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 _____	03/03/2016

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 February 29, 2016 and completed on March 3, 2016, the sample included two (2) residents for complete review, five (5) residents for focused review, and one (1) closed record for review. The sample included one (1) additional resident 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		4/7/16

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

Electronically Signed | 03/21/2016

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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: Based on record review and staff interview, the facility failed to notify the physician in a timely manner for 1 of 1 sampled resident (Resident #1) who experienced increasing edema and shortness of breath (SOB). Failure to notify the resident's physician resulted in a delay in treatment. Findings include: Review of Resident #1's medical record occurred on all days of survey. Diagnoses included CHF, hypertension, and edema. Review of Resident #1's progress notes from 11/12/15 through 11/21/15 showed 11 entries that documented the resident's shortness of breath (SOB) and increasing edema. The notes showed on 11/21/15 the facility contacted the medical provider regarding the change in condition. During an interview at 7:25 a.m. on 03/02/16 an administrative nurse (#2) confirmed facility staff documented on Resident #1's condition and did not act on it (Refer to F309).	F 157	POC for F Tag 157 SS = D #1. We cannot notify the physician/provider in a timely manner related Resident #1 because the resident no longer resides in our facility. #2. All residents have the potential for the physician/provider to not be notified of a change in condition. #3. All nurses, including newly hired and travel nurses, will be educated related to the requirements for timely notifications given to the physician/provider of any change of condition in the residents. Nurses will sign off on the education materials as read and understood. A mandatory educational session for all nurses will be held on March 24, 2016. #4. The Director of Nursing or designee will monitor compliance of notification of the physician/provider in a timely manner of any change in the residents' condition Compliance monitoring will be completed as each occurrence of a resident's change in condition. The DON or designee will randomly monitor the resident's condition for those who have	

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F 157	Continued From page 2	F 157	had physician/provider visits or order changes to see if notification was made timely of any change of condition. Charts will be monitored weekly for one month. If concerns are identified immediate corrective action will be implemented. If no concerns are noted, then random reviews will be conducted for two more months to ensure deficient practice is corrected. The Director of Nursing will submit a report of the QA monitoring to the QA committee at each scheduled monthly meeting for further action if necessary.	
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status;	F 272		4/7/16

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F 272	Continued From page 3 Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. 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), the facility staff failed to determine underlying causes, contributing factors, and risk factors for the triggered Care Area Assessments (CAAs) for 2 of 8 sampled residents (Resident #3, and #4) reviewed. Failure to determine underlying causes, contributing factors, and risk factors for the triggered CAAs limits the ability of the interdisciplinary team to determine the areas that require care plan intervention(s) and develop, revise, or continue the individualized care plan. Findings include: The Long-Term Care Facility RAI User's Manual, Version 3.0, dated October 2015, page 4-2 to 4-3, states, ". . . The completed MDS [Minimum	F 272	POC for F Tag 272 SS = D #1. A modified MDS related to CAA documentation will be completed for Resident #3's Annual MDS assessment dated 9.13.2015. An Annual MDS assessment with an ARD date of 3.14.2016 with CAAs will be completed within the allotted time frame for MDSs. A correction will not be made on Resident #4 related to CAA documentation as this resident no longer resides in our facility. #2. All residents' comprehensive MDS with CAAs have the potential for triggered areas not to be completed. #3. The interdisciplinary MDS team including DON/MDS Coordinator, Social	

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F 272	Continued From page 4 Data Set] must be analyzed and combined with other relevant information to develop an individualized care plan. To help nursing facilities apply assessment data collected on the MDS, Care Area Assessments (CAAs) are triggered responses to items coded on the MDS specific to a resident 's possible problems, needs or strengths . . . They are required only for OBRA [Omnibus Budget Reconciliation Act] comprehensive assessments (Admission, Annual, Significant Change in Status, or Significant Correction of a Prior Comprehensive). . . " Review of Resident #3 and #4's medical records occurred on February 29 - March 03, 2016. The following comprehensive MDSs lacked CAA documentation: * Resident #3: Annual MDS, dated 09/13/15 - Seven care areas triggered, with only one CAA completed (Nutritional Status). * Resident #4: Admission MDS, dated 12/11/15 - Nine care areas triggered, no CAAs completed.	F 272	Services Designee/Activity Director and Dietary Manager will review the educational/training materials received while attending the MDS Training in Bismarck, ND on January 11-14, 2016. The interdisciplinary MDS team will sign off on the educational materials as read and understood. All current residents' most current MDS at time of annual survey will be reviewed for completion of triggered areas on CAAs. #4. All members of the interdisciplinary MDS team will monitor compliance of CAA documentation. Compliance monitoring for CAA documentation will be prior to the RN Coordinator esigning and locking of all MDSs and will be conducted for 90 days. If concerns are identified, immediate corrective action will be implemented prior to esigning and locking all MDSs. If no concerns are noted, then random reviews for triggered areas on CAAs will be conducted for the next 90 days. The Director of Nursing will submit a report of the QA monitoring to the QA committee at each scheduled monthly meeting for further action if necessary.	
F 278 SS=E	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.	F 278		4/7/16

