STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355122	A. BUILDING _____ B. WING _____	12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHARDTON HEALTH CENTER INC	8885 HIGHWAY 10 RICHARDTON, ND 58652

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F 000	INITIAL COMMENTS The standard Medicare/Medicaid recertification started on 12/03/18 and concluded on 12/06/18.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to assess the safety of self-administration of medication (SAM) for 1 of 1 sampled resident (Resident #5) care planned to self-administer medications. Failure to evaluate/re-evaluate a resident's ability to safely self-administer medications may result in a medication error and/or harm to a resident. Findings include: Observation on 12/05/18 at 8:07 a.m. showed a nurse (#1) dispensed Resident #5's scheduled medications into a pill cup, placed the pill cup onto the breakfast table beside Resident #5, and then walked back to the medication cart. The nurse (#1) stated, "She [Resident #5] is one person we can give medications to and can take them on her own." Review of Resident #5's medical record occurred on all days of survey. A physician order, dated 6/20/13, showed Resident #5 may self administer all drugs. A problem start date of 11/07/18 on the current care plan showed, ". . . I self administer my own medications after they are set-up for me	F 554	1.Resident #5 has been assessed for Self-Administration of Medication and is no longer self-administering their medications. 2.All residents that currently self-administer their own medications and those that wish to self-administer their own medications have the potential to be affected. 3. A- Policy "Medication Self-Administration" will be created by 01.10.19 B- Nursing Staff In-service will be held 01.16.19 to review and educate on policy "Medication Self-Administration". 4.The DNS or her designee will conduct audits for residents that self- administer medications weekly x 4 weeks and then monthly x 11 months and the results will be reported to the QA Committee to monitor compliance.	1/24/19

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

Electronically Signed | 01/14/2019

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F 554	Continued From page 1 by the nurse . . . " Resident #5's medical record lacked an assessment and periodic evaluation of her ability to self-administer medications. During an interview on the afternoon of 12/06/18, an administrative nurse (#2) stated she was unable to locate a facility policy or Resident #5's SAM assessment/reassessment.	F 554		
F 577 SS=E	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced	F 577		1/24/19

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F 577	Continued From page 2 by: Based on observation and group interview, the facility failed to post the results of the most recent Federal and/or State surveys in a place readily accessible to residents, family members, and/or legal representatives for 3 of 4 days (December 03-05, 2017) of survey. Findings include: Observation on the morning of 12/03/18 through 12/04/18 showed no binder with survey results easily accessible to residents and/or family/representatives. During the group interview on 12/04/18 at 1:30 p.m., when asked if the Federal and/or State survey results were placed in a readily accessible location where residents, family members, and/or legal representatives wishing to examine them did not have to ask to see them, all five residents (A, B, C, D, E) (identified by the facility as interviewable) responded, "No." Observation on the morning of 12/05/18 showed a binder located near the nurses' station labeled as containing previous survey results. The binder failed to contain the most recent Federal and/or State survey, dated 01/11/18. The facility failed to post the 2017 Life Safety Code and 2018 Health survey results and failed to place these results in a location readily accessible to all residents, family members, and/or legal representatives.	F 577	1. Surveys conducted by Federal or State Surveyors from 2016, 2017 and 2018 will be placed in a binder and relocated to the main hallway where all residents going to the dining room may view the results. Resident Council meetings will include the location of the survey binder. 2. All residents that would like to review the most recent surveys would be affected by not knowing the location of the binder. 3. A-All staff will be in-serviced on the location of the survey results binder 01.15.19. B-Residents will be educated on the location of the survey binder during monthly resident council. 4. Social Services Designee will conduct monthly audits to ensure the resident council meeting agenda includes the location of the survey binder. SSD will conduct monthly audits to ensure all surveys are in the binder, monthly. These audits will be presented to the QA Committee monthly x 12 months.	
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g)	F 641		1/24/19

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F 641	Continued From page 3 §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. 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 (Version 1.16), review of the Advisory Committee on Immunization Practices (ACIP) recommendations, and staff interview, the facility failed to ensure the Minimum Data Set (MDS) accurately reflected the resident's status for 4 of 12 sampled residents (Resident #2, #5, #20, and #126). Failure to accurately complete Section I (Active Diagnoses), Section J (Health Conditions), Section M (Skin Conditions) and Section O (Special Treatments, Procedures, and Programs) of the MDS does not allow each resident's assessment to reflect their current status/needs, and has the potential to affect the accurate development of a comprehensive care plan and the care provided to the residents. Findings include: SECTION I: ACTIVE DIAGNOSES The Long-Term Care Facility RAI User's Manual, revised October 2018, page I-11 stated, "Item I2300 Urinary tract infection (UTI): . . . has a look-back period of 30 days for active disease instead of 7 days." Page I-12 further stated, "If the diagnosis of UTI was made prior to the resident's . . . reentry into the facility . . . A documented physician diagnosis of UTI prior to admission is acceptable. This information may be included in the hospital transfer summary or	F 641	1. Resident #126 expired 12.21.18 and there is no immediate action required. Resident #2 MDS was updated with accurate information 11.27.18. Resident #5 MDS was updated with accurate information 12.22.18. Resident #20 MDS will be reopened and updated with accurate information and resubmitted. 2. All residents at RHC have the potential to be affected. 3. New MDS staff is continuing to be educated on proper MDS documentation beginning 12.03.18 and ongoing. 18 of 27 MDS's have been reviewed and updates were made as necessary. The remaining 19-27 will be reviewed for updates. New MDS staff will continue to be educated on proper MDS documentation with a trained MDS Consultant. Upcoming MDS's for all other residents will be revised to provide accurate information to reflect the current status' of our residents. 4. The Administrator or her designee will create an audit to ensure that each MDS has accurate documentation. This audit will be completed weekly x 8 weeks then monthly x 10 months. The results of these audits will be reported to the QAPI Committee for further review or	

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F 641	Continued From page 4 other paperwork." Review of Resident #5's medical record occurred on all days of survey and identified a hospitalization for a UTI from 06/20/18 through 06/23/18. The hospital discharge summary, dated 06/23/18, showed a diagnosis of UTI. The following MDS assessments showed Section I2300 coded incorrectly: * 5-day/Significant Change in Status dated 06/30/18 * 14-day dated 07-06-18 * End of Therapy dated 07-13-18 During an interview on the afternoon of 12/06/18, an administrative nurse (#2) agreed staff failed to code Resdient #5's UTI on the above assessment dates. SECTION J: HEALTH CONDITIONS - The Long-Term Care Facility RAI User's Manual, revised October 2018, page J-2 stated, ". . . Coding Instructions for J0100B, Received PRN [as needed] Pain Medication . . .Code 1, yes: if the medical record contains documentation that a PRN medication was received or offered but declined." Review of section J0100B on Resident #5's quarterly MDS, dated 09/22/18, identified the resident received or was offered and declined a PRN pain medication in the 7-day look back period. Review of the residents medical record during the look back period failed to show a PRN pain medication was given or was offered and refused by the resident.	F 641	recommendations.	

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F 641	Continued From page 5 During an interview on the afternoon of 12/06/18, an administrative nurse (#2) stated she was unable to provide any documentation Resident's #5 received a PRN medication during the look-back period. The facility failed to correctly code section J0100B for Resident #5's most recent MDS. - The Long-Term Care Facility RAI User's Manual, revised October 2018, page J-24 stated, ". . . J1300: Current Tobacco Use: . . . Code 1, yes: if the resident or any other source indicates that the resident used tobacco in some form during the look-back period. . . ." Review of Resident #20's medical record occurred on all days of survey. The recent hospital discharge summary, dated 10/12/18, contained a Social History which noted the resident currently smoked one-fourth pack of cigarettes a day and last attempted to quit on 04/25/15. An annual MDS, dated 08/17/18, showed staff failed to code section J1300, Yes: current tobacco use. SECTION M: SKIN CONDITIONS The Long-Term Care Facility RAI User's Manual, revised October 2018, pages M-29 to M-37 stated, ". . . Coding Instructions Check all that apply in the last 7 days. . . . M1040H Moisture Associated Skin Damage (MASD) (superficial skin damage caused by sustained exposure to moisture such as incontinence, wound exudate, or perspiration) . . . M1200H Application of Ointments/Medications Other than to Feet . . . Ointments/medications may include topical	F 641		

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F 641	Continued From page 6	F 641		

creams, powders, and liquid sealants used to treat or prevent skin conditions. . . ."

