STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355034	A. BUILDING _____ B. WING _____	12/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIOGA MEDICAL CENTER LTC	810 N WELO ST TIOGA, ND 58852

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F 000	INITIAL COMMENTS The Standard Medicare/Medicaid recertification survey started on 12 02/19 and concluded 12/04/19.	F 000		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy and staff interview, the facility failed	F 657	1. Resident #1, #2, #8, #25 care plans were updated. Nursing staff were	1/8/20

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

Electronically Signed | 12/20/2019

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F 657	Continued From page 1 to review and revise the comprehensive care plan to reflect the residents' current status for 4 of 12 sampled residents (Resident #1, #2, #8, and #25). Failure to revise the care plan limited the staff's ability to communicate needs and ensure continuity of care for each resident. Findings include: Review of facility policy titled "Multidisciplinary Care Plan" occurred on 12/04/19. This policy, dated August 2003, stated, ". . . Assessment and care plan evaluation must be ongoing . . . monitor the resident's response to care and adjust the care plan accordingly." - Review of Resident #1's medical record occurred all days of survey. A nursing note, dated 11/25/19 at 3:24 p.m., stated, "After being evaluated by PT [physical therapy] careplan changed to standing lift for transfers with 2 staff and no ambulating at this time d/t [due to] weakness. Resident aware and agrees with this change. Direct care staff notified." Review of Resident #1's current care plan stated, "Falls: up with 1 assist et [and] gaitbelt as I get dizzy at times. . ." During an interview on 12/04/19 at 4:15 p.m., an administrative nurse (#1), agreed the facility failed to revise Resident #1's care plan. - Review of Resident #25's medical record occurred on all days of survey. The Minimum Data Set (MDS), dated 09/05/19, identified two or more falls since admission, and one fall with injury. Physician's orders, dated 11/08/19,	F 657	educated on revising care plans and keeping them up to date. 2. All residents have the potential to be affected by the facilities ability to revise the care plan and ensure continuity of care for each resident. 3. Staff will be educated on how to properly revise and update a care plan to ensure continuity of care for each resident. A mandatory all staff in-service will be held with POC□s on 1/6/2020. 4. QI monitoring will be implemented for residents #1, #2, #8, and #25 care plans, along with 2 random residents to ensure that their care plan addresses current care needs; random areas of care plans will be used for the QI monitoring. QI monitoring will be done by DON/QI designee weekly x4, then monthly x2, then quarterly x 2 unless determined by the QI committee at the monthly meeting. 5. 1/8/2020	

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F 657	Continued From page 2 stated, "O2 [oxygen] @ [at] 2L [liters] via NC [nasal cannula]". Observations on all days of survey showed Resident #25's bed in the lowest position and a fall mat next to the bed. Observations also showed the resident used continous oxygen. Resident #25's care plan failed to address the fall mat, the bed in lowest position, and oxygen use. - Review of Resident #2's medical record occurred on all days of survey. The admission MDS, dated 09/15/19, identified bed and chair alarm used daily. Observation on all days of survey identified the use of a bed and chair alarm. Resident #2's care plan failed to address the use of a bed or chair alarm. - Review of Resident #8's medical record occurred on all days of survey. The quarterly MDS, dated 10/20/19, identified a bed alarm used daily. Observation on all days of survey identified the use of a bed alarm. Resident #8's care plan failed to address the use of the bed alarm.	F 657		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted	F 761		1/8/20

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F 761	Continued From page 3 professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: EXPIRED MEDICATION 1. Based on observation, record review, review of manufacturer's guidelines, and staff interview, the facility failed to discard expired medications for 1 of 3 sampled residents (Resident #17) observed during medication administration. Failure to discard insulin after 28 days of opening may result in an adverse consequence for Resident #17. Findings Include: Prescribing information for NovoLog insulin,	F 761	1. Resident #17 insulin was disposed and replaced per protocol. The Ativan was wasted immediately when it was found 12/4/2019. 2. All residents have the potential to be affected by the facilities failure to discard expired medications. All residents have the potential to be affected by the facilities failure to ensure that opened controlled medication is properly disposed of. 3. Staff will be educated on when to	