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F 278	Continued From page 5 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 staff accurately coded the Minimum Data Sets (MDSs) for 6 of 7 sampled residents (Resident #1, #2, #3, #4, #5, and #6). Failure to complete the correct MDSs after being discharged from the facility with return anticipated (Resident #1, #2, and #4) and failure to accurately complete portions of the MDS, Section I (Active Diagnosis) (Resident #3 and #6), and Section P (Physical Restraints) (Resident #2 and #5). Failure to accurately code portions of the MDS does not allow each	F 278	POC for F Tag 278 SS = E ADMISSION ASSESSMENT #1. A correction on Resident#1 and Resident #4 will not be made as these two residents no longer reside in our facility. The correction for Resident #2 is to complete an Annual MDS Assessment with an ARD date of 4.7.2016. #2. All residents have the potential for an Admission MDS Assessment to be completed upon return from a hospital	

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F 278	Continued From page 6 resident's assessment to reflect the resident's current status/needs and may result in the inaccuracy of the facility's Resident Level Quality Measure Reports. Findings include: ADMISSION ASSESSMENTS The Long-Term Care Facility RAI User's Manual, revised October 2015, on page 2-8 stated, ". . . Admission refers to the date a person enters the facility and is admitted as a resident. A day begins at 12:00 a.m. and ends at 11:59 p.m. . . . this date is considered the 1st day of admission. Completion of an OBRA (Omnibus Budget Reconciliation Act) Admission assessment must occur in any of the following admission situations: * when the resident has never been admitted to this facility before; OR * when the resident has been in this facility previously and was discharged return not anticipated; OR * when the resident has been in this facility previously and was discharged return anticipated and did not return within 30 days of discharge . . . " - Review of Resident #1's medical record occurred on all days of survey and identified a hospital stay from October 17, 2015 through November 5, 2015. The facility completed a discharge assessment return anticipated MDS for the hospital stay and upon return from the hospital, incorrectly completed an admission MDS. - Review of Resident #2's medical record	F 278	stay after a discharge return anticipated was completed upon discharge from the nursing home. #3. All MDSs will be reviewed for correct assessment type being completed by the MDS interdisciplinary team including the Director of Nursing/MDS Coordinator, Social Service Designee/Activity Director and Dietary Manager prior to the RN Coordinator esigning and locking the MDS. All residents most current MDS at the time of survey will be reviewed for correct assessment being completed after a hospital stay when a discharge return anticipated assessment has been completed. Education/reeducation has begun with all members of the interdisciplinary MDS team on 3.17.2016. #4. All members of the interdisciplinary MDS team will monitor compliance of the correct assessment being completed after each occurrence of a hospital stay when a discharge return anticipated assessment has been completed. Compliance monitoring for completion of correct assessment type after each occurrence of a hospital stay when a discharge return anticipated assessment has been completed, will be conducted for 90 days. If concerns are identified, immediate corrective action will be implemented prior to the assessment being completed by the interdisciplinary MDS team. If no concerns are noted, then random reviews will be conducted for the next 90 days to ensure the deficient	

