STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355076	A. BUILDING _____ B. WING _____	06/09/2016

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NORTHWOOD DEACONESS HEALTH CNT	4 N PARK ST NORTHWOOD, ND 58267

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F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey started on 06/06/16 and completed on 06/09/16, the sample included two (2) residents for complete review, eight (8) residents for focused review, and one (1) closed record for review.	F 000		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement.	F 278		7/14/16

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

Electronically Signed | 06/23/2016

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 278	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual (Version 3.0), and staff interview, the facility failed to ensure accurate coding of Minimum Data Sets (MDSs) for 2 of 10 sampled residents (Resident #2 and #3). Failure to accurately complete portions of the MDS, Section J (Health Conditions) (Resident #2) and Section K (Swallowing/Nutritional Status) (Resident #3) does not allow each resident's assessment to reflect the resident's current status/needs and may result in the inaccuracy of the facility's Resident Level Quality Measure Reports. Findings include: The Long-Term Care Facility RAI Manual, revised October 2015, page J-27, stated, ". . . J1700 . . . 1. Ask the resident and family or significant other about a history of falls in the month prior to admission and in the 6 months prior to admission. This would include any fall, no matter where it occurred. 2. Review inter-facility transfer information (if the resident is being admitted from another facility) for evidence of falls. 3. Review all relevant medical records received from facilities where the resident resided during the previous 6 months; also review any other medical records received for evidence of one or more falls . . . Code 1, yes: if resident or family report or transfer records or medical records document a fall in the month preceding the resident's entry . . ."	F 278	For resident #2 the MDS coordinator consulted with Sheryl Kindsvogel regarding modification of MDS assessment that was found to be in error. Modification of resident #2 MDS assessment was submitted on 6/20/2016. Validation report of modification received on 6/23/2016. All other residents that have been coded in error of Section J 1900 have been reviewed and had modifications completed and submitted on 6/20/2016. CMS submission report and Department of Human Services accepted assessment report received on 6/23/2016. Care plan team, MDS coordinator and MDS staff were educated on correct coding of Section J 1900 per review of RAI manual on 6/23/2016. QA data will be collected by MDS coordinator prior to each submission for accuracy in coding Section J 1900. Data will be reported to QAPI committee monthly until compliance is determined, at a minimum of 6 months. For resident #3 Section K 0510 of MDS was reviewed by dietary manager and MDS coordinator. Modification of resident #3 MDS assessment was submitted on 06/20/2016. Validation report of modification received on 06/23/2016. All	

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F 278	Continued From page 2 - Review of Resident #2's medical record occurred on all days of survey. An admission MDS, dated 08/01/15, identified the resident experienced a fall with a major injury since admission. Resident #2's record lacked evidence to support this coding. During an interview on 06/08/16 at 10:15 a.m., a nurse (#5) confirmed staff coded Resident #2's admission assessment incorrectly for Section J. The nurse (#5) stated the resident did not have a fall with a major injury after being admitted, but rather prior to admission. The Long-Term Care Facility RAI Manual, revised October 2015, page K-11, stated, ". . . K0510: Nutritional Approaches . . . Review the medical record to determine if any of the listed nutritional approaches were performed during the 7-day look-back period . . . Check all that apply. If none apply, check K0510Z, None of the above . . . K0510C, mechanically altered diet - require change in texture of food or liquids (e.g., pureed food, thickened liquids) . . ." - Review of Resident #3's medical record occurred on all days of survey. A quarterly MDS, dated 04/29/16, identified the resident's nutritional approaches during the last seven days included a mechanically altered diet. Review of Resident #3's physician's orders identified the resident received a 1500 calorie, regular diet during the 04/29/16 MDS assessment reference period. During an interview on 06/07/16 at 4:20 p.m., a dietary staff member (#4) confirmed she coded	F 278	other residents that could have errors in coding in Section K 0510 will be reviewed for accuracy and modifications to MDS assessment will be completed and submitted appropriately. RAI manual regarding coding of Section K 0510 was reviewed with dietary manager and dietary consult on 6/20/2016. QA data will be collected by dietary manager prior to each submission for accuracy in coding Section K 0510 of MDS. Data will be reported to QAPI committee monthly until compliance is determined, at a minimum of 6 months.	

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F 278	Continued From page 3 Resident #3's MDS incorrectly.	F 278		
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: LABORATORY ORDERS 1. Based on record review and staff interview, the facility failed to follow the medical provider's orders regarding the collection of a laboratory sample for 1 of 4 sampled residents (Resident #10) on Coumadin therapy. Failure to implement and monitor for completion of all provider orders, including laboratory tests, and to notify the provider of abnormal results may affect the care and services provided for Resident #10 and other residents with the potential to be affected by this practice. Findings include: Review of Resident #10's medical record occurred on June 08-09, 2016. Diagnoses included atrial fibrillation, hypertension, and dementia. Current physician orders included Prothrombin Time (PT) and International Normalized Ratio (INR) (used to monitor individuals treated with the blood-thinning medication like Coumadin) every 30 days related to the resident's "ANTICOAGULATION THERAPY." On 03/01/16 and 03/15/16, the medical record	F 281	For resident #9 and #2 and all other residents at NDHC that receive prn medications, the nurse will evaluate and document the effectiveness of the prn medication administered. Resident #2 has had a consult with sports medicine completed. The pain management protocol has been updated to reflect this expectation. Also, the prn med charting protocol has been updated to indicate that other intervention implemented due to poor effectiveness of prn medication must be documented in resident's nurses notes. Education regarding these updates and expectations will be given to all nurses at staff meetings June 28 and 29, 2016. Initially QA data will be collected and monitored weekly by the QA nurse for six weeks and reported monthly to the QAPI committee until compliance is determined, for a minimum of 6 months. For resident #10 and all other residents at NDHC services will be provided to meet professional standards of quality.	7/14/16

