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

RECEIVED
APR 27 2015
Division of Health Facilities

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 _____	04/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHARDTON HEALTH CENTER INC	212 3RD AVENUE WEST RICHARDTON, ND 58652

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey, started on 03/30/15 and completed on 04/01/15, the sample included 2 residents for complete review, 5 residents for focused review, and 1 closed record for review. The sample included 4 additional residents to verify specific concerns during the survey.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.	F 157	1. Facility is unable to correct deficient practice for the resident cited. 2. Any residents have the potential to be affected by this deficient practice. 3. Inservice training for all nursing staff will be held on proper procedure for reporting falls. All nurses will be trained in proper procedure and reporting that should be done to family and physicians. Training for pain assessment will also be done. 4. Quarterly Quality Assurance meetings will address both pain, falls and reporting issues. Any staff found deficient in practice will be retrained in proper reporting of falls to family and physicians as an on-going practice. DON will review pain assessments weekly to assure that any issues of pain being suffered by residents have been recognized and reported to their physician in a timely manner. 5. Inservice will be held on or before May 6, 2015 for all licensed nursing staff.	05/06/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Adm	4/22/15

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	Continued From page 1 The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 03/06/2014. Based on record review, review of facility policy, and staff interview, the facility failed to promptly notify a resident's representative and physician of pain following a fall for 1 of 1 closed records reviewed (Resident #8). Failure to notify a resident's representative and the physician of pain may result in delayed treatment and does not allow participation in the resident's care. Findings include: Review of the facility policy titled "Change in a Resident's Condition or Status" occurred on 04/01/15. This policy, dated April 2014, stated, ". . . facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status . . . The Nurse Supervisor/Charge Nurse will notify the resident's Attending Physician or On-Call Physician when there has been: . . . An accident or incident involving the resident; . . . the Nurse Supervisor/Charge Nurse will notify the resident's family or representative (sponsor) when resident is involved in any accident or incident . . . notifications will be made within twenty-four (24) hours of a change in the resident's medical/mental condition or status . . ."	F 157		

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F 157	Continued From page 2 - Review of Resident #8's medical record occurred on 04/01/15 and diagnoses included Alzheimer's disease and dementia. Medications included Aleve (generalized pain) 220 mg twice a day, Advil (generalized pain) 200 milligrams (mg) 2 tablets every six hours PRN (as needed), and Tylenol (generalized pain) 325 mg every four hours PRN. Review of Resident #8's progress notes showed the following: * 02/21/15 at 11:45 a.m., ". . . Resident noted to be sitting on her w/c (wheelchair) cushion, in the hallway, at the foot of her w/c. Assisted resident to stand, replaced cushion to w/c and helped her sit back down . . ." * 02/21/15 at 4:00 p.m., ". . . Resident is teary during her cares at this time, guarding her right side. We assisted her to bed and I palpated her abdomen. She did not indicate any discomfort until I lightly touched a lower rib toward the outer right side, at which time she grimaced, flinched sharply and said 'ow.' Will continue to monitor and report condition to physician." * 02/22/15 at 8:50 a.m., "Resident has been indicating intermittent pain in her right upper quadrant abdominal area. Is not able to verbalize feelings to staff, but she sneezed at breakfast and grimaced, holding her hand to her right upper abdominal quadrant . . ." * 02/22/15 at 10:08 a.m., ". . . She did frown slightly when I touched the rib area that seemed to cause her pain yesterday." * 02/22/15 at 9:42 p.m., "Got report that resident had decreased consciousness but normal v/s (vital signs) from day nurse. Will pass on to next day nurse to inquire about chest xray for possible broken right rib to clinic, or possibility of something more serious in the AM [sic] . . ."	F 157		

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F 157	Continued From page 3 * 02/23/15 at 12:00 p.m., "Received in morning report from night nurse that resident had an unresponsive episode over the weekend . . . Will continue to monitor and phone family and MD (Medical Doctor) of this issue." * 02/23/15 at 4:36 p.m., ". . . Phoned [name of nurse practitioner] NP (nurse practitioner) at clinic regarding residents condition; petechial rash noted to both legs and to right trunk area, paleness, weakness, increased diarrhea, and a decrease in oral intake and 'normal activity.' [name of NP] came over to assess resident and voiced she would like to start by getting a UA (urine analysis) and then proceed with stool samples, CBC (complete blood count), chemistry and a Vitamin K level . . ." * 02/23/15 at 4:52 p.m., "Resident's husband . . . here at this time to visit resident. Talked with residents husband concerning residents condition and recent doctors orders/recommendations and he agreed to do the UA and whatever other labs needed to be done. Clinic is now closed for the day, I will call [name of NP] tomorrow concerning this." * 02/24/15 at 8:03 a.m., "[name of NP] from clinic called at this time asking if residents husband had agreed to go forth with testing/labs . . ." Review of a . . . nurse practitioner progress note, dated 02/23/2015, stated ". . . history of present illness: . . . seen today due to a petechial rash . . . nursing staff states over the past several days they have noticed that she is not doing as well as she has in the past . . . Impression and Plan: Petechial rash . . . I did recommend further evaluation and her family did agree to lab testing . . ." There was no documentation or follow-up that staff notified the nurse practitioner of Resident #8's pain following the fall on 02/21/2015.	F 157		

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F 157	Continued From page 4 The facility staff failed to notify Resident #8's physician and representative immediately following her fall with pain on 02/21/15. Staff notified the resident's NP regarding her rash and change of status on 02/23/15, but failed to inform her of the fall on 02/21/15. During an interview on 04/01/15 at 2:00 p.m., a supervisory nurse (#5) stated the facility procedure following a fall included completing an incident report and if the resident experienced pain or injury, staff are to immediately notify the physician and family.	F 157		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).	F 225		

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F 225	Continued From page 5 The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy and procedure, and staff interview, the facility failed to immediately report incidents of alleged neglect or abuse and/or failed to report the results of the investigation to the State Survey and Certification Agency for 3 of 4 investigations reviewed. Failure to report violations involving alleged abuse has the potential to place all residents at risk of neglect or abuse. Findings include: Review of the facility policy titled "Reporting Abuse to State Agencies and Other Entities/Individuals" occurred on 04/01/15. This policy, undated, stated, ". . . All suspected violations and all substantiated incidents of abuse will be immediately reported to appropriate state agencies and other entities or individuals as may be required by law. . . . 1. Should a suspected violation or substantiated incident of	F 225	1. Facility is not able to correct the deficient practice of timely reporting, which has taken place. 2. All residents have the potential to be affected by this deficient practice. 3. An Abuse Manual has been put together with all pertinent phone numbers, facility policy, correct forms for reporting to State and correct forms for investigating any suspected cases of abuse, neglect, or misappropriation of resident property. Staff will be inserviced regarding reporting requirements and timely reporting to both the Administrator and DON as well as to the State. 4. The Quarterly Quality Assurance meeting will review all Resident Incident Reports. Monitoring of incident reports will begin immediately and be done by the Administrator continually on a daily basis for all incident reports. Administrator will oversee all reports made to State for timely completion by the investigating personne l. 5. Inservice will be held on or before May 6, 2015 for all staff.	05/06/15

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F 225	Continued From page 6 mistreatment, neglect, injuries of an unknown source, or abuse . . . be reported, the facility Administrator, or his/her designee, will promptly notify the following persons or agencies (verbally and written) of such incident: a. The State licensing/certification agency responsible for surveying/licensing the facility; . . . 2. Verbal/written notices to agencies will be made within twenty-four (24) hours of the occurrence of such incident . . . 3. The Administrator, or his/her designee, will provide the appropriate agencies or individuals listed above with a written report of the findings of the investigation within five (5) working days of the occurrence of the incident. . . ." - Review of the facility's investigations of abuse/neglect occurred on 04/01/15 at 7:30 a.m. and 1:30 p.m. and identified the following: * 07/26/14: The facility initially contacted the State Agency on 07/30/14 (four days after the incident). * 01/21/15: The facility failed to contact the State Agency and failed to submit results of the investigation. During interview on the afternoon of 04/01/15, an administrative staff member (#7) confirmed the facility did not report the incident to the State Agency. *01/27/15: The facility initially contacted the State Agency on 02/02/15 (six days after the incident) and failed to submit results of the investigation to the State Agency within five days.	F 225		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate	F 278		

