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 _____	02/05/2024

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 recertification survey started on 01/29/24 and concluded 02/05/24.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy,	F 609	1. Resident #26 fall with major injury was	3/11/24

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

Electronically Signed | 02/17/2024

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F 609	Continued From page 1 and staff interview, the facility failed to investigate and report to the State Survey Agency (SSA) potential incidents of abuse/neglect for 1 of 1 sampled resident (Resident #26) who experienced a major injury. Failure to investigate and report allegations of potential abuse/neglect to the SSA places all residents at risk of potential abuse/neglect. Findings include: Review of the facility policy titled "Abuse, Neglect and Exploitation" occurred on 01/31/24. This policy, dated January 2021, stated, ". . . It is the policy of this facility to report all allegations of abuse/neglect/exploitation . . . including injuries of unknown sources . . . immediately to . . . appropriate agencies in accordance with state and federal regulations within prescribed timeframes. . . . Immediately: Means as soon as possible . . . not later than 2 hours after . . . events that cause the allegation involve or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse . . . Injuries of unknown source: . . . injury was not observed by any person, or the source of injury could not be explained by the resident; and the injury is suspicious because of the extent of the injury. . ." Review of Resident #26's medical record occurred on 01/29/24. Nurses' notes identified the following: * 01/10/24 6:20 a.m., "the CNA [certified nurse aide] heard a loud thud sound in the resident's room and saw the resident on the floor lying on his right side near the drawer of his roommate. This nurse hurriedly assessed the resident and,	F 609	reported to SSA on 2/1/2024 with follow up investigation completed 2/7/2024. 2. All residents have the potential to be affected by the facilities failure to investigate and report to the SSA potential incidents of abuse/neglect. 3. Nursing staff was educated on 2/12/24 of TMC policy on Abuse, Neglect and Exploitation and appropriate reporting as well as reporting within timeframes. All staff will be educated on the policy and procedure at a mandatory all staff meeting on 2/21/24. 4. QI monitoring will be implemented on 3 random incidents (or less if not 3) to ensure investigation is completed and any alleged abuse/neglect is reported to SSA as required. QI monitoring will be done by the DON/QI designee, weekly x 4, monthly x 3, then quarterly x 2 unless otherwise determined by the QI committee at the monthly meeting. 5. 3/11/2024	

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F 609	Continued From page 2 he was alert with memory lapses and some confusion wherein he couldn't recognize nurse [nurse name] whom he usually knows. . . . Bump was noted on back of his head on the right side, wound abrasion noted on tip of his nose. . . . The resident complained of headache, nausea, and vomiting. . . . head CT [computed tomography] scan result showed bilateral subarachnoid hemorrhage (heavy discharge of blood from the blood vessels) along frontal and temporal lobe. . . ." The record lacked evidence the above incident was reported to the SSA as possible abuse/neglect. During an interview on the morning of 02/01/24, two nurses (#1 and #2) confirmed the fall was unwitnessed and the resident appeared to be confused about what had happened. The nurse (#1 and #2) confirmed the facility failed to report the above incident to the SSA.	F 609		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.18.11), and staff interview, the facility failed to ensure accurate coding of the Minimum Data Set (MDS) for 1 of 11 sampled residents (Resident #5). Failure to accurately complete the MDS does not allow each resident's assessment to	F 641	1. Resident #5 MDS was corrected and resubmitted on 2/14/24. 2. All residents have the potential to be affected by the facilities failure to ensure accurate coding of the MDS. 3. MDS Coordinator will review dietary section K, as entered by dietary manager, for correct weight prior to submitting	3/11/24

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F 641	Continued From page 3 reflect their current status/needs and may affect the development of a comprehensive care plan and the care provided to the residents. Findings include: The Long-Term Care Facility RAI User's Manual, revised October 2023, Section K: Swallowing/Nutritional Status, pages K-3 through K-6, stated, ". . . K0200A: Weight: 1. Base weight on the most recent measure in the last 30 days. . . . K0300: Weight Loss . . . Coding Instructions . . . Code 1, yes on physician-prescribed weight-loss regimen: if the resident has experienced a weight loss of 5% or more in the past 30 days or 10% or more in the last 180 days, and the weight loss was planned and pursuant to a physician's order. . . . Code 2, yes, not on physician-prescribed weight-loss regimen: if . . . the weight loss was not planned and prescribed by a physician. . . ." Review of Resident #5's medical record occurred on all days of survey. A quarterly MDS, dated 12/05/23, identified a weight of "143" pounds and "no" weight loss. Weights recorded by staff included: 06/01/23 = 151.0 pounds (lbs) 09/01/23 = 145.4 lbs 11/27/23 = 134.3 lbs On 11/27/23, these weights reflected a 7.6% weight loss over 3 months and a 11.1% loss over 6 months. During an interview on 01/31/24 at 10:00 a.m., a dietary manager (#3) confirmed staff entered	F 641	MDS. Staff will be educated on the accurate coding of the MDS at the mandatory all staff meeting on 2/21/24. 4. All current MDS section K will be reviewed to ensure it is accurately coded. QI monitoring will be implemented on resident #5 section K of MDS quarterly x 1 year. QI will be done on 3 random residents section K of MDS weekly x 4, monthly x 2 then quarterly x 2 unless determined otherwise by the QI committee at the monthly meetings. 5. 3/11/24	