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F 278	Continued From page 7 occurred on all days of survey and identified a hospital stay from December 01-04, 2015 and December 30, 2015 through January 4, 2016. The facility completed a discharge assessment return anticipated MDS for both hospital stays and upon return from the hospital, incorrectly completed an admission MDS. - Review of Resident #4's medical record occurred on all days of survey and identified a hospital stay from December 22-23, 2015. The facility completed a discharge assessment return anticipated MDS for the hospital stay and upon return from the hospital, incorrectly completed an admission MDS. DIAGNOSIS The Long-Term Care Facility RAI User's Manual, revised October 2015, on page I-3 stated, ". . . There are two look-back periods for this section: Diagnosis identification (Step 1) is a 60-day look-back period. Diagnosis status: Active or Inactive (Step 2) is a 7-day look-back period (except for Item I2300 UTI, which does not use the active 7-day look-back period)." -Review of Resident #3's quarterly MDS, dated 12/14/15, lacked coding of diagnoses. - Review of Resident #6's quarterly MDS, dated 02/13/16, lacked coding of diagnoses. PHYSICAL RESTRAINTS The Long-Term Care Facility RAI User's Manual, revised October 2015, on page P-1 stated, " . . .	F 278	practice is corrected. The Director of Nursing will submit a report of the QA monitoring to the QA committee at each scheduled monthly meeting for further action if necessary. DIAGNOSIS #1. A modification for Resident #3's quarterly MDS dated 12.14.15 related to coding of diagnosis will be completed. A modification of Resident #6's quarterly MDS dated 2.13.16 related to coding of diagnosis will be completed. #2. All residents have the potential for all MDSs to lack coding of diagnosis. #3. All MDS Section I Diagnoses will be reviewed by all members of the interdisciplinary MDS team prior to the RN Coordinator esigning and locking the MDS. All residents' most current MDS at the time of survey will reviewed for coding of diagnosis. Education/reeducation has begun with all members of interdisciplinary MDS team on 3.21.2016. #4. All members of the interdisciplinary will monitor compliance of coding of diagnoses on all MDSs prior to the RN Coordinator esigning and locking the MDS. Compliance monitoring for coding of diagnoses on all MDSs will be conducted for 30 days. If concerns are identified, immediate corrective action will be implemented prior to the RN Coordinator esigning and locking of the	

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F 278	Continued From page 8 The intent of this section is to record the frequency over the 7-day look-back period that the resident was restrained by any of the listed devices at any time during the day or night. Assessors will evaluate whether or not a device meets the definition of a physical restraint and code only the devices that meet the definition in the appropriate categories of Item P0100 . . . Definition: Physical restraint, Any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body." - Review of Resident #2's admission MDS, dated 01/07/16 identified independent with bed mobility, transfer, walk in room and corridor, and restraint in bed, bed rail used daily. During an interview on 03/03/16 at 2:15 p.m., an administrative nurse (#2) reported the resident uses the rail to transfer in and out of bed. - Review of Resident #5's quarterly MDS, dated 01/08/16, identified extensive assist of one for bed mobility, restraint in bed, bed rail used daily. During an interview on 03/03/16 at 2:15 p.m., an administrative nurse (#2) stated the bed rail is for repositioning and is not a restraint for the resident.	F 278	MDS. If no concerns are noted, random reviews will be completed for additional 30 days to ensure the deficient is corrected. The Director of Nursing will submit a report of the QA monitoring to the QA committee at each scheduled monthly meeting for further action if necessary. RESTRAINTS #1. A modification for Resident #2's Admission MDS dated 1.7.2016 will reflect physical restraints were "Not Used" for this resident. A modification for Resident #5's quarterly MDS dated 1.8.2016 will reflect physical restraints were "Not Used" for this resident. #2. All residents have the potential for each MDS to be coded incorrectly for physical restraints. #3. All MDS Section P Physical Restraints will be reviewed by the interdisciplinary MDS team prior to the RN Coordinator esigning and locking the MDS. All residents most current MDS at the time of the survey were reviewed for data entry errors in coding for physical restraints on 3.21.2016 since our facility does not use physical restraints. Education/reeducation began with all members of the interdisciplinary MDS team on 3.21.2016. #4. All members of the MDS interdisciplinary team will monitor	

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F 278	Continued From page 9	F 278	compliance of the coding of physical restraints on all MDSs prior to the RN Coordinator esigning and locking of the MDS. Compliance monitoring on every MDS for the coding of physical restraints will be conducted for 30 days. If concerns are identified, immediate corrective action will be implemented prior to the RN Coordinator esigning and locking of MDSs. If no concerns are noted, random reviews will be conducted for an additional 30 days to ensure the deficient practice has been corrected. The Director of Nursing will submit a report of the QA monitoring to the QA committee at each scheduled monthly meeting for further action if necessary.	
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280		4/7/16