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F 281	Continued From page 4 identified the resident as over-anti-coagulated (excessive blood thinning) based on the PT/INR test results. On 03/15/16, the medical provider ordered a repeat PT/INR in one week. The medical record lacked evidence of a repeat PT/INR. The next test for a PT/INR occurred on 04/22/16, five and one half weeks later. During interview on 06/08/16 at 4:30 p.m., three administrative staff members (#1, #6, and #9) confirmed the facility failed to ensure the completion of the PT/INR order after the higher risk result identified on 03/15/16. The staff members stated the facility does not track laboratory reports to ensure completion, and the nurse is then responsible for notifying the medical provider/physician of the laboratory results. REASSESSMENT OF AS NEEDED MEDICATIONS 2. Based on review of professional reference, facility policy review, record review, and staff interview, the facility failed to assess and document the effectiveness of medications given to residents on an as needed (PRN) basis for 2 of 8 sampled residents (Resident #2 and #9) with pain. Failure to evaluate the resident's response to PRN medications limited the nursing staffs' ability to assess whether the medication achieved the desired effect or if the resident experienced any side effects or adverse reactions from the medication. Findings include: Review of the facility policy titled "PRN MED [Medication] CHARTING PROTOCOL" occurred	F 281	Resident #10 and all SCU resident lab orders for the past 3 months will be reviewed to ensure all have been completed. The lab ordering process in SCU has been changed to match the process being utilized in LTC as follows: Lab orders will be entered into AHT electronic record. All lab orders will be printed out by nursing and faxed to lab. Lab will create a lab episode in Centrique and scan the lab order into the lab episode. A lab result tracking process has been implemented to ensure all lab ordered by provider has been completed and results are obtained and included in the resident's medical record. All nursing staff will be educated in this lab process and tracking systems at staffing meetings June 28 and 29, 2016 by DON and ADON. Initially QA data will be collected and monitored weekly by the QA nurse. Data will be reported monthly to the QAPI committee until compliance is determined, for a minimum of 6 months.	

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F 281	Continued From page 5 on 06/09/16. This policy, dated 10/10/12, stated, ". . . Procedure: 1. Any PRN medication given to a resident/patient must be documented on the electronic MAR [Medication Administration Record]. 2. Corresponding documentation for each PRN med given must be documented under 'Chart Notes' tab; then choose 'Medication Response -PRN Effectiveness' under the Note Type box . . ." Berman and Snyder, "Kozier & Erb's Fundamentals of Nursing: Concepts, Process, and Practice," 9th ed., Pearson Education, Inc., New Jersey, page 862-870, states, ". . . Process of Administering Medications: When administering any drug, regardless of the route of administration, the nurse must do the following: . . . 6. Evaluate the client's response to the drug. . . . In all nursing activities, nurses need to be aware of the medications that a client is taking and record their effectiveness as assessed by the client and the nurse on the client's chart. . . . Skill 35-1 Administering Oral Medications: . . . Evaluation: Return to the client when the medication is expected to take effect (usually 30 minutes) to evaluate the effects of the medication on the client. . . ." - Review of Resident #9's medical record occurred on June 08-09, 2016 and identified diagnoses of chronic pain, osteoarthritis, and history of a left hip fracture. The record showed a physician's order for Tramadol 50 milligrams one tablet every six hours as needed for pain. Patient #9's Medication Administration Record (MAR) and chart notes showed the following administration times and resident responses for	F 281		

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F 281	Continued From page 6 the PRN medication: Tramadol *05/04/16 at 1:38 a.m. - response documented at 3:32 a.m., almost two hours later *05/05/16 at 5:16 a.m. - response documented at 7:36 a.m., over two hours later *05/09/16 at 1:13 a.m. - response documented at 3:35 a.m., over two hours later *05/13/16 at 2:36 a.m. - response documented at 4:32 a.m., almost two hours later *05/20/16 at 1:06 p.m. - response documented at 3:06 p.m., two hours later *05/24/16 at 1:58 a.m. - response documented at 3:55 a.m., almost two hours later *05/26/16 at 2:49 a.m. - response documented at 4:52 a.m., over two hours later *05/30/16 at 2:28 a.m., response documented at 4:35 a.m., over two hours later - Review of Resident #2's medical record occurred on all days of survey and identified diagnoses of right hip pain, Parkinson's, restless leg syndrome, and osteoarthritis. The record identified a physician's order for Tramadol 50 milligrams (mg) one tablet three times a day as needed for pain and Acetaminophen 325 mg two tablets every four hours as needed for pain. Resident #2's MAR and chart notes showed the following administration times and resident responses for the PRN medication: Acetaminophen *03/05/16 at 6:30 p.m. - response documented at 8:17 p.m., almost two hours later *3/05/16 at 6:15 p.m. - no response documented *5/02/16 at 10:05 a.m. - response documented at 11:50 a.m., almost two hours later *5/06/16 at 2:27 p.m. - response documented at	F 281		

