STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355041	A. BUILDING _____ B. WING _____	01/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN HOME OF THE GOOD SHEPHERD	1226 1ST AVE N NEW ROCKFORD, ND 58356

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F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey, started on 01/20/15 and completed on 01/22/15, the sample included 4 residents for complete review, 9 residents for focused review, and 2 closed records for review. The sample included 1 additional resident to verify specific concerns during the survey.	F 000		
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.	F 157	F157 1. Resident #8's blood sugars were assessed on 1/26/15 with physician and changes were made in her insulin dosage and diabetic monitoring continues. 2. The facility has determined that all residents have the potential to be affected. 3. Director of Nursing evaluated blood glucose levels of residents receiving anti-diabetic medications and changes were made as needed. A Hypoglycemia policy has been developed to indicate when physician should be notified of low blood glucose levels (see #1). Education was provided by the Director of Nursing at the nurses meeting on 1/28/15 in regards to circumstances that	

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

Administrator 2-17-15

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 157	Continued From page 1 The facility must record and periodically update 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, review of facility physician standing orders, and staff interview, the facility staff failed to notify the physician regarding symptomatic hypoglycemia (low blood glucose levels) for 1 of 2 sampled diabetic residents (Resident #8). Failure to notify the physician of symptomatic hypoglycemia limited the physician's ability to ensure quality care and placed Resident #8 at risk of coma and death. Findings include: Review of the facility's "Physician Standing Orders," revised on 04/05/14, occurred on 01/22/15. The orders stated ". . . MEDICATIONS: . . . 12) Glutose gel 1/2 tube orally for symptomatic hypoglycemia, may repeat within 15 minutes if needed. Notify physician of event. 13) Glucagon 1 cc [cubic centimeter] IM [intramuscularly] for symptomatic hypoglycemia and resident unresponsive. Notify physician of event. . . ." Review of Resident #8's medical record occurred on January 20-22, 2015. The facility admitted the resident in February 2014. Current diagnoses included diabetes mellitus II. Current physician orders lacked blood glucose parameters for physician notification. Resident #8's nurse's notes for the period, May 01, 2014 through January 21, 2015 showed the	F 157	require notification of a resident's physician, legal representative or family member (see #2). The notification of change policy (see #3)along with new policy on hypoglycemia and notification was reviewed at the nurses meeting on 2/17/15 (see #4). 4. The Director of Nursing or designee will conduct a QA on four residents weekly X 4, monthly X 3, then quarterly X 3, then reevaluate for further monitoring or interventions. These residents will be assessed to ensure that any declines in condition have been identified, properly evaluated and communicated to the appropriate people. 5. The facility is in substantial compliance with F 157 by 2/18/15.	2/18/15

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F 157	Continued From page 2 following regarding blood glucose levels: *05/15/14, 5:45 a.m. - ". . . Woke her now to check accu check prn. Skin cool, fingers more cool, shaking whole body in bed, alert and responds. Accu check 35 [milligrams/deciliter (mg/dl)]. Given orange juice 180 cc, yogurt and pudding cups. Swallowed and used straw well without choking or coughing, swallows food well. . . . Accucheck taken when done eating approximately 20 minutes later - 36 [mg/dl]. Monitor." The record showed no further accuchecks until approximately seven hours later. *07/06/14, 6:39 p.m. - "8:00 a.m. resident lethargic upon waking. Unable to stand with one assist. Unable to ambulate. Two person transferred into wheelchair and then onto toilet. Only responds by opening eyes and quickly closing them when name is called. 8:30 a.m. Accu check was 43 [mg/dl]. Scheduled insulin held until blood sugar rised [sic]. Resident drank 240 cc of chocolate milk alond [sic] with hot cereal, toast, prune juice, and coffee. 9:20 a.m. Resident blood sugar rechecked: 154 [mg/dl]. Scheduled insulin administered. Resident more stable rest of day. . . ." During interview, on 01/22/15 at 1:00 p.m., three administrative staff members (#1, #8, and #11) confirmed the facility staff failed to notify the resident's physician or the physician on call of Resident #8's symptomatic hypoglycemic events.	F 157		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe.	F 176	F176 1. An assessment for resident #7 was completed on 2/9/15 that identified that she continues to not be	

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F 176	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to complete an assessment for 2 of 2 sampled residents (Resident #7 and #9) identified as able to self administer medication with assistance (SAMA). Failure to determine if SAMA is a safe practice has the potential to result in a medication error and/or harm to a resident. Findings include: Review of the facility policy titled "Self Administration of Medication with Assistance (SAMA)" occurred on 01/21/15. This policy, dated 2014, stated, "Purpose: To assist the resident in taking their prescribed medications in a safe manner and to educate the resident regarding prescribed medications. Procedure: 1. Assessment for Self-Administration form must be completed by the nurse, making sure to mark the correct category. 2. Upon successful completion of the Assessment for Self-Administration form, the interdisciplinary team will determine if practice is safe. . . ." - Review of Resident #7's medical record occurred on all days of survey. Diagnoses included organic brain syndrome. Resident #7's care plan stated, " . . . Resident is able to take own meds [medications] with assistance. This is SAMA (Self-Administration of Medication with Assistance) . . . Approaches: Assessment of resident for safe administration of medications done before program instututed [sic]. Assess monthly by nursing at nurse's meeting . . ."	F 176	appropriate for SAMA (see #5). It was indicated on SAMA care plan that SAMA was discontinued on 11/13/14. Resident #9 had a SAMA assessment completed on 1/23/2015 and he was continued to be appropriate for SAMA (see #6). 2. All residents currently indicated for SAMA were checked for required SAMA assessments and assessments were completed if needed. It was also verified that a SAMA care plan was completed. 3. The facility will identify other residents who wish to self-administer medication with assistance by having the nurse complete a SAMA assessment 7 days following their admission. A fixed order has been entered into the computerized system. This fixed order will be activated upon admission and will trigger on the eMAR 7 days following admission and the nurse will be required to complete the assessment. The facility will continue to discuss SAMA residents monthly. A SAMA review form has been developed to evaluate cognition and motor skills for SAMA residents (see #7). The SAMA policy/procedure (see #8) has been reviewed and revised on 1/28/15 (see #2). Nurses were inserviced on	

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

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F 176	Continued From page 4 During an interview on the afternoon of 01/22/15, an administrative nurse (#12) stated staff failed to complete a SAMA assessment for Resident #7. - Review of Resident #9's medical record occurred on all days of survey. Diagnoses included dementia with behavioral disturbance and psychosis. The care plan, dated 08/26/14, stated, "Resident is able to take own meds with assistance. . . . Approaches: Assessment of resident for safe administration of medications done before program instututed [sic]. . . ." Review of Resident #9's record failed to include evidence of an initial assessment for SAMA. During an interview on 01/22/15 at 8:30 a.m., an administrative nurse (#8) stated she was unable to find a SAMA assessment completed before Resident #9 began SAMA.	F 176	2/17/15 on their expectations on completing the SAMA assessment (see #4). 4. The Director of Nursing or designee will monitor all admissions for completion of a SAMA assessment along with all residents currently participating in SAMA weekly X 4 weeks, monthly X 3 months, and quarterly X 3. 5. Nurses have been inserviced on revised SAMA policy and procedure and their responsibility in completing the SAMA assessment. The facility is in substantial compliance of F 176 as of 2/18/15.	2/18/15
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy and procedure, resident interview, and staff interview, the facility failed to provide the necessary social services for 1 of 4 sampled residents (Resident #2) previously or currently	F 250		

