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

PRINTED: 04/19/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355114	A. BUILDING _____ B. WING _____	04/03/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH DAKOTA VETERANS HOME	1600 VETERANS DRIVE LISBON, ND 58054

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F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey, started on 04/01/13 and completed on 04/03/13, the sample included 3 residents for complete review. 9 residents for focused review, and 1 closed record for review. The sample included 2 residents to verify specific concerns during the survey.	F 000	**F226 483.13 C) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES** The North Dakota Veterans Home objects to the allegation on noncompliance. A thorough background check is completed on all new employees when hired, including employee #6. Employee #6 had a thorough background check and reference check completed the first time she applied on 5/23/11. Prior to being hired in February 2013, we acquired a reference from a current supervisor who has known her for many years. We did not call the references employee #6 listed because it was her grandparents. The North Dakota Veterans Home has met the intent of the regulation and requests the citing of F226 be deleted for staff background check and a clean copy be provided. The preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or of the correctness of the conclusion set forth on the Statement of Deficiencies. This plan of Correction is prepared and submitted solely because of the requirement under state and federal law Plan of Correction.	
F 226 SS=B	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy and procedure, and staff interview, the facility failed to develop and implement effective policies and procedures regarding reporting the results of the facility's investigation to the state survey agency within 5 working days for 2 of 4 allegations of misappropriation of property, and failed to ensure complete screening, including reference checks, for 1 of 5 employees (Employee #6) hired within the last four months. Failure to report results of all investigations and screen all employees placed the residents at risk for possible neglect or abuse. Findings include: Review of the following facility policies occurred on April 1-3, 2013:	F 226		

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

Administrator 4/29/13

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 226	Continued From page 1 * "Preventing Resident Abuse, Neglect and Misappropriation of Resident Policy," dated 09//10/12, stated, "Procedure: 1. This community will not tolerate the abuse, neglect or misappropriation of property of any resident by an employee, a consultant, or others working under the direction of the community. . . . 3. Previous and current employers will be contacted for references prior to the decision to employ. . . ." * "Investigating Resident Abuse and Neglect," dated 09/10/12, stated, "1. . . . an incident that meets or has the potential to meet one of the definitions stated in the policy . . . is reported to the mentors [sic] an investigation of the incident will be commenced promptly. . . . 3. If there is any evidence that the incident meets the definition of a crime . . . local law enforcement will be notified by the mentors immediately. Team members will continue their investigation . . . 4. The Mentor will immediately make the proper notification to the North Dakota State Health Department. . . ." The facility policy lacked the requirement that results of all investigations be reported to the State survey and certification agency within 5 working days of the incident. - On 04/03/13 at 10:00 a.m., review of personnel files of five new employees hired in the preceding four months occurred with a human resources staff member (#1). The screening for one of the employees (#6) lacked evidence of an attempt to obtain a reference(s). The staff member (#1) confirmed no reference check had been completed prior to hiring the employee. - On 04/03/13 at 2:10 p.m., a social services staff member (#2) provided information on four	F 226	1. No residents were affected by deficient practice. 2. No residents were affected by deficient practice. 3. Policies and Procedures do not need to be changed. Future screenings will be done on all applicants if a lapse of time has occurred between an individual who has applied for work more than once. 4. The QA Team will do monthly audits on newly hired individuals for the first three months. After the first three months the team will audit newly hired employees quarterly for one year. 5. Completion date: 04/10/13 The North Dakota Veterans Home objects to the allegation of noncompliance. When resident #15 lost his money the incident was called into the state health department the same day the resident reported the money missing. One of our Social Service staff members had the resident's money before he reported it missing because it was found in the laundry on 11/23/13. The money was shown to the resident on 11/26/12; however, he did not think it was his	

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F 226	Continued From page 2 allegations for misappropriation of resident property that occurred in the last year. The review identified: * Resident #15 reported money missing on 11/26/12 at 3:30 p.m. The report showed notification of local law enforcement and the State survey agency occurred on 11/26/12. Review of the investigation included a report of the investigation to the State survey agency on 12/07/12, 11 days after the incident. * Resident #14 reported money missing on 11/16/12. The record contained documentation from a Licensed Social Worker (#7) on 11/19/12 which indicated notification to the State survey agency, three days after the resident informed the social services staff member. Review of the information included a report of the investigation to the State survey agency, dated 11/27/12, 11 days after the incident. On the afternoon of 04/04/13 at 4:30 p.m. an administrative staff member (#5) confirmed the facility's abuse prohibition policy lacked the requirement that results of all investigations are reported to the State agency within 5 working days of the incident.	F 226	money so the incident was called into the state health department. After thinking about it the resident came back that afternoon to get the money. This incident does not meet the definition of misappropriation of funds and should have never been reported. This incident was resolved the same day the resident reported the money missing, therefore, we request this incident be removed from the 2567L and a clean copy be provided. When resident #14 lost his money on Friday 11/16/13 a detailed search was conducted, however, laundry was closed so laundry personnel were not here to assist with the search. Phone calls were placed to son and to laundry about the lost money. After not receiving a call back from the family until Monday 11/19/13, a call was made to the state health department about the loss of money. The money was found in the laundry on 11/26/13. The money was returned and the state health department was contacted about the conclusion of our investigation. Please note this incident occurred over the week of Thanksgiving. Staff were sure the money had gone to laundry but few laundry staff worked over the holidays. This incident does not meet the definition of misappropriation of funds and should	
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		