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F 281	Continued From page 7 7:47 p.m., over five hours later Tramadol *3/14/16 at 1:41 p.m. - response documented at 5:32 p.m., almost five hours later *3/31/16 at 10:14 a.m. - no response documented *4/18/16 at 1:40 p.m. - response documented at 3:26 p.m., almost two hours later *4/19/16 at 2:52 a.m. - response documented at 5:10 a.m., over two hours later *4/25/16 at 9:50 a.m. - response documented at 12:16 p.m., over two hours later During an interview on 06/08/16 at 4:10 p.m., an administrative nurse (#1) stated she expected staff to reassess the effectiveness of as needed oral pain medications within one hour of administration and chart the response.	F 281		
F 309 SS=G	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: PAIN MANAGEMENT 1. Based on observation, record review, facility policy review, and resident and staff interview, the facility failed to provide the necessary care	F 309	For resident #2 the medical provider was notified immediately of unresolved pain issues and orders were received for consult with sports medicine and orders for RA program were clarified with	7/14/16

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F 309	Continued From page 8 and services to attain the highest practicable physical, mental, and psychosocial well-being for 1 of 1 sampled resident (Resident #2) with uncontrolled pain. Failure to address Resident #2's pain and follow physician's orders for restorative therapy resulted in continued severe pain and decreased his quality of life and well-being. Findings include: Review of the facility policy titled "PAIN MANAGEMENT PROTOCOL" occurred on 06/09/16. This policy, revised February 2013, stated, "Policy: It is the policy of NDHC [Northwood Deaconess Health Center] to assess all residents for pain and provide treatment/intervention to achieve optimal comfort and control of pain. Procedure: . . . 3. PRN [as needed]/Pain Medication Assessment should be completed with each prn medication . . . To chart response to medication effectiveness, go under 'Chart Notes' tab; then choose 'Medication Response - PRN Effectiveness' under the note type and enter resident response. 4. Resident's level of comfort will be monitored by CNA [certified nursing assistant] staff on a daily basis. CNAs will ask residents if they are comfortable or if having pain. CNAs will observe residents for signs of pain. Resident's report of pain, or staff observations of pain, will be reported to unit nurse. Pain will be assessed by licensed nurse and documented in chart note or in medication administration tabs of EMR [Electronic Medical Record]. Ineffective therapy will be reported to the medical provider. . ." Review of Resident #2's medical record occurred	F 309	medical provider and RA exercise program was discontinued. All other residents identified for being at risk for pain identified per MDS section J will be reviewed by MDS coordinator ensuring pain assessments are completed and interventions in place are appropriate and meeting residents goals for pain management. The pain management protocol has been revised to include observed resident behavior that may indicate pain. All nursing staff will be educated on facility's pain management protocol at staffing meeting June 28 and 29, 2016. To ensure resident #2 and all other residents pain control needs are being met and are able to meet their highest level of practical well being, initially QA data will be collected weekly by the QA nurse and reported to the QAPI committee monthly until compliance is determined, at a minimum of 6 months. For resident #10 all lab orders for the past 3 months have been reviewed to ensure all lab tests have been completed per orders. All lab orders for the past 3 months for residents in SCU have been reviewed to ensure all lab tests have been completed per orders. The lab ordering process in SCU has been changed to match the process being utilized in LTC and is as follows: Lab	

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F 309	Continued From page 9 on all days of survey. Diagnoses included Parkinson's, right hip pain, osteoarthritis, and restless leg syndrome. The Minimum Data Set (MDS), dated 04/22/16, identified the resident understood others and was able to make himself understood. The MDS identified the resident had moderately impaired cognition and received scheduled and as needed (PRN) medications for pain management. The current care plan stated, "Problem . . . Currently I am experiencing pain. Rt [right] hip. Goal, I would like to have pain managed through the next review. Approach, provide pain meds as needed, complete the pain assessment tool as per protocol and inform the MD [medical doctor] if current pain management is not effective, provide repositioning and warm blanket for comfort, WB [weight bearing] as tolerated Rt hip, no ambulation . . ." Review of physician's orders identified the following: Scheduled medications - *Sinemet 25-250 milligram (mg), ordered 09/02/15, one tablet five times daily for Parkinson's disease and restless leg syndrome. *Naproxen Sodium 220 mg, ordered 02/08/16, one tablet twice a day for osteoarthritis. *Fentanyl patch 12 micrograms (mcg) per hour, apply one patch to skin every 72 hours for pain, ordered 02/03/16. Discontinued on 03/09/16 per family request. *Tramadol 50 mg, ordered 04/27/16, one tablet three times a day. PRN medications - *Acetaminophen 325 mg, ordered 07/27/15, two tablets every four hours PRN for pain or fever.	F 309	orders will be entered into AHT electronic record per nursing. All lab orders will be printed out by nursing and faxed or hand delivered to lab. Lab/registration will create a lab episode in Centrique and scan the lab order into the lab episode. A lab result tracking process has been implemented to ensure all lab ordered by a provider has been completed and results are obtained and included in residents medical record. All nursing staff will be educated in this lab process and tracking systems at staff meetings June 28 and 29, 2016, by ADON. Initially QA data will be collected and monitored weekly by the QA nurse. Data will be reported monthly to the QAPI committee until compliance is determined at a minimum of 6 months.	