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F 761	Continued From page 4 found at www.novo-pi.com/novolog.pdf, stated, ". . . NOVOLOG® is rapid acting human insulin analog indicated to improve glycemic control in adults and children with diabetes mellitus . . .throw away all opened NovoLog vials after 28 days. . . ." - Observation on 12/04/19 at 8:07 a.m., showed a staff nurse (#3) preparing to administer NovoLog insulin to Resident #17. A hand written note on the insulin box stated, "opened 10/18/19 throw 11/18/19." When this surveyor brought this to the attention of the staff nurse (#3), she confirmed the vial out dated several days ago. During an interview on 12/04/19 at 3:46 p.m., an administrative nurse (#1) agreed staff should have discarded the outdated insulin vial. MEDICATION STORAGE 2. Based on observation, record review, review of facility policy, and staff interview, the facility failed to ensure staff stored medications securely in 1 of 1 medication refrigerator observed. Failure to ensure staff properly disposed of a partially used Lorazepam vial (a controlled medication) may result in drug diversion. Findings include: Review of facility policy titled "Storage of Drugs & Biologicals", occurred on 12/04/19. This policy, dated 3/08/10, stated, "Drugs and biological are stored in accordance with manufacturer's directions and state and federal requirements. . . . Any time controlled medication/substance is destroyed or disposed of . . . documentation is	F 761	properly dispose of expired medications and open controlled medications. Nurses nightly checklist will be revised to check insulin for outdates and to check that no open vials are unsecured in medroom/fridge. A lock box has been ordered for the medication fridge to allow for open controlled medication to be stored properly. A mandatory all staff in-service will be held with POC□s on 1/6/2020. 4. QI monitoring will be done by DON/QI designee for resident #17 and all residents on insulin to ensure that insulin is disposed of on the correct date per protocol. QI monitoring will also include monitoring the date of disposal on the vials. QI monitoring will be implemented on all opened controlled vials in the medication fridge. QI monitoring will be done by DON/QI designee weekly x4, then monthly x2, then quarterly x 2 unless determined by the QI committee at the monthly meeting. 5. 1/8/2020	

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F 761	Continued From page 5 required. . . ." - Observation of the medication room occurred on 12/04/19 at 3:05 p.m. and showed an opened two milligram vial Lorazepam (an antianxiety medication) in the medication refrigerator and medication still in the vial. The staff failed to label the vial with a resident's name and an open date. During an interview on 12/04/19 at 3:30 p.m., a staff nurse (#3) stated, "Resident #20 had needed a dose Monday or Tuesday and they [nurse] got it from the hospital and should have wasted what they didn't use." Review of Resident #20's medical record occurred all days of survey. Review of a physician's order identified an order, dated 12/01/19, to administer one milligram of Lorazepam IM (intramuscularly) STAT (immediately). During an interview on 12/04/19 at 3:46 p.m., an administrative nurse (#1) stated emergency medications, including controlled substances, are obtained from the Pyxis (automated medication dispensing system) at the hospital. Any medication not administered to a resident is then wasted through the Pyxis with a hospital nurse. The administrative nurse (#1) agreed the remaining Lorazepam should have been wasted on 12/1/19.	F 761		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F 812		1/8/20

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F 812	Continued From page 6 §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to ensure staff follow standards of practice when storing food in 1 of 1 kitchen. Failure to ensure foods are stored at appropriate temperatures, and failure to ensure the cleanliness of food storage areas has the potential to result in foodborne illness to residents, staff, and visitors. Findings include: TEMPERATURES Review of the facility policy titled "Food Storage" occurred on 12/05/19. This undated policy, stated, ". . . refrigerated food storage . . . temperatures for refrigerators should be between 35-39 degrees F (Fahrenheit) . . . check for proper functioning of the unit . . . all foods should	F 812	1. The policy entitled Refrigerator and Freezer Temperature Maintenance was implemented on 12/10/2019. Fridge #3 was serviced by Polar Refrigeration on 11/21/2019 and has been called to come service it again; will be here 12/23/19. Disposable plastic storage covers are used on all individual serving size containers that are stored in the fridge. Staff was educated on 12/18/2019 regarding covering individual serving containers and the Refrigerator and Freezer Temperature Maintenance Policy. Staff member that did not follow policy and cover items in fridge is no	