Review of Resident #126's medical record occurred on all days of survey. The nurse progress notes showed the following:
* 11/07/18 - ". . . has red excoriated skin on his coccyx and zinc paste has been applied to the area to promote healing. . . ."
* 11/08/18 - ". . . redness to coccyx (MASD) which has z-paste applied daily as a barrier. . . ."
* 11/09/18 - ". . . redness to coccyx (MASD) which has z-paste applied daily as a barrier. . . ."
* 11/10/18 - ". . . redness to coccyx (MASD) which has z-paste applied daily as a barrier. . . ."
* 11/11/18 - ". . . redness to coccyx (MASD) which has z-paste applied daily as a barrier. . . ."
* 11/12/18 - ". . . redness to coccyx (MASD) which has z-paste applied daily as a barrier. . . ."
* 11/13/18 - ". . . redness to coccyx (MASD) which has z-paste applied daily as a barrier. . . ."

Review of the significant change in status assessment (SCSA) MDS, dated 11/13/18, showed facility staff failed to code section M1040H and section M1200H.

SECTION O: SPECIAL TREATMENTS, PROCEDURES, AND PROGRAMS

The Long-Term Care Facility RAI User's Manual, revised October 2018, pages O-11 to O-12 stated, ". . . O0300: Pneumococcal Vaccine Coding Instructions O0300A, Is the Resident's Pneumococcal Vaccination Up to Date? Code 0, no: if the resident's pneumococcal vaccination status is not up to date or cannot be determined. Proceed to item O0300B, If Pneumococcal

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F 641	Continued From page 7 vaccine not received, state reason. Code 1, yes: if the resident's pneumococcal vaccination status is up to date. . . . "Up to date" in item O0300A means in accordance with current Advisory Committee on Immunization Practices recommendations. . . ." Review of the ACIP webpage (https://www.cdc.gov/vaccines/schedules/hcp/index.html. MMWR / September 4, 2015 / Vol. 64 / No. 34) stated, ". . . For immunocompetent adults aged > [greater than] 65 years who have not previously received pneumococcal vaccine, ACIP makes the following recommendation for intervals between PCV13 [13-valent pneumococcal conjugate vaccine] followed by PPSV23 [23-valent pneumococcal polysaccharide vaccine]: A dose of PPSV23 should be given >1 year following a dose of PCV13. The two vaccines should not be co-administered. If a dose of PPSV23 is inadvertently given earlier than the recommended interval, the dose need not be repeated. . . ." - Review of Resident #2's medical record occurred on 12/05/18. The record showed Resident #2 received the PPSV23 vaccine on 11/14/12 (prior to admission). The record lacked evidence the facility assessed the resident's pneumococcal immunization status for the PCV13 immunization and/or provided education to the resident and/or their legal representative. Resident #2's pneumococcal vaccine had not been given. Review of the quarterly MDS, dated 11/27/18, showed facility staff incorrectly coded section O0300, Yes: up to date.	F 641		

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F 641	Continued From page 8 - Review of Resident #5's medical record occurred on 12/05/18. The record showed Resident #5 received the PPSV23 vaccine on 03/09/11 (prior to admission). The record lacked evidence the facility assessed the resident's pneumococcal immunization status for the PCV13 immunization and/or provided education to the resident and/or their legal representative. Resident #5's pneumococcal vaccine had not been given. Review of the quarterly MDS, dated 09/22/18, showed facility staff incorrectly coded section O0300, Yes: up to date. - Review of Resident #126's medical record occurred on 12/05/18. The resident was admitted in August 2018. The record lacked evidence the facility assessed the resident's pneumococcal immunization status on admission and provided education to the resident and/or their legal representative. Review of the SCSA MDS, dated 11/13/18, showed facility staff left section O0300 blank. Facility staff failed to correctly code section O0300 for Resident's #2, #5, and #126 on their most recent MDSs.	F 641		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations	F 644		1/24/19

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F 644	Continued From page 9 from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review, review of the North Dakota Provider Manual for Preadmission Screening and Resident Review (PASARR) and Level of Care Screening Procedures for Long Term Care Services, and staff interview, the facility failed to complete a status change assessment for 3 of 3 sampled residents (Resident #6, #16, and #21) who had a new mental illness diagnosis on admission to the facility and/or a required level II PASARR. Failure to complete a change in status assessment for Resident #6 and #21 and complete a recommended level II PASARR for Resident #16 may result in the residents not receiving the appropriate care and services for their mental health disorders. Findings include: The North Dakota PASARR Provider Manual, page 7 and 13, stated, ". . . If the Level I Screen indicates that the applicant does have indicators for MI, ID, and/or RC, a Level of Care Form must be completed and forwarded to Ascend (regardless of the individual's method of payment). If the individual with MI, ID, and/or RC	F 644	1. Resident #6 expired 12.21.18 and no action required. Resident #16 level II PASARR was found in documentation dated 07.10.18. Resident #21 PASARR has been submitted for Level I 01.05.19 and currently pending. 2. All residents at RHC have the potential to be affected 3. The Social Services Designee will be educated on the North Dakota PASARR Provider Manual pages 7 and 13 focusing on when a new diagnosis is discovered or later emerges, and note that the PASARR must be updated and evaluated for Level II. 4. The Social Service Designee will create an audit to ensure that all residents that have had any diagnosis added that indicates MI, ID, and/or RC, will have a level I updated. This audit will be completed monthly x 12 months. The results of the audits will be reported to the QA Committee for further evaluation and	

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F 644	Continued From page 10 meets criteria for nursing facility level of care, s/he will be referred for a Level II PASARR evaluation, which then must be completed prior to the individual's admission to a nursing facility.. . . Change in Status Process . . . Whenever the following events occur, nursing facility staff must contact Ascend to update the Level I screen for determination of whether a first time or updated Level II evaluation must be performed. These situations suggest that a significant change in status has occurred: . . . If an individual with MI, ID, and/or RC (mental illness, intellectual disability, and conditions related to intellectual disability [referred to in regulatory language as related conditions or RC]) was not identified at the Level I screen process, and that condition later emerged or was discovered. . . ." - Review of Resident #6's medical record occurred on all days of survey. The record showed an initial Level I PASARR, completed on 01/05/17, identified no diagnosis of a major mental illness (MMI). The facility added a physician's diagnosis of schizophrenia on 05/11/17. The record lacked evidence of an updated Level I PASARR rescreening/change in status assessment for the new diagnosis. During an interview on the morning of 12/05/18, an administrative nurse (#2) stated staff failed to complete the required Level I PASARR rescreening. - Review of Resident #16's medical record occurred on all days of survey. The record showed a Level I PASARR, completed on 06/11/18, identified no diagnosis of a MMI, and ". . . Does not require a Level II at this time." The	F 644	recommendation.	

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F 644	Continued From page 11 facility added a physician's diagnosis of major depression on 06/15/18. A required Level I PASARR, completed 07/06/18, identified Resident #16, ". . . Will require a Level II." The medical record lacked evidence of a Level II PASARR screening completed. During an interview on the morning of 12/05/18, an administrative nurse (#2) stated staff failed to complete the Level II PASARR screening. - Review of Resident #21's medical record occurred on all days of survey. Admission diagnoses identified Bipolar disorder, current episode depressed, mild or moderate severity, unspecified. Review of the admission Minimum Data Set (MDS), dated 11/13/18, identified diagnoses including Manic Depression (bipolar disease). The record showed a completed pre-admission Level I PASARR identified no diagnoses of a MMI including Bipolar Disorder or depression (mild or situational), and ". . . No Level II Evaluation needed. . . ." During an interview on 12/04/18 at 3:50 p.m. and on the morning of 12/05/18, an administrative staff member (#3) stated staff failed to complete the required Level I PASARR after the diagnosis of a MMI (Bipolar).	F 644		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the	F 656		1/24/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355122	A. BUILDING _____ B. WING _____	12/06/2018

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F 656	Continued From page 12 resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by:	F 656		

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F 656	Continued From page 13 THIS IS A REPEAT DEFICIENCY FROM THE STANDARD SURVEY COMPLETED ON 01/11/18. Based on record review and staff interview, the facility failed to develop a comprehensive care plan for 5 of 12 sampled residents (Resident #5, #6, #19, #20, and #126). Failure to develop a care plan that includes the services to be provided to the resident may negatively impact the resident's quality of life. Findings include: - Review of Resident #19's medical record occurred on all days of survey. Diagnoses included pneumonia and unspecified dementia with behavioral disturbance. An annual Minimum Data Set (MDS), dated 11/03/18, identified a diagnosis of pneumonia, other open lesion(s) on the foot, and application of dressing to feet (with or without topical medications). Review of the current care plan showed the facility failed to develop a comprehensive care plan specific with goals and interventions for Resident #19's diagnosis of pneumonia and current skin issues. - Review of Resident #20's medical record occurred on all days of survey. The recent hospital discharge summary, dated 10/12/18, contained a Social History which noted the resident currently smoked one-fourth pack of cigarettes a day. Review of Resident #20's current care showed the facility failed to develop a comprehensive	F 656	1. Resident #126 expired 12-21-18 and resident #6 expired 12-22-18 and does not require immediate action. Residents #5, #19 and #20 will have comprehensive care plans developed to reflect the most current diagnosis, problems, goals and interventions. 2. All residents at RHC have the ability to be affected by not having updated comprehensive are plans. 3. A- Policy "Comprehensive Care Planning" will be created B- A Nursing Staff In-Service will be held 01.16.19 to educate staff and review policy "Comprehensive Care Planning". 4. DON or her designee will conduct weekly audits to ensure weekly meetings are being held and care plans are being updated weekly x 12 weeks and then bimonthly x 3 months, then monthly x 6 months. These audits will be reported to the QA committee to monitor compliance.	