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F 278	Continued From page 3 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, 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 1 of 2 sampled residents (Resident #12) identified with an active pressure ulcer during the assessment period and 1 of 1 sampled resident (Resident #9) coded as having a bowel training program. Failure to accurately complete portions of the MDS does not allow staff to develop a plan of care based on the residents' current status and needs.	F 278	be removed from the 2567L. Therefore the North Dakota Veterans Home has met the intent of the regulation and request the siting of F226 be deleted for misappropriation of property. The preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or of the correctness of the conclusion set forth on the Statement of Deficiencies. This plan of Correction is prepared and submitted solely because of the requirement under state and federal law Plan of Correction. 1. No residents were affected by deficient practice. 2. No residents were affected by deficient practice. 3. Policies and Procedures will be modified to include "Within five days the facility will report findings to the State Health Department". 4. At the monthly QA meeting all incidents of abuse, neglect and misappropriation of funds will be reviewed by the QA team after each incident is reported over the next year. 5. Completion date 5/15/13	

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F 278	Continued From page 4 Findings include: - The Long-Term Care Facility RAI User's Manual, October 2012, page M-8 stated, "Definition: Stage 2 Pressure Ulcer: Partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, without slough. . . . " Review of Resident #12's medical record occurred on 04/03/12. A quarterly MDS, dated 02/22/13, identified the resident had two stage 1 pressure ulcers and no stage 2 pressure ulcers during the seven day assessment period. An interdisciplinary progress note, dated 02/16/13 at 1:00 p.m. stated, ". . . Has open areas (R) [right] buttock & [and] coccyx - Allevyn [a type of dressing] used . . ." A Skin Assessment Sheet, dated 02/16/13, stated, "1. Type - open area coccyx. Description - 0.8 cm [centimeters] x [by] 1.0 cm . . . 2. Type - open area (R) coccyx. Description - 1.2 cm diameter . . . 3. Type - (R) buttock x [times] 2. Description - open area 1 cm diameter & 0.6 cm diameter . . ." An interview with an administrative nurse (#3) occurred on the afternoon of 04/04/13. The nurse agreed staff should have identified the stage 2 pressure ulcers on the 02/22/13 MDS. - The Long-Term Care Facility Resident Assessment Instrument User's Manual, October 2012, page H-11-12 states, ". . . A systematically implemented bowel toileting program may decrease or prevent bowel incontinence, minimizing or avoiding the negative	F 278	**F 278 483.20(g) – (i) ASSESSMENT ACCURACY/COORDINATION/ CERTIFIED** The North Dakota Veterans Home objects to the allegation on noncompliance. During the assessment reference period Resident #9 was trialing a scheduled bowel toileting program. A trend was identified after resident #9 experienced three falls; the falls were occurring while the resident was transferring self to the toilet for a bowel movement. Staff frequently reminded this resident about the need to call for assistance in order for the transfer to occur safely. However, the resident chose to complete transfers per self. After the trend was identified scheduled toileting times were tried. Schedule times were assessed and set to correspond with identified times that the falls occurred. During the trial the resident's input was included to help determine an appropriate schedule. The resident made a personal decision not to participate with the toileting schedule. Therefore, the North Dakota Veterans Home has met the intent of the regulation and request the siting of F278 be deleted. The preparation and submission of the plan of correction does not constitute an admission or agreement by the provider for the truth of the facts alleged or of the correctness of the conclusion set forth on the Statement of Deficiencies. This plan	

