first time or updated Level II evaluation must be performed. These situations suggest that a significant change in status has occurred: . . . If an individual with MI, ID, and/or RC (mental illness, intellectual disability, and conditions related to intellectual disability [referred to in regulatory language as related conditions or RC]) was not identified at the Level I screen process, and that condition later emerged or was discovered. . . ." Review of Resident #8's medical record occurred on all days of survey. The record showed an initial PASARR completed on 05/06/16 and identified no mental illness. The screening, dated 05/06/16, stated, ". . . has no diagnoses of major mental illness . . . no signs and symptoms related to a major mental illness . . ." Review of Resident #8's medical record identified a diagnosis of psychosis, dated 03/13/17. The record lacked evidence of an updated Level I screening/change in status assessment since the additional diagnosis. During an interview on 06/06/18 at 3:10 p.m., a social services staff member (#4) confirmed the facility failed to submit a PASARR for Resident #8 following the 03/13/17 diagnosis of psychosis.	F 644	this deficient practice. 3. The Social Services Director will be responsible for ensuring residents receive proper PASRR completion and reviewed the requirements: a. Any new admission of resident with a major mental health diagnosis will have a Level II screening prior to admitting. b. Any current resident with a change in mental health diagnosis will have a Level II screening completed. System process change now includes the HIM Director notifying Social Services Director with any resident's mental health diagnosis. Social Service Director will notify Ascend to request completion of resident's level II PASRR. DON and Unit Managers will be educated by Social Services Director on requirements for Level II screening found within the RAI Manual and also the Good Samaritan Society PASRR Policy and Procedure. 4. The HIM Director will audit resident medical records for mental health diagnosis and if present, verify copy of PASRR Level II report in medical record. Audit will be completed weekly X 4 weeks, monthly X 2 months and quarterly X 3 quarters. Audit results will be submitted to QAPI Committee monthly for review and further recommendations as indicated.	
F 657	Care Plan Timing and Revision	F 657		7/4/18

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F 657 SS=D	Continued From page 4 CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to review and revise the comprehensive care plan for 3 of 14 sampled residents (Resident #12, #15, and #28). Failure to revise the care plan limited the ability of staff to communicate care needs and ensure continuity of care for each	F 657	1. For Resident #12: The Care plan was revised to include pain interventions and comfort care interventions on 6/7/18 and 6/16/18. For Resident #15: The care plan was revised to include current treatment residents' dislike of being touched and	

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F 657	Continued From page 5 resident. Findings include: Review of the facility policy titled "Care Plan" occurred on 06/06/18. This policy, revised November 2016, stated, ". . . A qualified team of persons will review care plans at least quarterly. Care plans also will be reviewed, evaluated and updated when there is a significant change in the resident's condition. This plan of care will be modified to reflect the care currently required/provided for the resident. . . ." - Review of Resident #12's medical record occurred on all days of survey. Diagnoses included pain. An annual Minimum Data Set (MDS), dated 12/16/17, identified a staff assessment for pain showed facial expressions (grimace, winces, wrinkled forehead, furrowed brow, clenched teeth, jaw). A pain data collection form, dated 03/15/18, stated, " . . . At times with movements and transfer and during cares she will have a low tone cry. . . ." A Pain Assessment in Advanced Dementia (PAINAD), dated 03/15/18, stated, " . . . select area that best describes resident's vocalization . . . Occasional moan/groan or low level speech with a negative or disapproving quality. . . ." Resident #12 was placed on comfort cares 02/21/18. Observation on 06/05/18 at 2:51 p.m., showed two unidentified certified nursing assistants (CNAs) transferred Resident #12 from her Broda chair to her bed using a full body mechanical lift. During the transfer, the resident had her fists clinched, her face winced, and her forehead wrinkled. When the CNAs repositioned Resident	F 657	interventions to follow on 6/12/18. For Resident #28: The care plan was revised to include a skin integrity focus addressing the scabbed area to forehead and interventions on 6/25/18. 2. All residents have the potential to be affected by this deficient practice. 3. A. The current Comprehensive Care plan Policy and Procedure will be reviewed by the MDS Coordinators/DON/Charge nurses b/w 6/25 to 6/30/18. B. Charge Nurses will be re-educated to maximize the Point Click Care system of the Care plan library to revise or add new focuses to the plan of care b/w 6/26-6/30/18. 4. A. An audit will be developed by the Interdisciplinary team members to ensure residents' care plans are reviewed, evaluated, or revised with the quarterly MDS, any significant changes, and as the resident's needs/status changes. The audit will be done weekly x 6, every 2 weeks x 2, monthly x 3, and quarterly x 2, then PRN. B. Charge nurses will audit charts weekly x 6, every 2 weeks x 2, monthly x 3, and quarterly x 2 and PRN to review or revise the resident's current needs. Audits will be submitted to the DON who will then report to the Quality Assurance Performance Improvement Committee monthly. C. The MDS Coordinators will submit	