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F 656	Continued From page 14 care plan with goals and interventions related to smoking status. - Review of Resident #126's medical record occurred on all days of survey. Diagnoses included pleural effusion (fluid around the lung), localized edema (swelling), and chronic obstructive pulmonary disease (COPD). Current physician orders included supplemental oxygen to maintain saturations greater than 90%, resident to be transferred via Hoyer x 2 assist (mechanical lift with 2 staff), drain Pleurx (system consists of a tunneled catheter under the skin, used to drain fluid) per sterile fashion once a day every three days. The nursing progress notes following two hospital returns indicated the following: * 11/06/18 - ". . . On his right foot he has reddish/black sores on his great and 2nd toe. On the left foot he has black sore on the tip of his great and 2nd toe. . . . has red excoriated skin [damage to the surface of the skin] on coccyx [tailbone]. . . . zinc paste was applied . . . heal [sic] boots applied to bilateral [both] feet. 2+ edema to bilateral legs and arms . . . Drain has sterile dressing applied over and no drainage noted at this time." * 11/27/18 - ". . . transfers via HOYER x 2 assist, and has 02 [oxygen] @ [at] 2 lpm [liters per minute] to keep resident satting [sic] > 90%. . . . has +3-4 pitting edema . . . red, moist, & [and] excoriated buttocks/groin. Barrier cream and antifungal being applied. Wound (pluervax [sic] drain site) to left chest intact. . . . Heel booties on while resident in bed. . . ." Review of Resident #126's current care plan	F 656		

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F 656	Continued From page 15	F 656		

showed the facility failed to develop a comprehensive care plan with goals and interventions related to the diagnoses, the skin conditions on feet and buttocks, the swelling in all extremities, the location and care of the Pleurx drain, the use of a Hoyer lift with assistance of two for transfers, the use of oxygen, and the use of heel protectors. The facility failed to develop a comprehensive care plan for Resident #126 following two hospitalizations.

During an interview on 12/06/18 at 1:30 p.m., an administrative nurse (#2) acknowledged the care plans had not been updated to reflect current diagnoses, problems, goals, and interventions.

- Review of Resident #5's medical record occurred on all days of survey and identified a hospitalization from 06/20/18 through 06/23/18 for a urinary tract infection (UTI). The resident returned to the facility on 06/23/18 with an order for Keflex (antibiotic) 250 milligrams (mg) twice a day. A provider's progress note, dated 06/28/18, stated, ". . . Will start prophylactic Keflex 250 mg daily . . ."

Review of Resident #5's current care plan showed the facility failed to develop a comprehensive care plan with goals and interventions related to the UTI diagnosis and ongoing prophylactic antibiotic therapy.

During an interview the afternoon of 12/06/18, an administrative nurse (#2) acknowledged the care plan failed to reflect Resident #5's current diagnosis, problems, goals, and interventions.

- Review of Resident #6's medical record

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F 656	Continued From page 16 occurred on all days of survey. A provider's progress note, dated 07/19/18, stated, ". . . past history of dementia Alzheimer's type with behavioral disturbance, unspecified schizophrenia and unspecified depressive disorder . . . continues to be tearful and has frequent crying spells . . . Recommendations: Start Namenda XR [treats Alzheimer's Disease] 7 milligrams every morning . . . continue Zoloft [antidepressant] 50 mg every morning . . . continue risperidone [antipsychotic] 0.5 mg twice a day. . . ." Nursing progress notes included the following behaviors: * 10/20/18 14:55 - ". . . Resident has been hollering, 'water, water' repeatedly, as her water was sitting directly in front of her . . . staff approached resident several times and showed her that her drinks were in front of her and she stated, 'oh, shut up,' and continued hollering . . ." * 11/17/18 14:53 - ". . . upon sitting at the dining room table awaiting breakfast, resident kept hollering, 'I can't see.' I approached resident to see if her glasses were possibly dirty and she stated, 'shut up you damn fool.' Resident continued to call me names every time I walked past her and upon approaching her again to let her know her behavior was unacceptable, she stated, 'oh, I'm sorry . . ." * 11/25/18 00:25 - ". . . Resident has been hollering for help . . . Staff assists her and then she is yelling in her room for help and interrupting other resident's sleep. Staff helps her into her wheelchair and brings her down to the nurses station . . . is offered food and drinks. Resident gets upset and starts banging her right fist onto the counter. Resident stops when staff informs	F 656		

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F 656	Continued From page 17 her that she is gong to hurt herself if she continues . . ." Review of Resident #6's current care plan showed the facility failed to delevop a comprehensive care plan with goals and interventions related to behaviors. During an interview the afternoon of 12/06/18, an administrative nurse (#2) acknowledged the care plan failed to reflect Resident #6's current diagnosis, problems, goals, and interventions.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.	F 657		1/24/19

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F 657	Continued From page 18 (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to review and revise the comprehensive care plan for 2 of 12 sampled residents (Resident #16 and #20). Failure to review and revise the care plan limits the ability of staff to communicate care needs and ensure continuity of care for each resident. Findings include: - Review of Resident #16's medical record occurred on all days of survey. The care plan stated, "I transfer two person stand pivot transfer x 2 with FWW [front wheeled walker] with limited weight bearing to right ankle for surface-to-surface transfers . . . I receive antipsychotic/hypnotic/antidepressant medications Imipramine HCL, Paxil, Xanax and Wellbutrin XL [initiated 08/13/18] . . ." Observation on 12/03/18 at 9:32 a.m. showed a certified nursing assistant (CNA) (#9) pivot transfered Resident #16 from wheelchair to recliner with one assist, utilizing a FWW, a gait belt, and toe touch weight bearing to her right foot/walking boot. Observation on 12/05/18 at 4:05 p.m. showed an unidentified CNA pivot transfered Resident #16 from her recliner, into her wheelchair, and then to her bed with one assist, utilizing a FWW, a gait belt, and toe touch weight bearing to her right	F 657	1. Resident #16 and #20 will have comprehensive care plans developed to reflect the most current diagnosis, problems, goals and interventions. 2. All residents at RHC have the ability to be affected by not having updated comprehensive are plans. 3. A- Policy "Timely Care Plan Timing and Revisions" will be created. B- A Nursing Staff In-Service will be held 01.16.19 to educate and review policy "Timely Care Plan Timing and Revisions". 4. DON or her designee will conduct weekly audits to ensure weekly meetings are being held and care plans are being updated weekly x 12 weeks and then bimonthly x 3 months, then monthly x 6 months. These audits will be reported to the QA committee to monitor compliance.	

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F 657	Continued From page 19 foot/walking boot. During this transfer, an administrative nurse (#2) stated to the CNA, "Isn't she assist of two?" The CNA responded, "No, she is one." During an interview on the morning of 12/06/18, an administrative nurse (#2) stated Resident #16's transfer orders recently changed to one assist and acknowledged the care plan failed to reflect the resident's current level of assistance with transfers. The nurse (#2) also stated the physician discontinued the Wellbutrin a while ago and acknowledged the care plan failed to reflect the resident's current psychotropic medications. - Review of Resident #20's medical record occurred on all days of survey. The current care plan identified 12 problem/categories, with goals, and approaches specific to Resident #20's care and services. Nine of the 12 problem/category, goal, and approaches showed "Last Reviewed/Revised" dates in August 2018. The facility failed to review and revise the care plan with the most recent quarterly Minimum Data Set, dated 11/11/18.	F 657		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced	F 684		1/24/19