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F 641	Continued From page 4 Resident #5's weight incorrectly on the 12/05/23 MDS and failed to code Section K as weight loss.	F 641		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review, review of the North Dakota Provider Manual for Preadmission Screening and Resident Review (PASRR) and Level of Care Screening Procedures for Long Term Care Services, and staff interview, the facility failed to complete a status change assessment for 1 of 4 sampled residents (Resident #13) reviewed for PASRR. Failure to complete a change in status assessment with a newly diagnosed mental illness and/or change in treatment may result in the delivery of care and services that are inconsistent with residents'	F 644	1. Resident #13 PASRR was updated 2/12/24. 2. All residents have the potential to be affected by the faciliies failure to complete a status change assessment for PASRR, which may result in the delivery of care and services that are inconsistent with the residents' needs. 3. LSW and DON reviewed F tag on 2/12/24. LSW will review level 1 webinar from 2/1/24 and LOC webinar from 2/6/24 presented by Maximus ND PASRR.	3/11/24

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F 644	Continued From page 5 needs. Findings include: The North Dakota PASRR Provider Manual, revised December 2020, page 13, states, ". . . Change in Status Process: Whenever the following events occur, nursing facility staff must contact [the contracted agency] to update the Level I screen for determination of whether a first time or updated Level II evaluation must be performed. These situations suggest that a significant change in status has occurred: . . . If an individual with MI, ID, and/or RC [mental illness, intellectual disability, and conditions related to intellectual disability (referred to in regulatory language as related conditions or RC)] was not identified at the Level I screen process, and that condition later emerged or was discovered. . . ." Review of Resident #13's medical record occurred on all days of survey. A PASRR Level I screen, dated 02/25/21, included a mental health diagnoses of major depression. The outcome by the contracted agency, dated 03/1/21, stated, ". . . A level II evaluation is not required, this level 1 is approved with a level 1 negative outcome. If changes occur or new information refutes these findings, a new screen must be submitted." A psychiatry note, dated 07/07/23, stated, ". . . behaviors have improved with risperidone [antipsychotic] - accusing people of people stealing from him - other concerns toward his in-laws. . . . once you get on [name of Resident #13]'s bad side - he really becomes very paranoid - and he does not forget. . . . AXIS 1:	F 644	Diagnosis log will be started by the DON to record any new diagnosis', log will be reviewed at LTC Risk Management meeting every 1-2 weeks. Staff will be educated on status change assessments and new diagnosis' at mandatory all staff on 2/21/24. 4. All current residents diagnosis lists will be reviewed for any new mental illness diagnosis' and PASRR will be updated as needed. QI monitoring will be implemented on any new mental illness diagnosis charts to ensure a PASRR is completed when needed. QI will be done by DON/QI designee x 1 year, unless determined otherwise by the QI committee at the monthly QI meeting. 5. 3/11/2024	

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F 644	Continued From page 6 F20.9 [diagnosis code for schizophrenia] . . ." A physician's progress note, dated 7/13/23, stated, ". . . was begun on risperidone in addition to his zoloft [antidepressant] . . . dx [diagnosis] . . . schizophrenia, unspecified. . . . plan . . . we will follow his response to the risperidone for his behaviors. . . . " The medical record lacked evidence of an updated Level I screen with the new diagnosis of schizophrenia and an antipsychotic medication. During an interview on 02/01/24 at 10:00 a.m., a social worker (#4) agreed a new diagnosis of schizophrenia required submission of an updated Level I screen and confirmed the facility failed to complete a change in status Level I screen for Resident #13.	F 644		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and resident and staff interview, the facility failed to provide appropriate assistance and assistive devices for 1 of 4 sampled residents (Resident #3) observed during a transfer. Failure to use a gait belt and provide	F 689	1. Nursing staff, including CNA #5, were re-educated on gait belt use for resident #3 and all resident transfers per policy on 2/12/24. Staff will use a gait belt for all assisted transfers for resident #3. 2. All residents have the potential to be	3/11/24