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F 280	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on observation, record review, and review of facility policy, and staff interview, the facility failed to review and revise care plans to reflect the residents' current status for 4 of 8 sampled residents (Resident #1, #4, #5 and #7). Failure to ensure care plans reflected the residents' current status and needs limited staff's ability to ensure consistency and continuity of care. Findings include: Review of the policy titled "Care Plans - Comprehensive" occurred on 03/03/16. This policy, dated October 2010, stated, "Policy Statement: An individualized comprehensive care plan . . . to meet the resident's medical, nursing, mental and psychological needs is developed for each resident. Policy Interpretation and Implementation: 1. Our facility's Care Planning/Interdisciplinary Team, in coordination with the resident, . . . develops and maintains a comprehensive care plan for each resident that identifies the highest level of functioning the resident may be expected to attain. 2. The comprehensive care plan is based on a thorough assessment that includes, but is not limited to, the MDS [minimum data set]. 3. Each resident's comprehensive care plan is designed to: a. Incorporate identified problem areas; . . . g. Aid in preventing or reducing declines in the resident's functional status and/or functional levels; . . . 4. Areas of concern that are triggered during the	F 280	POC for F Tag 280 SS = E #1. No correction will be made for Resident #1 and Resident #4 related to current care plan and CNA care sheet because the resident no longer resides in our facility. A correction was made for Resident #7 on 3.16.2016 on the care plan and CNA care sheet on identifying the use of a sit to stand lift. A correction was made for Resident #5 on 3.4.2016 related to current care plan and CNA care sheet identifying interventions for floating heels and foot cradle over the feet. #2. All residents have the potential for care plans and CNA care sheets to not identify the use of sit to stand lift for transfers or identify interventions for floating heels and foot cradle over feet. #3. The nurse receiving a new order for any resident related to using a sit to stand lift for transfers will update the CNA care sheet and care plan at the time the order is received. The nurse implementing an intervention for floating heels/foot cradle will update the CNA care sheet and care plan at the time the intervention is implemented. All current residents' CNA care sheets and care plans were reviewed for updating related to the use	

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F 280	Continued From page 11 resident assessment are evaluated using specific assessment tools (including Care Area Assessments) before interventions are added to the care plan. . . ." - Review of Resident #1's medical record occurred on all days of survey. A resident progress note, dated 02/21/16, stated, "10:46 resident has area on 5th toe of L [left] foot appears as a blood blister . . . denies any pain but does states [sic] she has been wearing new shoes, area is closed, advised resident to wear gripper socks for a while to give it time to heal. . . ." Review of Resident #1's current care plan and certified nurse aide (CNA) care sheet lacked information regarding the resident's toe and to not wear her shoes. - Review of Resident #7's medical record occurred March 2-3, 2016. Current physician's order stated, "02/08/2016 . . . Please use E-Z stand lift to transfer resident due to severe arthritis bilateral knees. . . ." Observation at 2:05 p.m. on 03/02/16 showed a contract CNA (#6) and another CNA (#7) transfer Resident #7 using a sit to stand lift. Review of Resident #7's current care plan and CNA care sheet failed to identify the use of a sit to stand lift. During an interview at 2:15 p.m. on 03/03/16 an administrative nurse (#2) reported staff use a stand lift to transfer Resident #7.	F 280	of sit to stand lifts for transfers and interventions for floating heels/foot cradle over the feet on 3.21.2016. #4. The DON or designee will monitor for compliance review and update of CNA care sheets and care plans for sit to stand lifts for transfers and interventions for floating heels/foot cradles over the feet. Compliance monitoring for review and update for CNA care sheets and care plans will be conducted every day for two weeks, then three times weekly for two weeks, and then once per week for four weeks. If any concerns are identified, immediate corrective action will be implemented to update the CNA care sheets and care plans. If no concerns are noted, random reviews will be conducted for an additional 30 days to ensure the deficient practice has been corrected. The DON will submit a report of QA monitoring to the QA committee at each scheduled monthly meeting for further action if necessary.	