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F 684	Continued From page 20 by: Based on record review and staff and family interviews, the facility failed to provide the necessary care and services to maintain the highest practicable physical well-being for 2 of 2 sampled residents (Resident #19 and #126) requiring increased assessment and monitoring. Failure to reassess new and existing skin conditions and provide timely and appropriate interventions may contribute to further skin breakdown, increased risk for infection, and pain (Resident #19). Failure to assess and promote physical strength and mobility following a hospital return may contribute to further decline in strength, endurance, and increased risk for skin breakdown, and pain (Resident #126). Findings include: The facility failed to provide a copy of a policy addressing skin issues/pressure ulcers upon request. - Review of Resident #19's medical record occurred on all days of survey. Diagnoses included type 2 diabetes mellitus and Alzheimer's disease. Review of the current care plan showed the facility failed to address the resident's ongoing skin issues. Review of Resident #19's progress notes and provider communication showed the following: * 08/14/18 at 10:44 p.m. - ". . . I noted on her left foot middle toe that she has a blackened area and swelling. All toes have fungus and are in need of trimming. Bath is tomorrow and will have them looked at closer then." * 08/18/18 at 1:03 a.m. - ". . . Resident has no	F 684	1. Skin Assessment of resident #126 was not completed as resident expired 12.21.18. Resident #126 was screened for therapy PT/OT on 12.6.18 and deemed not appropriate for skilled OT/PT services. Resident #19 had a comprehensive skin assessment and pressure injury risk assessment completed on 12.27.18. Resident #19 was seen by podiatry on 12.26.18 and an order was obtained for treatment and initiated as ordered. Resident #19 was assessed by wound care nurse on 01.02.19 for ongoing treatment and weekly skin assessments. 2. All residents at RHC have the potential to be affected by untimely treatment. 3.A-Policy and procedure addressing skin assessment and pressure injury risk was drafted and implemented 01.02.19 B-All nursing staff will be educated on Policy "Pressure Injury Risk and Skin Assessment" by 01.15.19. All nursing staff will be educated on "Therapy Trigger Form" and initiating "Events and Observations" by 01.15.19. C-All residents will have PT/OT evaluation upon admission/readmission and change of status/PRN. D- Standing orders are in place for all residents PRN change of status/decline in ADL status. 4. DON or designee will audit each admission/readmission status as	

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F 684	Continued From page 21 new skin issues. . . ." * 08/20/18 at 8:50 p.m. - ". . . Noted her left foot and ankle are very red and swollen with 1+ edema. . . ." * 08/22/18 at 6:26 a.m. - ". . . Left foot and ankle is still swollen and red. No warmth to touch." * 08/22/18 at 1:08 a.m. - "Resident's left ankle and foot is noticeably more swollen with +2 pitting edema. It is warm to the touch. Resident is scheduled to be seen by [nurse practitioner] tomorrow regarding this." * 08/23/18 Provider communication (nine days after staff documented the toe as "blackened area and swelling"). Provider orders stated, "Cellulitis of left 3rd toe - Start Levaquin (antibiotic) 500 mg [milligrams] PO [by mouth] X1[times 1] dose then 250 mg PO daily days 2-10 - Also - Cleanse area [with] hibiclens Bid - Apply Medihoney to area and cover [with] absorbent dressing until healed." The facility failed to include the diagnosis of cellulitis in Resident #19's medical record. * 08/23/18 at 10:34 p.m. - ". . . Treatment to left toe done at this time . . . Also noted that she has a split under the toe in the crease." * 08/24/18 at 1:27 p.m. - ". . . Leg and foot 2+ edema w[with]/leg mildly red and warmer to touch than the right. Foot care done by staff - cleansed w/Hibiclens, Medihoney placed and absorbent dressing w/Coban wrap placed. . . ." * 08/25/18 at 3:22 p.m. - ". . . Resident is receiving oral Levaquin antibiotic therapy for cellulitis . . . Left third toe has an open area to the base; wound bed is red/beefy and bleeds a scant amount upon cleansing. . . ." * 08/26/18 at 3:56 p.m. - ". . . Base of left 3rd toe has an open area that is red/beefy in appearance; area cleansed well with Hibiclens,	F 684	available for therapy status and screens. DON or designee will audit all "Events and Observations". These audits will be conducted weekly x12 weeks, bimonthly x 3 months and monthly x 6 months. The results of these audits will be submitted to the QA Committee for further recommendations.	

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F 684	Continued From page 22	F 684		

rinsed, patted dry and then Medihoney and band-aide applied. Resident tolerated procedure fairly well, as she kept stating it was painful. . . ."
* 09/02/18 at 3:29 p.m. - "The last dose of ABT [antibiotic] for cellulitis to LLE [left lower extremity] was given. . . ."
* Documentation from 09/02/18 to 11/07/18 noted provider orders for treatment, and on 11/07/18 at 2:59 p.m. the last documentation regarding the left 3rd toe stated, "Band aid and bacitracin applied to residents left 3rd toe. Resident did complain of pain when the toes (sic) was touched to apply the band aid. . . ."
* 12/02/18 at 11:27 p.m. documentation regarding the left 3rd toe stated, ". . . left foot 3rd toe dry and scabbed, flaking noted to bottom of toe but is intact. . . ."
* 12/02/18 at 11:27 p.m., stated, ". . . small fluid-filled blister forming to lateral right 2nd toe (is intact at this time). . . ." The medical record failed to contain any further documentation through 12/06/18 of the newly discovered blister on the right 2nd toe.

During an interview on the afternoon of 12/05/18, a supervisory nurse (#2) stated she expected nursing staff to create an event for the observed right 2nd toe blister, consider implementing interventions or standing orders for skin issues if appropriate, communicate to the next nursing shift, update the physician and family, and continue to document the monitoring of the blister. The nurse also stated the facility had no specific or consistent procedure/form to report/document skin issues. The nurse indicated the resident chose her own shoes or slippers to wear each day, and staff had not determined the cause for either of the open toe (right or left foot)

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F 684	Continued From page 23 skin issues. The facility failed to ensure staff completed the following for Resident #19's left 3rd toe: * Initiate treatment in a timely manner which included notification of the provider regarding the left 3rd toe skin issue, identify possible reasons for the skin breakdown, and document communication of the issue with the family * Include the skin issue on the care plan to include goals and interventions for healing and prevention of further skin breakdown including cellulitis * Document the new diagnosis of cellulitis in the resident's medical record on 08/23/18 * Create or initiate a form and/or policy/procedure for consistently documenting, monitoring, and reassessing skin issues from the initial onset and until healed including tracking treatment results The facility also failed to reassess, determine the cause, monitor, and document/communicate Resident #19's right 2nd toe blister in a timely manner. - Review of Resident #126's medical record occurred on all days of survey. A progress note, dated 11/07/18 showed Resident #126 ambulated short distances with assistance of two staff, and used a wheelchair for mobility, propelled by staff. The resident returned to the nursing home on 11/27/18 following a hospitalization for pleural effusions (fluid on the lungs). The physician orders included resident to be transferred with a Hoyer (full body mechanical lift) with assistance of two staff. Resident #126's progress note dated 12/04/18 at	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355122	A. BUILDING _____ B. WING _____	12/06/2018

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F 684	Continued From page 24	F 684		

8:47 a.m., prior to a physician appointment, stated, ". . . staff report sliding out of w/c [wheelchair] upon getting into w/c. . . . staff report possible OH [orthostatic hypotension] syncopy [fainting] from transfer out of bed in in[sic] w/c. . . ."

During an interview on 12/06/18 at 9:50 a.m. a family member (F) stated, Resident #126 was very weak and had not been out of bed since he returned from the hospital except for a doctor appointment on 12/04/18. The family member (F) stated, "he struggled to sit up for the appointment" and stated she would like to see Resident #126 sit up in a chair a few times during the day so when he goes out for appointments it is not so hard on him."

During an interview on 12/06/18 at 11:30 a.m., the physical therapist (#12) stated they would evaluate a resident when there is a physician order or if a nurse orders to screen for therapy potential.

During an interview on 12/06/18 at 1:30 p.m., an administrative nurse (#2) acknowledged Resident #126 had not been out of bed since the hospital return, other than going to an appointment on 12/04/18. The administrative nurse (#2) stated the resident had remained in bed because there were no physician orders indicating activity level and verified a referral to therapy for a screen or a physician order for activity level had not been requested.