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F 250	Continued From page 5 residing in the facility's secured unit (Angel Wing). Failure to provide the necessary services resulted in Resident #2's verbal and physical behaviors towards other residents. Findings include: Review of the facility policy and procedure, "Administrative Abuse Policy," occurred on 01/22/15. This document, revised on 01/02/14, stated "POLICY: Each resident has the right to be free from verbal, sexual, physical . . . abuse . . ." Review of Resident #2's medical record occurred on January 20-22, 2015. The facility admitted the resident in July 2013 to the secured unit (Angel Wing) after the resident eloped from a basic care facility. Resident #2 resided on the secured unit until 01/06/15 when facility staff transferred him to an unsecured wing of the facility. Resident #2's current diagnoses included anxiety, dementia with behaviors, and depression. The resident's Minimum Data Sets (MDSs), annual and quarterly, dated 07/13/14 and 10/13/14 respectively, identified a Brief Interview for Mental Status (BIMS) score of "14" showing him to be cognitively intact, verbal behaviors occurred on one to three days during the seven day assessment period, transfers and walking required limited assistance of one person on 07/13/14 and independent on 10/13/14, and Resident #2 received antianxiety and antidepressant medications on seven of seven days during the assessment period. The 30 day MDS, dated 12/31/14, (on return from hospitalization) identified a BIMS of "14" no verbal behaviors, independent transfers and walking, and Resident #2 received an antipsychotic and an	F 250	F250 1. Resident #2 has been moved off the secured unit on 1/6/15 and is doing very well off the secured unit (Angel Wing). 2. Each resident currently residing in the secured unit (Angel Wing) has been reviewed by the interdisciplinary team for appropriateness on 2/13/15, and all current residents remain appropriate for the secured unit (Angel Wing). Each resident coming into the secured unit (Angel Wing) will	

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F 250	Continued From page 6 antidepressant medication seven of seven days during the assessment period. Resident #2's medical record identified the following behaviors toward other residents: *04/28/14 - Rubbing [resident's number] thigh. *05/25/14 - Resident #2's hand under a blanket near [resident's number], different from 04/28/14, thigh. *09/16/14 - An unidentified resident came into Resident #2's room, Resident #2 hit the resident twice, grabbed the resident, and caused redness. The record did not identify the resident. *10/23/14 - [Resident #10] entered Resident #2's room, Resident #2 threatened to break his arm. *11/07/14 - Resident #2 was upset with Resident #10 for drinking other residents' drinks in the dining room and grabbed Resident #10. *11/09/14 - Resident #2 was agitated with other residents sitting in his chair and verbally confronted them. *11/09/14 - Resident #2 punched a resident who was yelling and screaming. The record indicated no injuries occurred and did not identify the resident. *12/23/14 - Resident #10 entered Resident #2's room. Resident #2 pushed Resident #10 to the floor. Resident #10's record identified the following: *11/07/14 - ". . . Resident wandering in and out of resident's rooms, came to the dining area and tried to drink other residents drinks at the dining table. Resident #2 got upset with resident when resident picked up another resident's glass. Resident #2 grabbed Resident #10['s] right arm to make him stop . . . No redness or bruising noted to resident's right arm at this time. . . ." *12/24/14 (follow-up to incident on 12/23/14) - ". .	F 250	have an Angel wing Pre-Admission screening (see #9)completed and appropriateness of continued placement will be evaluated and documented with each residents MDS according to the admission and discharge criteria for the Angel Wing.(see #10) 3. A new policy for the Secured Unit (Angel Wing) has been developed. (see #11) The multidisciplinary team will be in-serviced on this policy by 2/18/2015. 4. Social Service staff or designee will be responsible to monitor to assure all residents are appropriate to be in the Secured Unit (Angel Wing). QA/monitoring will be implemented by 2/18/15. The Social Service staff will monitor this weekly for one month, monthly for three months and quarterly thereafter for a total of 1 year of QA's. Results will be immediately reported to Administration. If concerns are identified immediate corrective action will be implemented. The Social Service staff will submit a report of the monitoring results to the QA committee at each scheduled meeting.	

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F 250	Continued From page 7 . Resident was wandering into Resident #2's room unknowingly and by accident. Resident #2 trapped resident['s] legs between his legs and thrown [sic] him to the ground. . . . Resident wa [sic] moved from Resident #2's room and assisted to his own bedroom . . . Bruising observed . . . Monitor resident." Resident #2's Behavioral Care Area Assessment (CAA), dated 07/17/14, identified the resident as "touchy, feely," a history of alcohol abuse, fluctuations in mood, anxiety, family rarely involved, and a guardian making decisions. Resident #2's current care plan, dated 07/15/13, stated "Problem, [Resident #2] has depression and alteration in mood and behavior at times (anxiety) 05/28/14, [Resident #2] had sexual inappropriate behaviors . . . Med [medications] and/or treatments per DO [doctor's orders] . . . Social worker to visit PRN [as needed] . . . Visit with resident if any sexually inappropriate gestures or behaviors are noted with other residents or staff. Document any such behaviors. Resident has been instructed that this is wrong and any such behaviors could result in him being transferred. Monitor resident for any inappropriate behaviors regarding other residents. . . . [Resident #2] moved off the Angel Wing due to behaviors [sic] that occurred when others would enter his room. . . ." The medical record identified facility staff implemented the following interventions regarding Resident #2's behaviors: *11/13/13 - Room change to the end of the hall to have fewer disturbances. *11/21/13 - Sign "man's room" on Resident #2's door to discourage wandering female resident	F 250	5. Date of substantial compliance is 2/18/15.	2/18/2015

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F 250	Continued From page 8	F 250		

entering room.
*06/15/14 - "Stop" sign on door to keep wandering residents out.
*09/17/14 - Resident #2 reported wandering resident in his room three or four times in past month, reminded to use call light.
*11/21/14 - Psychiatrist follow-up and initiation of antipsychotic, Risperdal.
*12/24/14 - Box over door knob, accessible to Resident #2, inaccessible to other residents. "Yellow Caution tape" across door.
*01/06/15 - Transfer to unsecured wing.

The facility's Behavioral Meeting minutes regarding Resident #2 showed the following:
*10/30/14 - "Cursing/Verbal/Threatening. He's making more of it than it is with [Resident #10], accusing [Resident #10] of a lot. Stop sign is on & [and] has been successful, according to staff."
*12/26/14 - "Ref [Refuses] cares, hitting, pushing, threatening/None since this one day. Interventions put in place/[Psychiatrist] notified."
*12/31/14 -"Caution sign is working, box still on & [and] working, needs velcro."

During interview on 01/22/15 at 11:45 a.m., a social services management staff member (#2) and two administrative staff members (#1 and #8) reported facility staff updated Resident #2's current care plan when he moved to the unsecured unit on 01/06/15; the facility's electronic records system does not retain previous versions of the care plan; and, the facility did not keep a "hard copy" of the previous care plans. Additional care plan entries regarding Resident #2's behaviors and interventions before his transfer were not available. These staff members (#1, #2, and #8) reported the facility identified interventions in the facility's Behavioral

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F 250	Continued From page 9 Meeting minutes. These staff members (#1, #2, and #8) also reported Resident #2 was frustrated with being unable to get his way, such as smoking in the facility and seemed to "take out" his frustrations on other residents. During interview, on 01/22/15 at 8:35 a.m., Resident #2 reported he was pleased with the transfer from the Angel Wing to the unsecured unit. He stated "Grand Central Station" on the Angel Wing due to the wandering residents, no wandering residents in his current room, and the "best thing over here" regarding his current room. Failure to implement behavior interventions in a proactive manner, including questioning appropriateness of placement on the secured unit, may have contributed to continued behaviors by Resident #2 towards other residents and injuries to other residents.	F 250		
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's	F 280	F280 1. Resident #3's care plan was reviewed and revised on 2/9/15. Resident's care plan for falls was updated to include all interventions put into place to assist in preventing falls. The intervention of toileting resident prior to bed no longer applies as resident no longer uses the toilet. Resident #4's care plan was reviewed and revised on 2/9/15. A transfer assessment was completed by physical therapy on 2/6/15 and	