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F 280	Continued From page 12	F 280		

- Review of Resident #4's medical record occurred on all days of survey. Medical diagnoses included fusion of the lumbar region of the spine, lumbago with sciatica (left side), and fibromyalgia. An admission MDS, dated 12/11/15 and a return from the hospital MDS, dated 12/29/15, identified pain as a triggered care area assessment.

Review of Resident #4's nursing notes identified the facility admitted the resident on 12/02/15 with pain in the left leg and back pain. Nursing progress notes identified Resident #4 experienced pain and nursing staff administered scheduled pain medications as well as PRN (as needed) pain medications. Resident #4 had back surgery on 12/22/15 and returned to the facility on 12/23/15. The resident continued to have pain, and the provider made changes and additions in the resident's pain medication regime. On 02/29/16, Resident #4 had an epidural spinal injection for her back pain.

Review of Resident #4's current care plan failed to identify pain as an identified problem area.

- Review of Resident #5's medical record occurred on all days of survey. Medical diagnoses included peripheral vascular disease and history of left lower extremity skin graft to sacral decubitus (January 2014). Record review identified Resident #5 has a history of a recently closed pressure ulcer to her left heel (02/25/16), and currently has a reddened, painful area on her left great toe.

Observations on all days of survey showed staff floated Resident #5's heels on a pillow while in

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F 280	Continued From page 13 bed, with a foot cradle for the blankets over her feet. Resident #5's care plan identified "Problem Category : Pressure Ulcer . . . " and Problem Category: Pain . . . has complaints of chronic pain R/T [related to] impaired circulation in her legs and specifically great toe. . . ." The care plan failed to identify the interventions of floating heels and the foot cradle over the feet. Resident #5's daily CNA care sheet identified "float heels in bed blue booties" and did not identify using the foot cradle. Observations on all days of survey showed staff did not use blue booties on Resident #5's feet. During an interview in the afternoon of 03/03/16, an administrative staff member (#2) stated staff are not to use the blue booties on Resident #5. The staff member (#2) confirmed staff should update the care plan and the CNA care sheet.	F 280		
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: Based on observation, review of manufacturer's instructions, and staff interview, the facility failed to follow professional standards of practice for 1 of 1 sampled resident (Resident #2) observed receiving insulin during medication administration and and 1 supplemental resident (Resident #9) observed during medication administration.	F 281	POC for F Tag 281 SS = D #1. A correction on Resident #2 and Resident #9 related to failure to prime insulin pen cannot be made after the insulin has been administered. A correction on Resident #9 related to	4/7/16

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F 281	Continued From page 14 Failure to prime insulin pens may result in an incorrect dose of insulin. Findings include: Review of the manufacturer's instructions for NovoLog FlexPen occurred on the afternoon of 03/01/16. The instructions stated, ". . . Small amounts of air may collect in the cartridge during normal use. To avoid injecting air and to ensure proper dosing: . . . E. Turn the dose selector to select 2 units. F. Hold your NovoLog FlexPen with the needle pointing up. Tap the cartridge gently with your finger a few times to make any air bubbles collect at the top of cartridge. G. Keep the needle pointing upwards, press the push-button all the way. . . The dose selector returns to zero. A drop of insulin should appear at the needle tip. If not, change the needle, and repeat the procedure. . . ." - Observation on 03/01/16 at 8:05 a.m. showed a nurse (#3) obtained Resident #9's NovoLog FlexPen, dialed the FlexPen to 14 units as per physician's order, and administered the insulin to the resident. - Observation on 03/01/16 at 12:15 p.m. showed a nurse (#3) obtained Resident #2's NovoLog FlexPen, dialed the FlexPen to 20 units as per physician's order, and administered the insulin to the resident. On the afternoon of 03/01/16, the nurse (#3) provided the manufacturer's instructions for the NovoLog FlexPen and confirmed staff should prime the FlexPen with 2 units prior to administering insulin to the resident.	F 281	failure to prime insulin pen cannot be made because the resident no longer resides in our facility. Resident #2 and Resident #9 were administered insulin per physician's orders. #2. All residents have the potential for insulin pens to not be primed prior to administering insulin. #3. All nurses, including newly hired and travel nurses, will be educated to read/review and follow the manufacturer's instructions for priming insulin pens prior to administering insulin. All nurses will sign off on educational material as read and understood. A mandatory educational session for all nurses will be on 3.24.2016. #4. The DON or designee will monitor compliance by observing nurses priming insulin pens. Compliance monitoring of priming insulin pens will be conducted at a minimum of once daily for two weeks, three times weekly for two weeks, and then randomly for a minimum for eight times during the next 30 days. If any concerns are identified, immediate corrective actions will be implemented prior to insulin being administered. If no concerns are noted, then random reviews will be conducted for an additional 30 days to ensure the deficient practice is corrected. The DON will submit a report of QA monitoring to the QA committee at each scheduled monthly meeting for further action if necessary.	