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F 657	Continued From page 6 #12 side to side to perform perineal cares, her fists were clinched and her arms were raised up in a guarded position. Observation on 6/06/18 at 11:15 a.m., showed two CNAs (#2 and #3) performed perineal cares on Resident #12. The resident displayed facial wincing, a wrinkled forehead, hands clenched into fists, and both of her arms raised up in a guarded position. The current care plan failed to identify any interventions for Resident #12's pain or comfort cares. During an interview on 06/06/18 at 4:05 p.m., an administrative nurse (#1) confirmed Resident #12's care plan had not been updated to reflect her current care needs. - Review of Resident #15's medical record occurred on all days of survey. Diagnoses included dementia with behavioral disturbances. A Care Area Assessment for Behavioral Symptoms, dated 03/26/18, stated, ". . . Resident does have an actual behavior problem evidenced by documentation of disruptive noise making and rejection of care . . . Resident does not like to be touched, will often refuse bathing . . ." A Mood/Behavior progress note for Resident #15, dated 4/21/2018 at 4:29 p.m., stated, ". . . noting her again to be getting upset if staff touch her. Staff are reporting increased behaviors with cares. Will cont. [continue] to monitor. . . ." Resident #15's current care plan stated, ". . . The	F 657	audit reports starting 6/30/18 to the DON, who will then report to the Quality Assurance Performance Improvement (QAPI) Committee monthly for compliance, trends to make recommendation as needed. If concerns are identified, immediate corrective action will be implemented. The QAPI will use the Model for Improvement for any opportunities for improvement identified.	

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F 657	Continued From page 7	F 657		

resident has a behavior symptom R/T [related to] anxiety E/B [evidenced by] hollering out, repetitive disruptive sounds . . .The resident is resistive to care E/B refusing baths and clothing changes . . ." The care plan failed to address that the resident does not like to be touched resulting in increased behaviors with cares.

During an interview 06/06/18 at 3:10 p.m., a social services staff member (#4) confirmed Resident #15's care plan failed to address the resident's dislike to be touched.

- Review of Resident #28's medical record occurred on all days of survey. Medical diagnoses included dementia.

Observation on the morning of 06/05/18 showed Resident #28 with a scabbed area on her forehead and a later observation showed a Band-Aid covered the scabbed area.

Current nursing progress notes stated "(Resident #28) cont. (continues) with a scabbed area to her forehead. She frequently removes the bandaide used to cover area and then is noted to be picking @ area. When questioned if area itches she states no. No S.S. (signs and symptoms) of infection to area. Will cont. to encourage her to keep area covered and not pick @ area."

Resident #28's current care plan failed to address the scabbed area and identify interventions related to the picking behavior.

During an interview on 06/06/18 at 12:23 p.m., an administrative nurse (#1) stated Resident #28 picks at the scab area and when it bleeds staff

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F 657	Continued From page 8 apply a Band-Aid. This nurse confirmed the care plan failed to address the resident's scabbed area on her forehead.	F 657		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide a safe environment for 2 of 2 residents (Resident #5 and #15) with a history of falls and observed with a call light not accessible. Failure to provide interventions to assist residents in preventing falls, such as placing their call light within reach, has the potential to increase falls with or without injury. Findings include: Review of the facility policy titled "Call Light" occurred on 06/06/18. This policy, dated September 2012, stated, ". . . To ensure resident always has a method of calling for assistance . . . 3. When leaving the room place call light within easy reach of resident if in bed. If out of bed, stretch call light cord across bed so resident is able to reach it. . . ." - Review of Resident #15's medical record	F 689	1. For Resident #5 the call light will be within reach when in bed or lying across the bed or not tucked under the pillow when out of bed. Call light was placed across the bed by staff 6/7/18. For Resident #15 the call light will be within reach when in bed or lying across the bed when out of Bed. 2. All resident have the potential to be affected by this deficient practice. 3. A) Staff at the 6/20/18 all staff meeting were in-serviced regarding the practice of having call lights within reach when a resident is in bed or across the bed when out of bed. B) The DON will review the Call Light procedure with the certified nursing assistants' b/w 6/26-7/02/18. 4. An Audit will be developed to ensure	7/4/18