The facility staff failed to request a therapy screen or a physician order for physical activity to attain or maintain Resident #126's strength and

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F 684	Continued From page 25 physical functioning.	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on review of the facility policy, record review, observation, and staff interview, the facility failed to assess a resident's capabilities and deficits to determine the level of supervision required to assure the safety for 1 of 1 sampled resident (Resident #20) who smoked. Failure to complete an assessment to determine the resident's safety while smoking placed all residents at risk for potential injury. Findings include: Review of the facility policy titled "[name of nursing home] is a Smoke Free Facility" occurred on 12/05/18. This policy, dated June 2016, stated, " . . . This policy applies to all residents, visitors, and employees, for both smokers and non-smokers. Smoking is prohibited in all areas of the facility and facility grounds. . . . Residents and/or resident representative will be informed of the facility's 'Smoke Free' policy during the pre-admission and/or admission process. . . . Residents with a history of smoking will be further assessed to determine whether [sic] or not	F 689	1. On 12.05.18 a safety plan was implemented for resident #20. The Administrator and Activities Director educated resident #20 on the policy "Smoke Free Facility" and resident was agreeable to an immediate plan to ensure safety. Resident #20 Care Plan was updated to include problems, goals and approaches. On 12.05.18 All staff on duty and with changing shifts received an in-service on the safety program for resident #20. 2. All residents at RHC have the potential to be affected. 3. An All Staff In-Service will be held on 01.15.19 to review policy "Smoke Free Facility" and emphasize the portion related to "safety" when a resident does not comply with the policy. 4. The DON or her designee will create	1/24/19

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F 689	Continued From page 26 interventions are needed to help them cope with the 'Smoke Free' policy. Examples include pharmacological and/or behavioral interventions to curb urges to smoke. . . . If a resident does not abide by the smoking policy, care plan revisions shall be documented and implemented to promote safety. Progressive interventions may include room searches and discharge." During the entrance conference the morning of 12/03/18, the facility provided the following written information; "Currently [name of nursing home] has no residents that smoke". Review of Resident #20's medical record occurred on all days of survey. The recent hospital discharge summary, dated 10/12/18, contained a Social History which noted the resident currently smoked one-fourth pack of cigarettes a day and last attempt to quit in 04/25/15. Resident #20's current care plan lacked problems, interventions or goals regarding smoking status. Observation on 12/03/18 at approximately 5:30 p.m. showed Resident #20 outside the facility alone and self-propelled the wheelchair toward the main entrance. During an interview on 12/05/18 at 11:30 a.m., an administrative nurse (#2) stated she read in the hospital discharge summary that Resident #20 smokes and has heard reports from the night staff that Resident #20 goes outside and returns with a smell of tobacco. The administrative nurse (#2) acknowledged the facility did not complete a safety assessment or provide supervision regarding Resident #20's smoking status.	F 689	an audit to monitor for the continued compliance of Resident #20 with the designated safety plan. An audit will be created to ensure that resident #20 receives education and documentation regarding policy "Smoke Free Facility" and interventions available to cope with the policy. These audits will be completed monthly x 12 months. The results of these audits will be reported to the QA Committee for further evaluation and recommendations.	

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	355122	A. BUILDING _____ B. WING _____	12/06/2018

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F 689	Continued From page 27 The facility failed to identify Resident #20 as a smoker and/or complete a safety assessment or follow the "Smoke Free" facility policy.	F 689		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to offer fluids to 2 of 2 sampled residents (Resident #21 and #76) observed during cares and required staff assistance for fluid intake. Failure to provide assistance with fluid intake may result in dehydration, constipation, and urinary tract infections (UTIs).	F 692	1. Resident #21 and #76 had water pitchers immediately placed in the residents rooms in order to offer fluids between meal times and PRN. 2. All residents at RHC are at risk for dehydration and could be affected.	1/24/19

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F 692	Continued From page 28 Findings include: Review of the facility policy titled "RHC [facility name] Hydration" occurred on 12/06/18. This undated policy stated, ". . . 1. Staff will offer fluids at meals and periodically between meals. 2. Fluids are offered between meals and PRN [as needed]. . . ." - Observation on 12/03/18 at 3:18 p.m. showed two certified nurse aides (CNAs) (#4 and #5) failed to offer fluids to Resident #21 after toileting or before transporting the resident to the sitting room where the husband had waited. Observation during the noon meal on 12/03/18 and breakfast on 12/04/18 showed Resident #21 needed total assist for consuming food and fluids. Observation on 12/05/18 at 10:30 a.m. showed two CNAs (#6 and #7) transferred Resident #21 from the wheelchair to the toilet and then to bed utilizing a mechanical stand lift. The CNAs failed to offer fluids after cares. Review of Resident #21's medical record occurred on all days of survey. Diagnoses included dementia and constipation. An admission Minimum Data Set (MDS), dated 11/13/18, identified extensive assist of one staff for eating. The current care plan stated, ". . . need assistance with my meals as I need cueing and physical guidance." - Observation on 12/05/18 at 9:58 a.m. showed two CNAs (#8 and #9) transferred Resident #76	F 692	3. An All Staff in-service will be held 01.15.19 to educate all staff on the importance of hydration for all residents and to review Policy, "RHC Hydration". 4. The DON or her designee will conduct audits between mealtimes and randomly with cares to ensure that residents are being offered fluids between meal times and PRN with cares. These audits will be completed biweekly x 12 weeks, then weekly x 3 months, then monthly x 6 months. The results of the audits will be submitted to the QA Committee for evaluation and further recommendations.	

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F 692	Continued From page 29 utilizing a full body mechanical lift from the wheelchair to the bed. The CNAs identified no water container located in the room and failed to obtain and offer fluids after cares and before leaving the room. Review of Resident #76's medical record occurred on all days of survey. Diagnoses included dementia, constipation, and a recent right hip fracture. The current care plan stated, ". . . Assist/cueing/encourage as needed with oral/fluid intake. . . ." During an interview on 12/06/18 at 3:40 p.m. two administrative staff members (#2 and #3) agreed staff failed to follow the policy and to offer fluids during cares.	F 692		
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.	F 726		1/24/19

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F 726	Continued From page 30 §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure nursing staff were knowledgeable on the location and proper use of the suction machine for 1 of 1 suction machine. Failure to ensure staff were knowledgeable regarding the location and operation of the suction machine placed all residents at risk for choking and aspiration. Findings include: Following the medication room inspection the afternoon of 12/05/18, the licensed nurse (#1) was asked to show the location of the suction machine. The licensed nurse (#1) indicated she was unsure of its location and would need to ask an administrative nurse. On 12/05/18 at 3:30 p.m. an administrative nurse (#2) showed the suction machine to be located in the medical supply room. Observation showed the suction machine placed inside a clear plastic bag, tied at the top with a note indicating, "last cleaned 2-22-18." The administrative nurse (#2) stated she was unsure when it was last checked for	F 726	1. The current suction machine was assembled 12.05.18 and worked properly after inspection by Maintenance. Administrative staff placed an order for a new suction machine that would arrive the same day to have a secondary unit that is battery operated. Immediately beginning with the current staff 12.05.18, an in-service was held each shift change to educate staff on the location and assembly of the suction machine. 2. All residents at RHC have the potential to be at risk for choking and require suctioning. 3. An all-staff in-service was initiated immediately 12.05.18 and continued with changing shifts to review Policy "Suction Machine Protocol". The same policy will be added to the orientation packet for new hires and travel staff. 4. The DON or her designee will conducts	

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F 726	Continued From page 31 proper functioning. The administrative nurse (#2) removed the suction machine from the medical supply room and placed it in the medication room. She attempted to connect the tubing to the suction machine and collection canister to check its function. The administrative nurse (#2) attempted for a total of 10 minutes to connect and operate the suction machine. The administrative nurse (#2) failed to properly connect the tubing to operate the suction machine. During an interview on 12/05/18 at 4:10 p.m., the administrative nurse (#2) verified the facility's orientation process does not include review of the location and/or proper use of the suction machine.	F 726	audits to ensure that newly hired staff and travel staff have received orientation on the suction machine protocol. DON or her designee will create and maintain an audit to ensure proper functioning of the suction machine. These audits will be completed weekly x 6 months, then monthly x 6 months.	
F 727 SS=D	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on review of the facility nursing staff	F 727	1. The schedule going forward from	1/24/19

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F 727	Continued From page 32 schedule and staff interview, the facility failed to provide the services of a registered nurse (RN) for eight consecutive hours a day, seven days a week, for two days of the 30 day period in November 2018. Failure to assure sufficient qualified nursing staff are available on a daily basis has the potential to affect all the residents residing in the facility. Findings Include: The facility provided a copy of the nurse schedule for the months of November and December 2018. A review of the schedules showed the facility lacked the required RN coverage for two days in November, on the 10th and 11th. During an interview on 12/04/18 at 4:00 p.m., an administrative staff member (#3) confirmed the facility lacked an RN working eight consecutive hours on 11/10/18 and 11/11/18.	F 727	11.12.18 was verified by the Administrator and DNS to have 8 hours of RN staffing every day through the remainder of the schedule ending January 1, 2019. 2. All residents at RHC have the potential to be affected by the absence of an RN for 8 consecutive hours daily. 3. A-An All Staff In-service will be held 01.15.19 to review the Federal regulations requiring 8 consecutive hours of RN coverage. B-Nursing staff schedules will be verified prior to posting by the Administrator and DON to ensure daily RN coverage. 4. The DON or her designee will create an audit to verify 8 hours of RN coverage weekly x 6 months then monthly x 6 months. The results of the audits will be reported to the QA Committee for review and recommendations.	
F 730 SS=D	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on review of facility staff employment records, and staff interview, the facility failed to	F 730	1. No residents were affected. CNA #10 annual performance review was	1/24/19