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F 278	Continued From page 7 participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual Version 3.0, and staff interview, the facility failed to ensure the Minimum Data Sets (MDSs) accurately reflected the residents' status for 2 of 3 sampled residents (Resident #2 and #3) coded as having physical behaviors. Failure to correctly code the MDS does not provide an accurate assessment of the residents' current status and needs. Findings include:	F 278	1. Facility will submit a modified MDS for the two residents cited in the survey. 2. Any resident can be affected by an MDS which does not accurately reflect their condition and all residents with behaviors have been assessed for accurate MDS and modifications have been completed. 3. Staff will be inserviced on the correct manner in which an MDS is completed, where to look for documentation on various behaviors that should be reported on the MDS even if the staff reports verbally that they have observed certain behaviors. Matrix training for documentation is on going and involves both licensed and certified staff as well as other departments. All MDSs have been reviewed for accurate coding and documentation of behaviors and necessary modifications have been submitted on residents in addition to the two cited during survey. 4. Those managers who participate in the MDS process will verify	

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F 278	Continued From page 8 The Long-Term Care Facility RAI User's Manual Version 3.0, October 2014, Chapter 3, page E-5 stated, "E0200: Behavioral Symptom - Presence & [and] Frequency . . . Steps for Assessment: 1. Review the medical record for the 7-day look-back period. 2. Interview staff , across all shifts and disciplines, as well as others who had close interactions with the resident during the 7-day look-back period . . . 3. Observe the resident in a variety of situations during the 7-day look-back period. Coding Instructions . . . Code 1, behavior of this type occurred 1-3 days: if the behavior was exhibited 1-3 days of the last 7 days . . ." - Resident #2's medical record, reviewed on all days of survey, identified diagnoses including dementia with behavior disturbance. A quarterly MDS, dated 03/08/15, identified Resident #2 exhibited physical behaviors 1-3 days of the 7 day look-back period. Record review failed to identify the resident exhibited physical behaviors during the look-back period. - Resident #3's medical record, reviewed on all days of survey, identified diagnoses including senile dementia. A Significant Change in Status MDS, dated 03/10/15, identified Resident #3 exhibited physical behaviors 1-3 days of the 7 day look-back period. Record review failed to identify the resident exhibited physical behaviors during the look-back period. During an interview on 03/31/15 at 2:27 p.m., an MDS nurse (#13) stated the staff member (#8) completing Section E of the above MDSs visited with direct care staff regarding behaviors for	F 278	that documentation is in place before completing the MDS based solely on verbal reports and will discuss with the Director of Nursing any questions they may have regarding conditions of residents that have been verbally reported to them but for which they are unable to find proper documentation. 5. Correction is on-going. MDSs submitted over the next three months will be reviewed by two nurses ~~people~~ for accuracy and correct documentational support, particularly regarding behaviors. Results will be reported to the QA committee. Per tc 2 Linda Hill CED 4/28/15 9am (CT)	05/06/15

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F 278	Continued From page 9 Resident #2 and #3, but did not check the record to ensure the behaviors occurred during the 7-day look-back period.	F 278		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: TRANSCRIPTION OF PHYSICIAN'S ORDERS 1. Based on review of policy and procedure, record review, and staff interview, the facility failed to accurately transcribe physician's orders for 1 of 3 sampled residents (Resident #6) with orders to reduce the dose of psychotropic medication. Failure to accurately transcribe the physician's orders resulted in Resident #6 continuing to receive Lorazepam (an anti-anxiety medication) every night for approximately three months (December 11, 2014 - April 1, 2015) instead of on a PRN (as needed) basis. Findings include: Review of the facility policy titled, "Medication Orders" occurred on 04/01/15. The policy, dated 2006, stated, ". . . Procedures . . . 2. The following steps are initiated to complete documentation and receive the medications: a. Clarify the order. . . . c. Call, fax, or electronically transfer the medication order to the provider pharmacy. d. Transcribe newly prescribed medication on the MAR [medication administration record] . . ."	F 281	1. The resident on whom the order was incorrectly taken has been corrected. Resident who had a contaminated urine sample had the sample re-taken to be submitted. 2. All residents are or can be affected when orders are not transcribed properly or when testing material is not gotten properly. 3. All licensed staff will be inserviced regarding proper handling of doctor orders, entering them into Matrix and notification of changes to doctor orders. All licensed and certified staff will be inserviced on the proper and sanitary manner in which to obtain a urine sample. CNA staff will be overseen by the Charge Nurse for proper clean catch procedures and for proper handling of all urine samples going forward.	

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F 281	Continued From page 10 Review of the pharmacist's medication review progress note, dated 11/30/14, stated, "Irregularity: [Resident #6] may be due for gradual dose reduction trial of anxiolytics as defined by CMS [Centers for Medicare and Medicaid Services] guidelines. Patient currently takes lorazepam 0.5 mg [milligram] 1/2 tablet by mouth at bedtime. CMS recommends an annual review of anxiolytics and last dose reduction was successful January 2014. Suggested action: Consider a dose reduction to Lorazepam 0.5 mg 1/2 tablet by mouth at 2000 [8:00 p.m.] as needed for anxiety. I would suggest to evaluate effectiveness of change in 14 days. Thank you . . ." Resident #6's physician responded "Agree" to the pharmacist's recommendation on 12/11/14. A nurse signed off the order and entered the order in the computer on 12/11/14. The nurse entered the order for Lorazepam at bedtime daily, instead of "as needed," resulting in the resident receiving the medication at the same dose and time for approximately three months. During interview, the afternoon of 04/01/15, an administrative nurse (#5) confirmed staff had incorrectly transcribed the physician's order. COLLECTION OF URINE SAMPLE: 2. Based on observation, record review, review of facility policies and procedures, and staff interview, the facility failed to ensure staff followed facility policy when collecting a urine sample for 1 of 6 sampled residents (Resident #3) with a history of urinary tract infections (UTIs). Failure to follow appropriate technique when	F 281	4. Quality Assurance committee will review all doctor orders at their quarterly meetings to assure that orders are written properly and entered properly into Matrix. DON will monitor and report weekly to QA committee on doctor orders taken and that the order is correctly written and correctly entered into Matrix Nursing staff have been instructed to use two people to review orders for any issues to assure that orders are entered properly and that updates / changes to orders are made correctly. Quality Assurance will also review, quarterly, all UTI's and other infections to assure that proper sanitary techniques are being employed during procedures. 5. Re-training for nursing staff will take place before May 6, 2015 and will be on-going when / if errors are detected during the QA monitoring process.	05/06/15

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F 281	Continued From page 11 collecting a urine sample may result in contamination of the sample. Findings include: Review of the facility procedure "Clean Catch Urine Specimen" occurred on 04/01/15. The procedure, dated October 2010, stated, ". . . The purpose of this procedure is to collect a clean catch urine specimen for laboratory analysis. . . . Preparing the female resident: . . .b. Using a 4x4 sponge (4 x 4 inch gauze) soaked with an antiseptic or soap solution (or towelette), wipe [perineal area] from the front to the back on one side. Discard the sponge or towelette . . .c. Follow the same procedure for the other side . . . 9. Place the lid on the specimen container . . .12. Put the specimen container into the clear plastic bag. Seal the bag. . . ." Resident #3's medical record, reviewed on all days of survey, identified the physician treated the resident for UTIs on 01/23/15, 03/04/15 (at the hospital), and 03/20/15. In each case, the urine cultures identified Escherichia coli or Enterococcus (bacteria from the bowel) in the resident's urine. On 02/07/15 a urine culture identified "Multiple species present - probable contamination." Observation on 04/01/15 at 1:30 p.m. showed two Certified Nursing Assistants (CNAs) (#2 and #15) placed a urine collection container in the toilet then assisted Resident #3 to the bathroom using a sit-to-stand lift. When the CNA (#2) removed the resident's brief observation showed incontinence of urine and stool. Without cleansing her perineum, the CNAs lowered Resident #3 to the toilet. After Resident #3 voided and had a	F 281		

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	355122	A. BUILDING _____ B. WING _____	04/01/2015