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F 689	Continued From page 9 occurred on all days of survey. Diagnoses included macular degeneration and dementia with behavioral disturbances. A quarterly Minimum Data Set (MDS), dated 03/22/18, identified extensive assist of two persons with bed mobility, transfers and walking. Observations showed the following: *On 06/05/18 at 9:28 a.m. Resident #15 sat in her wheelchair beside her bed. Resident #15 gave the surveyor permission to enter her room and said, "Help, I want to lie down." When asked how she calls for assistance, she stated,"I put my light on." The resident felt along the edge of the bed attempting to locate the call light. Observation showed her call light located at the head of the bed under the pillow. The surveyor then stepped into the hallway to find a certified nursing assistant (CNA) (#7) to assist the resident. When asked if the resident uses her call light, the CNA (#7) stated, "She is good about using her light." *On 06/06/18 at 8:50 a.m. Resident #15 sat in her wheelchair by her bed and the call light was at the head of the bed under the pillow. Facility staff failed to ensure Resident #15's call light was within her reach. Review of Resident #15's current care plan stated, ". . . The resident has impaired visual function R/T [related to] Macular Degeneration E/B [evidenced by] being legally blind . . . Tell resident where you are placing their items. Be consistent with placement of personal items (phone, tissues, water glass, call light) . . . The resident is at risk for falls R/T vision/hearing problems and use of O2 [oxygen]. . . Educate resident about safety reminders and what to do if	F 689	call lights are within reach when residents are in or out of bed weekly x 4, monthly x 3, and quarterly x 2, and PRN. B) The nursing department or designee will submit reports starting the week of 7/1/18 to the DON, who will then report to the Quality Assurance Performance Improvement (QAPI) Committee monthly for compliance, trends to make recommendation as needed. If concerns are identified, immediate corrective action will be implemented. The QAPI will use the Model for Improvement for any opportunities for improvement identified.	

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F 689	Continued From page 10	F 689		

a fall occurs. Remind resident to use her walker when ambulating and call for assistance when needed . . ."

The progress notes stated the following:
* 01/29/18 at 4:53 p.m., ". . . Resident continues at a fall risk d/t [due to] self transfers. She does have a bed and chair check which alarmed today as she was self transferring to the bathroom. Resident reminded that she needs to wait for help."
* 02/25/18 at 2:20 a.m.,". . . Resident attempting self transfers, CNA tried to secure gait belt around resident when she became noncompliant and fell backward, hitting her head on the nightstand . . ."
* 03/14/18 at 07:15 a.m., ". . . was found on the floor this am . . ."
* 03/16/18 at 12:15 p.m., ". . . Resident was found on floor in her bathroom. She was sitting on her buttocks in the middle of the room. She stated she was trying to get to bed. . . ."

During an interview on 06/06/18 at 11:15 a.m., an administrative nurse (#8) confirmed staff should place Resident #15's call light within her reach as she does attempt to self transfer. An administrative nurse (#1) responded, when asked about the resident, "she is legally blind and she will put the call light on or just yell for help."

During an interview on 06/06/18 at 11:45 a.m., an administrative nurse (#5) confirmed staff should place the call lights within the resident's reach.

- Observation on 06/06/18 3:49 p.m., showed Resident #5 sitting in her recliner, calling out for help, saying she needed to use the bathroom.

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F 689	Continued From page 11 Resident #5's call light was lying on her bed approximately 5 feet away from her recliner. Facility staff failed to ensure Resident #5's call light was within her reach. During an interview on 06/06/18 at 3:55 p.m., a CNA (#9) who entered the resident's room, confirmed Resident #5's call light should be placed within her reach. Review of Resident #5's medical record occurred on all days of survey. A quarterly MDS, dated 03/06/18, identified extensive assistance of two persons required for dressing, personal hygiene, transfers, and locomotion. Review of Resident #5's current care plan stated, ". . . requires assist of two staff for toileting . . . requires assist of one staff for transfers chair to bed with gait belt . . . resident is at risk for falls R/T history of falls . . . gait/balance problems. Failure of facility staff to place Resident #5 and #15's call lights within reach, placed the resident at risk of falls with/without injury.	F 689		
F 697 SS=G	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of	F 697	1. A) For Resident #12 – A Pain	7/4/18