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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: Based on record review, and staff interview the facility failed to provide the necessary care and services for 1 of 1 sampled resident (Resident #1) with increasing edema and shortness of breath (SOB). Failure to act on assessments of symptoms of congestive heart failure (CHF) resulted in a delay in treatment and notification of the health care provider. Findings include: Review of Resident #1's medical record occurred on all days of survey. Diagnoses included CHF, hypertension, and edema. The resident's care plan identified the following problem with a start date of 03/15/15, ". . . Potential for SOB on exertion related to edema . . . Approach: . . . Monitor for S/SX [signs and symptoms] or fluid retention, edema of SOB . . . " Review of an admission history and physical dated 10/22/15 included admission problems of duodenal ulcer with perforation, pulmonary edema, fluid overload, and acute renal failure.	F 309	POC for F Tag 309 SS = D #1. A correction cannot be made on Resident #1 because the resident no longer resides in our facility. #2. All residents have the potential to have a delay in treatment and the health physician/provider not notified in a timely manner. #3. All nurses, including newly hired and travel nurses, will be educated/reeducated related to acting on clinical assessments of symptoms for congestive heart failure that result in delay of treatment and notification of physician/provider. All nurses will sign off on educational materials as read and understood. A mandatory education session for nurses will be held on 3.24.2016. #4. The DON or designee will monitor residents' charts with a diagnosis of	4/7/16

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F 309	Continued From page 16 Review of resident's progress notes showed the following: * 11/05/15 5:20 p.m., "Resident admitted from the hospital . . . " This is a return from the hospital as she was a resident. * 11/09/15 1:49 p.m., "Resident alert & [and] oriented . . . 1+ [plus] edema both legs . . . " * 11/10/15 4:01 p.m., ". . . No complaints or evidence of chest pain; does exhibit SOB upon exertion. . . . + 1 edema noted to BLE [bilateral lower extremities]. . . ." * 11/11/15 10:48 a.m., ". . . [physician's name] . . . no new orders at this time. . . ." * 11/12/15 2:36 p.m., ". . . Resident does display SOB upon exertion . . . +1 edema noted to bilateral ankles . . . " * 11/13/15 3:37 a.m., ". . . slightly SOB with activity . . . 1+ edema ankles legs elevated. . . ." * 11/13/15 5:01 p.m., ". . . Does get SOB with moderate activity . . . +1 edema noted to bilateral ankles . . . " * 11/14/15 2:27 p.m., ". . . Resident does display SOB upon exertion . . . +2 edema noted to bilateral ankles. . . ." * 11/15/15 1:48 a.m., ". . . 1-2+ edema in her legs. Elevated legs. . . ." * 11/15/15 2:10 p.m., ". . . resident does exhibit SOB upon exertion . . . Continues to have +2 edema to bilateral ankles . . . " * 11/16/15 2:30 a.m., ". . . She had 3+ edema in her legs . . . " * 11/17/15 3:08 p.m., ". . . does exhibit SOB upon exertion . . . +2 edema noted to bilateral ankles and to tops of her feet . . . " * 11/18/15 2:46 p.m., ". . . resident does exhibit SOB with exertion . . . Continues to have +2 edema to bilateral tops of feet and ankles . . . " * 11/20/15 10:47 a.m., ". . . complains she [sic]	F 309	congestive heart failure for actions after a clinical assessment has revealed congestive heart failure symptoms. Compliance monitoring will be conducted daily for two weeks, then three times a week for two weeks, and then weekly for two weeks. If concerns are identified, immediate corrective action will be implemented including immediate notification of the health care physician/provider. If no concerns are noted, random reviews will be conducted weekly for an additional 30 days to ensure the deficient practice is corrected. The DON will submit a report of QA monitoring to the QA committee at each scheduled monthly meeting for further action if necessary.	

