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 _____	11/20/2018

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

(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 The standard Medicare/Medicaid survey started on 11/18/18 and concluded on 11/20/18.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance	F 578		12/25/18

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

Electronically Signed | 12/13/2018

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F 578	Continued From page 1 with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure the medical record for 1 of 14 sampled residents (Resident #25) accurately reflected the resident's Advanced Directive regarding code status. Failure to ensure the resident's medical record accurately reflected his/her wishes limited emergency personnel from knowing the residents' wants in the event of a medical emergency. Findings include: Review of Resident #25's medical record occurred all days of survey. The paper chart included a signed code status form and a sticker on the outside of the binder indicating a code level II (no CPR [cardiopulmonary resuscitation] status. The electronic medical record (EMR) indicated a code level II status on the face sheet and in a section of the EMR titled "Advance Directive." This showed inconsistency with the physician's orders which included an order for code level I (full code). During an interview on 11/19/18 at 4:25 p.m., an administrative nurse (#1) indicated she would expect all areas of the medical record to be consistent regarding code status.	F 578	1. Resident #25 orders were updated to reflect code level II as requested by the resident. 2. All residents have the potential to be affected by failure to ensure the resident□s medical record accurately reflects his/her wishes. 3. Staff will be educated on Advanced Directives and corresponding orders at the mandatory all staff in-service that will be held on 12/20/2018. 4. QI monitoring will be implemented for resident #25, along with 3 random residents to ensure that their advanced directives and their orders correspond. QI monitoring will be done by DON/QI designee weekly x4, then monthly x4, unless determined by the QI committee at the monthly meeting. 5. 12/25/2018	
F 658	Services Provided Meet Professional Standards	F 658		12/25/18

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F 658 SS=D	Continued From page 2 CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, review of professional reference, and staff interview, the facility failed to follow professional standards of practice during 2 of 14 observations of medication pass. Failure to ensure staff offered food within the recommended time frame after rapid-acting insulin administration may result in hypoglycemia (low blood sugar). Failure to assist a resident to a sitting position during medication administration may result in aspiration. Findings include: Prescribing information for NovoLog insulin, found at www.novo-pi.com/NovoLog., stated, ". . . NOVOLOG® is rapid acting human insulin analog indicated to improve glycemic control in adults and children with diabetes mellitus . . . Inject subcutaneously within 5-10 minutes before a meal into the abdominal area, thigh, buttocks or upper arm. . . ." Berman, Snyder, and Frandsen's "Kozier & Erb's Fundamentals of Nursing: Concepts, Process, and Practice," 10th ed., Pearson Education, Inc., Massachusetts, page 778 states ". . . assist the client to a sitting position . . . [this] position facilitates swallowing and prevents aspiration . . ."	F 658	1. Resident #4 will be given fast acting insulin sooner than 10 minutes before consuming food, or snack will be given at the time of insulin. Resident #14 will be assisted to sitting position before medication administration. 2. All residents on fast acting insulin have the potential to be affected by failure to meet professional standards of quality. All residents have the potential to be affected by failure to assist a resident to a sitting position during medication administration. 3. Staff will be educated regarding the administration timeline of Novolog insulin in regards to the resident□s first bite of food and assisting residents to sitting position before medication administration at the all staff in-service held on 12/20/2018. 4. QI monitoring will be implemented for resident #4 and #14, along with 3 random residents to ensure that professional standards of quality are met with insulin administration along with monitoring that residents are sitting up before medication administration is completed. QI monitoring will be done by DON/QI designee daily x4, weekly x4, then monthly x4, unless determined by the QI	

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F 658	Continued From page 3 -Observation on 11/18/18 at 5:18 p.m. showed a licenced nurse (#3) administered 14 units of NovoLog insulin to Resident #1. Observation showed Resident #1 received his meal tray at 5:50 p.m., 32 minutes after receiving NovoLog insulin. -Observation on 11/18/18 at 4:06 p.m. showed a licenced nurse (#3) administered an oral medication to Resident #14 while the resident was lying in bed at approximately a 25-30 degree angle. After attempting to swallow water in an effort to get the medication to go down into the stomach, the Resident coughed, wheezed, and started choking during the medication administration. During an interview on the morning of 11/20/18, an administrative nurse (#2) agreed staff are to assure residents receive food in a timely manner after fast acting insulin administration and proper positioning during oral medication administration to prevent aspiration is standard practice.	F 658	committee at the monthly meeting. 5. 12/25/2018	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:	F 684		12/25/18