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F 280	Continued From page 10 legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy review, and staff interview, the facility failed to review and revise the comprehensive care plan to reflect the resident's current status for 7 of 13 sampled residents (Resident #1, #2, #3, #4, #7, #8, and #9). Failure to revise the care plan limited staff's ability to communicate care needs and ensure continuity of care for each resident. Findings include: Review of the facility's policy titled "Care Plans" occurred on 01/22/15. The policy, dated 10/06/10, stated, "3. A resident's care plan is designed to: a. Include goals and objectives that are measurable and within a specified time frame. b. Incorporate identified problem areas and risk factors associated with these problems. . . . 4. Care plans are revised as changes in the resident's condition dictates. Reviews are made at least quarterly or when the resident has been readmitted to the facility from a hospital/rehabilitation stay. 5. . . . Care Plans include the bedside Kardex (kept in the CNA [certified nursing assistant] book), CNA orders (kept in the CNA book), . . ." - Review of Resident #3's medical record occurred January 20-22, 2015. The resident's diagnoses included Alzheimer's Disease and	F 280	the care plan was updated to indicate that resident transfers with a sit to stand lift with leg strap and 1 assist. Resident #2's care plan was reviewed and revised on 2/9/15. Resident's care plan was updated to include interventions for alterations in mood or behaviors. An elopement assessment was completed on 1/27/15 and a care plan for risk for elopement was added. Resident's wanderguard was removed as it was felt that resident physically could not exit the building independently without assistance at this time. Resident #8's care plan was reviewed and revised on 2/9/15. Resident #8's care plan was updated to include the appropriate recommended transfer method. Resident #1's care plan was reviewed and revised on 2/9/15. Resident's care plan was updated to include proper transfer method of a sit to stand lift with 1 assist. The care plan has also been updated to include	

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F 280	Continued From page 11 anxiety. The quarterly Minimum Data Set (MDS), dated 11/17/14, identified extensive assistance of two persons with transfers and locomotion on the unit. Resident #3's nurses' notes identified the following self transfers from her wheelchair and resulting falls: *02/23/14, 2:36 p.m. - room *02/25/14, 3:18 p.m. - TV area *03/22/14, 9:48 p.m. - location not identified *04/02/14, 5:54 p.m. - dining room *05/01/14, 6:26 p.m. - TV area *06/14/14, 8:15 p.m. - TV area (fracture of right arm/humerus) *07/06/14, 7:15 p.m. - room *08/15/14, 12:30 p.m. - bathroom (fracture of femur) *09/09/14, 7:10 p.m. - location not identified *10/08/14, 7:45 p.m. - TV area Resident #3's current care plan, dated 10/08/13, identified . . . PROBLEM . . . increased risk for falls . . . cognitive assessment PRN [as needed] . . . fall team to review PRN . . . Dr. to review meds [medications] [every] 2 months and PRN . . . Therapy per DO [doctor order] . . . Encourage to attend activity program . . . Monitor for possible side effects of any psychotropic . . . Bed alarm in place to alert staff to attempts to transfer per self . . . PROBLEM . . . fell and sustained a [right] upper arm fx . . . Alarms to bed/chair per DO . . ." Information provided by an administrative nursing staff member (#8) identified the following approaches: *02/25/14 - "alarms . . . restorative program . . . 3 day bowel and bladder assessment . . . correlation falls to voiding"	F 280	interventions put into place to assist in preventing falls. Resident #9's care plan was reviewed and revised on 2/9/15. A care plan has been developed for Risk for Elopement along with interventions. An elopement assessment was completed on 1/18/15 which indicated resident was not at risk for elopement at this time so his wanderguard was discontinued. Resident #7's care plan was reviewed and revised on 2/9/15. Resident's care plan was updated to include the proper transfer method which is to transfer with FWW and 1 assist. (All care plan information stapled together in order of residents. See form #12). 2. All resident have the potential to be affected by failure to revise and update the comprehensive care plan to reflect the resident's current status. 3. The fall team will review all falls weekly at the fall meetings. Any interventions put into place during the fall meetings	

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F 280	Continued From page 12 *04/07/14 -". . . lower wheelchair . . ." *07/09/14 - ". . . toilet prior to bed . . . allow resident to sit in recliner . . ." *08/15/14 - ". . . CNA educated on staying with resident at all times and asking someone else to get shirt . . ." *10/08/14 - ". . . lateral arm support to the right side of wheelchair . . . removed elevated foot rests and placed regular foot rests on chair." Facility staff failed to revise Resident #3's care plan with all the above approaches. - Review of Resident #4's medical record occurred on January 20-22, 2015. The resident's diagnoses included dementia with behavior disturbances, generalized pain, and osteoarthrosis. The admission MDS, dated 12/02/14, identified transfers and walk in room with extensive assistance of two persons. A "Transfer Assessment," dated 12/02/14, indicated the recommended transfer method as transfer with two [persons] with gait belt and a front wheeled walker. The assessment stated if Resident #4 is not participating in the transfer use a Hoyer [full body] lift for safety. Resident #4's current care plan, dated 12/02/14, identified ". . . requires staff assistance with ADL's [activities of daily living] at times . . . Transfer with two assist with gait belt and front wheeled walker. Transfer with Hoyer lift PRN." Resident #4's current care guide (utilized by CNAs) identified transfer and ambulation with assistance of one to two persons and no wheeled walker indicated.	F 280	will be entered into the care plan by a member of the fall team. When a nurse identifies a resident at risk for falls, interventions will be care planned by that nurse. The nurses will notify therapy when a change of resident transfer method is needed. After completion of an assessment, the nurse will enter the change into the care plan. All interventions for falls and change in transfer method will also be updated on the careguide for the CNAs. When interventions for elopement or behaviors need to be in place they will be added to the care plan by the nurse. Staff responsible for building care plans will be responsible to do immediate updates into the computer and either print a new careguide or manually highlight corrections to the old careguide. Current Kardexes have been replaced with Careguides. Careguides are printed directly from the care plan and any change to the care plan will automatically be changed on the careguide.	

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F 280	Continued From page 13 Observation on January 20-21, 2015, showed Resident #4 transferred from a wheelchair with a stand lift with assistance of two persons. During an interview on 01/22/15 at 9:05 a.m., a CNA (#9) stated facility staff have transferred Resident #4 with a stand lift for approximately 75% of the time she's been a resident of the facility. The staff member stated facility staff tried to walk Resident #4 but she wanted to go the opposite direction. Failure to ensure Resident #4's care plan and care guide matched and provided for an exact mode of transfer may result in falls/injury. - Review of Resident #2's medical record occurred on January 20-22, 2015. The facility admitted the resident to the secure unit in July 2013 after elopement from a basic care facility. Resident #2 demonstrated verbal, sexual, and physical behaviors towards other residents on the secured unit. The facility transferred Resident #2 to an unsecured wing in January 2015. Observation throughout the survey showed Resident #2 wearing a wanderguard alarm to alert facility staff if he attempted to leave the facility unattended. Resident #2's current care plan, dated 07/15/13 and updated 05/28/14, stated "Problem, [Resident #2] has depression and alteration in mood and behavior at times (anxiety) 05/28/14, [Resident #2] had sexual inappropriate behaviors . . . Med and/or treatments per DO . . . Social worker to visit PRN . . . Visit with resident if any sexually inappropriate gestures or behaviors are noted with other residents or staff. Document any such behaviors. Resident has been instructed that this is wrong and any such behaviors could	F 280	These careguides will be available at the nurses station for viewing by the CNA. Education was provided by nurses on 1/28/15 on care plans and have been directed on how to appropriately modify and enter care plans as well as updating careguides on 2/17/15. They have also been educated on reviewed and revised Care Plan Policy (see #13). 4. The Director of Nursing or designee will be responsible in evaluating four residents entire care plan will be reviewed for accuracy and completeness weekly X 4, monthly X 3, and quarterly X 3. Care guides will also be evaluated weekly X 4, monthly X 3, and quarterly X 3 to assure that they are updated with the care plan. 5. The facility is in substantial compliance with F 280 on fall interventions and method of transfers as of 2/18/15. All care plans will be reviewed and revised for completeness by 2/26/15.	2/26/15

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result in him being transferred. Monitor resident for any inappropriate behaviors regarding other residents. . . . [Resident #2] moved off the Angel Wing [secure unit] due to behaviors [sic] that occurred when others would enter his room. . . ."