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F 281	Continued From page 12 bowel movement, the CNAs assisted her to stand using the sit-to-stand lift. One CNA (#2) then provided perineal care, requiring multiple wipes to cleanse the stool from the perineum. After assisting the resident to her bed, the CNA (#2) poured urine from the collection container into a specimen container and, without placing the container in a plastic bag, took the specimen to the soiled utility room. At 2:00 p.m. observation showed the CNA (#2) brought the unbagged specimen to the nurses station, and handed it to a licensed nurse (#12), who placed in on top of papers lying on the desk. When interviewed, on 04/01/15 at 2:20 p.m., an administrative nurse (#5) confirmed Resident #3's urine specimen may have been contaminated during collection. The nurse then instructed staff to obtain a new specimen.	F 281		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT CITATION FROM THE SURVEYS COMPLETED ON 01/31/13 AND 02/06/14.	F 309		

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

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 309	Continued From page 13 SWALLOWING CONCERNS: 1. Based on observation, record review, and staff interview, the facility failed to ensure the resident received appropriate care and services to prevent aspiration for 1 of 3 sampled residents (Resident #2) with physician's orders for thickened liquids. Failure to ensure the resident received liquids in the consistency ordered by the physician resulted in the resident exhibiting signs of difficulty swallowing while drinking fluids. Findings include: Resident #2's medical record, reviewed on all days of survey, identified diagnoses including dyphagia (difficulty swallowing). A quarterly Minimum Data Set, dated 03/08/15, identified the resident required extensive assistance with eating. A physician's order, dated 07/17/14, stated, "Diet recommendation from speech therapy: pudding thick liquids and puree diet." The resident's care plan, dated 03/08/15, identified a problem: "Potential for Altered Nutritional Status R/T [related to] difficulty in swallowing, dx [diagnosis] dysphagia, and poor oral intake . . ." Approaches to the problem included: "Diet: Pureed diet with pudding thickened liquids. . . . monitor for difficulty swallowing . . . Monitor for signs and symptoms of aspiration pneumonia . . . Observe resident closely for signs of choking and/or aspiration. . . ." A "Speech Therapy Plan of Treatment for Dysphagia," dated 07/17/14, stated, " Pt. [patient] seen in her room for breakfast meal. . . . Pt. appears to have a delayed swallow. When given nectar liquids - pt coughed. It appears the liquid may be going to pharyngeal area before swallow	F 309	1. Resident #2 will be given properly thickened liquids as per orders. Resident #2 will receive proper BM management per standing orders. The deficient practice cited on resident #8 cannot be corrected as she is no longer here. 2. Any resident who suffers from dysphagia is at risk for aspiration if properly thickened liquids are not supplied to them. Any resident who is not monitored for regular BM's is at risk for constipation. Any resident who complains of pain and does not receive proper intervention is not having pain control. 3. All certified, licensed and dietary staff will receive re-training in how to properly thicken liquids. All nursing staff will be inserviced on proper bowel management practice and on pain management protocol. 4. Nurses will make a practice of checking water in the rooms of residents with dysphagia and will assure that liquid is the proper consistency. Nurse will also monitor special liquid during meals to see that thickening has been done properly. DON will monitor bowel management and counsel nursing staff regarding	

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F 309	Continued From page 14 has occurred putting pt. at high risk for aspiration for thin/nectar liquid consistencies. Pt. tolerated pudding thick liquids. A cough was noted after meal." Observations during the survey showed the following: * 03/30/15 at 12:20 p.m.: Resident #2 seated at a table near the nurses' station and assisted by an administrative nurse (#5). The resident consumed pudding thick liquids with no signs of difficulty swallowing. * 03/30/15 at 1:20 p.m.: A Certified Nursing Assistant (CNA) (#3) offered Resident #2 water in her room. Observation showed the water thickened, but not to pudding consistency. The resident coughed when consuming the water. * 03/31/15 at 8:30 a.m.: Resident #2 seated in the dining room and feeding herself. Observations showed the liquids thickened but not to pudding consistency. The resident exhibited frequent coughing and throat clearing when consuming the liquids. * 03/31/15 at 9:40 a.m.: A CNA (#1) offered Resident #2 water in her room. The resident coughed when consuming the water. The CNA stated, "Don't choke. Her water is too thin. Whoever made it, it's too thin." When asked who prepares the water for the resident's room, the CNA (#2) stated CNAs thicken the water for the residents' rooms. She stated instructions for thickening liquids are printed on the container of thickener. * 03/31/15 at 12:35 p.m.: Resident #2 seated near the nurses's station and assisted by a CNA (#16). Observation showed the liquids thickened, but not to pudding consistency. Resident #2 exhibited frequent coughing and a wet sounding voice when consuming the liquids.	F 309	proper procedures if / when a resident experiences constipation. All nurses will complete pain assessments on residents who exhibit signs of pain, particularly after a fall, after being admitted from a hospital, after having had pain symptoms reported to them by other staff members, and on any resident who is behaving in a manner to suggest they should be assessed for pain. Quality Assessment team will also receive quarterly reports regarding dietary orders, bowel training and pain assessment training that may be necessary if / when errors are detected. 5. Correction is immediate and on-going. Dietary Manager will hold an inservice before May 6, 2015 for education / re-education of nursing and dietary staff on thickened liquids. Inservice will be held on the proper protocol for constipation. Inservice will be held on pain management and pain assessments.	05/06/15

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F 309	Continued From page 15 During an interview on 03/31/15 at 1:45 p.m., a dietary supervisor (#17) stated dietary staff thicken the liquids for the residents' meals and nursing staff thicken the liquids for the residents' rooms. She confirmed Resident #2's liquids should be pudding thick. BOWEL MANAGEMENT: 2. Based on record review and staff interview, the facility failed to provide the necessary care and services to manage constipation for 1 of 5 sampled residents (Resident #2) with a diagnosis of constipation. Failure to develop and implement a bowel management program may have contributed to Resident #2 requiring suppositories and digital removal of stool and has the potential to result in fecal impaction. Findings include: Resident #2's medical record, reviewed on all days of survey, identified a diagnosis of constipation. A quarterly Minimum Data Set, dated 03/08/15, identified the resident always incontinent of bowel and required total assistance of two or more persons with toileting. The resident's care plan, dated 03/08/15, identified a problem: "Potential of Altered Nutritional Status R/T [related to] . . . poor oral intake . . ." Approaches to the problem included: "Natural Laxative prn [as needed] (fruit ball, prune juice) for dx [diagnosis] constipation. . . ." Physician's orders identified the following bowel medications: 09/20/14: Milk of Magnesia (MOM) 30 milliliters (ml) as needed	F 309		

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F 309	Continued From page 16 09/20/14: Dulcolax suppository 10 milligrams (mg) as needed 09/27/14: Senna Plus 8.6-50 mg daily 01/13/15: MiraLax powder 17 grams daily Orders for the "as needed" medications failed to identify at what point (number of days without a bowel movement) staff should administer the medication. Resident #2's progress notes, bowel records, and medication administration records (MARs) identified the following: * 12/15/14 at 3:21 a.m.: Dulcolax suppository administered on the seventh day without a bowel movement (BM). The MAR stated "somewhat effective . . . had to be digitally removed on 12/16/14." The record lacked evidence staff attempted less invasive interventions prior to administering the suppository. * 12/24/14 at 1:24 p.m.: Dulcolax suppository administered on the eighth day without a BM. Progress notes on 12/24/15 at 1:00 p.m. stated staff administered prune juice and MOM with "no results" however, the MAR lacked evidence staff administered the MOM. * 01/13/15 at 12:10 p.m.: Dulcolax suppository administered on the seventh day without a BM. The record lacked evidence staff attempted less invasive interventions prior to administering the suppository. A physician's note, dated 01/13/15 stated, "Patient still is having trouble with constipation. Nurses have tried almost everything. They have tried Dulcolax suppositories 10 mg, but even with that she throws up after she has a suppository, because of the central nervous effect from it. We are going to try Miralax 17 grams daily. . . ." During an interview on 04/01/15 at 10:00 a.m. an	F 309		

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F 309	Continued From page 17 administrative nurse (#5) stated the facility does not have a bowel management program. She stated staff follow the standing orders for bowel medications. Review of the physician's standing orders, dated 12/11/14, identified the following bowel medications: Senna 8.6 mg daily as needed MOM 30 ml three times a day as needed Dulcolax suppository rectally if greater than four days since a BM Fleets Enema rectally if greater than four days since a BM Failure to develop and implement an individualized bowel management plan for Resident #2 resulted in the resident requiring suppositories and, at one point, digital removal of stool after an extended period without a bowel movement. PAIN CONTROL 3. Based on record review and staff interview, the facility failed to ensure 1 of 1 closed record reviewed (Resident #8) received the necessary services for comfort from pain. Failure to provide pain management measures for Resident #8's recurrent verbal reports of pain may affect the resident's quality of life. Findings include: -Review of Resident #8's medical record occurred on 04/01/15. Resident #8's medical diagnoses included Alzheimer's disease and dementia. Medications included Advil (generalized pain) 200 milligrams (mg) 2 tablets every six hours PRN (as	F 309		