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F 309	Continued From page 10 *Tramadol 50 mg, ordered 03/09/16, one tablet three times daily PRN for pain. Radiology/Laboratory - *X-ray of right hip due to increased pain, ordered 01/13/16. The radiology report, dated 01/14/16, stated, ". . . Findings: There is a lucent line through the lateral acetabulum [hip], questionable for fracture. Bones are otherwise intact. There is osteopenia [lower bone density] . . ." *Computed Tomography (CT) (detailed picture of structures in the body) of right hip, ordered 01/20/16. The radiology report, dated 01/27/16, stated, ". . . Findings . . . Degenerative changes at the hips bilaterally without evidence of fractures over the pelvis or hip on either side . . ." *Sedimentation rate (sed rate) (a blood test that can reveal inflammatory activity in the body), ordered on 04/27/16 for next lab draw day. A laboratory report, dated 05/04/16, identified a sedimentation rate within normal limits. Restorative Therapy - *Restorative Aide Program, lower extremity stretching five times a week, NO ABDUCTION OR ADDUCTION TO RIGHT LOWER EXTREMITY SECONDARY TO FRACTURE, ordered 01/19/16. Observation of Resident #2 on 06/07/16 at 9:30 a.m. showed a restorative aide (#2) stretching the resident's lower extremities bilaterally. The resident moaned, grimaced, frowned, clenched his jaw and reached down to his right hip/leg during treatment. The restorative aide (#2) stopped stretching and asked Resident #2 if he wanted something for pain. The resident stated "yes." The restorative aide (#2) exited the room and reported his pain to the nurse. When asked by the surveyor if the exercises increased his	F 309		

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pain, the resident stated "yes."

Record review identified staff failed to administer a PRN pain medication or provide any non-pharmacological interventions following his restorative therapy and lacked an assessment of his pain.

During an interview on 06/08/16 at 12:35 p.m., a supervisory nurse (#3) stated she spoke with the nurse (#7) who cared for Resident #2 on 06/07/16. The supervisory nurse (#3) stated the nurse (#7) verified the restorative aide notified her of the resident's pain during his morning exercises. When the nurse (#7) assessed the resident for pain, he was laying in bed, indicated his pain had lessened, and stated he was "fine" just receiving his scheduled Sinemet at that time. The supervisory nurse (#3) confirmed the nurse working on 06/07/16 failed to document her assessment and stated it is "normal" for Resident #2 to be stiff and sore during his exercises.

Nursing staff failed to assess Resident #2's pain in a timely manner when reported by the restorative aide.

Observation on 06/09/16 at 9:15 a.m. identified a restorative therapy aide (#2) performing passive range of motion and stretching exercises on Resident #2. The aide (#2) stated the resident just received a PRN pain pill (Tramadol) for shoulder and back pain. During the exercises, the aide (#2) abducted, adducted, and rotated the resident's left leg/hip. Resident #2 grimaced and verbalized pain, but when the aide (#2) offered to stop, the resident directed her to continue. The aide (#2) then abducted, adducted,

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and rotated the resident's right leg/hip. Resident #2 grimaced and asked the aide (#2) to stop, which she did. The resident stated he experienced frequent pain, indicated his pain medications help, but "take a while to kick in."

Review of Resident #2's nurse's notes and Medication Administration Records (MAR) identified the following:
*01/23/16 at 9:26 a.m. - "Medication (PRN Acetaminophen) was not effective. Resident states that he is still in 'terrible pain.'"
*01/25/16 at 8:37 a.m. - "Medication (PRN Acetaminophen) was not effective: Resident states 'it helps for a little bit but it doesn't hold. When it comes back around it hurts even worse.'"
*01/25/16 at 1:42 p.m. - ". . . call in to [name of MD] regarding increased pain with no relief from current medications. Will await return call."
*01/26/16 at 2:16 p.m. - "Resident states pain is still a 6/10 (after PRN Acetaminophen) and is laying in bed at this time."
*02/03/16 at 3:32 p.m. - "Seen by [name of MD] today, right hip again checked. Order written for Fentanyl patch for pain . . ." Resident #2 waited 10 days before being seen by the physician and receiving an order for a change in his pain medication.
*02/07/16 at 10:04 a.m. - "Medication (PRN Acetaminophen) was not effective. Resident states his pain is better, but still rates it at a 7/10."
*02/15/16 at 12:25 p.m. - "Medication (PRN Acetaminophen) was not effective: Resident states pain is 'better' and rates it at a 7 or 8/10."
*02/15/16 at 7:01 a.m. - "Resident states pain is now a 6/10 (after Acetaminophen)."
*03/04/16 at 8:30 a.m. - "Medication (PRN

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F 309	Continued From page 13 Acetaminophen) was not effective. Resident states pain is now at a 6/10, but is grimacing while sitting in his wheelchair." *03/05/16 at 9:54 a.m. "Medication (PRN Acetaminophen) was not effective: Resident states that pain is better, but is still grimacing . . ." *03/05/16 at 6:30 p.m. - ". . . Given (PRN Acetaminophen) for c/o [complaints of] back pain. Rated the pain 10 out of 10." *03/05/16 at 9:40 p.m. - ". . . C/O back pain at 1815 [6:15 p.m.] - Tylenol 650 mg po [by mouth] PRN given. Rated the pain 10 out of 10 . . ." *03/09/16 at 1:32 p.m. - ". . . Daughter expressing concern over [Resident #2's] recent poor appetite and lethargy during her visits. States she feels the Fentanyl patch may be contributing to the change. Phone call to [name of MD] to inform him of the daughter's concerns. New orders given to discontinue the Fentanyl patch and give Tramadol as needed for pain . . ." *03/09/16 at 2:51 p.m. - "Fentanyl patch removed at 1400 [2:00 p.m.] per [name of MD]. Fentanyl patch dc'd [discontinued]." *03/12/16 at 7:14 a.m. - "Medication (Tramadol PRN) was effective: resident stated some relief rated pain 5/10." *03/29/16 at 4:12 p.m. - "Resident states pain (after PRN Tramadol) is now an 8/10, but also states 'it's better than it's been' and 'it's much better." *03/31/16 at 10:16 a.m. - "Reports left shoulder pain rating pain 6-7/10. Medicated with Tramadol 50 mg oral at 1015. Plan to evaluate effectiveness." (Staff failed to reevaluate effectiveness.) *04/18/16 at 3:26 p.m. - "Medication (PRN Tramadol) was effective. Resident states feeling 'much better', but rates pain at an 8/10."	F 309		