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F 278	Continued From page 5 consequences of incontinence. . . . Look for documentation in the medical record showing that the following three requirements have been met: implementation of an individualized, resident-specific bowel toileting program based on an assessment of the resident's unique bowel pattern; evidence that the individualized program was communicated to staff and the resident (as appropriate) verbally and through a care plan, flow records, verbal and written report; and notations of the resident's response to the toileting program and subsequent evaluations, as needed. . . ." Review of Resident #9's record occurred on 04/03/13. Quarterly MDSs, dated 12/19/12 and 03/19/13, identified the resident with an indwelling catheter and bowel continence as "Always continent." The 03/19/13 MDS also identified a bowel toileting program. Resident #9's record failed to identify staff performed an assessment of his unique bowel pattern prior to implementing the program. The resident's current care plan, dated 01/03/13, identified an undated, discontinued intervention of "Trial toileting schedule, sit on toilet at [10:00 a.m.] et [and] [2:00 p.m.]" A nursing progress note, dated 02/14/13 at 2:00 p.m., stated, "Writer visited [with] Res [resident] in regard to recent fall et toileting. Res was asked if we could better assist him [with] a certain schedule . . . Res was unable to come [with] specific times he likes to use the bathroom. Will continue to assist as needed." A progress note, dated 03/21/13 at 1:45 p.m., stated, "RLS [Resident Living Specialist] reports	F 278	of Correction is prepared and submitted solely because of the requirement under state and federal law Pan of Correction. 1. Resident # 12, the identified assessment had been accepted into the QIES ASAP system, therefore 5.7 from the Long Term Care Facility Resident Assessment User Manual, was followed. A modification record was completed and submitted on 4-12-2013 to include items identified during the survey. Following the instructions, a significant change in status assessment was also completed with an assessment reference date of 4-16-2013, completed on 4-23-2013 and will be submitted. The resident care plan was reviewed to ensure that it was up to date. Resident #9's assessment was not accepted into the QIES ASAP system and it was still within the 7 day encoding period, therefore instruction under section 5.6 of the Long Term Care Facility Resident Assessment User Manual was followed to make the changes the survey team identified. That revision was made to the paper copy, and then completed in the computer file. The assessment was completed and locked on 4-5-2013 and submitted on 4-12-2013. 2. Identified sections on all current MDS's completed by identified staff.	

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F 278	Continued From page 6 Res does not like to follow toileting schedule. She reports that Res will tell her when he wants to use the bathroom. . . ." During an interview on 04/03/13 at 2:10 p.m., a supervisory nurse (#3) confirmed staff did not complete an assessment of the resident's bowel pattern prior to implementing the toileting schedule. She stated staff chose the toileting times based on times Resident #9 fell in the bathroom and confirmed staff implemented the toileting schedule as a fall intervention. The above MDSs identified Resident #9 as continent of bowel. Implementation of the toileting schedule as a fall intervention failed to meet the requirements for coding a toileting schedule on the MDS.	F 278	member will be reviewed by another nurse who has completed the RAC-CT Certification. 3. The identified staff member is registered and will be attending the MDS training sponsored by the North Dakota Department of Health, Resident Assessment Instrument Basic MDS (Version 3.0) training, on May 14-16, 2013. 4. QA audits will be completed by the Performance Improvement Nurse, to ensure continued accurate completion of the MDS's. Will be completed monthly for 3 months and then quarterly x3. 5. Completion date: May 19, 2013 →	
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 appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the	F 431	**F 431483.60(b), (d) (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS** The North Dakota Veterans Home objects to the allegation on noncompliance. Identified solutions and creams were noted in the stock storage area outside of direct resident care areas. This area is for storage; including storage of items waiting to be destroyed by the Pharmacist. Medications available for resident use are stored in a cart in the direct resident care areas. We feel the North Dakota Veterans Home has met the intent of the regulation as these	

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F 431	Continued From page 7 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: Based on observation, policy review, and staff interview, the facility failed to ensure outdated medications/biologicals were discarded after the recommended usage period in 1 of 1 Medication (Drug) Room. Failure to dispose of expired medications allows usage beyond the recommended expiration date. Findings include: Review of the facility policy, titled "Discarding Drugs - Outdated and No Longer Used," occurred on 04/03/13. This policy, not dated, stated, "Policy: Outdated and unused drugs will not be stored with currently used drugs. . . . 3. On the date of expiration, the drug shall be removed by the medication nurse to a locked cupboard in the Drug Room - designated for old or discontinued drugs. . . . The outdated drugs will be stored until	F 431	medications were stored there waiting to be destroyed. We request the citing of F431 to be deleted for storage of Drugs and Biological. The preparation and submission of the plan of correction does not constitute an admission or agreement by the provider for the truth of the facts alleged or of the correctness of the conclusion set forth on the Statement of Deficiencies. This plan of Correction is prepared and submitted solely because of the requirement under state and federal law Pan of Correction. 1. Stock storage area has been reviewed to ensure all outdated medication, creams and solutions have been removed. 2. Medication carts in the direct resident care areas have been reviewed to ensure that outdated medications, creams and solutions are not stored in that location. 3. Routine periodic review/inspection of stock storage room and medication carts has been assigned to the night shift staff. The required schedule has been posted and when completed, will be signed off by that individual. 4. QA audits will be completed by the Performance Improvement Nurse, to ensure continued proper medication storage. Will be completed monthly for 3 months, then quarterly x3. 5. Completion date: May 19, 2013.	

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F 431	Continued From page 8 destruction during the next visit of the Pharmacist." On 04/03/13 at 9:55 a.m. observation of the Drug Room, with a staff nurse (#4), showed the following expired creams and solutions stored with currently used drugs: * A vial of sterile water, opened, not dated; * Sterile water for irrigation, expired 08/2012; * Banophen cream, expired 11/2012; and * E Cream, expired 10/2012. As the nurse (#4) removed these medications from the stock drug storage area, she stated they would be returned to the pharmacist, who checks the drug room monthly. Failure to follow facility policy allowed expired [five to seven months] solutions and creams to be available for possible use.	F 431		