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F 309	Continued From page 18 needed), Tylenol (generalized pain) 325 mg every four hours PRN, and Aleve (generalized pain) 220 mg twice a day. Resident #8's current care plan stated, ". . . Problem . . . Pain . . . Goal . . . will not exhibit any non-verbal signs of pain . . . Approach . . . Administer medications per MD (Doctor of Medicine) order. Evaluate effectiveness of pain management interventions, Adjust if ineffective . . ." Review of Resident #8's progress notes showed the following: * 02/21/15 at 4:00 p.m., ". . . Resident is teary during her cares at this time, guarding her right side. We assisted her to bed and I palpated her abdomen. She did not indicate any discomfort until I lightly touched a lower rib toward the outer right side, at which time she grimaced, flinched sharply and said 'ow.' Will continue to monitor and report condition to physician." * 02/22/15 at 8:50 a.m., "Resident has been indicating intermittent pain in her right upper quadrant abdominal area. Is not able to verbalize feelings to staff, but she sneezed at breakfast and grimaced, holding her hand to her right upper abdominal quadrant . . ." * 02/22/15 at 10:08 a.m., ". . . She did frown slightly when I touched the rib area that seemed to cause her pain yesterday." * 02/22/15 at 9:42 p.m., "Got report that resident had decreased consciousness but normal v/s (vital signs) from day nurse. Will pass on to next day nurse to inquire about chest xray for possible broken right rib to clinic, or possibility of something more serious the AM [sic] . . ." Review of Resident #8's PRN medication	F 309		

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F 309	Continued From page 19 administration history report, dated February 01-28, 2015 showed the facility staff provided no PRN medications for pain from February 21-24, 2015. During an interview on 04/01/15 at 2:00 p.m., a supervisory nurse (#5) stated the facility staff should have given Resident #8 PRN pain medication when the resident displayed pain. The facility failed to manage Resident #8's pain by not administering PRN pain medication.	F 309		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide the necessary interventions to prevent the development/reoccurrence of pressure ulcers for 3 of 6 sampled residents (Resident #1, #3, and #5) at risk for pressure ulcers. Failure to implement preventative measures may result in the reoccurrence of pressure ulcers. Findings include:	F 314		

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F 314	Continued From page 20 Review of the facility policy titled "Repositioning" occurred on 04/01/15. This policy, dated April 2013, stated, ". . . Purpose . . . to aid in the development of an individualized care plan for repositioning, to promote comfort for all bed or chair-bound residents and to prevent skin breakdown, . . . and provide pressure relief for residents . . . General Guidelines . . . Repositioning is a common, effective intervention for preventing skin breakdown . . . and providing pressure relief . . . Repositioning is critical for a resident who is immobile or dependent on staff for repositioning . . . Residents who are in a chair should be on an every one hour (q 1 hour) repositioning schedule . . ." -Review of Resident #1's medical record occurred on March 30-31, 2015. Diagnoses included history of right heel pressure ulcer, dementia, and Alzheimer's disease. The quarterly Minimum Data Set (MDS), dated 12/22/14, and the Annual MDS, dated 04/15/14, identified extensive to total assistance for transfers, toilet use, and personal hygiene. Resident #1's current care plan stated, ". . . Problem . . . Resident requires extensive to total assist with ADL's [activity of daily living] . . . Problem . . . Pressure Ulcer . . . Resident is at risk for pressure ulcers due to extensive to total assist with mobility . . . Approach . . . Float heels with pillows to relieve pressure on the heels when in bed. Blue booties to feet . . . turn and reposition every 2-3 hours . . ." Review of Resident #1's weekly pressure ulcer record identified the following: * 01/18/15: "stage I . . . area noted to right outer	F 314	1. Facility will position / reposition residents #1, #3 and #5 in the manner and at the times specified in the Plan of Care. 2. Any resident who is unable to turn and reposition themselves is at risk for skin breakdown. 3. All residents who have been assessed as at risk for skin breakdown and who need assistance with repositioning themselves will be monitored every two hours for repositioning and documentation will be done. Special needs such as pillows will be monitored every two hours. 4. The DON and the nurse will monitor any resident at risk who is care planned to be turned and repositioned timely and will monitor any devices (booties, pillows, cushions, mattresses) for proper compliance with the care plan on a daily basis. Quality Assurance members will monitor skin issues at all meetings and determine whether further measures should be in place to prevent breakdown or if the measures that are in place are adequate.	

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F 314	Continued From page 21 heel to be blotchy pink to dark red in color . . . 1.2 x 2 cm [centimeter] . . ." * 02/01/15: "stage I . . . 2 areas to right heel area to bottom of heel pink in appearance and measures 4 cm x 3 cm area . . . directly to right side of heel measures 1.7 cm x 1.2 cm, brownish/scabbed appearance . . ." * 02/13/15: "stage I . . . bottom of right heel is scarring from previous ulcer measures 4x3. To right side back area of right heel measures 1.2 x 1 cm. Area is scabbed . . ." * 02/21/15: ". . . stage I . . . 1.2 x 1 cm . . . same as describe in previous entry . . ." Observation showed the following: * 03/30/15 at 11:52 a.m.: resident in bed sleeping with heels resting directly on the bed. Bilateral blue booties in place, no pillow noted under the heels while in bed. * 03/31/15 at 9:16 a.m.: resident transferred from wheelchair to bed by certified nursing assistants (CNAs) (#1 and #2). The CNAs turned the resident to lay on his side. The CNA (#2) adjusted the resident's support stockings and reapplied the blue booties. The resident's right heel red in color with no open area noted. No pillow noted under the heels. * 04/01/15 at 1:30 p.m.: resident sleeping in bed, laying on his side with no pillow under his heels. The facility failed to provide Resident #1 the necessary preventative measures, as identified in his care plan. Resident #1 is at risk for and had a history of pressure ulcers. - Review of Resident #5's medical record occurred on March 30-31, 2015. Diagnoses included history of pressure ulcers, dementia, and cerebrovascular weakness. The quarterly MDS,	F 314	5. Training is on-going and staff will be inserviced before May 6, 2015 on review of Care Plan, proper use of aids in positioning and reasons for additional equipment for at risk residents.	05/06/15

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F 314	Continued From page 22 dated 12/29/2014, and the annual MDS, dated 06/29/2014, identified the resident as at risk for developing pressure ulcers and required extensive to total assistance for transfers, toilet use, and personal hygiene. Resident #5's current care plan stated, ". . . Problem . . . Pressure Ulcer . . . Resident is at risk for pressure ulcers R/T [related to] history of pressure ulcers . . . Approach . . . Proper foot support provided while up in Broda chair when feet are not touching foot rest. Pillows between back of foot rest and legs . . . Turn and reposition every 2-3 hours while in bed. Float heels with pillows to relieve pressure on the heels when in bed. Blue booties to feet . . . turn and reposition every 2-3 hours . . . turning and reposition schedule . . ." Observation showed the following: 03/30/15: * 12:00 p.m.: Resident #5 seated in wheelchair in dining room. No pillow between the back of the foot rest and his legs. Bilateral blue booties noted on feet. Resident #5's heels rested directly on the leg rest. * 1:25 p.m.: Resident #5 seated in wheelchair in the living room. Resident's right heel rested directly on the back of the leg rest, bilateral blue booties in place. No pillow between the back of the foot rest and his legs. * 3:20 p.m.: Resident #5 sat in same position since 12:00 p.m. Resident's right heel rested directly on top of left foot, bilateral blue booties in place. No pillow between back of the foot rest and his legs. 03/31/15: * 7:25 a.m.: Resident #5 seated in wheelchair in living room. Resident has bilateral blue booties	F 314		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 23 on, no pillow between back of the foot rest and his legs, and bilateral heels rested directly on the back of leg rest. *11:25 a.m.: Resident seated in wheelchair at dining room table in same position. * 3:15 p.m.: The CNAs transferred the resident from the bed to his wheelchair and then transferred him to the living room. The resident's heels rested directly on the back of the wheel chair. Bilateral blue booties were in place, no pillow placed behind the resident's legs or heels. * 4:55 p.m.: Resident #5 sat in his wheelchair in living room with bilateral blue booties on, no pillow in place, and both heels rested directly on the back of the leg rest. 04/01/15: * 12:42 p.m.: Resident #5 sat in his wheelchair in living room, no pillow in place, and both heels rested directly on the wheelchair leg rest. * 2:35 p.m.: Resident #5 sat in his wheelchair in living room in same position as seen at 12:42 p.m.. No pillow in place, and both heels rested directly on the back of the leg rest. During an interview on 04/01/15 at 2:00 p.m., a supervisory nurse (#5) stated Resident #5's heels should not be resting directly on the chair or foot board. She stated that staff are responsible for making sure the resident is repositioned when sitting in the wheelchair for long periods of time. Failure of facility staff to provide appropriate/adequate pressure relief to Resident #5's legs and feet placed the resident at risk of skin breakdown. - Resident #3's medical record, reviewed on all days of survey, identified diagnoses including senile dementia, chronic pain, and rheumatoid	F 314		