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F 689	Continued From page 7 appropriate assistance during a pivot transfer places the resident and staff at risk for accidents, falls, and/or injuries. Findings include: Review of the facility policy titled "Transfer/Gait Belts" occurred on 01/31/24. This policy, dated November 2015, stated, . . . Staff transferring residents will properly apply and use a transfer/gait belt . . . transferring residents whose . . . balance is impaired . . . strength is decreased . . ." Review of Resident #26's medical record occurred on all days of survey. The current care plan stated, ". . . Limited assist/one-person physical assist. Resident transfers with assistance but is unable to walk. Can stand well enough to transfer. . ." A progress note, dated 11/28/2023 at 4:14 p.m., stated, ". . . one person stand by assist for transfers with gait belt. . . ." Observation on 01/29/24 04:02 p.m. showed a certified nurse aide (CNA) (#5) assisted Resident #3 to a standing position from the edge of the bed by lifting under the left arm. The resident's left arm stayed next to his body and tremored while he pivoted to the right without assistance from the CNA. The CNA failed to apply a gait belt before assisting with the transfer. During an interview on 01/30/24 at 6:00 p.m., Resident #3 confirmed his left arm weakness. During an interview on the morning of 02/01/24, an administrative nurse (#1) stated she expected staff to transfer Resident #3 with a gait belt and	F 689	affected by the facilities failure to provide appropriate assistance and assistive devices making all residents at risk for accidents, falls and/or injuries. 3. Transfer/gait belts policy will be reviewed and updated. Nursing staff, including CNA #5 were re-educated on gait belt use on 2/12/24. Staff will be educated on transfer/gait belt policy at mandatory all staff meeting on 2/21/24. 4. QI will be implemented for resident #3 and 3 random residents to ensure gait belt is being used with transfer. QI will be done by DON/QI designee daily x 5, weekly x 3, monthly x2 then quarterly x 3 unless otherwise noted by QI committee at monthly QI meeting. 5. 3/11/2024	

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F 689	Continued From page 8 not lift under his arm.	F 689		
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 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: Based on observation, review of facility policy, and staff interview, the facility failed to ensure safe and secure storage of controlled medications for 1 of 1 medication cart. Failure to store medications securely may result in unauthorized access to medications.	F 761	1. Medication storage policy will be updated. Pharmacy was made aware of policy and change needed. Resident #13 medication will be repackaged via pharmacy and placed in counters in narcotic locked drawer within medication cart.	3/11/24

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F 761	Continued From page 9 Findings include: Review of the facility policy titled "Medication Storage" occurred on 02/01/24. This policy dated January 2020, stated, ". . . Schedule II drugs and back up stock for III, IV, and V medications are stored under double-lock and key. . . ." This policy failed to address the requirement of controlled medications II-V needing to be locked in a permanently affixed compartment within the medication cart. Observation of the medication cart with a nurse (#2) occurred on 02/01/24 at 11:10 a.m. and showed a bottle of gabapentin (nerve pain medication) for Resident #13 stored with non-controlled medications and not double locked. The nurse (#2) stated, "I was unaware this needed to be locked." During an interview on the morning of 02/01/24, an administrative nurse (#1) confirmed staff failed to double lock the controlled medication.	F 761	2. All residents have the potential to be affected by the facilities failure to address the requirement of controlled medications II-V needing to be locked in a permanently affixed compartment of the medication cart. 3. All residents medications will be reviewed for any narcotics not properly stored in medication cart. Nursing staff updated on list of controlled medications needing to be locked in medication cart narcotic drawer on 2/12/24. All staff will be educated on policy at all staff mandatory meeting on 2/21/24. 4. QI will be implemented for resident #13 medications long with 2 random residents receiving narcotics to ensure narcotics are properly locked in compartment on medication cart. QI will be done by DON/QI designee weekly x 4, monthly x 5 then quarterly x 2 unless determined otherwise by the QI committee at the monthly QI meeting. 5. 3/11/2024	
F 880 SS=D	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 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	F 880		3/11/24

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F 880	Continued From page 10 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 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	F 880		

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F 880	Continued From page 11 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, review of facility policy, and staff interview, the facility failed to follow standards of infection control for 1 of 7 sampled residents (Resident #26) observed during toileting cares. Failure to follow infection control standards has the potential to transmit infections to residents, staff, and visitors. Findings include: Review of the policy/procedure titled "Hand Hygiene" occurred on 02/01/24. This policy, dated January 2022, stated, ". . . Hand hygiene is indicated and will be performed. . . After assistance with personal body functions . . ." Observation on 01/29/24 at 2:49 p.m. showed two certified nurse aides (CNAs) (#5 and #6) transferred Resident #26 onto the toilet. The CNA (#5) donned gloves and performed perineal	F 880	1. Nursing staff, including CNA #5, was educated on the hand hygiene policy; infection control standards for all residents including resident #26 on 2/12/24. Staff will practice proper glove removal and hand hygiene procedures with all cares for resident #26. 2. All residents have the potential to be affected by the facilities failure to follow infection control standards with the potential to transmit infections to residents, staff and visitors. 3. Nursing staff was re-educated on the infection control standards on 2/12/24. All staff will be educated on infection control standards at mandatory all staff on 2/21/24 4. QI will be implemented for resident #26 and 3 random residents to ensure proper hand hygiene is being done with cares.	

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 _____	02/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 12 cares. Without removing the soiled gloves, the CNA (#5) transferred Resident #26 to bed, adjusted the resident in bed, moved the resident's bedside table, closed an open bag of chips, moved the resident's water, and adjusted the resident's call light pendant. The CNA (#5) then removed the soiled gloves and performed hand hygiene. The CNA (#5) failed to remove gloves and perform hand hygiene after perineal cares and before assisting the resident with other tasks. During an interview on the morning of 02/01/24, an administrative nurse (#1) stated she expected staff to remove gloves after personal cares and perform hand hygiene.	F 880	QI will be done by DON/QI designee weekly x 4, monthly x2 then quarterly x 3 unless otherwise noted by QI committee at monthly QI meeting. 5. 3/11/2024	