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 _____	01/26/2017

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 01/23/17 and completed on 01/26/17, the sample included 4 residents for complete review, 9 residents for focused review, and 2 closed records for review.	F 000		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE (b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, and staff interview, the facility failed to complete a significant change in status assessment (SCSA) for 1 of 13 sampled residents (Resident #7) reviewed. Failure to determine the need for and complete a SCSA in response to a resident's decline limited the facility's ability to accurately assess the resident's status, and identify and implement appropriate interventions. Findings include:	F 274	1.No corrective action is indicated for resident #7 because the facility is unable to change past events. It is out of the allowable time frame to complete a correction to the MDS assessment dated 5/25/16. Resident #7 is scheduled to have a significant change in status completed with an ADR of 2/15/17. 2.The facility has identified that all residents have the potential to be affected by not completing a significant change of status when necessary. 3.The facility has developed a "Significant Change Criteria form" that in addition to	3/2/17

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

Electronically Signed | 02/09/2017

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F 274	Continued From page 1 The Long-Term Care Facility RAI 3.0 User's Manual (Version 1.13), dated October 2015, page 2-20 stated, ". . . A "significant change" is a decline or improvement in a resident's status that: 1. Will not normally resolve itself without staff intervention . . . 2. Impacts more than one area of the resident's health status; and 3. Requires interdisciplinary review and/or revision of the care plan. . . ." and page 2-23 stated, "A SCSA is appropriate if there are either two or more areas of decline or two or more areas of improvement. . . . [such as] increase in the number of areas where behavioral symptoms are coded as being present and/or frequency of a symptom increases . . . Any decline in an ADL [activity of daily living] physical functioning area where a resident is newly coded as Extensive assistance . . ." Review of Resident #7's medical record occurred on January 23-25, 2017. The annual Minimum Data Set (MDS), dated 02/15/16, identified rejection of cares occurred on 1-3 days, limited assistance with walking in room, limited assistance with locomotion on unit, and limited assistance with eating. The quarterly MDS, dated 05/25/16, identified rejection of cares occurred on 4-6 days (a worsening of a behavior) and extensive assistance with walking in room, locomotion on unit, and eating (a decline in three activities of daily living). During an interview on 01/25/17 at 11:00 a.m., an administrative nurse (#1) stated the facility should have considered completing a significant change MDS after the resident returned from the hospital in May.	F 274	the Rug Analysis Worksheet, will allow MDS staff to compare different areas of care from a previous MDS assessment to a current MDS assessment (see attachment). This form will help guide them in determining if a significant change in status assessment is needed. Also, the "Resident's Current Status Communication Form" will help determine if off-cycle MDS assessments are needed to be completed(see attachment). Staff completing MDS assessments as well as nurses were educated on 2/8/17 on criteria that may indicate the need for a significant change in status assessment as well has how to use the "Resident's Current Status Communication Form". 4.The facility will be in compliance of F 274 as of 03/02/2017. 5.In order to check MDS for accuracy prior to submission, a QA will be developed that will address the need for a significant change. The QA will involve having two MDS nurses review the MDS, using the "Significant Change Criteria" form (see attachment), comparing previous and current RUG levels which may indicate a change in status, and reviewing the RUG analysis worksheet (see attachment C1-C3). The Director of Nursing, MDS Coordinator, or designee(s) will complete the QA on 2 resident assessments/weekly X 4 weeks, 4 residents/monthly X 3, 8 resident/quarterly X 3, then reevaluate for further monitoring or interventions.	
F 309	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES	F 309		2/9/17

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F 309 SS=D	Continued From page 2 FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. 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, consistent with the resident's comprehensive assessment and plan of care. 483.25 (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to provide the necessary care and services to attain the highest practicable physical well-being possible for 1 of 4 sampled residents (Resident #7) identified by the facility with a current infection. Failure to assess and monitor a new condition in a timely manner and on a regular basis may have delayed treatment for an eye infection.	F 309	1.Resident # 7 was started on an antibiotic for conjunctivitis on 1/19/17 and infection has since resolved. 2.The facility has determined that all residents have the potential to be affected when new conditions are not assessed and monitored in a timely manner and on a regular basis. 3.The facility has updated their process	

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F 309	Continued From page 3 Findings include: On 01/24/17 at 8:25 a.m., observation showed slight redness to Resident #7's left eye. Review of Resident #7's medical record occurred on January 23-25, 2017. Diagnoses included Alzheimer's disease and unspecified acute conjunctivitis, bilateral. The current care plan stated, ". . . Problem Onset: 01/19/2017, [name of resident] has conjunctivitis . . . Approaches: *Meds [medications]/tx [treatment] per orders . . . *Standard precautions, including good hand hygiene *Monitor infected eye/eyes for worsening sx [symptoms] (increased redness, drainage, pain) . . ." The care plan contained the same problem of conjunctivitis on 11/16/15 and 08/05/16, resolved on 11/23/15 and 08/12/16 respectively. Resident #7's physician orders included the following: * 12/21/15, "Artificial Tears drops instill 2 gtts [drops] into both eyes twice daily for dry eyes" * 01/19/17, "Tobradex [antibiotic/anti-inflammatory] eye drops 1 drop both eyes three times daily X [times] 7 days for conjunctivitis" Resident #7's nurses' notes stated the following: * 01/06/17 at 6:40 p.m., ". . . (L) [left] eye yellow matter present, and sclera slightly red. . . . cleansed well, will monitor and assess need for tx." * 01/19/17 at 9:26 a.m., ". . . Res. [resident] left eye very red and mattery. She does have some redness noted to the conjunctivi [sic]. . . . Orders	F 309	on assessing and monitoring for a new condition by utilizing the American Health Tech tool for follow-ups. This tool allows the nurse to select follow-up at the bottom of their nurse□s notes when they feel a condition needs to be monitored or assessed. This follow-up will then carry over to the compliance center which is a notification that is received by the DON or designee. A follow-up report will also be reviewed to assure concerns are addressed in a timely manner (see attachment A). A Resident□s Current Status communication Form (see attachment B)has also been developed to assure communication between nurses continues from shift to shift. Nurses were educated on 2/8/17 on the process of continuation of assessment and monitoring resident changes and how to use the follow-up feature of the American Health Tech program. They were also educated on how to use the resident current status communication form on 2/8/17. 4. The facility is in compliance of F 309 as of 2/9/17. 5. The Director of Nursing or designee will review nurse□s notes to assure assessment and monitoring was completed for those residents that a follow-up was indicated. This audit will be completed weekly X 4, monthly X 3, and quarterly X 3, then reevaluated for further monitoring or interventions.	

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F 309	Continued From page 4 received for Tobradex 1 gtt OU [both eyes] TID [three times daily] x 7 days. . . ." * 01/23/17 at 9:53 p.m., "Slight pinkness to conjuctivi [sic]. NO drainage to eyes. Denies pain. . . ." During an interview on 01/26/17 at 10:55 a.m., an administrative nurse (#2) stated Resident #7 had episodes since admission of reddened eyes one day and fine the next day, and the physician ordered artificial tears because the resident rarely blinked. This nurse stated staff should have followed up on the redness prior to 01/19/17. The record lacked evidence the facility assessed and monitored the condition of Resident #7's eyes from the first indication of an infection until 13 days later when the physician ordered treatment for conjunctivitis.	F 309		