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	355122	A. BUILDING _____ B. WING _____	04/01/2015

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F 314	Continued From page 24 arthritis. A Significant Change in Status Minimum Data Set, dated 03/10/15, identified the resident required total assistance of two or more persons with transfers and toileting and at risk for pressure ulcers. The residents care plan, dated 03/10/15, identified a problem: "Resident is at risk for potential skin integrity impairment due to aging, health problems and limited mobility." Approaches to the problem included: ". . .Turn and reposition as per standard of care and nursing home policy. . . . Use lifting device hoyer [full body lift] to move resident in and out of bed. . . ." The "Mini Care Plan," used by Certified Nursing Assistants (CNAs) when providing care, stated, "Turn & [and] change Q [every] 2 h [hours]." Observations on 03/31/15 showed the following: * 7:43 a.m.: Two CNAs (#2 and #16) transferred Resident #3 from the bed to her wheel chair with a Hoyer lift and transported her to the dining room. * 9:50 a.m.: Resident #3 seated in the wheel chair in the lounge. A CNA (#2) stated they may not toilet the resident this morning due to her weakness and needing the Hoyer lift. * 12:20 p.m.: Resident #3 seated in her wheel chair in the dining room. * 2:12 p.m.: Two CNAs (#2 and #1) transported Resident #3 to her room and assisted her to bed with the Hoyer lift, approximately 6 1/2 hours after the CNAs first assisted the resident to her chair. Failure to reposition Resident #3 every two hours, as identified in her care plan, placed the resident at risk for impaired skin integrity and may result in the development of a pressure ulcer.	F 314		
F 322	483.25(g)(2) NG TREATMENT/SERVICES -	F 322		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 322 SS=D	Continued From page 25 RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that -- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to administer a bolus feeding and medications per gastrostomy tube according to policy during 2 of 2 observations (03/30/15 at 1:40 and 2:10 p.m.) of medication/feeding for 1 of 1 supplemental resident with a gastrostomy tube (Resident #10). Failure to follow gastrostomy tube procedures for feeding and medication administration has the potential to cause complications for the resident. Findings include:	F 322	1. The facility will assure that the bolus feeding and medications per gastrostomy tube are correctly administered to resident #10 as Interim DON has met individually with all staff nurses regarding proper procedures. 2. Any resident with a gastrostomy or naso gastric tube is at risk when cares are not performed properly. 3. All staff will be trained in proper administration of medication through the gastrostomy tube of any resident who has one. The policy will be given to all nursing staff to read and sign off on. The Director of Nursing or RN will oversee the first three administrations of medication through the tube on new employees to be certain they understand the procedure and are practicing the proper methods of administration. Director of Nursing will intermittently observe all nursing staff during this procedure to verify that they have proper training. Results of monitoring will be reported to the Quality Assurance committee.	

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F 322	Continued From page 26 Review of the facility policy titled "Administering Medication through an Enteral Tube" occurred on 04/01/15. This policy, dated 07/09/14, stated, ". . . 2. Do not add medication directly to the enteral feeding formula. 3. Do not mix medications together prior to administering through an enteral tube. Administer each medication separately. . . . 6. Dilute medications and flush the tube with room temperature or warm sterile water. . . . 18. For nasogastric (NG) and gastrostomy (G) tubes, check tube placement: . . . b. Observe for signs of respiratory distress. c. Auscultate the abdomen, but do not rely on this as the singular method to differentiate between respiratory, gastric, esophageal and bowel placement: (1) Attach 60 ml syringe containing approximately 10 cc [cubic centimeter] air. (2) Auscultate the abdomen (approximately 3 inches below the sternum) while injecting the air from the syringe into the tubing. (3) Listen for 'whooshing' sound to check placement of the tube in the stomach. d. Check pH of aspirate . . . 19. If any of the above suggests improper tube positioning do not administer feeding or medication. Notify the Charge Nurse or Physician. . . . 21. When correct tube placement . . . have been verified flush tubing with 15-30 ml [milliliter] warm sterile water (or prescribed amount). . . . 23. Dilute the crushed or split medication with 15-30 ml sterile water (or prescribed amount). . . . 25. Administer the medication by gravity flow. Pour diluted medication into the barrel of the syringe while holding the tubing slightly above the level of insertion. . . . Clamp tubing (or begin flush) before the tubing drains completely. 26. If administering more than one medication, flush with 5 ml (or prescribed amount) warm sterile water between medications. 27. When the last of the medication begins to drain from the tubing, flush the tubing	F 322	4. Quarterly Quality Assurance meetings will monitor aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities and nasal-pharyngeal ulcers for indications that gastrostomy tube administration of medication is being done properly. If symptoms of any of these conditions are noted further investigation will be done by DON to determine whether the issue is caused by improper gastrostomy tube administration of medications. 5. The Interim Director of Nursing has inserviced all nursing staff on the proper technique for administering medications via the gastrostomy tube.	05/06/15

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F 322	Continued From page 27 with 15-30 ml of warm sterile water (or prescribed amount). . . ." - Observation on 03/30/15 at 1:40 p.m., showed the nurse (#9) crushed 12 medications together, mixed the crushed meds in approximately two teaspoons of yogurt, and diluted this mixture in 90 to 120 ml of tap water. The nurse connected the G-tube extension and a 60 ml syringe to Resident #10's G-tube port. The nurse (#9) administered the resident's medication and bolus feeding in the following order: bolus feeding, medication mixture, bolus feeding, mixed feeding with the medication mixture, remainder of the medication mixture, and the last of the bolus feeding. The first and second bolus feeding and the first medications administered flowed by gravity. After mixing the medications and feeding, the nurse (#9) inserted the plunger into the syringe to push in the medication/feeding mixture. The nurse drew up the last feeding into the syringe and pushed the feeding into the G-tube. The nurse then disconnected the syringe and G-tube extension. The nurse (#9) failed to check placement of the G-tube, failed to provide a water flush before administering the feeding, failed to administer the medications separately, failed to flush between the bolus feeding and the medication mixture administration, and failed to flush the tube at the end of the procedure. Observation on 03/30/15 at 2:10 p.m., showed the nurse (#9) obtained 10 ml of liquid docusate sodium to administer to Resident #10. The nurse added water to the docusate for a total of approximately 50 ml. The nurse (#9) attached the G-tube extension and a 60 ml syringe to Resident	F 322		

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F 322	Continued From page 28 #10's G-tube port. The nurse (#9) poured the liquid into the syringe, inserted the plunger, and pushed in the medication. The nurse then disconnected the syringe and G-tube extension. The nurse (#9) failed to flush before and after administering the medication. During an interview on 04/01/15 at 11:40 a.m., an administrative nurse (#5) confirmed the facility expects staff to check placement of G-tubes, to administer G-tube medications separately and to administer medications and bolus feedings with proper flushing as per policy.	F 322		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to ensure staff utilized the appropriate assistive device for transfers for 1 of 3 sampled residents (Resident #3) identified as transferred with a Hoyer (full body) lift. Failure to transfer the resident as identified in the care plan placed Resident #3 at risk of an injury. Findings include:	F 323		