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F 684	Continued From page 4 Based on observation, record review, review of professional literature, and staff interview, the facility failed to ensure 1 of 1 sampled resident (Resident #3) on a mechanically-altered diet received the services necessary to attain the highest degree of safety possible while being fed in the dining room. Failure to provide the appropriate thickened liquids placed Resident #3 at risk for aspiration. Findings include: Swigert's "The Source for Dysphagia," 3rd ed., Pro-Ed, Inc., Texas, 2007, pages 10 and educational handouts stated, ". . . Signs and Symptoms of Dysphagia . . . Coughing and choking are very obvious symptoms of dysphagia . . . Some patients cough or even clear their throats when they aspirate. . . ." - Review of Resident #3's medical record occurred on all days of survey. A progress note, dated 09/23/18, identified, "Resident noted to have difficulty in swallowing thin liquids, gurgling sound was noted, also noted to be coughing more excessively. . . . [Nurse Practitioner] was informed and order now made for resident to receive thickened liquids . . ." The current physician's orders included orders for a pureed diet and honey-thickened liquids secondary to a diagnosis of dysphagia. The current care plan further identified, ". . . Pureed diet with honey-thickened liquids: due to resident having a hard time chewing and coughs with thin liquids. . . ." Observations showed the following:	F 684	1. Resident #3 dietary tray card was updated to ensure resident proper fluid consistency was noted. Facility now has ordered pre-thickened liquids to match dietary orders. Thickening agents are also available in the kitchen to thicken if needed. 2. All residents with swallowing problems have the potential to be affected by failure to provide the appropriate thickened liquids. 3. Staff will be educated on appropriate thickened liquid consistencies and dietary cards at the mandatory all staff in- service that will be held on 12/20/2018. Education will be provided at the Mandatory C.N.A. meeting on 12/20/2018, and Mandatory Dietary Meeting held on 12/19/2018. 4. QI monitoring will be implemented for #3, along with 3 random residents to ensure that their dietary cards match dietary orders along with liquid consistency matching the dietary order. QI monitoring will be done by DON/QI designee weekly x4, then monthly x4, unless determined by the QI committee at the monthly meeting. 5. 12/25/2018	

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F 684	Continued From page 5 * 11/18/18 at 5:47 p.m., Certified Nursing Assistant (CNA) (#9) fed Resident #3 in the dining room. Resident #3's meal tray contained honey-thickened coffee, a shake, and glasses of thin milk and water. The CNA (#9) added a thickening agent to some of the liquids. When asked what type of liquids Resident #3 should have received on her tray, the CNA (#9) stated "Honey, nectar, no honey." Resident #3 cleared her throat/coughed during the meal. * 11/19/18 at 5:40 p.m., Two CNAs (#10 and #11) fed residents at Resident #3's table in the dining room. Resident #3's meal tray contained a shake, a glass of thin milk, and a glass of water. The glass of water appeared thin on top, with a thickening agent settled at the bottom. One of the CNAs (#11) gave Resident #3 a drink of thin milk from her glass. Resident #3 cleared her throat/coughed. The surveyor stopped the CNA (#11) from giving her more of the thin liquid. When asked what type of liquids Resident #3 should have received, both CNAs (#10 and #11) stated, "Honey." One of the CNAs (#10) added, "The dietary staff puts [Resident #3's] liquids on her tray, not always thickened. We've talked about it. They are currently out of liquid thickener packets, but can add whatever to it." During an interview on 11/19/18 at 5:50 p.m., an administrative nurse (#1) reported staff should refer to the resident's tray card to confirm his/her current diet. She also stated, "The thickening mix should be available for staff to ensure the correct liquid texture." Resident #3's tray card showed, "Fluids: Regular." During an interview on 11/20/18 at 8:05 a.m., a dietary staff member (#12) reported, "[Staff] had	F 684		