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F 730	Continued From page 33 complete an annual performance review to include skills competency for certified nurse aide (CNA) for 1 of 1 CNA (#10) requiring a performance review. Failure to ensure CNA staff received annual performance and competency reviews to address areas of weakness, and develop training for staff based on those weaknesses placed all residents at risk for neglect, harm and/or injury. Findings include: Review of staff employment records occurred on 12/05/18. The employment record for CNA (#10), hired in 2016, lacked yearly performance and competency reviews. During an interview on 12/05/18 at 3:25 p.m., the personnel manager (#11) confirmed the employment record did not contain yearly evaluations or skills competency reviews.	F 730	completed 01.02.19. CNA #10 competency review will be completed by 01.14.19. 2. All residents at RHC have the potential to be affected by staff that have not received annual performance and competency reviews. 3. A-All CNA's with over 12 months of employment will receive annual performance and competency reviews. B-A spreadsheet of hire dates for Certified Nursing Assistants will be created for the DON or her designee to ensure that annual performance and competency reviews are conducted timely. 4. The DON or her designee will create an audit to monitor the completion of annual performance and competency reviews monthly x 12 months. These audits will be reported to the QA Committee for further review and recommendations.	
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart.	F 756		1/24/19

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F 756	Continued From page 34 §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to ensure the consultant pharmacist reported all irregularities to the attending physician and failed to ensure the attending physician reviewed the pharmacist's	F 756	1. Resident #9 has a GDR recommendation for Seroquel and Risperidone 01.09.19 from the consultant pharmacist and RHC is waiting for physician response. Resident #19 has a	

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F 756	Continued From page 35 recommendations for 3 of 9 sampled residents (Resident #9, #19, and #20) with an as needed (PRN) psychotropic drug and/or a rejected gradual dose reduction (GDR). Failure of the pharmacist to identify all drug irregularities and the physician to review and document the response to the pharmacist's recommendations may result in the prolonged and unnecessary use of medications and adverse consequences. Findings include: Review of the facility policy titled "Medication Regimen Review" occurred on 12/06/18. This policy, revised December 2017, stated, "The pharmacist must report any irregularities to the attending physician and [facility name] medical director and director of nursing, and the reports must be acted upon. . . . The attending physician must document in the resident' (sic) medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication the attending physician should document his or her rationale in the resident's medical record. . . . Residents who use psychotropic drugs receive gradual dose reductions . . . PRN orders for psychotropic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluated the resident for the appropriateness of that medication. . . ." - Review of Resident #9's medical record occurred on all days of survey. Medications included Seroquel (anti-psychotic) 100 milligrams (mg) at bedtime and risperidone 1 mg twice daily.	F 756	recommendation for Olanzapine 01.09.19 to be evaluated for continued PRN use from the consultant pharmacist and RHC is waiting for physician response. Resident #20 has a GDR recommendation for Trazadone and Ativan 01.09.19 from the consultant pharmacist and RHC is waiting for physician response. 2. All residents at RHC have the potential to be affected by unnecessary and prolonged use of medications. 3. A-Consultant pharmacist will receive education on policy "Medication Regimen Review" B-Attending Physician and Medical Director will receive education on policy "Medication Regimen Review" C-Consultant pharmacist will create a log for GDR and other recommendations and DON will confirm receipt from physician with timely response to recommendations using form "Addressing Medication Regimen Review Irregularities". 4. The DON or her designee will create an audit to monitor consultant pharmacist recommendations logged on the "Addressing Medication Regimen Review Irregularities" ensuring the consultant addressed the irregularity. The audit will track when the irregularity was faxed to physician and the date received back from physician are followed up for	

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F 756	Continued From page 36 Review of the Resident #9's progress notes identified a consultant pharmacist note, dated 02/19/18, stated, "No irregularities at this time . . . Seroquel dose increased to 100mg [milligrams]. [Resident] continues to have episodes of aggression and outbursts toward other residents and staff. I feel that a GDR of risperidone would be inappropriate at this time." The record lacked the physician's response to the pharmacist's review. - Review of Resident #19's medical record occurred on all days of survey. Medications included olanzapine (Zyprexa) (anti-psychotic) 20 mg at bedtime and disintegrating olanzapine 5 mg daily PRN. Review of the resident's progress notes identified a consultant pharmacist note, dated 09/29/18, stated, "No irregularities at this time . . . GDR olanzapine deemed contraindicated. [Resident] symptoms seem to be getting worse and nursing notes indicate she's a danger to herself and/or others. PRN disintegrating olanzapine 5mg added for increased episodes." The record lacked the physician's response to the pharmacist's review. Further review of Resident #19's progress notes, dated 10/27/18, identified the consultant pharmacist documented, "No irregularities at this time." The pharmacist failed to identify the PRN olanzapine, ordered on 09/26/18, required physician evaluation after 14 days for continued use. During an interview on 12/06/18 at 3:40 p.m., a supervisory nurse (#2) confirmed the record	F 756	completion monthly x 12 months. These audits will be reported to the QA Committee and reviewed for further recommendations.	

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F 756	Continued From page 37 lacked the physician's response to the pharmacist's recommendation regarding the GDR for Resident #9 and #20, and the pharmacist failed to identify the physician's required evaluation and reordering of the PRN olanzapine after 14 days. - Review of Resident #20's medical record occurred on all days of survey. Medications included: * Trazadone (antidepressant) 100 mg at bedtime, ordered 09/07/17. * Ativan (antianxiety) 0.5 mg at bedtime, ordered 02/22/18. Review of the medical record for Resident #20 showed the consulting pharmacist completed medication regimen reviews (MRR) from March through November 2018. The pharmacist documented the following note each month; "No irregularities at this time." The consultant pharmacist failed to recommend a GDR for Trazadone and Ativan.	F 756		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its	F 757		1/24/19

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F 757	Continued From page 38 use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to ensure a medication regimen free from unnecessary drugs for 1 of 1 sampled resident (Resident #5) on long term antibiotic therapy. Failure to monitor for adverse consequences, demonstrate indications for its continued use, and to avoid excessive duration may increase the development of adverse effects. - Review of Resident #5's medical record occurred on all days of survey and identified Resident #5 hospitalized for a urinary tract infection (UTI) from 06/20/18 to 06/23/18 and returned to the facility with an order for Keflex (antibiotic) 250 milligrams (mg) twice a day. A provider's progress note, dated 06/28/18, stated, ". . . Family is concerned because she [Resident #5] has become septic in the past. They question about getting routine UA's [urinalysis]. . . Would not do routine UA's . . . Family is very adamant they were [sic] something done. Will start prophylactic Keflex 250 mg daily. Although again run the risk of making super bugs. Will need to monitor closely . . ." The resident received this dose of Keflex for almost six months, and the medical record lacked monitoring and indications	F 757	1.Resident #5 has a recommendation from the consultant pharmacist 01.09.19 and RHC is waiting for physician response. 2. All residents at RHC have the potential to be affected. 3. A-The consultant pharmacist, attending physician and medical director will be educated on policy "Antibiotic Stewardship" and forms, "Addressing Medication Regimen Review Irregularities" and form "Physician Report Card" for Antibiotic use. B- A Licensed Nurses In-Service will be held 01.17.19 to review policy "Antibiotic Stewardship" and forms "Addressing Medication Regimen Review Irregularities" and "Physician Report Card" as well as a review of potential adverse reactions with common medications. 4. The DON or her designee will create an audit to monitor the receipt of consultant pharmacist recommendations	

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F 757	Continued From page 39 for continued use. During an interview on the afternoon of 12/06/18, an administrative nurse (#2) stated she was unable to locate a policy or any documentation the facility monitored Resident #5's continued use of antibiotics. Refer to F 881 Antibiotic Stewardship Program	F 757	and receipt of attending physician response in a timely manner using form "Drug Regimen Review-Validation Checklist". These audits will be weekly x 6 months, then monthly x 6 months. The audits will be reported to the QA Committee for further evaluation and recommendations.	
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;	F 758		1/24/19

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F 758	Continued From page 40 §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to ensure orders for as needed (PRN) psychotropic drugs were limited to 14 days and residents who use psychotropic medication receive gradual dose reductions (GDRs), unless clinically contraindicated for 2 of 5 residents (Resident #19 and #20) reviewed for psychotropic medications. Failure to ensure the physician renewed the PRN order after 14 days (Resident #19) and attempt a GDR, or document why a GDR is clinically contraindicated (Resident #20) placed residents at risk for receiving unnecessary medications and experiencing adverse consequences related to their use.	F 758	1. Resident #19 has a recommendation for Olanzapine 01.09.19 to be evaluated for continued PRN use from the consultant pharmacist and RHC is waiting for physician response. Resident #20 has a GDR recommendation for Trazadone and Ativan from the consultant pharmacist and RHC is waiting for physician response. 2. All residents at RHC have the potential to be affected by unnecessary and prolonged use of psychotropic medications. 3.	