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F 697	Continued From page 12 facility policy, staff interview, and resident interview, the facility failed to provide care and services to control pain for 2 of 2 sampled residents (Resident #12 and #31) observed experiencing pain. Failure of staff to report, document, evaluate and act on the resident's pain resulted in unresolved pain, worsening health conditions and decreased quality of life. Findings include: Review of the facility's policy titled "Care of the Dying Resident" occurred on 06/06/18. This policy, dated September 2012, stated, " . . . To continue to provide physical care and comfort until death. . . ." Review of the facility's policy titled "Pain Management, Data Collection and Assessment and Non-pharmacological Pain Interventions" occurred on 06/06/18. This policy, revised 2017, stated, " . . . To promote well-being by ensuring that residents are as comfortable as possible, consistently collect data related to pain, To determine what pain relief interventions specific to the resident can be used to aid in maintaining a comfortable level of function and quality of life . . . Individualized approaches will be developed to address the resident's pain management needs in a holistic manner . . . The nurses working directly with residents must continually monitor and observe the resident for success of the pain management plan and report to the nurse manager and prescriber as necessary to keep the resident comfortable . . . The interdisciplinary team and nurses must have ongoing communication with the resident and monitor and evaluate the pain management plan . . .	F 697	Assessment in Advanced Dementia (PAINAD) was done 6/7/18. Med orders were received for scheduled Acetaminophen suppository BID. Care plan revised 6/7/18. 6/17/18 received orders to discontinue suppositories and start Acetaminophen 325 mg 2 tabs TID. Care plan revised 6/21/18. B) For Resident #31 –Resident was seen by Specialty MD 6/8/18 for pain medication regime. No new medication orders received. The Resident was to see Primary Physician the following week. The Primary Physician saw resident 6/15/18 ordered a Fentanyl patch. A Pain Collection was re-done 6/17/18 and Pain assessment re-done 6/18/18. 6/19/18 Primary Physician notified, updated on medication regime, he reassessed wanting to schedule Oxycodone 10/325 mg BID and resident refused. Orders received for Pain clinic consultant. Unit manager worked with Pain clinic and provided information; 6/22/18 Pain clinic referred her back to Primary care provider as they had no further interventions. 6/24/18 eINTERACT Change in Condition Evaluation, Pain data collection and Pain assessment done. Family Nurse Practitioner ordered Resident to go to ER for Pain Control. Resident returned from ER without any new interventions or new medication orders except Primary Care Provider to follow. 6/25/18 New Med orders received from Primary Physician for scheduled Oxycodone 15 mg. Resident in agreement to take the scheduled medication now. Oxycodone	

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F 697	Continued From page 13 Residents with a history of pain or a diagnosis that is often painful will be reviewed weekly by the RN [registered nurse] who will also work with the medical provider . . . The RN should document the effectiveness of the pain management plan weekly if pain is identified at 4 or higher. . . ." Review of Resident #31's medical record occurred on all days of survey. Diagnoses included diabetes mellitus (DM) with neuropathy, skin ulcer, foot ulcer, edema, peripheral vascular disease, rash with skin eruption and cellulitis of the left lower leg. A quarterly Minimum Data Set (MDS) dated 04/13/18 identified the resident as having frequent pain, pain makes it hard to sleep, limits daily activities, and is an 8 out of 10 on a verbal pain scale. The most current care plan stated, " . . . Resident's identified level of pain tolerated is a score of 6 out of 10 . . . Notify health care provider if interventions are unsuccessful. . . ." Observation on 06/04/18 at 10:56 a.m., showed a nurse (#6) entered Resident #31's room to perform a dressing change on the resident's legs. When the nurse (#6) removed the dressing and began cleansing the left leg the Resident #31 called out in pain and stated, "That area is very sore. I bumped it earlier this morning." Observation showed the entire calf on the left leg to be red, draining, and swollen, with blisters below her knee. The nurse (#6) did not acknowledge the resident's pain, continued with the dressing change, then applied an elastic bandage over the entire dressing. Resident #31 stated the elastic bandages make her legs, "burn like fire and itch." Observation showed the	F 697	was denied by insurance so Facility is covering the cost of the medication while prior authorization is being obtained. 2. All residents have the potential to be affected by this deficient practice. The Consultant pharmacist evaluated all residents' PRN med usage to determine if scheduled pain medication were needed 6/28/18. 3. A) Unit managers/MDS Coordinator/Charge Nurses will be in-serviced and will review the procedure titled "Pain management, Data Collection, and Assessment and Non-Pharmalogical Pain Interventions 6/26/18-6/30/18 with emphases on pain assessment, follow-up, and notifying the medical provider. B) 1. A procedure will be developed and started by 7/1/18 to review the effectiveness of residents pain management plan (if pain is identified at 4 or higher) weekly by a nurse regarding their pain status. Review monthly if pain management is effective and resident is stable. 2. If new pain is identified a Pain Data Collection and Pain assessment UDA must be done. C) Certified Nursing Assistants will be in-serviced 6/26/18-6/30/18 on Pain scale and PAINAD to verbally alert Nurses and use eINTERACT Stop & Watch. D) All staff at the 6/20/18 meeting were instructed to report any s/s of pain they notice to the Charge nurses.	