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F 309	Continued From page 17 feeling SOB this morning . . . Her feet are swollen 3+ edema and 2+ ankles and legs bilat. [bilateral] * 11/21/15 6:02 a.m., ". . . Skin intact. 1+ edema rt [right] ankle and part of leg . . . " * 11/21/15 7:50 a.m., "Resident called as she was SOB. She was getting dressed at this time. Breath sounds clear diminished to bases. 3+ edema to bilateral lower extremities . . . Resident states she was like this before and she needs more Lasix [a diuretic medication]. I looked at her chart and before she was in hospital she was getting 40 mg [milligrams] Lasix am [a.m.] and noon. . . I placed a call to [hospital name] . . . " * 11/21/15 10:10 a.m., "Orders received from [physician's name] to resume . . . Lasix as before hospital admission. Extra dose Lasix 40 mg given . . . " Upon returning from the hospital on 11/05/15, Resident #1's physician order's identified to start Lasix 20 mg daily on 11/06/15. Prior to her hospital stay the medical record identified the resident received Lasix 40 mg twice a day for CHF and a history of edema. During an interview at 7:25 a.m. on 03/02/16 an administrative nurse (#2) confirmed facility staff documented on Resident #1's condition, however, did not act on it. After Resident #1's return from the hospital, the facility staff documented the resident's SOB and increasing edema, but failed to notice the dosage of Lasix had changed. Staff documented 11 times in the medical record the resident was SOB and had edema from 1 to 3+ before notifying the physician and receiving orders.	F 309		
F 315	483.25(d) NO CATHETER, PREVENT UTI,	F 315		4/7/16

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F 315 SS=D	Continued From page 18 RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure timely services and treatment for 2 of 2 sampled residents (Resident #3 and #6) with orders from the health care provider (HCP) for a urinalysis (UA). Failure to obtain a specimen in a timely manner after an order was received (5 days later) resulted in delayed treatment of a multi-drug resistant organism. Findings include: - Review of Resident #3's medical record occurred on all days of survey. Diagnoses included history of urinary tract infections. A quarterly MDS, dated 12/14/15, identified supervision of one staff for toileting and severely impaired cognition. Review of the HCP note, dated 10/08/15, stated, ". . . During the exam the only thing that [Resident #3] complains of is burning with	F 315	POC for F Tag 315 SS= D 1. A correction for Resident #3 and Resident #6 cannot be made related to obtaining a urine specimen in a timely manner because the order was received on 10.8.2015. #2. All residents have the potential for not having a urinalysis specimen obtained in a timely manner after the order is received resulting in a delay in treatment. #3. All nurses, including newly hired and travel nurses, will be educated/reeducated related to obtaining a urinalysis specimen timely after an order is received. All nurses will sign off on the educational materials as read and understood. A mandatory educational session for nurses will be held on 3.24.2016.	

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F 315	Continued From page 19 urination . . . Plan: . . . 2. due to complaint of dysuria [painful urination] a urinalysis will be collected, nursing staff will be notified of the results and any recommendations. . . ." A lab report, dated 10/15/15, identified the urine specimen collected on 10/13/15 showed Extended Spectrum Beta-Lactamase (ESBL) organism. A progress note, dated 10/15/15, stated, ". . . Final UA noted to have ESBL organism present . . . ordered Bactrim [antibiotic] . . . place resident on contact isolation . . . " - Review of Resident #6's medical record occurred on March 02-03, 2016. Diagnoses included history of urinary tract infections. A quarterly MDS, dated 02/13/16, identified moderately impaired cognition and independent in toilet use. Review of nursing notes identified the following: *10/08/15 - ". . . [name of HCP] here at this time and seen resident and gave verbal orders to have the following labs drawn : . . . and a UA." *10/12/15 - "UA that was ordered by [name of HCP] was obtained and sent to clinic for evaluation." *10/15/15 - "Final culture results received at this time and noted to have ESBL organism present. [Name of HCP] gave orders to start Bactrim DS . . . and place resident on contact isolation. . . ." The medical record failed to provide evidence for the delayed collection of urine specimens for Resident #3 and #6. Failure of staff to obtain the specimens in a timely manner resulted in continued signs and symptoms for Resident #3 and the delay in treatment for both residents.	F 315	#4. The DON or designee will monitor compliance of obtaining urinalysis specimens in a timely manner by reviewing timeliness of specimen collection after the order is received. Compliance monitoring will be conducted each time a urinalysis order is received for 30 days. If concerns are identified, immediate corrective action will be implemented including obtaining a urinalysis specimen. If no concerns are noted, random reviews will be conducted for an additional 30 days to ensure deficient practice is corrected. The Director of Nursing will submit a report of the QA monitoring to the QA committee at each scheduled monthly meeting for further action if necessary.	