Resident #2's "Resident Care Card," used by the facility's direct care staff, failed to identify verbal, sexual, or physical behaviors, elopement, or the wanderguard.

Resident #2's care plan lacked approaches for facility staff to prevent sexual behaviors or to monitor for residents who may wander into his room. Resident #2's care plan also failed to identify his risk for elopement, approaches including the wanderguard, and monitoring that the wanderguard was operational.

- Review of Resident #8's medical record occurred on January 20-22, 2015. The resident's current diagnoses included Parkinson's disease.

Resident #8" current care plan, dated 02/06/14, stated "Problem, [Resident #8] requires staff assistance for ADL's at times. . . . Approaches . . . Transfer with 1 with gait belt and FWW [front wheeled walker]. Transfer with EZ stand [mechanical sit to stand lift] PRN. . . ."

Resident #2's "Resident Care Card" identified, "Transfers, Assist of 1, Mechanical lift, Sit to stand, EZ Stand or walks with walker."

Observations throughout the survey showed CNAs ambulated Resident #8 with a front wheeled walker and a gait belt.

The facility failed to ensure Resident #7's care

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plan and care card matched and specified one mode of transfer, instead of leaving the decision to the CNA performing the transfer.

- Review of Resident #1's medical record occurred on all days of survey. The nurses' notes identified the resident fell multiple times from 11/16/14 to 01/18/15. The current care plan stated, "Problem: [Name of resident] has an increased risk for falls. Goal: [Name of resident] will be able to make safe decisions related to asking and waiting for assistance with ADL's [Activities of Daily Living] . . . Approaches: . . . Position bed in lowest position at all times when staff is not in attendance." Resident #1's Resident Care Card identified she transferred with a "sit to stand" lift on the day shift, and with "assist of 1-2" staff on the evening and night shifts. The Resident Care Card included equipment of bed check, chair check, and an air mattress.

Observation throughout the survey showed staff placed a fall mat in front of the chair or bed when Resident #1 sat in the chair or laid in the bed, with the bed in the lowest position. Observation showed an air mattress overlay on the bed and staff utilized bed and chair alarms. On 01/21/15, observation of staff transferring Resident #1 with a sit to stand lift showed inconsistencies in the number of staff assistance: at 8:36 a.m. a CNA (#14) and a nurse (#15) transferred Resident #1, and at 11:37 a.m. a CNA (#14) performed the transfer.

During an interview on 01/22/15 at 1:15 p.m., two administrative nurses (#8 and #11) stated the facility tried various interventions to reduce Resident #1's falls including a different mattress, alarms, fall mat, encouragement to eat in the

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F 280	Continued From page 16 dining room, non-skid material to recliner seat, toileting program, medication changes, gripper socks, encouragement to participate in activities, and tip stabilizers to the recliner. The nurses agreed not all the interventions were listed on the care plan or Resident Care Card. The care plan failed to indicate Resident #1 experienced multiple falls and failed to include interventions, such as the fall mat, and all the interventions tried. The Resident Care Card failed to identify the exact number of staff required to transfer the resident, versus leaving the decision to the CNA to transfer Resident #1 with the assistance of one or two people. - Review of Resident #9's medical record occurred on all days of survey. The Resident Care Card identified Resident #9 wore a code alert (wanderguard bracelet that alarms when the resident attempts to exit the building). An elopement assessment, dated 03/19/14, indicated the resident eloped to the business next door to the facility without informing the staff, and the resident's physician ordered the code alert to be placed on the resident. The nurses' notes, dated 09/02/14, stated, ". . . resident was viewed by back door of building, where staff clocks in, attempting to exit building. . . ." Review of Resident #9's care plan showed staff failed to identify the problem of elopement and develop goals and approaches, including the use of the code alert. During an interview on 01/22/15 at 1:00 p.m., an administrative nurse (#8) agreed staff should have developed a care plan for Resident #9 related to elopement.	F 280		

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F 280	Continued From page 17 - Review of Resident #7's medical record occurred on all days of survey. Diagnoses included organic brain syndrome and fracture of the right hip on 08/25/14. Resident #7's care plan stated, ". . . Requires more assistance d/t [due to] fx [fracture] R [right] hip . . . Approaches: . . . transfer with 1 with gait belt and FWW [front wheeled walker] . . ." Resident #7's care card identified the resident is transferred with assist of one or two persons with no indication to use the FWW. The facility failed to ensure the care card included the FWW, and failed to specify one staff or two staff assist Resident #7 with transfers, instead leaving the decision to the CNA performing the transfer.	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET 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 record review, facility policy review, and staff interview, the facility failed to follow professional standards for 2 of 6 residents (Resident #1 and Resident #3) following an unwitnessed fall with evidence of head injury. Failure to ensure adequate monitoring (i.e. neurological assessment) after a possible head injury may cause a deterioration in condition to go unnoticed by staff.	F 281	F281 1. Resident #1 and 3 were not affected by deficient practice so no corrective action needed. 2. The facility will complete neuro checks for all residents who have falls resulting in head injury or have an unwitnessed fall in which the resident cannot reliably state whether injury to the head occurred.	

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F 281	Continued From page 18 Findings include: Review of the facility policy titled "Neurochecks" occurred on 01/22/15. The policy, dated 03/02/14, stated, ". . . 1. After a resident sustains a fall where a bump to the head or laceration to the head occurs, a neuro check is to be completed. 2. A Neuro check consists of Pupils of the eye being equal, round, reactive to light and accommodation (PERRLA). 3. Checks are to be completed every 15 minute intervals X 4; If within expected limits do every 30 minute X 2; then if within expected limits do Hourly x 4; Every 4 hours for 4 times. 4. If Neuro checks are not within expected limits, notify Physician on call. . . ." - Review of Resident #3's medical record occurred on all days of survey. The nurses' notes identified the following unwitnessed falls with a bump/lump to the head: * 09/09/14 at 7:10 p.m. - ". . . Resident chair alarm sounding off and resident on the floor face down . . . not aware if she hit her head, Bumped to (L) [left] forehead (she's leaning on that side to elevate face from the floor) . . . Pupil reactive to light . . . Neuro check per protocol . . ." The record showed staff completed additional neuro checks at 7:45 p.m., 8:00 p.m., 8:15 p.m., 8:45 p.m., 9:15 p.m., 10:15 p.m., and 11:15 p.m. On 09/09/14 at 11:22 p.m., the record showed Resident #3 had a "6 X 10 cm [centimeter], slightly reddened and swollen" left forehead. Nursing staff failed to complete neuro checks per facility policy. * 10/08/14 at 7:45 p.m. - ". . . CNA [certified	F 281	3. To ensure that neuro checks are completed for all residents with falls resulting in injury to the head or any unwitnessed falls where the resident cannot reliably state whether a head injury occurred a neuro check worksheet has been developed. The neuro check worksheet and assessment were developed on 1/26/15. By completing the neuro check worksheet (see #14) and entering the information into the neuro check assessment (see #15), there will be consistency with all nurses and information will be readily available for viewing. This will also be stored in the resident's permanent record. CNAs were educated on 1/27/15 (see #16) and nurses on 1/28/15 (see #2) on revised neuro check policy (see #17) and procedure and how to complete the neuro check worksheet and enter information into the assessment. 4. The Director of Nursing, or designee will monitor to assure all falls resulting in injury to the head or unwitnessed falls in which a resident cannot reliably state	

