STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	8095	A. BUILDING: _____ B. WING _____	04/06/2016

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) COMPLETE DATE
B 000	INITIAL COMMENTS For the unannounced licensure survey started on April 5, 2016 and completed on April 6, 2016, the sample included 4 residents for complete review and 1 closed record for review. Tier II citations included B1320 and B1700.	B 000		
B1320	33-03-24.1-13,2 RESIDENT RECORDS 2. Resident records must include: a. The resident's name, social security number, marital status, age, sex, previous address, religion, personal licensed health care practitioner, dentist, and designated representative or other responsible person. b. The licensed health care practitioner's orders and report of an examination of the resident's current health status. c. An admission note. d. A copy of an initial and current assessment and care plan. e. Documentation of resident observations by authorized staff. f. Documentation of death, including cause and disposition of the resident's personal effects, money, or valuables deposited with the facility. g. A quarterly progress note documenting the resident's current health condition, level of functioning, activity involvement, nutritional status, psychosocial interactions, and needs.	B1320	1. No corrective action is indicated for resident # 1 because the facility is unable to change past events. 2. The facility has identified that all residents residing in the facility have the potential to be affected by the same deficiency. 3. Nurses were educated on 4/8/16 through the use of a message board which displays across the main screen of the facility EMAR program regarding the need to complete a transfer/discharge summary. The nursing staff will also be reeducated on 4/20/16 at the nurse's meeting on the requirement of completing a transfer/discharge summary for all residents residing in the Basic Care Unit when a resident is transferred or discharged to the Hospital or other health care facility. 4. The facility has corrected the deficiency as of 4/11/16. 5. The Director of Nursing or designee will perform audit checks to assure that a transfer/discharge summary is completed with all transfers or discharges of a Basic Care resident.	

Health Resources Section
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Administrator — 4/19/16

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B1320	Continued From page 1 h. Documentation of review of prescribed diets. i. Transfer forms that are completed, signed, and sent with the resident when transferred to another facility. j. A medication administration record documenting medication administration consistent with applicable state laws, rules, and practice acts. k. Documentation of an annual medication regimen review. l. A written report of any funds kept at a resident's request. Such record shall show deposits to and withdrawals from the fund. m. Documentation of a fire drill walk-through within five days of admission. n. All agreements or contracts entered into between the facility and the resident or legal representative. o. A discharge note. This state licensing rule is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure resident records contained completed transfer forms for 1 of 1 sampled resident (Resident #1) with a transfer to the emergency room (ER). Failure to complete transfer forms with necessary medical information limits staff's ability to ensure appropriate care and	B1320		

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B1320	Continued From page 2 treatment at the receiving facility. Findings include: Review of Resident #1's medical record occurred on all days of survey. A nurses' note, dated 12/31/15, identified the resident experienced a fall with a head injury. Facility staff called an ambulance and transferred Resident #1 to the ER. Resident #1's medical record lacked evidence staff completed a transfer form to send with the resident. During an interview on the morning of 04/06/16, a supervisory nurse (#1) confirmed the record lacked a transfer form.	B1320		
B1700	33-03-24.1-17 NURSING SERVICES 33-03-24.1-17. Nursing services. Nursing services must be available to meet the needs of the residents either by the facility directly or arranged by the facility through an appropriate individual or agency providing nursing services. This state licensing rule is not met as evidenced by: Based on record review and staff interview, the facility failed to provide nursing services to meet resident needs for 1 of 1 sampled resident (Resident #1) with physician's orders for weekly blood pressure/pulse monitoring. Failure to monitor Resident #1's blood pressure and pulse as ordered may result in negative health outcomes.	B1700	1. Physician orders were verified for resident #1 and the task to obtain a weekly blood pressure and pulse was added to the kioske to alert CNAs every week that a blood pressure and pulse need to be obtained. 2. Nurses were educated on 4/8/16 through the message board which is a communication tool located on the software program used by nursing staff. Further education will be provided on 4/20/16 at the scheduled nurse's meeting on requirements for completing a weekly blood pressure and pulse for those administered an antipsychotic medication. Ward Clerks and RCC nurses were educated on 4/8/16.	

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B1700	Continued From page 3 Findings include: Review of Resident #1's medical record occurred on all days of survey. Diagnoses included hypertension, dizziness, and unspecified dementia. Current physician's orders included orthostatic blood pressure and pulse every Wednesday (start date 09/22/15). The resident's current care plan identified, ". . . 9/18/15 [Resident #1] restarted on Seroquel [an antipsychotic] due to her increased behaviors/moods. . . . Approaches . . . Ortho [orthostatic] blood pressure and pulse every Wednesday. . . ." Review of Resident #1's vitals signs since September 2015 identified staff failed to monitor the resident's orthostatic blood pressure and pulse every Wednesday. During an interview on the morning of 04/06/16, a supervisory nurse (#1) stated staff should monitor Resident #1's blood pressure and pulse weekly as ordered by the physician.	B1700	3. The facility has identified that all residents residing in the facility have the potential to be affected by the same deficiency. 4. The facility corrected the deficiency on 4/11/16 5. The Director of Nursing or designee will perform audit checks on Basic Care residents who are prescribed an antipsychotic to assure that a weekly blood pressure and pulse is completed according to physician orders. This will be completed weekly X 4, monthly X 3, and quarterly X 3.	