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F 323	Continued From page 29 Review of the facility policy "Safe Lifting and Movement of Residents" occurred on 04/01/15. The policy, dated August 2009, stated, ". . . In order to protect the safety and well-being of staff and residents, and to promote quality care, this facility uses appropriate techniques and devices to lift and move residents. . . . . 3. Nursing staff, in conjunction with the rehabilitation staff, shall assess individual residents' needs for transfer assistance on an ongoing basis. Staff will document resident transferring and lifting needs in the care plan. . . ." Resident #3's medical record, reviewed on all days of survey, identified diagnoses including senile dementia, chronic pain, rheumatoid arthritis, and osteoporosis. A Significant Change in Status Minimum Data Set, dated 03/10/15, identified the resident required total assistance of two or more persons with transfers and toileting. The resident's care plan, dated 03/10/15, identified a problem: "Resident is at risk for potential skin integrity impairment . . ." Approaches to the problem included: ". . .Use lifting device Hoyer to move resident in and out of bed. . . ." and "Resident requires extensive to total assist with ADL's [Activities of Daily Living]." Approaches to the problem included: Transfer with full/Hoyer lift and 2 staff members. . . ." The "Mini Care Plan," used by Certified Nursing Assistants (CNAs) when providing care, stated, "2 Assist w [with] /Hoyer." A therapy "Staff Instruction Sheet," completed by a Physical Therapist (PT) and dated 03/23/15, stated, "May use E-Z Stand [sit-to-stand] lift to transfer resident if she is alert, cooperative & [and] demonstrates ability to weight bear with transfer. If resident is not able to stand in E-Z	F 323	1. The facility has corrected the manner in which the cited resident is transferred per the Care Plan that is via Hoyer. 2. Any resident is at risk if they are not transferred in the manner and with the equipment which has been determined to be safest for them. 3. All new residents will be assessed for the correct type of transfer that will be safest and most effective for their level of competence. Residents will be reassessed upon a change in condition, a hospital stay or other significant event to determine whether the method of transfer currently care planned is safest and most effective for them. 4. The nurse will monitor all residents after any significant event to determine that they have been assessed for the correct method of transfer and all care plans will reflect the correct method of transfer. No resident will be assessed for more than one method of transfer. DON will monitor transfers on an on-going basis to assure Care Plans are followed. 5. Training is on-going. Inservice will be held for nursing staff before May 6, 2015.	05/06/15

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F 323	Continued From page 30 Stand when up and hangs on her armpits it is not safe to transfer her in this fashion & staff should use hoyer lift. . . ." This instruction sheet conflicts with the resident's care plan which identifies staff should transfer the resident with a Hoyer lift. Observations during the survey identified the following: 03/30/15: * 2:45 p.m.: Two CNAs (#2 and #3) assisted Resident #3 to the bathroom using an E-Z Stand lift. One CNA (#2) stated, "Should we have the Hoyer here just in case?" Following toileting, the CNAs transferred Resident #3 to her bed with the E-Z Stand lift. During the transfer, the resident did not stand upright, as her knees were bent and her arms out to the side, with her elbows above her shoulders. A CNA (#2) stated if the resident is "really weak" staff use the Hoyer lift. 03/31/15: * 7:43 a.m.: Two CNAs (#2 and #16) transferred Resident #3 from the bed to her wheel chair with a Hoyer lift and transported her to the dining room. * 2:12 p.m.: Two CNAs (#2 and #1) transported Resident #3 to her room and assisted her to bed with the Hoyer lift. One CNA (#2) stated staff use the Hoyer as needed. "When she's strong she goes to the toilet." The CNA stated staff can ask the licensed nurse for advice. She stated this morning the resident did not sit well so they used the Hoyer. 04/01/15: * 9:55 a.m.: Two CNAs (#2 and #15) assisted Resident #3 out of bed with a Hoyer lift. The CNA (#2) stated they used the Hoyer because the resident was weak today. * 1:30 p.m.: Two CNAs (#2 and #15) assisted Resident #3 to the bathroom using an E-Z Stand	F 323		

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F 323	Continued From page 31 lift. The CNA (#2) stated, "If she doesn't stand, we'll put her back down." Observation showed the resident incontinent of urine and stool. The CNAs stood Resident #3 in the lift to provide perineal care. Observation showed the resident unable to stand erect and her elbows went outward and upward above her shoulders. The CNAs (#2 and #15) lowered her to the toilet. After allowing the resident to rest for a few minutes, the CNAs again stood her in the lift and provided more perineal care. Again, the resident was unable to stand in an erect position and the CNAs lowered her to the toilet. The CNAs stood Resident #3 for a third time and one CNA (#2) stated, "Let's just get her down." The resident did not stand upright, her knees were bent and her arms were up and out to the side as the CNAs transported her to her bed. As the CNAs lowered the resident to her bed the resident stated, "Ow, Ow, Ow, Ow, my leg!" and pointed to her right leg. The CNAs then assisted the resident to lie down on her bed. During an interview on 04/01/15 at 10:30 a.m. an administrative nurse referred to the PT Staff Instruction Sheet dated 03/23/15 and stated CNAs will sit Resident #3 at the edge of the bed to determine which lift to use. If the resident sits well, staff will use the E-Z Stand and if she doesn't sit well they will use the Hoyer. The facility failed to ensure a licensed nurse assessed the resident to determine the appropriateness of transferring Resident #3 with the E-Z stand lift to prior to the CNAs completing the transfer. Failure to use the Hoyer lift for all transfers, as identified in the care plan, placed Resident #3 at risk for an injury.	F 323		
F 329	483.25(l) DRUG REGIMEN IS FREE FROM	F 329		

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F 329 SS=D	Continued From page 32 UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to implement non-pharmacological interventions and assess the necessity of pain medication for 2 of 4 residents sampled (Residents #1 and #2) receiving antianxiety medication in conjunction with pain medication. Failure to implement non-pharmacological interventions and/or administering pain medication in conjunction with	F 329	1. The residents affected by the deficient practice will receive correct medication for their assessed condition. 2. Any resident for which antianxiety and pain management medications are prescribed are at risk for unnecessary drugs being given. 3. Nursing staff will be educated regarding assessment of pain and assessment of the effects of medications. Nurses will be educated regarding documentation of results of antianxiety medication on the resident. They will be educated regarding documentation of results pain (narcotic) medication on the resident as well. Nurses will also be educated regarding non-pharmacological interventions and assessment of same prior to administration of medication. Nurses will also be educated regarding the separate use of pain and anti-anxiety medications, not the mixture of them. DON will monitor weekly and report monthly to QA Committee regarding education outcomes.	

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FORM APPROVED
OMB NO. 0938-0391

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F 329	Continued From page 33 anti-anxiety medication may have resulted in the residents receiving unnecessary medications. Findings include: Review of Resident #1's medical record occurred on March 30-31, 2015. Diagnoses included dementia, Alzheimer's disease, anxiety, parkinsonism, chronic pain, and hallucinations. The quarterly Minimum Data Set (MDS), dated 12/22/14 and the Annual MDS, dated 04/15/14, identified delirium, mood &[and] behaviors, and pain. The current care plan, dated 01/03/14, stated, ". . . Problem . . . Behavioral Symptoms . . . Resident yelling out, rumination and demanding . . . Goal . . . needs will be met . . . Approach . . . Attempt to identify resident's current needs . . . May use sensory approach when resident displays behaviors such as lavender oil . . . Treat pain - see if that helps overall discomfort/frustration . . ." Review of Resident #1's medication administration record (MAR) from September 2014 - March 2015 identified Ativan tablet 1 milligram (mg) by mouth every 2 hours PRN for anxiety or restlessness and Percocet tablet 5-325 mg every 6 hours PRN for pain. The MAR and nursing progress notes indicated nursing staff administered PRN Percocet in conjunction with PRN Ativan before implementing non-pharmacological interventions or assessing for pain and the effectiveness of pain medication before administering the PRN anti-anxiety medication: * 7 out of 13 times in September 2014 * 3 out of 16 times in October 2014 * 3 out of 10 times in November 2014 * 5 out of 9 times in December 2014	F 329	4. During the quarterly Quality Assurance meetings all antianxiety and pain medication prescriptions will be reviewed and proper documentation will be evaluated. If deficient assessments are found staff will re-educate regarding assessing effects before giving additional and perhaps unnecessary medications. 5. Training and education is on-going and all nurses will be inserviced before May 6, 2015.	05/06/15