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F 697	Continued From page 14 resident's face wincing in pain. She covered her face with her right hand and grabbed the bedding with the other hand while she performed deep breathing. The nurse (#6) asked Resident #31 if she wanted to take a break before starting the next leg. The resident responded, "Yes." Observation 06/04/18 at 11:26 a.m., showed the nurse (#6) reentered Resident #31's room to complete the dressing change to her right leg. After removal of the dressing, the nurse cleansed the right leg. Observation showed the resident had facial wincing and verbalized pain. The nurse continued cleansing the leg and did not acknowledge the resident's pain. Resident #31 stated, "I'm getting a Charlie horse." The nurse (#6) stated, "I'll hurry." The nurse (#6) completed the dressing to Resident #31's right leg as the resident continued to display facial wincing. The resident stated, "The back of my calf is burning so bad the past couple days, I don't know why." The nurse (#6) again failed to acknowledge the resident's pain. Review of Resident #31's nursing progress notes, dated 06/04/18 at 10:56 a.m. and 11:26 a.m., failed to show documentation of the resident's complaints of pain, pain interventions, or notification of the physician. Review of Resident #31's medication administration record (MAR) did not include any scheduled pain medications. The MAR showed oxycodone-acetaminophen 10-325 milligram (mg), give one tablet by mouth every six hours as needed (PRN) for pain. The MAR identified oxycodone was administered as follows: when the resident's pain was 6 or greater:	F 697	4. A) An audit will be developed to ensure that residents with a history of pain greater than 4 are reviewed weekly, and monthly when pain management is effective. B) An audit will be developed to ensure that Pain data collections and Pain Assessment UDA's are done with new symptoms of pain. Audits will be done weekly x 4, then every 2 weeks x 2, then monthly x 3, and then quarterly x 2, and PRN. C) The Charge nurses, Unit managers, or designee will submit audits starting the week of 7/1/18 to the DON, who will then report to the Quality Assurance Performance Improvement (QAPI) Committee monthly for compliance, trends to make recommendation as needed. If concerns are identified, immediate corrective action will be implemented. The QAPI will use the Model for Improvement for any opportunities for improvement identified	

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F 697	Continued From page 15 * February 2018 - 63 tablets * March 2018 - 48 tablets * April 2018 - 52 tablets * May 2018 - 67 tablets * June 1-6, 2018 - 15 tablets The current care plan stated, " . . . Resident's identified level of pain tolerated is a score of 6 out of 10 [on a 0 to 10 verbal pain scale] . . . The resident has chronic pain . . . Notify health care provider if interventions are unsuccessful. . . ." Review of nursing progress notes, dated May 1-31, 2018, failed to show the health care provider was notified of Resident #31's continued pain. During an interview with Resident #31 on 06/05/18 at 9:18 a.m., the resident stated, "My pain medications are just not working anymore, I wish they could find something that works. My right leg has gotten worse. The pain woke me up last night." Observation on 06/06/18 at 10:55 a.m., showed Resident #31 in her room, sitting in her wheelchair with her head bent down, weeping into her hands. When asked if she was ok, she stated, "I just can not handle this pain anymore, it's out of control, my acceptable pain is a 5 or 6 out of 10. Pain is the first thing I need to talk with my leg doctor about." During an interview on 06/07/17 at 9:04 a.m., an administrative nurse (#5) confirmed the facility failed to assess, document, and manage Resident #31's pain needs and failed to contact the physician when the resident's pain needs	F 697		

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F 697	Continued From page 16 were not met. During an interview 06/07/18 at 11:30 a.m., an administrative nurse (#1) agreed the facility failed to address Resident #31's pain with the physician. Failure to evaluate, re-assess, and implement pain management interventions for Resident #31 resulted in the resident requiring frequent use of as needed (PRN) narcotic pain medication and experiencing episodes of unresolved pain. - Observation on 06/05/18 at 2:51 p.m., showed two unidentified certified nursing assistants (CNAs) transferred Resident #12 from her Broda chair to her bed using a full body mechanical lift. During the transfer, the resident had her fists clinched, her face winced, and her forehead wrinkled. When the CNAs repositioned Resident #12 side to side to perform perineal cares, her fists were clinched and her arms were raised up in a guarded position. Observation on 6/06/18 at 11:15 a.m., showed two CNAs (#2 and #3) performed perineal cares on Resident #12. The resident displayed facial wincing, a wrinkled forehead, hands clenched into fists, and both of her arms raised up in a guarded position. Review of Resident #12's medical record occurred on all days of survey. Diagnoses included pain, and impaired cognitive function/dementia or impaired though processes. A physician's order, dated 02/21/18, showed the resident was placed on comfort cares. A review of the most recent pain data collection	F 697		