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F 758	Continued From page 41 Findings include: Review of the facility's policy titled "Medication Regimen Review" occurred on 12/06/18. This policy, revised December 2017, stated, ". . . Residents who use psychotropic drugs receive gradual dose reductions . . . PRN orders for psychotropic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluated the resident for the appropriateness of that medication. . . ." - Review of Resident #19's medical record occurred on all days of survey and identified a physician's order, dated 09/26/18, for olanzepine (antipsychotic) 5 milligrams (mg) every day PRN. Staff failed to discontinue the medication or obtain a new physician's evaluation and order for the PRN olanzepine after 14 days (October 10, 2018). Review of Resident #19's Medication Administration Records (MAR) identified the order for the PRN olanzepine remained on the MAR through December 06, 2018 without a new physician's order. During an interview on 12/06/18 at 3:40 p.m., a supervisory nurse (#3) confirmed staff failed to obtain a new physician's order after 14 days for Resident #19's olanzepine. - Review of Resident #20's medical record occurred on all days of survey. Medications included: * Trazadone (antidepressant) 100 mg at bedtime, ordered 09/07/17 * Ativan (antianxiety) 0.5 mg at bedtime, ordered 02/22/18	F 758	A-Consultant pharmacist will receive education on policy "Medication Regimen Review" and form "Addressing Medication Regimen Review Irregularities". B-Attending Physician and Medical Director will receive education on policy "Medication Regimen Review" and "Addressing Medication Regimen Review Irregularities". C-Consultant pharmacist will create a log for GDR and other recommendations and DON will confirm receipt from physician with timely response to recommendations using form "Drug Regimen Review-Validation Checklist". D- A Nursing Staff In-Service will be held 01.16.19 to educate and review Policy "Medication Regimen Review" and Policy "Addressing Medication Regimen Review Irregularities" and form "Drug Regimen Review-Validation Checklist". 4. The DON or her designee will create an audit to monitor irregularities and ensure they are followed up for completion weekly x 6 months and monthly x 6 months. These audits will be reported to the QA Committee and reviewed for further recommendations.	

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F 758	Continued From page 42 Resident #20's record lacked evidence the physician addressed a GDR for Trazadone or Ativan since the order dates.	F 758		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE STANDARD SURVEY COMPLETED ON 01/11/18. Based on observation, and staff interview, the	F 761	1. On 12.05.18 the Vitamin C, Debrox, Venotlin inhaler, Refresh tears and four unlabeled syringes with the note "flu shots" were removed from the medication	1/24/19

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F 761	Continued From page 43 facility failed to properly store medications for 2 of 2 storage areas (medication room and medication cart). Failure to discard expired medications increases the risk of residents receiving outdated medications with reduced efficacy. Findings include: Observation of the medication room and medication cart occurred on the afternoon of 12/05/18 with a licensed nurse (#1). Observation identified the following expired medications and locations: Medication Cart: * Vitamin C 100 mg tabs - August 2018 Medication Room: * Debrox (ear drops) - 10/05/18 * Ventolin Inhaler - 11/17/18 * Refresh tears (eye drops) - 08/21/18 * Four unlabeled syringes contained in a biohazard bag with a hand written note "Flu shots - 10/04/18" During the observation, the licensed nurse (#1) agreed the above items needed to be discarded.	F 761	cart and medication room and discarded immediately. 2. All residents at RHC have the potential to be affected. 3. A Nursing Staff In-Service will be held 01.16.19 to review Policy "Label/Storage of Drugs and Biologicals" with an emphasis on the immediate removal and disposal of expired medications and biologicals. 4. The DON or her designee will create an audit to ensure that all medications in the medication carts and medication storage areas have expired medications removed immediately upon expiration. These audits will be performed weekly x 3 months, then bimonthly x 3 months and monthly x 6 months. Results from these audits will be reported to the QA Committee and reviewed for further recommendations.	
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on review of the North Dakota	F 867	1. A QAPI Committee meeting was held	1/24/19

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F 867	Continued From page 44 Department of Health, Division of Health Facilities provider files, record review, review of facility policy, and staff interview, the facility failed to maintain a Quality Assurance (QA) process, which identified and addressed quality issues; and failed to develop and implement appropriate plans of action to correct deficient practices to ensure compliance with federal requirements. Findings include: Review of the facility's policy and procedure titled "2017 QAPI Plan" occurred on 12/06/18. This policy, dated October 2017, stated, ". . . We set goals to improve performance, measure progress towards the goal, and revise the goal when necessary. . . . The QAPI [Quality Assurance Performance Improvement] program will be sustained during transitions in leadership and staffing. . . . [Facility] will monitor multiple data sources and performance indicators in determining areas of concern, gaps and opportunities and also to determine effectiveness of system modifications and other interventions. . . . [Facility] will review the designated sources of data; identify areas where gaps in performance may negatively affect resident or staff outcomes. . . . The QAPI program will be evaluated annually by the QAPI Committee. This review will include whether goals were met, if standards of practice are being followed, any training needs will be identified and addressed, and staff opinion on the QAPI process will be obtained. . . . This plan was established on October 2, 2017 and will be revisited and revised as needed annually at a minimum." Review of the North Dakota Department of	F 867	01.10.19 to review the citations for the facility and a plan has been developed to monitor compliance for 12 months beginning with January 2019. 2. All residents at RHC have the potential to be affected. 3. A-All QAPI Committee members were educated 01.10.19 on the citations with an emphasis on the citations that were repeated. The team agreed to monitor compliance with the audits for a full 12 months and keep a centralized location for QAPI meeting documentation. B-At each QAPI meeting the audits generated from the Plan of Correction will be reviewed and an action plan for next steps will be implemented. The repeat citation audits will be prioritized for compliance. C-The QAPI team will identify and correct some things immediately if necessary and Performance Improvement Plans (PIP) will be utilized as necessary. D-An All Staff meeting was held 01.15.19 to discuss QAPI processes and goals to include multiple levels of staff involvement including front line care givers. 4. The Administrator or her designee will create an audit to ensure that the QAPI Committee is meeting monthly and reviewing all audits with an emphasis on the audits for the citations that are repeated. The QA Committee will keep record of the audits on the QA Committee	

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F 867	Continued From page 45 Health, Division of Health Facilities Provider Files identified the facility failed to maintain compliance in the following areas previously cited: * F656 - Develop/Implement Comprehensive Care Plan * F761 - Label/Store Drugs & Biologicals Review of sampled residents' (Resident #5, #6, #19, #20, and #126) medical records identified the facility failed to develop and implement a comprehensive care plan that included the current services (skin breakdown, current and/or new diagnoses, safety related to smoking, edema, transfer assistance, location and care of a drainage unit, oxygen use, prophylactic antibiotic, and behaviors) each resident required to maintain the resident's quality of life. (Refer to F656) Review of the medication cart and storage room identified expired residents' medications. (Refer to F761) During an interview on 12/06/18 at 3:00 p.m., an administrative staff member (#3) reported the facility's QA committee last met in August 2018. Notes from the meeting showed the following items discussed included census, falls, weights, behavior, advance directives, nutrition, tube feedings, pressure ulcers, restraints, and alarms. The notes from the meeting failed to show the discussion or current status for each area, any QA completed for the facility areas/departments to identify issues with respect to necessary quality assessment and assurance activities. The staff member (#3) also agreed the QAPI Plan had not been reviewed since October 2017.	F 867	Agenda and Meeting Minutes.	

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F 867	Continued From page 46 Failure of the facility to effectively utilize QAPI resulted in continued noncompliance at F656 and F761 and currently identified additional areas of noncompliance.	F 867		
F 868 SS=D	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i) §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; §483.75(g)(2) The quality assessment and assurance committee must: (i) Meet at least quarterly and as needed to identifying issues with respect to which quality assessment and assurance activities are necessary. This REQUIREMENT is not met as evidenced by: Based on review of the facility's Quality Assurance Performance Improvement (QAPI) program, review of facility policy, and staff interview, the facility failed to ensure the QAPI Committee met at least quarterly for 1 of 3 quarters reviewed (January to March 2018) and 1 of 4 required committee members (Medical Director) actively participated at least quarterly as a member of the QA committee from January 2018 through December 06, 2018. Failure to meet quarterly and have the medical director participate in the facility's quality assurance	F 868	1. A QAPI Committee members met on 01.10.19 to create an agenda for the January QAPI Quarterly meetings to review the citations for the facility and a plan has been developed to monitor compliance for 12 months with calendar tracking of those in attendance including the Medical Director attending quarterly beginning with January 2019. 2. All residents at RHC have the potential to be affected.	1/24/19