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F 281	Continued From page 19 nursing assistant] heard the chair alarm and found resident on the floor, laying on her right side, with her w/c [wheelchair] tip [sic] over . . . Lump and bruise noted on her right forehead and down to her right eye area. Doing Neuro check per [facility name] protocol . . ." On the afternoon of 01/22/14, a nursing staff member (#3) provided one "Neurological Assessment" form, dated 10/09/14 at 1:30 p.m. Nursing staff failed to complete neuro checks per facility policy. During an interview on 01/22/15 at 2:15 p.m., an administrative staff member (#1) confirmed nursing staff are to complete neuro checks per facility policy. - Review of Resident #1's medical record occurred on all days of survey. The nurses' notes identified the following falls with head injury: * 11/22/14 at 3:58 p.m. - "Found resident lying on floor . . . Has 2 cm hematoma to R. [right] forehead. Alert and confused. . . . Eyes PERRLA. . . . VS [vital signs] [temperature, pulse, respiration, and blood pressure recorded]. . . ." Staff completed neuro checks at 6:45 p.m., 7:00 p.m., 7:15 p.m., 7:30 p.m., 8:00 p.m., 8:30 p.m., 9:30 p.m., and 4:30 a.m.. At 10:30 p.m., 11:30 p.m., and 12:30 a.m., staff recorded vital signs only, and noted the resident was "sleeping." No further neuro checks were completed as per facility policy. * 01/18/15 at 11:47 p.m. - "Resident was observed on the floor . . . She denied pain and did verbalize hitting head . . . neuro and injury assessment; . . . Assessments and VS stable . .	F 281	whether a head injury occurred, that neuro checks are completed per LHGS policy. This will be done weekly X 4, monthly X 3, and quarterly X 3 and evaluate for further monitoring and intervention. 5. The facility is in substantial compliance of F 281 as of 2/18/15.	2/18/15

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F 281	Continued From page 20 ." Staff documented neuro checks on 01/19/15 at 4:32 a.m. as ". . . All assessments are the same as the initial assessment . . . VSS [vital signs stable] see as follows: [Eight sets of VS listed, each lacked the time obtained]. . . ." Staff documented neuro checks on 01/19/15 at 8:02 p.m. as ". . . Neuro checks done VS 0645 [6:45 a.m.] [VS results] . . . 1045 [10:45 a.m.] [VS results] . . . 1445 [2:45 p.m.] [VS results] . . . Pupils equal and brisk. . . ." On the afternoon of 01/22/15, an administrative nurse (#8) stated a travel nurse worked the night of this fall, which occurred around 9:30 p.m., and recorded the VS on a piece of paper to transcribe in the computer later. This nurse provided the scratch paper with those VS for January 18-19, 2015, which were timed at 9:30 p.m., 9:45 p.m., 10:15 p.m., 10:45 p.m., 11:45 p.m., 12:45 p.m., 1:45 p.m., 2:45 p.m., 6:45 a.m., 10:45 a.m., 2:45 p.m., and noted 6:45 p.m. "in computer." The nurse (#8) also provided the one neurological assessment staff entered into the computer. The form lacked a date and time. The nurse (#8) stated the reason for a lack of date and time was because the nurse who created it, failed to sign it, but stated it was completed on 01/19/15. Staff failed to complete two of the four every 15 minute neuro checks, document in the medical record the time of the fall, the time staff completed the vital signs, and the results of the neuro checks (including pupil checks) with each set of VS. Failure to follow facility policy and complete neurological assessments after a fall with a head injury may lead to a delay in treatment for a deteriorating neurological condition.	F 281		

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	355041	A. BUILDING _____ B. WING _____	01/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN HOME OF THE GOOD SHEPHERD	1226 1ST AVE N NEW ROCKFORD, ND 58356

(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 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. This REQUIREMENT is not met as evidenced by: Based on record review, review of professional reference, review of the facility's physician standing orders, and staff interview, the facility failed to ensure the provision of necessary care and services for 1 of 2 sampled diabetic residents (Resident #8) regarding low blood glucose levels and blood glucose parameters. Failure to re-check blood glucose levels after administering food for low levels and failure to establish high and low blood glucose parameters placed diabetic residents at risk and limited the physicians' ability to ensure quality of care. Continued use of a liquid carbohydrate source (milk) during episodes of limited responsiveness placed Resident #8 at risk of aspiration, inadequate glucose intake, and lowered blood glucose levels. Findings include: "Managing Diabetes in the Long-Term Care Setting," Clinical Practice Guideline, 2002, American Medical Directors Association, pages 27-30, states "When to Call the Physician, A systematic facility approach to diabetes management can streamline day-to-day care and	F 309	F309 1. Resident #8's blood sugars were evaluated by primary care physician and insulin adjusted on 1/26/15 and blood sugars continue to be monitored. 2. It is the responsibility of the facility to assure that a policy is in place to provide guidelines in treating hypoglycemia and when to notify the primary care physician as all residents who receive anti-diabetic medications have the potential to have low blood sugars. All residents receiving anti-diabetic medications were evaluated on 1/28/15 for blood glucose levels below 70 mg/dl and orders were changed if needed. 3. A policy was developed on 2/1/15 to provide standard guidelines on how to treat hypoglycemia (see #18) and hyperglycemia (see #19) unless a specific physician ordered plan has been documented in the resident's chart. This policy will also provide guidance on when to notify the primary care	

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F 309	Continued From page 22 reduce the frequency of episodes of hypoglycemia [low blood glucose], hyperglycemia [high blood glucose], and other acute metabolic complications. The following are steps that facilities may consider implementing. . . . Develop protocols that guide first-line caregivers (nurses and nursing assistants) in deciding when a prompt physician referral is necessary for a diabetes-related problem. Make use of standing orders that are approved by the primary care physician when the patient is admitted. For example, the physician may write an order stating that he or she is to be notified when an individual patient's blood glucose values are outside of a specified range. When patients' blood glucose levels are poorly controlled and when patients are extremely frail or cognitively impaired, the physician may wish to note specific individual blood glucose or symptom parameters in the orders. These parameters should be transcribed to the Medication Administration Record and the patient's care plan. Treating Hypoglycemia . . . Hypoglycemia is the most feared short-term complication of treatment for diabetes. If not promptly recognized and treated it can result in long-term disability, particularly in cognitively impaired individuals. . . ." The American Diabetes Association internet site, ada.org, reviewed on 01/22/15, stated ". . . Hypoglycemia is a condition characterized by abnormally low blood glucose (blood sugar) levels, usually less than 70 mg/dl [milligrams per deciliter]. However, it is important to talk to your	F 309	physician of a resident who has alterations in blood sugars. A policy was also developed for Glucagon Administration on 2/1/15 see #20). Physician Standing Orders will be revised and updated. Education was provided to nurses on 1/28/15 (see #2). Further education was provided on new policies on 2/17/15 at the nurses meeting (see #4). 4. The Director of Nursing or designee will be responsible for monitoring that the policy is followed appropriately and will also be responsible for monitoring the current blood sugars of all resident's receiving anti-diabetic medications. Four residents will be monitored weekly X 1 month, monthly X 3, and quarterly X 3. If concerns are identified, immediate corrective action will be implemented. 5. The facility is in substantial compliance of F 309 as of 2/18/2015.	2/18/15