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F 812	Continued From page 7 be covered, labeled and dated . . ." During the initial kitchen tour on 12/02/19 at 12:55 p.m., observation showed the temperature of refrigerator #3 measured 29 degrees F. The refrigerator contained several partially frozen items including eight half gallons of milk, two large packages of shredded cheese, butter, and eggs. Review of the "daily food temperature record" indicated refrigerator #3 temperatures out of range for 8 out of 8 consecutive days from 11/27/19 to 12/04/19. Temperatures ranged from 20 degrees F to 34 degrees F. During an interview on 12/02/19 at 1:15 p.m., a dietary staff member (#5) stated they have "been having problems with refrigerator #3 the past few weeks" and have not had it repaired. STORAGE On 12/02/19 at 12:55 p.m. during the initial kitchen tour, observation showed approximately 25 uncovered, undated bowls containing a whip cream topped dessert with a fan blowing directly on the food. During an interview on 12/04/19 at 11:59 a.m., a dietary staff member (#5) confirmed all food items should be covered and dated.	F 812	longer employed at TMC. 2. All residents have the potential to be affected by the facilities failure to ensure foods are stored at appropriate temperatures and all food items are covered in the refrigerator. 3. Dietary staff was educated on 12/18/2019 on Refrigerator and Freezer Temperature Maintenance Policy and re-educated on the proper storage of food. A mandatory all staff in-service will be held with POC□s on 1/6/2020. 4. QI monitoring will be done by DON/QI designee on refrigerator #3 and one random refrigerator/freezer temperatures daily x1 week, then weekly x1 month, monthly x3 then quarterly x2 unless determined by the QI committee at the monthly meeting. QI monitoring will be implemented on two random refrigerators/freezers daily x1 week, then weekly x1 month, monthly x3, then quarterly x2 unless determined by the QI committee at the monthly meeting to ensure that food is being stored/covered properly. 5. 1/8/2020.	
F 838 SS=C	Facility Assessment CFR(s): 483.70(e)(1)-(3) §483.70(e) Facility assessment. The facility must conduct and document a	F 838		1/8/20

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F 838	Continued From page 8 facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include: §483.70(e)(1) The facility's resident population, including, but not limited to, (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population; (iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population; (iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.70(e)(2) The facility's resources, including but not limited to, (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy,	F 838		

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F 838	Continued From page 9 pharmacy, and specific rehabilitation therapies; (iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to conduct a facility-wide assessment to evaluate the resident population and identify the resources needed to competently provide care and services to residents during both day-to-day operations and emergencies. This had the potential to affect all 24 residents currently residing in the facility. Findings include: On 12/02/19 at 1:00 p.m., two administrative staff members (#1 and #2) received a copy of the required items which included a copy of the Facility Assessment. During an interview on 12/04/19 at 4:36 p.m., an administrative nurse (#1) stated she remembered	F 838	1. The facility assessment was initially completed 11/27/2017. The facility assessment was updated and reviewed on 12/17/2019, 2. All residents have the potential to be affected by the facilities failure to conduct a facility-wide assessment to evaluate the resident population and identify the resources needed to competently provide care and services to them. 3. A mandatory all staff in-service will be held with POC□s on 1/6/2020. A calendar invite was sent out to the IDT members for annual review December 2020.	

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F 838	Continued From page 10 completing the assessment, but could not find it. The facility failed to provide a copy of the 2019 Facility Assessment.	F 838	4. QI monitoring will be done by DON/QI designee yearly x1 then determined by the QI committee to ensure that the facility assessment is reviewed annually. 5. 1/8/2020.	