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F 697	Continued From page 17 assessment, dated 3/15/18, showed, " . . . At times with movements and transfer and during cares she will have a low tone cry. Then stops when activity is complete. . . ." Review of the current care failed to address the resident's pain. Review of Resident #12's medication administration record (MAR) showed no scheduled pain medication. Review of the progress notes from 01/01/18 through 06/06/18 showed no documentation of the resident's pain or pain interventions. During an interview on 06/07/18 at 9:04 a.m., an administrative staff nurse (#5) stated the facility had not care planned or implemented any interventions to address Resident #12's pain.	F 697		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed	F 755		7/4/18

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F 755	Continued From page 18 pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to ensure secure storage of controlled medications in 1 of 2 medications rooms (South). Failure to securely store and account for controlled medications may result in unauthorized access to these medications. Findings include: Review of the facility policy titled, "Policy and Procedure, controlled substances and added procedure", occurred on 05/06/18. This policy, dated 02/08/18 stated, ". . . to provide verification and correct count of all controlled substances on hand, and to provide safe storage for all controlled substances . . . every time the keys that secure medications change from on nurse to another . . . nurses to count all controlled substances, including discontinued controlled substances . . . scheduled drugs that have been discontinued . . . should continue to be counted	F 755	1. A) Ativan injectable emergency stock will be securely stored in a locked permanently fixed fridge and counted each shift starting 6/25/18. B) The 111 Ativan tablets that were in the double locked narcotic cabinet in south med room have been put in a locked box and stored in a locked cabinet in the Director of Nursing's office until destroyed by Consultant pharmacist starting 6/25/18. Only the DON has access to the cabinet. 2. All controlled medication discontinued or needs to be refrigerated has the potential to be affected. 3. Charge nurses will be in-serviced regarding the revised procedure for Disposition of Medication and review the Controlled Substances procedure with emphases on Emergency stock controlled substances that need refrigeration or	

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F 755	Continued From page 19 until disposal is completed . . . ". The facility policy titled, "Disposition of Medications, Local Pharmacy Medication Ordering Guidelines, dated 03/04/18, stated the following: " . . . discontinued medications are to be kept in a secure place in the medication room until these can be returned to pharmacy . . . disposal of any medication will be carried out under state guidelines . . . ". - Observation in the South Medication room in the morning of 06/06/18, showed 111 tablets of Ativan (an antianxiety schedule IV medication) to be disposed of stored in a double locked cabinet. Review of the drug disposal logs on 06/06/18 showed the nursing staff accounted for medications to be disposed of one time per week. - Observation on 06/06/18 showed a vial of Ativan stored in the South medication room in an unlocked refrigerator without a permanently affixed double locked compartment. - Observation on 06/06/18 in the North medication room showed the controlled medication of Ativan was stored in a locked refrigerator not permanently affixed with a locked key entry door to the medication room. During an interview on the morning of 06/07/18, a nurse (#12), stated the controlled medications are stored in the south medication room and counted by nursing one time a week, not daily, until the pharmacy collects the medications once a month for disposal. During an interview on 06/07/18 at 1:30 p.m., and	F 755	Controlled Substances that have been discontinued. 4. A) An audit will be developed to ensure that the facility is locking controlled substances that need refrigeration in a permanently affixed fridge and Controlled substances that are discontinued are counted each shift until they can be locked in the Director of nursing's office to be disposed by the Consultant Pharmacist. Audits will be done weekly x 4, monthly x 3, and quarterly x 2 and PRN. B) The Director of nursing or designee will submit audit reports starting the week of 7/1/18 to the DON, who will then report to the Quality Assurance Performance Improvement (QAPI) Committee monthly for compliance, trends to make recommendation as needed. If concerns are identified, immediate corrective action will be implemented. The QAPI will use the Model for Improvement for any opportunities for improvement identified.	

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F 755	Continued From page 20 administrative staff (#5) stated they follow their controlled medication storage/count procedures for operating. The Ativan vial (an antianxiety schedule IV medication) vial was in an unlocked, not permanently affixed refrigerator in the South medication room. The facility failed to account for/count the 111 tablets of Ativan tablets to be disposed of by pharmacy.	F 755		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified	F 756		7/4/18