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F 329	Continued From page 34 * 1 out of 5 times in January 2015 * 2 out of 3 times in February 2015 * 12 out of 13 times in March 2015 During an interview, on 04/01/15 at 2:00 p.m., a nurse supervisor (#5) indicated nursing staff should implement non-pharmacological interventions for pain. She stated if staff give PRN pain medication, the nurse should assess the effectiveness of that medication before administering the PRN anti-anxiety medication. The nursing progress notes did not consistently identify documentation of interventions and effectiveness of PRN pain medications to determine if pain was a causative factor of the resident's behaviors before administering a PRN anti-anxiety medication. Failure to assess and determine if the resident required pain medication or an antianxiety medication, administer the appropriate medication, and assess the response resulted in Resident #5 receiving unnecessary medications. - Observation on all days of survey showed Resident #2 called out "Help me, help me" nearly continuously when out of bed, but quieter when in bed. Resident #2's medical record, reviewed on all days of survey, identified diagnoses including dementia with behavior disturbance, depressive disorder, and chronic pain. A quarterly Minimum Data Set (MDS), dated 03/08/15, identified the resident had short and long term memory problems and moderately impaired decision making skills. The resident's care plan, dated 03/08/15, identified a problem: "Resident has	F 329		

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F 329	Continued From page 35 difficulty making self understood or understanding others." Approaches to the problem included: "Monitor behaviors and mood to see if they indicate an acute need . . . and intervene prn [as needed]." and "Resident continually yells out the same phrase such as 'Help me, help me.' Yells continuously during group programs and impairs residents enjoyment of the activity." Approaches to the problem included: "Staff will provide programs of interest . . ." Physician's orders included: 08/05/14: Ativan (lorazepam) 0.5 mg every four hours as needed (the order failed to specify the indication for use of the Ativan) 06/09/14: Narco (hydrocodone-acetaminophen) 5/325 mg one tablet every six hours as needed for pain (discontinued on 02/27/15) Review of Resident #2's MARs for December 2014 - March 2015 identified staff administered Ativan and Narco together without first assessing to determine if the resident required a pain medication or an antianxiety. The MARs indicated staff administered the Narco for "Pain." The record lacked evidence staff assessed the effectiveness of the pain medication prior to administering the Ativan: * 16 of 18 times in December 2014 * 17 of 17 times in January 2015 * 3 of 3 times in February 2015 During an interview on 04/01/15 at 10:40 a.m. an administrative nurse (#5) stated staff administered the Narco and Ativan together to control Resident #2's pain. Failure to assess and determine if the resident required pain medication or an antianxiety	F 329		

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F 329	Continued From page 36 medication, administer the appropriate medication, and assess the response resulted in Resident #2 receiving unnecessary medications.	F 329		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, record review, facility policy review, and staff interview, the facility failed to ensure a medication error rate of less than five percent affecting 3 of 8 residents (Resident #3, #10 and #11) observed during medication pass. Failure to provide medication by the right time or technique (Resident #3 and #10) and to follow the physician order (Resident #11) may adversely affect the desired benefits of the medications or cause unwanted side effects. Six errors occurred during staff administration of 33 medications, which resulted in an 18 percent error rate. Findings include: Review of the facility policy titled "Administering Medications" occurred on 04/01/15. This policy, dated 05/21/14, stated, ". . . 3. Medications must be administered in accordance with the orders, including any required time frame. 4. Medications must be administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders). . . ." Review of the facility policy titled "Administering	F 332	1. Facility will assure that medications for residents #3 and #10 are given at the correct time and using the correct technique and the physician order for resident #11 will be followed. 2. All residents can be affected by medications given incorrectly. 3. Employees will be trained in the correct administration of medications upon hire by the Director of Nursing or an RN. DON or designated RN will monitor the various medication passes for 30 days beginning immediately to assure that staff has been correctly trained and understand the proper manner in which medications are given, including but not limited to medications given through a tube and medications that must be given only after blood pressure has been verified. 4. Over a three month period Director of Nursing or designated RN will observe three medication passes on each nurse employed. Quality Assurance committee will receive a report regarding the results of	

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F 332	Continued From page 37 Oral Medications" occurred on 04/01/15. This policy, dated 07/09/14, stated, ". . . 13. Perform any pre-administration assessments. . . ." - Observation on 03/30/15 at 1:35 p.m., showed the nurse (#9) administered a nasal inhalant, Flonase, to Resident #3. Review of the physician order identified staff are to administer the medication at 12:00 p.m. Per facility policy, the nurse (#9) administered the Flonase 35 minutes late. - Observation on 03/30/15 at 1:40 p.m. and 2:10 p.m. showed the nurse (#9) provided crushed or liquid medications through the G tube. Refer to F322 for the detailed observation. The nurse (#9) failed to check placement of the G tube, failed to provide a water flush before administering the feeding and/or medication, failed to administer the medications separately, failed to flush between the bolus feeding and the medication mixture, and failed to flush the tube at the end of both procedures. This resulted in two errors related to flushing of the G tube while administering medications. Review of the physician orders for Resident #10 identified staff are to administer the observed medications at 11:00 a.m. Per facility policy, the nurse (#9) administered the mixed medications 1 hour and 40 minutes late and the docusate sodium 2 hours and 10 minutes late. Two of the medications, clonidine and metoprolol tartrate (both antihypertensives) are administered by staff members twice a day at 11:00 a.m. and 8:00 p.m., improper spacing could affect the blood pressure lowering effect of these medications.	F 332	retraining and observations. Any nurse found to be incorrectly performing the medication pass will immediately be corrected and retrained in correct technique. 5. Interim Director of Nursing has begun retraining of employees regarding medication errors.	05/06/15

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F 332	Continued From page 38 - Observation on 03/31/15 at 7:55 a.m. showed the nurse (#9) administered hydralazine with other medications to Resident #11. Review of the physician order identified staff are to check the resident's blood pressure prior to administration and hold if the resident's blood pressure is too low. Observation failed to show the nurse (#9) checked Resident #11's blood pressure. During an interview on 04/01/15 at 10:35 a.m., the nurse (#9) confirmed she did not take Resident #11's blood pressure before administering the hydralazine, nor did a certified nurse aide check the resident's blood pressure for her. The nurse (#9) failed to complete the pre-administration assessment as ordered by the physician. During an interview on 04/01/15 at 11:40 a.m., an administrative nurse (#5) confirmed the facility expects staff to administer medications on time, complete pre-administration assessments as ordered, and administer G-tube medications separately with proper flushing.	F 332		
F 354 SS=E	483.30(b) WAIVER-RN 8 HRS 7 DAYS/WK, FULL-TIME DON Except when waived under paragraph (c) or (d) 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. Except when waived under paragraph (c) or (d) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. The director of nursing may serve as a charge	F 354	1. Facility will hire a full-time Director of Nursing. 2. All residents are affected by the absence of a Director of Nursing. 3. Facility is in active pursuit of a DON candidate. An interviewee April 17th has accepted a position at another facility. An agency has been contacted and stated they may have an RN who could be contracted until a permanent DON	

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F 354	Continued From page 39 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's nursing schedule and staff interview, the facility failed to have a registered nurse serve as the director of nursing on a full time basis for 6 of the past 6 weeks (February 13 - April 1, 2015). Failure to have a full time director of nursing impacts the delivery of care for all residents of the facility and contributed to citations under 483.10 Resident Rights, 483.13 Resident Behavior and Facility Practice, 483.20 Resident Assessment, 483.25 Quality of Care, and 483.60 Pharmacy Services. Findings include: During the entrance conference, on 03/30/15 at 8:15 a.m., office staff members (#6 and #18) stated the Director of Nursing (DON) was on medical leave and an interim filled in two days a week, on Mondays and Tuesdays. The Interim DON (#5) was not present at the entrance conference and arrived at the facility at approximately 10:00 a.m. after a staff member (#6) notified her of the survey. Review of the facility's nursing schedule for March 15 - April 11, 2015 confirmed the Interim DON was scheduled to be at the facility March 17, 18, 24, 25, 30 and April 7 and 8. The schedule lacked evidence the Interim DON was scheduled to be at the facility on a full time basis. On the afternoon of 04/01/15, a business office staff member (#18) provided information verifying	F 354	is found or the DON on FMLA has returned. 4. Administrator will continue to pursue avenues of employment for DON candidates in order to hire a permanent Director of Nursing. Facility has contracted with Titan Nurse Staffing, Delta Healthcare Providers, Primetime Nursing, PRN Nursing and Dakota Travel Nurses for qualified candidates. Position has been posted on Indeed.com and also at Job Service in Dickinson. 5. Pursuit of a qualified candidate for the Director of Nursing position is on-going. An interim DON will be available one or two days a week from a sister facility. The travel agencies are all looking for qualified candidates and we will contract for a full-time (35 hours per week) DON with one of them as soon as a candidate is available.	05/06/15