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F 309	Continued From page 14 *04/25/16 at 9:50 a.m. - "Given (PRN Tramadol) for c/o 10 1/2 [10.5] out of 10 bilat [bilateral] 'behind the knee' pain." *04/25/16 at 12:16 p.m. - "Medication (PRN Tramadol) was effective: Resident states pain is 'better', but still rates it at a 7/10 . . ." *04/27/16 at 10:37 a.m. - ". . . [name of doctor] informed of [Resident #2's] increase in pain. Order written to scheduled [sic]Tramadol TID [three times a day] as well as every 4 hrs [hours] PRN. Will check sedrate [sic] on next lab draw day." *05/02/16 at 10:05 a.m. - ". . . PRN tylenol given 650 mg for complaints of 10/10 all over." *05/02/16 at 11:50 a.m. - ". . . Now rating pain 4/10." *05/06/16 at 2:27 p.m. - "Acetaminophen 325 mg tablet give two . . . Given for c/o 10/10 all over pain." *06/09/16 at 8:01 a.m. - ". . . esident [sic] does state he is having pain this morning in his shoulder, rates at an 8/10. When asked, 'so it hurts really bad?' Resident stated, 'yeah, it's painful.' Repositioned and tramadol (scheduled) given . . ." *06/09/16 at 8:21 a.m. - "Resident is unable to characterize pain other than 'it's painful.' Fax sent to [name of MD] regarding changes in pain. Will await [name of MD] orders." *06/09/16 at 11:22 a.m. - "Received [sic] order from [name of MD] to consult [name of MD], [name of specialized clinic]." Review of a fax communication to Resident #2's physician, dated 06/09/16, stated, ". . . [Resident #2] is having more pain - 8/10 - 10/10 right hip/shoulder. Unable to explain if it's stiffness or type of pain. Currently takes scheduled tramadol	F 309		

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F 309	Continued From page 15 50 mg TID and PRN and Sinemet 25/250 [mg] 5x [times]/day . . . Questioning need for increase in Sinemet or pain medication? . . . Physician response . . . Let's consult [name of MD at specialized clinic]." During an interview on 06/08/16 at 2:50 p.m., a staff nurse (#8) stated she believed Resident #2 lacked understanding of the numerical scale to rate the severity of his pain and confirmed staff failed to consistently use an alternative method to assess his pain. During an interview on 06/09/16 at 11:30 a.m., an administrative nurse (#1) stated she spoke with staff in the therapy department and they stated after the CT showed the resident did not have a fracture they resumed his previous restorative therapy orders, but failed to get the actual physician's order in his medical record changed. During this interview, the administrative nurse (#1) also stated Resident #2 experienced pain not only to his right hip, but to his shoulders, back, legs, feet, "all over." Failure of facility staff to clarify restorative therapy orders with the physician resulted in the resident experiencing unnecessary pain during his exercises. Resident #2 experienced an increase in pain starting on 01/23/16. The facility staff administered PRN Acetaminophen with minimal relief before contacting the physician for new orders. The physician ordered a Fentanyl patch on 02/03/16 (10 days after Resident #2's increase in pain). The physician discontinued the Fentanyl patch on 03/09/16 per family request and ordered PRN Tramadol. The resident continued to experience pain and the physician	F 309		

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F 309	Continued From page 16 ordered scheduled Tramadol on 04/27/16. Failure of facility staff to effectively manage and assess Resident #2's pain and provide further interventions when the first pain intervention was unsuccessful resulted in the resident experiencing continued severe pain. ANTI-COAGULANT THERAPY 2. Based on record review and staff interview, the facility failed to ensure follow-up occurred for 1 of 4 sampled residents (Resident #10) who received anti-coagulant therapy. Failure to ensure a therapeutic range during the use of Coumadin could result in serious adverse effects, including easily bruised, internal hemorrhage, and bleeding. Findings include: Review of Resident #10's medical record occurred on June 08-09, 2016. Diagnoses included atrial fibrillation, hypertension, and dementia. A quarterly Minimum Data Set (MDS), dated 03/15/16, identified the resident required extensive assistance of one person for bed mobility, transfers, walking in room and corridor, dressing, toileting, personal hygiene and bathing. The MDS stated the resident experienced one fall with no injury since admission/reentry or prior assessment. The record showed the resident experienced no falls between 03/01/16 and 04/19/16, but on 04/20/16, staff found the resident next to the recliners in the day room. The resident stated her buttock and bilateral arms hurt. Current physician orders included Prothrombin	F 309		

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Time (PT) and International Normalized Ratio (INR) (used to monitor individuals treated with the blood-thinning medication like Coumadin) every 30 days related to the resident's "ANTICOAGULATION THERAPY."

The testing laboratory controls referenced a normal PT as 11.00 - 14.00 seconds; and a normal range for INRs as 0.90 - 1.20; therapeutic INR range as 2.0 - 3.0; and a "High Risk Range 2.5 - 3.5."

Physician's progress notes, dated 04/22/16, 02/12/16 and 01/29/16, stated "Warfarin [Coumadin] adjusted to protime."