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F 756	Continued From page 21 irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the consulting pharmacist failed to identify and report drug regimen irregularities regarding an increased use of an as needed (PRN) pain medication to the attending physician, the medical director, and the director of nursing for 1 of 1 sampled resident (Resident #31). Failure to monitor and assess PRN medications may result in the resident receiving unnecessary medications and experiencing adverse consequences related to the medications. Findings include: Review of the facility polity titled, "Pharmaceutical Services" occurred on 06/06/18. This policy, dated September 2012, stated, ". . . Review the medication regime of each resident at the time of change of condition . . . at least once a month . . . report any irregularities to the attending physician or the director of nursing services or both. . . ."	F 756	1. For Resident #31 multiple PRN use was reported to Specialty Physician 6/8/18 and to Primary Physician 6/15/18 and medication orders were received. 2. All resident who are on PRN pain medications have the risk for irregularities and have the potential to be affected. 3. A) The facility will ensure the Consultant Pharmacist reports all irregularities including multiple PRN pain med usage to attending Physician by DON or designee. B) The Pharmacist was in-serviced and reviewed the GSS Medication Regime Review Policy and Procedure on 6/28/18. 4. A) An audit will be developed to ensure that the Consultant Pharmacists reports all irregularities or issues of concern using the Medication Regimen Review Summary for QAPI Committee, the audit will be done monthly x 6 , and	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 22 Review of the facility policy titled, "Medication Regimen Review" occurred on 06/06/18. This policy, revised 2017, stated, ". . . the drug regimen of each resident is reviewed at least once a month by a licensed pharmacist. The review must include a review of the resident's medical chart . . . It may be necessary to conduct the medication regimen review (MRR) more frequently depending on the resident's condition and the risk of adverse consequences related to a current medication . . . Review of the medications to assure that doses and duration are appropriate to each resident's clinical condition, age and complicities . . . Monitoring the medications for efficacy and adverse consequences . . . potential medication irregularities and response to these irregularities . . . Drug irregularities will be reported to the attending physician by the director of nursing services or designee. The location must designate someone to ensure that these reports have been acted upon and documented. . . ." Review of Resident #31's Medication Administration Record (MAR) showed the pain medication; oxycodone-acetaminophen 10-325 milligram (mg) ordered to be administered one tablet by mouth every six hours as needed for pain. The record showed staff administered the oxycodone as follows; * January 2018 - used 27 of 31 days. * February 2018 - used 28 of 28 days * March 2018 - used 29 of 31 days * April 2018 - used 30 of 30 days * May 2018 - used 30 of 31 days * June 1-6, 2018 - used 6 of 6 days	F 756	quarterly x 2 and PRN. B) The Consultant Pharmacist or designee will submit audit reports starting the week of 6/28/18 to the DON or QAPI Coordinator, who will then report to the Quality Assurance Performance Improvement (QAPI) Committee monthly for compliance, trends to make recommendation as needed. If concerns are identified, immediate corrective action will be implemented. The QAPI will use the Model for Improvement for any opportunities for improvement identified.	

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	355094	A. BUILDING _____ B. WING _____	06/07/2018

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F 756	Continued From page 23 The MAR also showed the following medications scheduled daily or PRN for Resident #31: * Trazodone (an antidepressant) 50 mg daily at bedtime * Lexapro (an antidepressant) 10 mg once daily mouth one time a day * Cyclobenzaprine (a muscle relaxer) as needed * Gabapentin (for diabetes mellitus nerve pain) 600 mg three times a day The Pharmacist failed to evaluate the multiple use of prn (as needed) ocycodone and report to the attending physician by the director of nursing services or designee.	F 756		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) 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. §483.45(h)(2) 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	F 761		7/4/18

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F 761	Continued From page 24 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: Based on observation, record review, review of professional reference and staff interview the facility failed to ensure accurate labeling and storage of medications for 2 of 6 residents (Resident #31, and supplemental Resident A) observed during medication pass. Failure to correctly label, store, and dispose of medications may result in medications errors. Findings include: Berman, Snyder, S., Kozier, and Erb's, "Fundamentals of Nursing Concepts, Process, and Practice," 9th edition, Pearson Education, Inc., New Jersey, page 860-865, stated, ". . . . Before administering a medication, identify the client correctly using the appropriate means of identification . . . use only medications that are labeled correctly . . . before administering a medication, identify the client . . . right medication . . . right dose . . . right time . . . right route . . . right documentation . . ." - Observation of the North medication cart on 06/06/18 at 9:47 a.m. noted an insulin pen in Resident #A's medication bin. The insulin pen lacked a label identifying the resident's name, medication, dose, date, physician, and pharmacy. During an interview on the morning of 06/06/18, a staff nurse (#10) stated Resident #A's insulin pen should have a label.	F 761	1. For Resident # 31 her Novolog pen had a “Change in direction sticker” applied to the label on 6/8/18”. For Resident #A the Insulin Pen had a name applied and “Change in direction sticker” applied to the pen (prescription label on box in fridge with other Pens), and the Lasix card had a “Change in direction sticker” applied to the label on 6/25/18. 2. All resident with Prescription medication have the potential to be affected. 3. A) The facility will ensure that if the prescription label does not match the physician orders that a “Change in directions” sticker or similar sticker will be placed on the label. If a medication is improperly or inaccurately labeled the medications will be refused and returned to pharmacy. B) Charge Nurses/Unit managers/ Med Aides will be in-serviced regarding the Procedure for “Medication-Change of Direction Stickers” b/w 6/26-6/30/18. 4. A) An audit will be developed to ensure that the prescription labels are in accordance with currently accepted professional principles, and include the resident’s name, medication, dose, date, physician, expiration date, and pharmacy. B) The Charge nurses or designee will submit audit reports starting the week of	