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F 684	Continued From page 6 the wrong tray card on the table last night. Dietary staff are to mix the thickened liquids in the kitchen. Due to the facility running out of the [liquid] thickener and the powdered thickener turning to cement, the dietary staff thicken the liquids part way and staff at the table add additional powder to ensure the correct thickness."	F 684		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, review of professional reference, and resident and staff interviews, the facility failed to provide the necessary care and services for 2 of 3 sampled residents (Resident #3 and #13) with orders for continuous oxygen. Failure to provide oxygen as ordered has the potential for residents to experience complications related to inadequate or excessive oxygen administration. Findings include: Berman, Snyder, and Frandsen, "Kozier & Erb's Fundamentals of Nursing Concepts, Process, and Practice," 10th ed., Pearson Education, Inc.,	F 695	1. Resident #3 and #13 concentrators were marked with the appropriate ordered oxygen. #13 care plan was updated to state that she refuses the amount ordered on the liquid oxygen and prefers a lesser amount. 2. All residents that receive oxygen have the potential for failure to ensure that a resident who needs respiratory care is provided such care according to professional standards of care. 3. Staff will be educated on oxygen therapy and receiving the proper liters ordered at the mandatory all staff meeting held on 12/20/2018. 4. QI monitoring will be implemented for	12/25/18

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F 695	Continued From page 7 New Jersey, pages 1257-1259, stated, "OXYGEN THERAPY . . . Like any medication, oxygen is not completely harmless to the client. Clients can receive an inadequate amount or an excessive amount of oxygen and both can lead to a decline in the client's condition. An inadequate amount of oxygen (hypoxia) will lead to cell death, and if left untreated can ultimately lead to death. Excessive amounts of oxygen can lead to pulmonary tissue damage . . ." Review of the facility's policy titled "OXYGEN THERAPY" occurred on 11/20/18 at 9:23 a.m. This policy, revised November 2015, stated, ". . . Observe provider's order. . . . Adjust liter flow as needed. . . ." - Observation in the chapel on 11/18/18 at 2:14 p.m. showed Resident #13 receiving 2L (liters) of O2 (oxygen) via NC (nasal cannula) from a portable O2 tank. She stated she receives 2L while using the portable tank and 5L while in her room using the oxygen concentrator. During an interview on 11/19/18 at 5:44 p.m., Resident #13 stated she was out of her room earlier on 2L of O2. She reported she became short of breath and had to turn her portable tank up to 3L. Review of Resident #13's medical record occurred all days of survey and included a physician's order for ". . . O2 AT 5L PER NC . . . " The current care plan stated, ". . . Oxygen 5 L per NC . . ." The TAR (Treatment administration record) stated, ". . . O2 AT 5L PER NC . . ." The shift report tool, dated 11/16, stated, ". . . Other . . . O2 5L . . . "	F 695	resident #3 & #13, along with 3 random residents to ensure that oxygen administration is provider per provider order. QI monitoring will be done by DON/QI designee daily x4, weekly x4, then monthly x4, unless determined by the QI committee at the monthly meeting. 5. 12/25/2018	

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F 695	Continued From page 8 During an interview on 11/20/18 at 9:23 a.m., an administrative nurse (#2) stated she expected staff to follow the physician's orders whether the resident received O2 from a portable tank or an oxygen concentrator. - Review of Resident #3's medical record occurred on all days of survey. The most recent physician's orders included an order for 2 L of continuous 02 via NC. The current care plan stated, "Administer oxygen therapy as ordered." Observations showed the following: *11/18/18 at 1:49 p.m., two certified nursing assistants (CNAs) (#4 and #8) entered Resident #3's room, transferred her into bed, adjusted her nasal cannula, and set the 02 concentrator on 4 L. Prior to exiting the room, they reported, "[Resident #3] is on two liters on her portable [tank]." Neither CNA questioned the discrepency in flow rates between the 02 concentrator and the portable tank. * 11/19/18 at 4:17 p.m., Resident #3 laid in bed with her nasal cannula in place, and the 02 concentrator set on 4 L. During an interview on 11/20/18 at 10:05 a.m., an administrative nurse (#2) confirmed staff should administer oxygen therapy per physician's order.	F 695		
F 730 SS=D	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these	F 730		12/25/18