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F 309	Continued From page 23 health care provider about your individual blood glucose targets . . . Hypoglycemic symptoms are important clues that you have low blood glucose. . . . The only sure way to know whether you are experiencing hypoglycemia is to check your blood glucose . . . Severe hypoglycemia has the potential to cause accidents, injuries, coma, and death. Signs and Symptoms of Hypoglycemia - Shakiness - Nervousness or anxiety - Sweating, chills and clamminess - Irritability or impatience - Confusion, including delirium - Sleepiness - Weakness or fatigue . . . Treatment - Consume 15-20 grams of glucose or simple carbohydrates - Recheck your blood glucose after 15 minutes - If hypoglycemia continues, repeat. . . . - 15 grams of simple carbohydrates commonly used: . . . 4 ounces (1/2 cup) of juice or regular soda (not diet) . . . 8 ounces of nonfat or 1% milk . . ." Review of the facility's "Physician Standing Orders," revised on 04/05/14, occurred on 01/22/15. The orders stated ". . . Glucometer checks . . . PRN [as needed] . . . MEDICATIONS: . . . 12) Glutose gel 1/2 tube orally for symptomatic hypoglycemia, may repeat within 15 minutes if needed. Notify physician of event. 13) Glucagon 1 cc [cubic centimeter] IM [intramuscularly] for symptomatic hypoglycemia and resident unresponsive. Notify physician of event. Begin BID [two times daily] glucose	F 309		

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F 309	Continued From page 24 monitoring with event. . . ." The "Physician Standing Orders" lacked any other orders regarding blood glucose monitoring or blood glucose parameters. Review of Resident #8's medical record occurred on January 20-22, 2015. The facility admitted the resident in February 2014. Current diagnoses included diabetes mellitus II. Current physician's orders included the following and date ordered: *Lantus insulin, 100 units/milliliter (ml), 20 units every morning (q am) subcutaneously (sub q), 07/28/14 *Lantus insulin, 100 units/ml, 5 units q night, sub q, 07/10/14 *Accu checks (blood glucose checks), twice daily every week on Mondays, 04/14/14 *Accu checks, as needed, 05/01/14 Resident #8's current care plan, dated 02/06/14, stated "Problem, [Resident #8] has alterations in blood sugars, Goal . . . [Resident #8] will have FBS [fasting blood sugar] of 80-120 [mg/dl] when checked, Approaches . . . Glucose monitoring as DO [doctor's orders] and prn [as needed], Meds [Medications] per DO . . ." FBS typically requires an eight hour period without eating before checking the blood glucose level. Resident #8's blood glucose monitoring records, for the period May 01, 2014 through January 21, 2015, showed the following values less than 60 mg/dl and a lack of interventions in the record as noted: *05/15/14, 6:21 a.m. - 35 mg/dl *06/30/14, 5:06 a.m. - 59 mg/dl *07/01/14, 4:01 a.m. - 58 mg/dl *07/03/14, 5:52 a.m. - 58 mg/dl	F 309		

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F 309	Continued From page 25 *07/07/14, 5:21 a.m. - 38 mg/dl *08/04/14, 5:38 a.m. - 43 mg/dl *08/11/14, 5:27 a.m. - 57 mg/dl *09/08/14, 5:42 a.m. - 46 mg/dl *09/15/14, 4:54 a.m. - 53 mg/dl *09/22/14, 5:33 a.m. - 54 mg/dl *10/04/14, 12:14 p.m. - 39 mg/dl *10/06/14, 5:21 a.m. - 46 mg/dl *10/13/14, 4:44 a.m. - 49 mg/dl *10/20/14, 4:41 a.m. - 57 mg/dl *10/27/14, 6:11 a.m. - "Low" *10/30/14, 6:45 a.m. - 56 mg/dl, no interventions *11/03/14, 5:59 a.m. - 45 mg/dl, no interventions *11/12/14, 6:50 a.m. - "Low" *11/24/14, 5:42 a.m. - 59 mg/dl, no interventions *12/22/14, 5:02 a.m. - 50 mg/dl *12/29/14, 6:36 a.m. - 54 mg/dl, no interventions *01/12/15, 4:36 p.m. - 54 mg/dl Resident #8's blood glucose records and nurse's notes showed the facility staff failed to re-check the resident's blood glucose level 19 of the 22 episodes (86%) identified above. On two occasions staff provided the resident with chocolate milk, even though she was noted to be lethargic. Resident #8's nurse's notes for the period, May 01, 2014 through January 21, 2015 showed the following regarding blood glucose levels: *05/15/14, 5:45 a.m. - ". . . Woke her now to check accu check prn. Skin cool, fingers more cool, shaking whole body in bed, alert and responds. Accu check 35 [mg/dl]. Given orange juice 180 cc, yogurt and pudding cups. Swallowed and used straw well without choking or coughing, swallows food well. . . . Accucheck taken when done eating approximately 20 minutes later - 36 [mg/dl]. Monitor." No further accuchecks were	F 309		

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F 309	Continued From page 26 completed until approximately seven hours later. *07/06/14, 6:39 p.m. - "8:00 a.m. resident lethargic upon waking. Unable to stand with one assist. Unable to ambulate. Two person transferred into wheelchair and then onto toilet. Only responds by opening eyes and quickly closing them when name is called. 8:30 a.m. Accu check was 43 [mg/dl]. Scheduled insulin held until blood sugar rised [sic]. Resident drank 240 cc of chocolate milk alond [sic] with hot cereal, toast, prune juice, and coffee. 9:20 a.m. Resident blood sugar rechecked: 154 [mg/dl]. Scheduled insulin administered. Resident more stable rest of day. . . ." During interview, on 01/22/15 at 1:00 p.m., three administrative staff members (#1, #8, and #11) confirmed the facility lacked individual resident blood glucose parameters. These staff members did not provide an expectation of parameters for staff to call physicians in the event of low blood glucose levels. Failure to establish blood glucose parameters for contacting physicians limited the physician's ability to provide quality care for residents. Failure of staff to provide snacks and monitor glucose levels when low blood glucose levels were identified placed Resident #8 at risk of life threatening events. Continuing to offer milk while Resident #8 was lethargic placed the resident at risk of aspiration, inadequate glucose intake, and complications.	F 309		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following	F 328		

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F 328	Continued From page 27 special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to administer oxygen as ordered for 2 of 4 sampled residents (Resident #1 and #5) with oxygen therapy needs. Failure to administer oxygen as ordered placed the residents at risk for low oxygen levels and possible adverse effects. Findings include: Review of the facility policy titled "Oxygen" occurred on 01/21/15. This policy, dated 2014, stated, "Purpose: To provide oxygen to residents whose oxygen level is low. Procedure: . . . 2. Oxygen is to be used only per doctors' order and/or standing order. . . ." - Review of Resident #1's medical record occurred on all days of survey. Diagnoses included chronic obstructive pulmonary disease (COPD) and emphysema. The care plan, dated 11/05/14, stated, "Problem: [Name of resident] has COPD and I get SOB [short of breath] at times. . . . Approaches: . . . Oxygen per MD [medical doctor] orders." A physician's order, dated 11/05/14, stated, "Oxygen @ [at] 3L [liters]/NC [nasal cannula] continuously."	F 328	F328 1. Physician's order for Resident #1 was verified immediately for correct liter flow rate. Physician order changed on 1/23/15 for resident #5 to reflect oxygen on at 2 Liters per nasal cannula continuously. 2. All residents who use oxygen, whether PRN or continuous have the potential to be affected if oxygen is not set at the appropriate liter flow. An appropriate setting is necessary to maintain adequate oxygen saturations. All residents currently on oxygen either PRN or continuous were verified to have oxygen set at appropriate liter flow rate.	