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F 761	Continued From page 25 - Observation during the medication pass on 06/06/18 at 8:52 a.m. showed a cartridge of Lasix for Resident #A. The label identified Lasix 40 mg (milligrams) with instructions to give 1.5 tablets (60 mg) every day. The physician's order stated Lasix 40 mg, give one tablet by mouth one time a day. During an interview on the morning of 06/06/18, a staff nurse (#10) stated the label/dose has been incorrect since the resident was admitted to the facility. - Observation on 06/06/18 at 12:15 p.m., showed a staff nurse (#10) administered 25 units of NovoLog insulin to Resident #31. The label on the insulin vial identified a dose of 20 units three times a day. The physician's orders identified 25 units three times a day. During an interview on 06/06/18, an administrative nurse (#5), stated the label on the insulin vial was incorrect.	F 761	7/1/18 to the DON, who will then report to the Quality Assurance Performance Improvement (QAPI) Committee monthly for compliance, trends to make recommendation as needed. If concerns are identified, immediate corrective action will be implemented. The QAPI will use the Model for Improvement for any opportunities for improvement identified	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility	F 812		7/4/18

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F 812	Continued From page 26 gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to store food under safe and sanitary conditions in 1 of 1 walk-in coolers in the facility kitchen. Failure to store foods properly increases the risk of cross-contamination of food items that may result in a food borne illness or affect the food quality for all who eat food prepared in the facility. Findings include: Review of the facility policy titled, "Proper Thawing Methods" occurred on 06/07/18. This policy, revised December 2017, stated, " . . . 1. In the refrigerator a. Place raw meats on the bottom shelf in a drip-proof container so that there is no chance of juices splashing on ready-to-eat foods. . . ." An initial tour on 06/04/18 at 10:45 a.m. with a dietary supervisor (#11) showed the following in the walk in cooler: * Two large packs of hamburger in a tub stored over an open box containing a mashed potato product. * A pipe near the condenser dripping on a box of bacon and the mashed potato product. The	F 812	1 Open box of mashed potatoes stored under hamburger in cooler was removed upon discovery on 6/4/18. Upon inspection the mashed potatoes were in sealed bag, not contaminated, so properly re-stored. Tub with sealed hamburger packages was moved to bottom shelf of cooler on 6/4/18. Box of bacon exposed to dripping water from pipe was removed and destroyed upon discovery on 6/6/18. Bag of mashed potatoes stored under roast beef removed on 06/06/18. Upon inspection the mashed potatoes were in sealed bag, not contaminated, so properly re-stored. Roast beef in sealed container was moved to bottom shelf of cooler on 6/6/18. Containers placed under dripping pipes on 6/6/18. Director of Food and Nutrition verbally educated staff working at time of discovery and the next shift staff on 06/04/18. On 6/6/18, Director of Food and Nutrition posted reminder signage in cooler and put written training in Dietary Communication binder. 2. All residents have the potential to be affected by this deficient practice. All refrigerators and freezers were checked	

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F 812	Continued From page 27 dietary supervisor removed the boxes containing the bacon and the potato product. A tour of the kitchen on 06/06/18 at 9:33 a.m. with a dietary supervisor (#11) showed the following in the walk in cooler: * A pack of roast beef stored over a sealed plastic bag containing a mashed potato product. The dietary manager removed the mashed potato product. * The pipe near the condenser continued to drip. Staff placed empty containers on the shelf to catch the drip. During an interview on the morning of 06/06/18 a dietary supervisor (#11) confirmed she expected staff to store hamburger and roast beef on the bottom shelf and staff should not store food items near the dripping pipe.	F 812	by Director of Food and Nutrition on 6/6/18 to verify all meat products are in sealed packaging, placed in tubs, stored on bottom shelf and moisture from dripping pipes was not making contact with any food products. 3. New system practice was implemented with a Daily Food Storage Monitoring Log being initiated on 6/25/18. All dietary staff will received re-education by July 3rd, 2018 on GSS Food Storage P&P. 4. Dietary manager will audit daily monitoring form completion and visual inspection of food storage areas weekly X 4 weeks, monthly X 2 months and quarterly X 3 quarters. Audit results will be submitted to QAPI committee monthly for review and recommendations as indicated.	