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F 354	Continued From page 40 the DON began medical leave on 02/13/15. Failure to ensure the services of a full time Director of Nursing directly impacts delivery of care for all residents. Refer to: F157, F225, F278, F281, F309, F314, F322, F323, F329, F332, and F425.	F 354		
F 363 SS=C	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. This REQUIREMENT is not met as evidenced by: Based on observation, review of daily menus, and staff interview, the facility failed to meet the nutritional needs of residents by serving incorrect portion sizes for 2 of 2 observations (lunch meal on 3/31/15 and breakfast meal on 04/01/15). Failure to follow recommended portion sizes as outlined in the facility's menus may result in weight loss and inadequate nutritional intake. Findings include: - Observation of tray line occurred on 03/31/15 during the lunch meal. Observation showed staff used a 6 ounce scoop as the serving size for the chili, and the menu identified 8 ounces as the serving size for this item. Observation of tray line occurred on 04/01/15	F 363	1. Facility will assure that correct serving sizes are given to all residents, according to their dietary orders. 2. All residents, but particularly those at risk for weight loss, are affected by this deficient practice. 3. The Dietary Manager will observe and evaluate meal service periodically for three months and report results of monitoring to Quality Assurance monthly. She will counsel and direct any staff who are deficient in portion control and service. 4. Dietary Manager will inservice all new employees in proper portion control. Dietary Manager will observe and correct if necessary various meal services to assure that residents are receiving the correct portion as per the menu.	

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F 363	Continued From page 41 during the breakfast meal. Observation showed the following inconsistencies between portion sizes listed on the facility's menus and the actual amount served to residents: *Oatmeal served with a 1/2 cup scoop (the menu identified 2/3 cup) *Cream of wheat with a 1/2 cup scoop (the menu identified 2/3 cup) During an interview on the afternoon of 04/01/15, an administrative dietary staff member (#17) confirmed staff should follow the serving sizes listed on the menu.	F 363	5. On April 22, 105 Dietary Manager inserviced current dietary staff regarding scoop and cup sizes and instructed them in observing the proper portions as per the menu.	05/06/15
F 425 SS=C	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.	F 425		

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F 425	Continued From page 42 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure the removal of expired medications in 2 of 2 medication storage areas (medication room and medication cart). Failure of facility staff to ensure the removal of expired medications may result in residents receiving expired medications. Findings include: Observation of the medication room and medication cart occurred on 03/31/15 at 3:00 p.m. with a licensed nurse (#9) and an administrative nurse (#5) and identified the following: Medication room: * One bottle of Vitamin E expired September 2014 * Two bottles of Vitamin B-6 expired November 2014 * One bottle of Vitamin B-1 expired December 2014 Medication Cart: * One bottle of Vitamin B complex expired October 2014 * One bottle of docusate sodium expired December 2014 * One box of Mucinex expired February 2015 * One box Tussin Chest Congestion expired February 2015 * One box Levalbuterol inhalation solution expired February 2015 * One bottle of Imodium lacked an expiration date. During observation of the medication room, the	F 425	1. No residents were cited as having been affected by the deficient practice. 2. Any resident may be affected by expired medications. 3. Director of Nursing and / or designated nurse will, on a monthly basis check all medications in the medication cart and in the medication room for outdated products and dispose of any outdated products in an appropriate manner. 4. Medications that were discovered during the survey have been disposed of. RN will review during May for next expired products and dispose of as appropriate. Quarterly Quality Assurance meeting will receive a report on expired medications. 5. This is an on-going process and will be done monthly.	05/06/15

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F 425	Continued From page 43 administrative nurse (#5) stated the night nurse checks the expiration dates of the medications stored in the medication room and the medication cart. The administrative nurse (#5) or the licensed nurse (#9) confirmed the medication observed as expired and discarded these medications.	F 425		
F 492 SS=D	483.75(b) COMPLY WITH FEDERAL/STATE/LOCAL LAWS/PROF STD The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. This REQUIREMENT is not met as evidenced by: Based on review of Medicare records, Centers for Medicare and Medicaid Services guidelines, and staff interview, the facility failed to submit a demand bill requested by the resident's representative for 1 of 4 residents (Resident #12) reviewed for Medicare billing. Failure to act upon the requested demand bill limited the facility's ability to ensure residents were able to exercise their right to request a demand bill and/or appeal from Medicare. Findings include: The Centers for Medicare and Medicaid Services (CMS) outlined standards of practice regarding information provided Medicare beneficiaries regarding their rights related to billing. The facility must provide a liability notice . . . to the resident or his/her legal representative when the facility	F 492	1. The cited resident was not affected by the deficient practice. 2. Any resident who does not receive proper notification and who has requested a demand bill could be harmed by the facility not sending a demand bill. 3. The facility contacted the family member who is the POA and who signed the request for a demand bill and discussed the mistake that we made. The family member did not read the notice correctly and he stated to the Business Office Manager, who discussed this issue with him, that he did not wish for the resident to continue to receive Skilled Therapy Services at her own expense. The discussion he had during telephone contact with the DON earlier made him think he had to sign up for restorative therapy for the resident. The Business Office Manager assured him that restorative therapy has been done with the resident, but the facility failed to send	

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F 492	Continued From page 44 believes the skilled services will no longer be covered. The facility must submit the bill to a fiscal intermediary (demand bill) when requested by the resident or his/her legal representative . . . Review of Medicare billing records occurred on 03/31/15 at 1:00 p.m. with a business office supervisor (#6). During the review, the staff member stated the facility determined Resident #12 would no longer qualify for Medicare Part A benefits effective on 10/28/14. She stated the facility had sent the required notices to the legal representative. The staff member stated the facility received the representative's request for a demand bill on 11/15/14. This staff member could not provide evidence the facility submitted a Demand Bill. During an interview on 03/31/2015 at 4:20 p.m., an administrative staff (#7) confirmed the facility failed to submit the demand bill requested by Resident #12's representative.	F 492	the demand bill in a proper manner when his indication was he wished to have skilled therapy services continued. 4. Business Office Manager will mail all notices with a stamped and return envelope which has been addressed "attention Business Office" to assure that any demand bill request is received and acted upon in a timely manner. QA will receive a report of any residents being lettered and the outcome of that lettering from the Business Office Manager monthly. 5. Correction has been put into place, family member stated their intention to send a note of explanation regarding the incorrect completion of the form.	05/06/15
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and	F 520		

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F 520	Continued From page 45 develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on review of the North Dakota Department of Health, Division of Health Facilities provider files, and staff interview, the facility failed to conduct quarterly meetings of the quality assurance (QA) committee for 3 of 4 quarters (April-June 2014, October-December 2014, and January-March 2015) as required resulting in a failure to ensure the QA committee identified and addressed quality issues and a failure to develop and implement plans of action to correct deficient practice and sustain compliance with federal requirements as evidenced by repeat citations at F157 and F309. Findings include: During an interview on 04/01/15 at 2:00 p.m., an administrative staff member (#7) identified two QA meetings were held in July and September of 2014. The facility held both meetings within the same quarter. The facility could not provide evidence of meetings held during the following quarters: April-June 2014, October-December	F 520	1. No residents were cited in this deficient practice. 2. All residents have the potential to be affected by this deficient practice. 3. Quarterly Quality Assurance Meetings will be held each quarter beginning May 1, 2015. 4. Administrator and Director of Nursing will both monitor these meetings to assure that one is held each quarter, that the appropriate personnel are invited, that issues that have been assigned to the QA team are reviewed and corrective actions are agreed upon and enacted per attendees' input. 5. Second Quarter Quality Assurance Meeting will be held May 5, 2015.	05/06/15

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHARDTON HEALTH CENTER INC	212 3RD AVENUE WEST RICHARDTON, ND 58652

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 520	Continued From page 46 2014, and January-March 2015. Failure to effectively implement the QA program resulted in the facility not sustaining compliance with the following repeat deficiencies: F157: notification of physician and family/resident representative of change. F309: maintaining the resident at his/her most practicable wellbeing.	F 520		