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F 328	Continued From page 28 On 01/20/15 at 5:52 p.m., observation showed Resident #1 pulled her oxygen cannula off and a certified nurse aide (CNA) (#16) placed it back on her nose. The oxygen liter flow from the O2 (oxygen) concentrator was set at 2L. On 01/21/15 at 8:36 a.m., observation showed Resident #1 with oxygen on at 2L/NC from the O2 concentrator. After completing morning cares, a CNA (#14) and a nurse (#15) transferred the resident to the wheelchair and applied her oxygen at 2L/NC from the O2 tank on the wheelchair. The CNA confirmed the oxygen setting at 2L. On 01/21/15 at 11:45 a.m., observation showed a CNA (#14) transferred Resident #1 to her wheelchair following toileting, and applied her oxygen at 2L/NC from the O2 tank on the wheelchair. During an interview on 01/21/15 at 4:48 p.m., a nurse (#15) stated Resident #1's oxygen was set at the wrong level, and she increased it to 3L/NC as ordered. - Review of Resident #5's medical record occurred on all days of survey. Diagnoses included COPD. Resident #5's care plan stated, " . . . [Resident] has COPD and I get SOB at times. I am on constant O2 . . . Approaches: O2 at al [sic] times per DO [doctor's order] . . ." Resident #5's physician's orders stated, ". . . O2 @ 2-3 liters per NC prn [as needed] to keep O2 sats [saturation] above 90% . . ." Observation on all days of survey showed Resident #5 using continuous oxygen at 2 liters	F 328	3. The current policy on oxygen use was reviewed and revised on 1/28/15 (see #21). Oxygen cards have been developed which will indicate the correct liter flow and whether oxygen is PRN or continuous. These cards will be attached to the concentrator/portable oxygen tank. CNAs were educated on 1/27/15 (see#16) and nurses on 1/28/15 (see # 2) on reviewed policy and the use of the oxygen cards. 4. The Director of Nursing Services, or designee will conduct a random audit of all residents currently on oxygen as well as newly admitted residents weekly X 4, monthly X 4 and quarterly X 3 for all to assure oxygen concentrators and/or portable tanks are set according to physician's orders and will assure that oxygen cards are present. 5. The facility is in substantial compliance with F 328 as of 2/18/15.	2/18/15

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F 328	Continued From page 29 per nasal cannula. During an interview on the morning of 01/22/15, an administrative nurse (#8) confirmed Resident #5's physician's orders stated to use O2 prn.	F 328		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, policy and procedure review, professional literature review, and staff interview, the facility failed to store and serve food under sanitary conditions in 1 of 1 kitchen and 3 of 4 unit kitchenettes (Grace, Faith, and Hope Units). These practices have the potential to increase the risk of food borne illness and can affect all residents who eat food stored or served in these areas. Findings include: Review of the following policies occurred on the afternoon of 01/22/15: The policy titled "Dietary Infection Control," dated 10/02/14, stated, ". . . Dishes are washed in temperature of 120 [required 150] degrees and	F 371	Ftag 371 1. There were no residents affected by this Citation. 2. All residents could be affected by serving food under unsanitary conditions.	

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F 371	Continued From page 30 rinsed at 180 degrees. A sanitizer is used and a rinse agent." The policy titled "Safely Serving, Holding, Cooling, Reheating, and Disposing of Foods," dated 09/30/14, stated, "Reheat [Cook] poultry to at least 165 degrees F for 15 seconds . . . Reheat [Cook] pork to at least 155 degrees F for 15 seconds . . ." The policy titled "Walk-In Fridge and Freezer," dated 10/01/14, stated, ". . . All raw meat products in walk-in fridge are to be stored on lower shelf. . . ." - The initial dietary tour of the kitchen occurred on 01/20/15 at 1:40 p.m. with an administrative dietary staff member (#4). Observation showed six plastic bags of raw chicken breasts in a tub thawing on top of a case of raw bacon on the top shelf of a rolling cart. The dietary tour of the unit kitchenettes occurred on 01/22/15 at 9:40 a.m. with an administrative dietary staff member (#4). The unit kitchenettes contained dish machines utilizing hot water for sanitation. Observation showed the following: *The surveyor and the administrative dietary staff member (#4) placed multiple irreversible registering temperature measuring devices in the compartment dish machine on each unit. The measuring devices on the Grace, Faith, and Hope Units failed to change to a black color indicating did not reach the required temperature of 160 degrees F at plate level. The gauges for these dish machines showed a final rinse temperature between 190 and 195 degrees F. During an interview on the morning 01/22/15, an administrative dietary staff member (#4) confirmed the dish machines were not meeting	F 371	3. The facility took several steps to confirm compliance with dish washer and sanitizing temps. We installed pressure gauges at each dishwasher station. We had Ecolab come in and reset the regulators to reduce pressure to 15lbs, allowing water to heat to required temps. We monitored internal temps with T strips and thermometer to ensure compliance of 160 degrees at plate level. Dietary infection control policy(see #22) was reviewed and updated to reflect changes in the wash/sanitize temperature of dishes. Education for dietary staff (see 23)on policies included "walk-in Fridge and freezer"(see #24), "Cleaning and sanitizing"(see #25), "Department infection control" on 1-29-15. Health care academy course titled "food preparation and safe food handling"(see #26) was assigned to all dietary staff to be completed by 2-17-15.	

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F 371	Continued From page 31 the required sanitization temperatures. This staff member stated dietary staff shouldn't rely on the dish machine's gauge temperatures to ensure the required sanitization temperatures. The gauges do not measure temperature at tray level. During an interview on the morning of 01/22/15, an administrative dietary staff member (#4) stated dietary staff place one teaspoon of a sanitizer, "HiLite," labeled as a chlorinated detergent in each load of the dish machine. The surveyor and the administrative dietary staff member (#4) placed a chlorine test strip in the dish machine water remaining from a wash cycle and the test strip failed to change color, indicating no chlorine. During a phone interview on 01/22/15 at 11:10 a.m., a representative from the chemical company distributing this product stated, "HiLite is just a detergent not a sanitizer." During interview on the morning of 01/22/15 when questioned about recording the temperature of the dish machines, used to wash dishes periodically throughout the morning, staff stated the following: *Dietary staff member (#5) Grace Unit -"No temperature yet. [Not measured]." *Dietary staff member (#6) Faith Unit - "Temperature was about 175 degrees F at 6:30 a.m. [This temperature is at the gauge and did not reflect sanitization temperatures at plate level]." *Dietary staff member (#7) Hope Unit - "[Temperature] not yet." Observation during the dietary tour further identified: *Wet wiping cloths not stored in sanitizing solution in the unit kitchenettes (Grace, Faith, and	F 371	Dietary staff will keep a Log of temperatures of wash and rinse cycles performed 3 times daily, to monitor the above standards set per policy. Maintenance will take plate level temps weekly with a thermometer and log on the individual kitchenette documentation. 4. Dietary manager or designee will monitor kitchenette dishwasher logs, walk-in cooler log, and sanitizing solution weekly X 4, monthly X3, and quarterly X3 to identify if any further interventions need to occur. 5. LHGS is in substantial compliance as of 2-18-15.	2/18/15.

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F 371	Continued From page 32 Hope Units). During an interview on the morning of 01/22/15, the dietary staff member (#7) stated she used the wet wiping cloth to wipe syrup from her hands during tray service and dietary staff member (#6) stated she used the wet wiping cloth to wipe kitchen cabinet surfaces. During an interview on 01/22/15, an administrative dietary staff member (#4) confirmed wet cloths should be kept in the sanitizing solution when not in use. Observation on 01/22/15 at 11:30 a.m. showed an administrative dietary staff member (#4) instructed dietary staff to use disposable dishware for service of meals. Facility staff determined dietary staff should complete three dish machine runs with an empty rack to reach required sanitization temperatures. Review of the infection control logs for the months of October 2014 through January 2015 occurred on the morning of 01/22/15. The logs indicated there was no evidence of food borne illness outbreaks within the facility.	F 371		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control	F 441	F 441. 1. There was no specific resident that was affected by this. 2. All residents have the potential to be affected by this deficient practice.	