The record, between 08/12/15 to current, included a record of Resident #10's adjustments in Coumadin dosages in relation to PT/INR blood tests. On 05/18/16 the physician ordered Coumadin 2.5 milligrams (mg) every Monday, Wednesday, and Friday; and Coumadin 1.25 mg every Tuesday, Thursday, Saturday and Sunday. This order occurred after a PT result of 22.10 and INR result of 1.80 completed on 05/17/16.

PT/INR test results identified the following:
* 03/01/16: PT 62 seconds; INR 5.2; the medical provider held the Coumadin for two days, ordered a dosage change, and a recheck of the PT/INR in two weeks
* 03/15/16: PT 81.40; INR 6.8; the medical provider held the Coumadin for two days, ordered a dosage change, and a recheck of the PT/INR in one week.

The next documented PT/INR occurred on 04/22/16, five and one half weeks later. At that

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F 309	Continued From page 18 time, the test results identified a sub-therapeutic PT of 14.50 seconds and INR of 1.2. During interview on 06/09/16 at 10:30 a.m., the medical director (#10) stated he considers the PT/INR results obtained on 03/15/16 as significant and critical. The director stated he does not track the completion of lab tests as he depends on nursing staff to inform him of the results of all lab reports. Failure to ensure follow-up monitoring occurred after an identified abnormally elevated PT/INR placed Resident #10 at risk for bleeding and internal hemorrhage. The resident's need for extensive assistance with activities of daily living, unsteady gait and falls placed the resident at increased risk of bleeding related to an over-anti-coagulation.	F 309		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy/procedure, and staff interview, the facility failed to adequately assess, implement, and reevaluate the toileting plan to prevent falls and injury for 1 of 10	F 323	Immediate action taken for resident #2 found to have been affected include: Bladder assessments and fall risk assessments. Appropriate revisions were made to the care plan to reflect all current	7/14/16

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F 323	Continued From page 19 sampled residents (Resident #2) who experienced falls. Failure to appropriately assess and provide assistance for toileting resulted in Resident #2 experiencing multiple falls and may result in increased risk of falls and injury to residents requiring assistance. Findings include: Review of the facility policy titled "FALLS PREVENTION" occurred on 06/09/16. This policy, revised March 2016, stated, ". . . Purpose: 1. To provide a safe environment for residents/patients and enhance resident/patient care by reducing number of falls. 2. Implement appropriate fall prevention strategies. Procedure: . . . 5. Residents/patients at risk for falls or who have fallen must have fall prevention strategies implemented: . . . Observe and toilet resident as demanded or needed . . . Toilet schedule . . ." Review of Resident #2's medical record occurred on all days of survey. Diagnoses included Parkinson's, dementia, right hip pain, and osteoarthritis. The Minimum Data Set (MDS), dated 04/22/16, identified the resident understood others and is able to make himself understood. The MDS identified the resident had moderately impaired cognition, frequent urinary incontinence, and occasional bowel incontinence. The MDS identified the resident required extensive assistance of one staff member for transfers, bed mobility, and toileting. The current care plan stated, "Problem . . . I am incontinent of both bowel and bladder. Goal, Decrease the number of incontinence of both	F 323	safety interventions, including the current toileting plan. The revised assessments and care plans were reviewed with staff involved in the care of resident #2. Identification of other residents having the potential to be affected will be accomplished by July 14, 2016. The nursing management team will review the falls prevention plans for all residents who have been identified as having a high risk for falls, ensuring fall risk assessments are completed and interventions currently in place are appropriate and on care plan. A Preventing Falls brochure has been developed and will be given to all current residents and families and provided to residents/families at admission. Actions put into place to reduce the risk of future occurrence include: all licensed nursing staff will be educated on the facility falls policy and toileting plans at staff meetings on June 28 and 29, 2016. All resident falls will be reviewed by the falls team to ensure appropriate safety interventions are included in the care plan. Falls prevention policy was revised to include assessment for toileting needs, pain needs and personal items in reach. How the corrective actions will be monitored to ensure the practice will not recur: the falls team will review each fall incident report to ensure appropriate interventions are implemented and updated plan of care is complete. The QA nurse will completed weekly chart audits	

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F 323	Continued From page 20 bowel and bladder through next review. Approach, do not leave alone when on toilet or commode, provide me with proper incontinence product, transfer with assistance of EZ [mechanical lift] stand to and from the toilet . . . report any changes in toileting needs to charge nurse, and assist to toilet when getting up in a.m. (by 8 a.m.), 10:30 a.m., 1:30 p.m., 4:30 p.m., 7:30 p.m. [and] offer urinal at 10 pm and 1st and last rounds @ [at] night and PRN (as needed) . . . Problem . . . Parkinson movements makes it difficult to maintain W/C [wheel chair] positioning . . . Goal, To have a decreased number of falls throughout the next review. Approach . . . Complete the fall assessment tool as per protocol and implement any safety measures as indicated . . . Keep his bed in the lowest position and with the brakes on at all times. Place fall mat on floor when he is in bed. Make sure call light is in place. Make sure bed and chair alarms are in place and working correctly. Bilateral upper siderails up at all times. Transfer to bed between meals as he desire [sic] . . ." Review of the CNA care guide stated, ". . . if restless, toilet him - allow him to sit long enough to empty out . . . unplug recliner when resident is in recliner . . ." Review of Resident #2's nurse's notes and available incident reports identified the following: *08/06/15 at 1:47 a.m. - "0130 [1:30 a.m.] Resident found on his knees on the fall mat with his upper body on the bed . . . L) [left] knee is red. No other injuries noted. Denies pain. Resident is confused and unable to explain what happened." No incident report provided for this fall.	F 323	for 6 consecutive weeks and review all fall incident reports to ensure that appropriate interventions have been put in place to reduce risk of resident falls and that care plans have been updated to reflect these interventions. QA data collected will be reviewed by the QAPI committee until such time consistent compliance has been achieved as determined by the committee at a minimum of 6 months.	