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F 730	Continued From page 9 reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on review of performance evaluations, review of twelve months of education records, and staff interview, the facility failed to ensure certified nursing assistants (CNAs) received twelve hours of in-service education per year for 2 of 3 staff records reviewed. Failure to ensure CNAs A and B staff attended twelve hours of mandatory meetings/educational inservices per year may result in their lacking the necessary knowledge/skills to provide the care and services necessary to meet the residents' needs. Findings include: Review of staff performance evaluations and education records occurred on 11/20/18. CNA A and B's performance evaluations identified "below average attendance at mandatory meetings/educational inservices." The education records identified CNA A acquired approximately 6.5 continuing education hours and CNA B acquired approximately 7.5 hours during the 12 month period reviewed. During an interview on the morning of 11/20/18, an administrative nurse (#1) confirmed the facility failed to ensure all staff members completed twelve hours of in-service education per year.	F 730	1. New computer program purchased to provide mandatory training for all C.N.A.□s. 2. All C.N.A.□s have the potential to be affected by failure to complete 12 hours of yearly in-service. 3. Staff will be educated on mandatory in-service hours at the mandatory all staff meeting held on 12/20/2018. 4. QI monitoring will be implemented for 3 random C.N.A.□s to ensure that at least 3 hours are recorded of mandatory education is completed quarterly x4 totally 12 hours per year. 5. 12/25/2018	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program	F 880		12/25/18

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F 880	Continued From page 10 designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism	F 880		

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F 880	Continued From page 11 involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which 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; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to follow infection control practices for 3 of 3 sampled residents (Resident #13, #17, and #28) and 2 supplemental residents (Resident #10 and #12). Failure to practice infection control related to cleaning of transfer equipment (mechanical stand lift) has the potential for transmission of communicable diseases and infections to residents and staff. Findings include:	F 880	1. Residents #10, #12, #13, #17, & #28 lifts are cleaned in between use. 2. All residents that require transfer lifts have the potential to be affected by failure to follow infection control practices related to the use of transfer lifts. 3. Staff will be educated on proper lift cleaning, along with cleaning wipes having been placed in a cleanable bag on each transfer lift at the mandatory all staff meeting held on 12/20/2018. 4. QI monitoring will be implemented for	

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 _____	11/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 12 - During an observation on 11/18/18 at 2:32 p.m., two certified nursing assistants (CNA's) (#5 and #6) transferred Resident #13 from her wheelchair to a bedside commode and back to her wheelchair using a mechanical stand lift. Following the transfer, the CNAs placed the lift in the hallway and failed to disinfect it. - During an observation on 11/18/18 at 3:22 p.m., two CNA's (#5 and #7) transferred Resident #10 from his bed to the toilet and then to his wheelchair using a mechanical stand lift. Following the transfer, the CNAs placed the lift in the hallway and failed to disinfect it. - During an observation on 11/18/18 at 4:15 p.m., two CNA's (#9 and #16) transferred Resident #12 from the bathroom to his/her wheelchair with a mechanical stand lift. Following the transfer, the CNAs placed the lift in the hallway and failed to disinfect it. - During an observation on 11/18/18 at 5:23 p.m., two CNA's (#10 and #4) transferred Resident #17 from his/her bed to wheelchair with a mechanical stand lift. Following the transfer, the CNAs took the lift to an exam room and failed to disinfect it. - During an observation on 11/18/18 at 5:29 p.m., two CNA's (#4 and #10) transferred Resident #28 from his/her recliner to the wheelchair with a mechanical stand lift. Following the transfer, the CNAs took the lift to the soiled utility room and failed to disinfect it. - During an observation on 11/19/18 at 11:16 a.m., two CNA's (#11 and #5) transferred Resident #17 from his/her wheelchair to the toilet	F 880	residents #10, #12, #13, #17, & #28 along with 1 random resident to ensure proper infection control practices are completed in between lift use. QI monitoring will be done by DON/QI designee daily x4, weekly x4, then monthly x2, unless determined by the QI committee at the monthly meeting. 5. 12/25/2018	

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F 880	Continued From page 13 and back to the wheelchair using a mechanical stand lift. Following the transfer, the CNAs placed the lift in the hallway and failed to disinfect it. During an interview on 11/20/18 at 8:34 a.m., an administrative nurse (#2) stated she expected staff to disinfect transfer equipment between each resident. During an interview on the morning of 11/20/18, and administrative nurse (#2) stated it is expected that staff are to disinfect any transfer equipment used between each resident.	F 880		