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	355122	A. BUILDING _____ B. WING _____	12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 868	Continued From page 47 activities deprives the committee of the physician's unique contributions for analysis of quality concerns and assisting with decision making based on identified concerns. Findings include: Review of the facility's policy and procedure titled "2017 QAPI Plan" occurred on 12/06/18. This policy, dated October 2017, stated, ". . . The Quality Assessment and assurance [QAA] Committee consists of the Director of Nursing, the Medical Director, Administrator, Social Services Designee, clinical Coordinator, Maintenance Supervisor and the Infection Prevention and Control Preventionist. The QAA committee meets at least quarterly. . . ." The facility provided documentation showing the QA committee met May and August of 2018. The August 2018 meeting failed to have the medical director in attendance. During an interview on the afternoon of 12/06/18, an administrative staff member (#3) confirmed the QAPI committee had not met on a quarterly basis and failed to ensure the required quarterly attendance of the medical director.	F 868	3. The Medical Director will receive education on policy "Quality Assurance and Performance Improvement" with an emphasis on the Medical Director or his/her designee attending QA Committee meetings quarterly. In the event that the Medical Director is unable to attend the quarterly meeting, the Administrator will meet with the Medical Director within the quarter to review Quarterly QAPI Meeting Minutes to give him the chance to review and made recommendations. The Medical Director will sign off on all documentation for the Quarterly QAPI Meetings. 4. The Administrator or her designee will create an audit to ensure that the QAPI Committee is meeting with an emphasis on the participation of the Medical Director quarterly. The audits will be completed monthly x 12 months. The audits will be reviewed with the QA Committee monthly.	
F 881 SS=D	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program	F 881		1/24/19

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F 881	Continued From page 48 that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on review of facility policy, record review, and staff interview, the facility failed to implement the facility protocol for antibiotic use for 1 of 1 sampled resident (Resident #5) on prophylactic antibiotics. Failure to ensure the appropriate use of antibiotics to include a system of monitoring for the correct indication, dose, and duration may result in unnecessary use of antibiotics and the development of antibiotic-resistant organisms. Findings include: Review of the facility policy titled "Antibiotic Stewardship" occurred on 12/06/18. This policy, dated 06/23/17, stated, ". . . [name of nursing home] will discuss antibiotic therapy at weekly IDT [interdisciplinary team] meetings and monthly QAPI [quality assurance process improvement] meeting. [name of nursing home] will communicate with the physician(s) prescribing antibiotics with an 'Antibiotic Report Card' on a monthly basis and as needed. . . . [name of nursing home] will monitor for all adverse reactions/outcomes related to antibiotic therapy." Review of Resident #5's medical record occurred on all days of survey and identified Resident #5 hospitalized for a urinary tract infection (UTI) from 06/20/18 to 06/23/18 and returned to the facility with an order for Keflex (antibiotic) 250 milligrams (mg) twice a day. A provider's progress note, dated 06/28/18, stated, ". . . Family is concerned because she [Resident #5] has become septic in the past . . . Family is very	F 881	1. Resident #5 has a recommendation from the consultant pharmacist to review the continued use of Keflex and RHC is waiting for physician response. 2. All residents at RHC have the potential to be affected. 3. A-Consultant pharmacist will be educated on policy "Antibiotic Stewardship" and form "Physician Report Card" for antibiotic use. B-Attending physician and Medical Director will be educated on policy "Antibiotic Stewardship" and form "Physician Report Card". C-A Nursing Staff In-Service will be held 01.16.19 to review policy, "Antibiotic Stewardship" and form "Physician Report Card" for antibiotic use. 4. The DON or her designee will create an audit to monitor the use of Antibiotic per physician weekly x 6 months and monthly x 6 months. The results of the audits will be reported to the QA Committee for further recommendations.	

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F 881	Continued From page 49 adamant they were [sic] something done. Will start prophylactic Keflex 250 mg daily. Although again run the risk of making super bugs. Will need to monitor closely . . ." During an interview on the afternoon of 12/06/18, an administrative nurse (#2) identified the facility failed to monitor Resident #5's continued antibiotic use through the weekly IDT meetings, monthly QAPI meetings, and to communicate with the physician with the Antibiotic Report Card.	F 881		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza	F 883		1/24/19

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F 883	Continued From page 50 immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on policy review, review of the Centers for Disease Control and Prevention (CDC) guidelines and recommendations, record review, and staff interview, the facility failed to assess each resident's pneumococcal status and provide education to residents and/or their legal representatives regarding the benefits and potential side effects of receiving the vaccination	F 883	1. Resident #2 representative will receive education on Prevnar 13 immunization and will be given the opportunity to consent or decline. Resident #5 representative will receive education on Prevnar 13 immunization and will be given the opportunity to consent or decline. Resident #126 expired on	

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F 883	Continued From page 51 for 3 of 4 sampled residents (Resident #2, #5, and #126) reviewed for immunization status. Failure to offer pneumococcal vaccine to all residents, provide education to residents and their legal representatives, and document the administration or refusal has the potential for non-immunized residents to contact pneumonia and also spread the infection to other residents, visitors, and staff. Findings include: Review of the facility policy titled "Pneumococcal Vaccine (Series)" occurred on 12/05/18. This policy, dated 10/11/17, stated, "Policy: It is our policy to offer our residents, staff, and volunteer workers immunization against pneumococcal disease in accordance with current CDC guidelines and recommendations. . . . Each resident will be assessed for pneumococcal immunization upon admission. . . . Prior to offering the pneumococcal immunization, each resident or the resident's representative will receive education regarding the benefits and potential side effects of the immunization. The individual receiving the immunization, or the resident representative, will be provided with a copy of the CDC's current vaccine information statement relative to that vaccine. . . . The type of pneumococcal vaccine (PCV13 [pneumococcal conjugate vaccine], PPSV23/PPSV [pneumococcal polysaccharide vaccine]) offered will depend upon the recipient's age and susceptibility to pneumonia, in accordance with current CDC guidelines and recommendations. The resident's medical record shall include documentation that indicates at a minimum, the following: a. The resident or resident's	F 883	12-21-18. 2. All residents at RHC have the potential to be affected by not receiving the pneumococcal immunization and/or follow the CDC recommendations for the pneumococcal vaccinations. 3. A-Every resident/resident representative will have VIS (Vaccination Information Statement) reviewed with education provided regarding the benefits and the potential side effects of vaccination. B-Every resident/resident representative will be given the opportunity to consent/decline the vaccination with their signature. If they decline the vaccination the resident will have documentation and a progress note to indicate reason for refusal/declination. If they consent to the vaccination, then the resident will be referred to the local clinic for vaccination with documentation in the progress note and on the face sheet. C-A Nursing Staff In-Service will be held 01.16.19 to review the policy "Pneumococcal Vaccination" 4. The DON or her designee will create an audit to monitor the distribution of education materials to residents/resident representatives. An audit will also be created to verify there is a signed consent/declination in the chart and there is documentation added to the Electronic Health Record Face Sheet indicating the	

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F 883	Continued From page 52 representative was provided education regarding the benefits and potential side effects of pneumococcal immunization. b. The resident received the pneumococcal immunization or did not receive due to medical contraindication or refusal." Review of the CDC: Vaccines and Preventable Diseases webpage(https://www.cdc.gov/vaccines/vpd/pneumo/hcp/recommendations.html), last reviewed December 6, 2017, states, ". . . CDC recommends pneumococcal vaccination (PCV13 or Prevnar13, and PPSV23 or Pneumovax23) for all adults 65 years or older: Give a dose of PCV13 to adults 65 years or older who have not previously received a dose. Then administer a dose of PPSV23 at least 1 year later. If the patient already received one or more doses of PPSV23, give the dose of PCV13 at least 1 year after they received the most recent dose of PPSV23. . . ." - Review of Resident #2's medical record occurred on 12/05/18. The resident was admitted in 2014. The record showed Resident #2 received the PPSV23 vaccine on 11/14/12 (prior to admission), the record lacked evidence the facility assessed the resident's pneumococcal immunization status for the PCV13 immunization and/or provided education to the resident and/or their legal representative. - Review of Resident #5's medical record occurred on 12/05/18. The resident was admitted in 2015. The record showed Resident #5 received the PPSV23 vaccine on 03/09/11 (prior to admission), the record lacked evidence the	F 883	date of vaccination, declination or medical contraindication. These audits will be completed weekly x 3 months, then bi-monthly x 3 months and monthly x 6 months. These audits will be reported to the QA Committee for further evaluation and recommendations.	

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F 883	Continued From page 53 facility assessed the resident's pneumococcal immunization status for the PCV13 immunization and/or provided education to the resident and/or their legal representative. - Review of Resident #126's medical record occurred on 12/05/18. The resident was admitted in August 2018. The record lacked evidence the facility assessed the resident's pneumococcal immunization status on admission and provided education to the resident and/or their legal representative. The facility failed to follow their policy and the CDC recommendations for pneumoccal vaccine administration. During an interview on 12/05/18 at 11:30 a.m., an administrative nurse (#2) verified the facility failed to assess residents for pneumococcal immunization and/or follow the CDC recommendations for the pneumococcal vaccinations.	F 883		