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F 323	Continued From page 21 *08/07/15 at 1:27 a.m. - "0130 - Bed alarm sounding, resident was found kneeling on the mat next to his low bed. Denies pain . . ." No incident report provided for this fall. *08/07/15 at 2:28 p.m. - "Resident did not go to noon meal as was in bed at 1140 [11:40 a.m.] and requested to not get up. Resident was left in bed and plan to offer meal when out of bed. At 1400 [2:00 p.m.] resident was found sitting on his knees on the floor matt [sic] next to his bed, arms resting on bed. Resident was incontinent of bowel and bladder and reported that he was trying to walk to the bathroom. No evidence of new injury. Vital signs assessed. Resident assisted to toilet with use of full body lift . . ." No incident report provided for this fall. *08/08/15 at 1:34 p.m. - "1325 [1:25 p.m.] resident was found kneeling next to his bed on his fall mat with his pants pulled down, incontinent of BM [bowel movement]. Alarms sounding. Was assisted with brief and clothing change, and back to bed. Denied discomfort." No incident report provided for this fall. *08/11/15 at 11:48 a.m. - ". . . Shows signs of aggitation [sic]/discomfort when needing to void. If asked, 'do you need to go to the bathroom?' Resident will reply, 'Yes.' Is is [sic] toileted per careplan as needed in between." *08/12/15 at 1:40 a.m. - "2330 [11:30 p.m.] -Bed alarm sounding. Resident found on the fall mat, next to his low bed. No injury noted . . ." No incident report provided for this fall. *08/28/15 at 8:01 p.m. - "CNA and writer responded to resident's bed alarm sounding at 1905 [7:05 p.m.] and found resident laying on the floor on his left side. Resident stated that he had tried to stand unassisted from bed to go to the restroom to have another BM but slipped on floor	F 323		

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F 323	Continued From page 22 matt [sic] and landed on his buttocks and left elbow. Resident sustained 0.4cm [centimeter] x [by] 1.3cm skin tear to left elbow and skin tear to dorsal aspect of right hand at base of thumb 0.5cm x 0.7cm, areas cleansed with NS [normal saline] and covered with steri strips. Resident stated left elbow was 'hurting a little' but denied any other pain and moved all extremities . . ." The incident report for this fall identified the resident last voided at 6:20 p.m. *09/09/15 at 6:56 a.m. - "At 4:55 [a.m.] found resident sitting up on the edge of bed, states he needs to go to the BR [bath room]. Resident was then taken." *11/10/15 at 10:41 a.m. - "2230 [10:30 p.m.] - Bed alarm sounding. Resident found on his knees on the fall mat, next to his low bed. Resident said he was trying to get up to turn the beeping thing off. Denies pain or injury . . ." No incident report provided for this fall. *11/15/15 at 9:33 p.m. - "2120 [9:20 p.m.] - Bed alarm sounding. Resident found on his knees, on his fall mat, next to his low bed. Resident denies pain or injury . . ." No incident report provided for this fall. *12/02/15 at 5:07 a.m. - "At 4:30 am found resident sitting on floor. Alarm was sounding. States he sat on the edge of the bed and slid to the floor mat. No noted injuries . . ." No incident report provided for this fall. *Review of a document provided by the facility identified the Fall Team reviewed Resident #2's falls on 12/07/15 and 12/14/15 and stated to continue with current plan of care and encourage toileting. *Review of an incident report, dated 12/25/15 at 2:00 p.m., stated, "Resident found sitting on knees on floor matt [sic] next to bed. Reports that	F 323		

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	355076	A. BUILDING _____ B. WING _____	06/09/2016

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F 323	Continued From page 23	F 323		

he was trying to get to the bathroom. Redness to knees bilat, reported that he did land on his knees and reports knee pain 5/10. Able to move all extremities." Incident report identified the last time Resident #2 voided was unknown.
*12/28/15 at 4:35 p.m. - "Resident had near miss from bed at 1440 [2:40 p.m.]. Resident was trying to shut off bed alarm and came out of bed onto knees on bedside mat. No injuries noted, denies pain . . ."
*Review of Fall Team notes, dated 12/28/15, stated will reeducate staff on toileting plan.
*Review of Fall Team notes, dated 01/04/16, stated to continue with current plan.
*01/07/16 at 4:11 a.m. - "At 4 am resident's alarm sounded, and upon entering the room found the resident on his knees on the floor mat next to his bed. States he was going to get up for the day. Assisted back into bed at this time. No noted injuries." No incident report provided for this fall.
*01/12/16 at 6:05 p.m. - "Resident was found in the room sitting on floor mat on buttocks at 1530 [3:30 p.m.] . . ." No incident report provided for this fall.
*02/27/16 at 4:48 p.m. - "CNA noted res. [resident] sitting on mat next to bed at 16:15 [4:15 p.m.] -as she passed the rm [room] . . ."
No incident report provided for this fall.
*03/15/16 at 4:08 a.m. - "0345 [3:45 a.m.] -Resident's bed alarm was sounding. Resident was found on the mat, next to his bed. He had taken his brief off and his bedding was wet with urine. Resident said, 'I was trying to get up to take care of some things' . . ." No incident report provided for this fall.
*Review of Fall Team note, dated 3/21/16, identified staff will make sure urinal is offered during the night shift.