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F 315	Continued From page 20 This increased the potential of the infection to spread to other residents.	F 315		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of	F 441		4/7/16

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F 441	Continued From page 21 infection. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to follow standard infection control practices for 2 of 4 sampled residents (Resident #1 and #5) observed during personal cares. Failure to follow infection control practices has the potential to cause or spread infection within the facility. Findings include: Review of the policy titled "Handwashing/Hand Hygiene" occurred on 03/03/16. This policy, dated April 2012, stated, "Policy Statement. This facility considers hand hygiene the primary means to prevent the spread of infections. Policy Interpretation and Implementation . . . 5. Employees must wash their hands for at least fifteen (15) seconds using antimicrobial or non-antimicrobial soap and water under the following conditions: . . . h. Before and after assisting a resident with personal care (e.g., oral care, bathing); . . . n. Before and after assisting a resident with toileting . . ." - Observation on 02/29/16 at 3:25 p.m. showed a contract certified nurse aide (CNA) (#4) provided personal cares to Resident #5. Wearing gloves, the CNA used wipes to clean the resident's rectal area after the resident was incontinent of a soft bowel movement. After completing the cares, and wearing the same gloves, the CNA (#4) reached into Resident #5's beside stand and	F 441	POC for F Tag 441 SS = D #1. A correction for Resident #1 cannot be made because the resident no longer resides in the facility. A correction for Resident #5 cannot be made related to the observation of failing to perform hand hygiene after providing perineal care and before completing other tasks on 2.29.2016. #2. All residents have the potential for staff not to perform hand hygiene after providing perineal care and before completing other tasks. #3. All CNAs, including newly hired and travel CNAs, will be educated/reeducated related to performing hand hygiene after providing perineal care and before completing other tasks. A return demonstration of hand hygiene after perineal care will be included in this educational process. All CNAs will sign off on educational material as read and understood. A mandatory educational session for CNAs will be held on 3.24.2016. #4. The DON or designee will monitor for compliance of hand hygiene after perineal care and before completing other tasks.	

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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 441	Continued From page 22 retrieved a container of ointment, which she applied to the buttocks and to the resident's front inner thighs. The CNA (#4) removed her gloves, and without hand hygiene, donned a new pair of gloves. The CNA fastened Resident #5's brief, repositioned the resident in bed, covered the resident with a blanket, provided oral cares to the resident with a Toothette oral swab, and then removed gloves and washed her hands. The CNA (#4) failed to perform hand hygiene after providing perineal care and before completing other tasks. - Observation on 03/01/16 at 2:05 p.m. showed two CNAs (#5 and #6) assisted Resident #1 in the bathroom. The contract CNA (#5) donned gloves and provided perineal cares after the resident had a large amount of soft, loose stool. The CNA (#5) removed her gloves after providing perineal care and without performing hand hygiene, donned a new pair of gloves. The CNAs (#5 and #6) then transferred the resident from the bathroom to the room with the mechanical stand lift and into the resident's wheelchair. The CNA (#5) then repositioned the resident in her wheelchair. The CNA failed to perform hand hygiene after completing perineal cares and prior to completing other tasks.	F 441	Compliance monitoring will be conducted at a minimum of daily and randomly on each shift for seven days, then a minimum of five times weekly for two weeks, and then a minimum of three times weekly for two weeks. If concerns are identified, immediate corrective action will be implemented to include performing hand hygiene correctly. If no concerns are noted, then random reviews will be conducted for an additional 30 days to ensure the deficient practice is corrected. The DON will submit a report of the QA monitoring to the QA committee at each scheduled monthly meeting for further action if necessary.	