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F 441	Continued From page 33 Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, policy review, and staff interview, the facility failed to follow standard infection control practices for 3 of 6 sampled residents (Resident #1, #3, and #7) observed receiving a treatment or assistance with personal cares. Failure to perform hand hygiene after competing perineal care and removal of a soiled dressing has the potential to spread infection	F 441	3. All staff were assigned the Health Care Academy course on Hand Hygiene. See attached Hand Hygiene course description (see # 27). This is to be completed by 2/17/15. The nurses were reeducated on proper Hand Hygiene Policy (see #28) and Glove Usage Policy (see # 29) and Proper Dressing Change Policy (see #30) at the nurses meeting on 1/28/15 (see #2). The CNAs were reeducated on proper hand hygiene and glove usage policies on 1/27/15 (see #16). The dietary staff were also reeducated on hand hygiene policy at the dietary meeting on 1/29/15 (see #23). 4. The Director of Nursing or designee will complete random validation checklist of personnel and the timing and technique of hand hygiene procedure to ensure personnel are performing the procedure in accordance with LHGS facility hand hygiene policy. Four random employees will be monitored weekly X 4, monthly X 3, and then quarterly X 3. Will evaluate for further	

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F 441	Continued From page 34 within the facility. Findings include: Review of the following facility's policies occurred on 01/22/15: * The policy titled "Peri Care," dated 08/06/08, stated, ". . . wash hands when peri cares completed. . . ." * The policy titled "Wound Dressing Change," dated 08/12/08, stated, ". . . 5. Remove soiled dressing . . . 6. Discard dressing in biohazard marked bag or container, measure and assess wound and dispose of gloves. 7. Cleanse hands and create a clean or sterile field with the dressing or equipment wrapper . . . 9. Put on gloves and cleanse wound as necessary, apply and secure dressings. . . ." - On 01/21/15 at 8:48 a.m., observation showed Resident #1 voided in the toilet. A certified nurse aide (CNA) (#14) and a nurse (#15) lifted the resident with the sit to stand lift, the CNA performed perineal cares, the two staff removed their gloves, adjusted the resident's clothes, and lowered her into the wheelchair. The CNA (#14) failed to perform hand hygiene before completing the following cares for Resident #1: removed the lift sling, applied slippers, placed the oxygen cannula, and moved the lift into the hall. The CNA again failed to perform hand hygiene before she conned another pair of gloves, retrieved deodorant from a closed drawer, changed Resident #1's shirt, lotioned her back, applied deodorant, applied lip moisturizer, performed oral cares, inserted dentures, and brushed her hair. The CNA (#14) then removed her gloves and washed her hands.	F 441	monitoring and intervention. We will also complete QA on proper wound dressing changes performed by 1 nurse weekly X 4, monthly X 3, and then quarterly X 3 and will evaluate for further monitoring or intervention. 5. The facility is in substantial compliance of F 441 as of 2/18/15.	2/18/15.

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F 441	Continued From page 35 - Observation on 01/21/15 at 10:40 a.m. showed two CNAs (#9 and #10) transferred Resident #3 from her wheelchair to the bathroom, Resident #3 voided, the CNA (#9) performed perineal care, removed her gloves, and the two CNAs transferred the resident to her wheelchair. The CNA (#9) touched the handles of Resident #3's wheelchair and the resident's hand. Resident #3 refused to wash her hands. The CNA (#9) failed to perform hand hygiene after completing perineal cares and prior to performing other tasks once the resident was transferred to a safe position. During an interview on 01/22/15 at 2:15 p.m., an administrative nursing staff member (#11) confirmed CNAs should perform hand hygiene after perineal care once the resident is safe. - Observation on 01/21/15 at 8:55 a.m. showed a nurse (#12) donned gloves and removed a dressing from Resident #7's right hip. Without removing gloves or performing hand hygiene, the nurse (#12) went into Resident #7's bathroom and obtained more supplies. The nurse irrigated the open area and removed her gloves. The nurse (#12) failed to remove her gloves and perform hand hygiene before obtaining supplies from the resident's bathroom.	F 441		
F 456 SS=D	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced	F 456		

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F 456	Continued From page 36 by: Based on observation and staff interview, the facility failed to ensure emergency equipment was readily available for use for 1 of 2 suction machines (Faith Lane and Grace Court Units). Failure to have the suction machines readily available for use placed residents requiring emergency suction at risk for choking and aspiration. Findings included: Review of the suction machine storage occurred on 01/21/15 at 4:20 p.m. with a staff nurse (#12). Observation showed a suction machine in a storage room located off the unit. The suction machine lacked connecting tubing and suction tubing. This nurse went to a nearby clean utility room to obtain tubing and looked through numerous cabinets. The nurse (#12) left this area, went to the administrative nurse area and asked an unidentified nurse where the supplies were located. Approximately 10 minutes had passed and the necessary supplies for the suction machine were not available. The nurse then went to the supply room located in the far end corner of the building to obtain the necessary supplies. During an interview on the morning of 01/22/15, an administrative nurse (#8) confirmed supplies need to be immediately available for the suction machine. Failure to have the essential supplies immediately available could delay the implementation of emergency treatment for a resident requiring suction.	F 456	1. No specific resident was identified for this deficiency. 2. All residents who require oral suctioning have the potential to be affected if suction machine and equipment are not readily available. 3. Two new suction machines were purchased on 2/5/15 along with the necessary suctioning equipment. These will be placed in appropriate locations with the required equipment readily available for use in emergency situations. A policy for suction machines was developed (see #31). 4. The Director of nursing or designee will be responsible for assuring appropriate equipment is present with the suction machines. We will continue to monitor all suction machines weekly X 4, monthly X 3, and quarterly X 3 and evaluate for further monitoring or interventions needed. 5. The facility is in substantial compliance for F 456 as of 2/18/15.	2/18/15

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F 494	Continued From page 37	F 494		
F 494 SS=B	483.75(e)(2)-(3) NURSE AIDE WORK > 4 MO - TRAINING/COMPETENCY A facility must not use any individual working in the facility as a nurse aide for more than 4 months, on a full-time basis, unless that individual is competent to provide nursing and nursing related services; and that individual has completed a training and competency evaluation program, or a competency evaluation program approved by the State as meeting the requirements of §§483.151-483.154 of this part; or that individual has been deemed or determined competent as provided in §483.150(a) and (b). A facility must not use on a temporary, per diem, leased, or any basis other than a permanent employee any individual who does not meet the requirements in paragraphs (e)(2)(i) and (ii) of this section. Nurse aides do not include those individuals who furnish services to residents only as paid feeding assistants as defined in §488.301 of this chapter. This REQUIREMENT is not met as evidenced by: Based on review of State Agency (SA) nurse aide registry files, facility files, and staff interview, the facility failed to ensure 1 of 4 nursing assistants (Individual A) providing resident care and reviewed for current certification, maintained certification. Failure to ensure nursing assistants maintain certification may result in residents receiving inadequate care.	F 494	F 494 No POC is necessary. The facility has revised their hiring policy. The facility requires HR and Scheduler to print off the verification from NDDH website to have a copy to place in the employees file. This will give a double check process to ensure compliance with F 494.	

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F 494	Continued From page 38 Findings include: The SA received information Individual A worked with residents without certification. Review of the nurse aide registry information showed Individual A's nursing assistant certification expired on 02/01/14. During interview, on 01/22/15 at 11:30 a.m., a management staff member (#1) reported the facility hired Individual A on 07/28/14; Individual A worked with residents; and, the facility identified Individual A lacked certification in August 2014. The staff member (#1) also reported Individual A did not return to work after the facility identified the lack of certification. Review of the facility's records showed Individual A worked with residents without certification a total of 79 hours from 08/04/14 to 08/20/14.	F 494		