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F 323	Continued From page 24 *04/03/16 at 12:26 a.m. - "0015 [12:15 a.m.] - Resident's call light on. Resident was found on the fall mat, next to his low bed . . . Resident said he was trying to get up to go to the bathroom. Reminded resident to call for assistance." No incident report provided for this fall. *04/19/16 at 3:05 a.m. - "At 2:35 am resident's room call light went off. Upon entering the room found resident on his knees on the fall mat next to his bed. States he was crawling out of bed . . ." No incident report provided for this fall. *05/02/16 at 12:47 a.m. - "Resident was found sitting on the mat, next to his low bed. Bed alarm was not sounding because resident had his arm resting on the bed . . . Resident said he was trying to get to the bathroom. He had a brief change at 2330 [11:30 p.m.] . . ." *05/06/16 at 12:30 a.m. - "At 0015 [12:15 a.m.], resident's bed alarm was sounding. Resident was vound [sic] sitting on the mat, next to his low bed . . ." No incident report provided for this fall. *05/09/16 at 6:30 p.m. - "Resident was found on his knees on the bedside mat at 1600 [4:00 p.m.]. Resident stated that he was trying to put the remote back on the siderail . . ." The incident report provided for this fall, identified the resident's last voiding time was unknown. *A Fall Team note, dated 05/09/16, identified staff will encourage the toileting plan to be followed on all shifts. During an interview on 06/08/16 at 8:08 a.m., an administrative staff member (#6) stated the facility discussed falls and toileting plans at weekly meetings, but did not document these discussions. The staff member (#6) stated the facility's incident reports related to Resident #2's falls lacked the time staff last toileted him prior to	F 323		

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F 323	Continued From page 25 his fall. During an interview on 06/08/16 at 8:20 a.m., an administrative nurse (#1) stated she could provide no evidence staff adjusted Resident #2's toileting plan in relation to the times and circumstances surrounding his falls. The nurse (#1) stated the certified nursing assistants (CNAs) charted at the end of their shift for their entire shift worked, so the specific times they toileted Resident #2 in relation to the time he fell could not be determined. The facility's failure to adequately assess the resident's voiding habit/pattern, and implement scheduled toileting at times consistent with the assessment resulted in avoidable falls and injury to Resident #2.	F 323		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on review of facility policy and record review, the facility's consulting pharmacist failed to review and report recommendations to the	F 428	For resident #10 and all other residents at NDHC that have lab and pharmacy services provided will have monthly drug	7/14/16

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F 428	Continued From page 26 attending physician and the director of nursing for 1 of 4 sampled residents (Resident #10) identified as receiving Coumadin (anti-coagulant medication) therapy. Failure to report irregularities to the attending physician regarding medication adjustments in relation to laboratory results has the potential for the resident to experience adverse side effects. Findings include: Review of the policy "Consulting pharmacist monthly drug review of resident drug regime" occurred on 06/09/16. The policy, dated 08/29/86, stated, "PROCEDURE: As follows: 1. Review all medications prescribed . . . 3. Address potential significant and insignificant problems by communication to medical director and/or attending physician. . . ." Review of the "Monthly Summary and Comments Consultant Pharmacist Report," dated 04/04/16, identified the pharmacist's specific review included: "Chart Review: Charts were reviewed. See enclosed report for details. . . . Consultant Pharmacists Services: Clinical review of the resident charts encompasses many aspects of medication use including but not limited to diagnosis . . . monitoring of side effects and laboratory values. . . . Any concerns will be addressed in my monthly reports. Urgent issues are shared with a member of the licensed nursing staff . . ." - Review of Resident #10's medical record occurred on June 08-09, 2016. Diagnoses included atrial fibrillation, hypertension, and dementia. Current physician orders included	F 428	regimen reviewed completed by a licensed pharmacist that include reporting of any irregularities to the attending physician and the DON. Monthly drug review and format for consulting pharmacist policies have been updated to reflect current requirements. Education given to consulting pharmacist/DON on June 20, 2016 regarding changes in policies and education given to consulting pharmacist on NDHC's new lab results tracking system. Initially QA lab completion data will be collected weekly by unit manager. Monthly pharmacist drug regimen review report will be reviewed by DON to ensure abnormal lab results are included until compliance is determined at minimum of 6 months. This data will be reported to the QAPI committee monthly.	

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F 428	Continued From page 27 Prothrombin Time (PT) and International Normalized Ratio (INR) (used to monitor individuals treated with the blood-thinning medication like Coumadin) every 30 days related to the resident's "ANTICOAGULATION THERAPY." The record identified frequent adjustments in Resident #10's Coumadin dosage in relation to PT/INR blood tests. These adjustments occurred on 03/01/16 and 03/15/16 after significantly elevated PT/INR blood test results. The medical provider's orders, dated 03/15/16, included a recheck of the PT/INR in one week. The record showed nursing staff failed to obtain this test. The next PT/INR occurred on 04/22/16, five and one half weeks later. The pharmacy review, completed on 04/04/16, did not identify this irregularity for Resident #10. During interview on 06/08/16 at 4:30 p.m., an administrative staff member (#6) stated the pharmacy reviews may have been done remotely on the computerized record and laboratory results are kept on paper in a binder and not entered into the computer. Failure to have laboratory results available for pharmacy review does not allow the pharmacist to complete a thorough review of the resident's drug regimen, including any potential irregularities.	F 428		