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 _____	12/07/2017

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 For the standard Medicare/Medicaid recertification survey, started on 12/04/17 and completed on 12/07/17, the sample included 12 residents for review and 2 closed records for review.	F 000		
F 574 SS=C	Required Notices and Contact Information CFR(s): 483.10(g)(4)(i)-(vi) §483.10(g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including: (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes - (A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section; (B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act. (C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and (D) A statement that the resident may file a complaint with the State Survey Agency	F 574		1/11/18

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

Electronically Signed | 12/22/2017

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F 574	Continued From page 1 concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.) (iii) Information regarding Medicare and Medicaid eligibility and coverage; (iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program; (v) Contact information for the Medicaid Fraud Control Unit; and (vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. This REQUIREMENT is not met as evidenced by: Based on interview with the resident council,	F 574	1. No one resident was affected by this	

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F 574	Continued From page 2 observation, review of the admission packet, and staff interview, the facility failed to provide residents, in writing, with a complete and/or accurate list of names, addresses (mailing and email), and/or telephone numbers of all the pertinent State regulatory, advocacy, and informational agencies, which includes the State Survey, Certification & Licensure Agency, the State Long-Term Care Ombudsman program, the protection and advocacy project, the agency to report Medicaid fraud and abuse, adult protective services, the aging and disability resource link, the local contact agency for returning to the community, and the home and community-based services program; and failed to provide residents with a statement that they may file a complaint with the State Survey Agency concerning any suspected violation of nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. Failure to provide this written information to residents has the potential to limit residents' and their families' access to these agencies. Findings include: During the resident council interview conducted on 12/06/17 at 9:00 a.m., the residents revealed they were not clear about how to contact the pertinent State regulatory, advocacy, informational agencies, etc. Observation on December 06-07, 2017, showed a binder located by the entrance to the central bath, that contained written information for the	F 574	deficiency. The facility posted a list of names, addresses, and telephone numbers of all pertinent State agencies and advocacy groups and corrected the binder. The resident council will be notified at their next monthly meeting held 12/28/2017 The updated information will also be sent to family members. 2. All residents have the potential to be affected by failure to be notified of required notices and contact information. 3. The postings and the binder were updated with correct contact information. Staff will be re-educated on required notices and contact information and where it can be found at the mandatory all staff meeting held on 12/27/2017. 4. QI monitoring will be implemented on postings/binder to ensure pertinent and correct information is listed. QI monitoring will be completed by the DON/QI Designee weekly X 2 then monthly x3 and then quarterly x2, unless determined otherwise by the QI committee at the monthly meeting. 5. 1/11/2018	

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F 574	Continued From page 3 residents and public to view. The binder contained a list with some names, mailing addresses, and telephone numbers, such as the State Ombudsman program, the State Survey Agency, etc. However, the list contained some inaccurate information (i.e. names, addresses, etc.) and failed to include all the pertinent required agencies. In addition, the binder lacked a statement informing residents that they may file a complaint with the State Survey Agency concerning any suspected violation of nursing facility regulations, non-compliance with the advance directives requirements, and requests for information regarding returning to the community. On the morning of 12/06/17, review of the facility packet of written information/material provided to the residents upon admission contained the same inaccurate information as in the above-stated binder. During an interview on the morning of 12/07/17, two administrative staff members (#4 and #5) verified the facility failed to provide residents, in writing, with a complete and/or accurate list of names, addresses, and/or telephone numbers of all the pertinent State regulatory, advocacy, and informational agencies.	F 574		
F 575 SS=C	Required Postings CFR(s): 483.10(g)(5)(i)(ii) §483.10(g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives: (i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the	F 575		1/11/18

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F 575	Continued From page 4 State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and (ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to post a complete and/or accurate list of names, addresses (mailing and email), and/or telephone numbers of all the pertinent State agencies and advocacy groups on 2 of the 2 days observed (December 06-07, 2017); and failed to post a statement that the resident may file a complaint with the State survey agency concerning any suspected violation of nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements, and requests for information regarding returning to the community. Failure to provide this written information to residents has the potential to limit residents' and their families' access to these agencies.	F 575	1. The facility posted a complete and accurate list of names, addresses (mailing and email), and telephone numbers of all the pertinent State agencies. The facility posted a statement that the resident may file a complaint with the State survey agency concerning any suspected violation of nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements, and requests for information regarding returning to the community. The updated information will also be sent to family members.	

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F 575	Continued From page 5 Findings include: During the resident council interview conducted on 12/06/17 at 9:00 a.m., the residents revealed they were not clear about how to locate information on how to contact the pertinent State regulatory, advocacy, and informational agencies. Observation on December 06-07, 2017, showed a bulletin board located by the entrance to the dining room, that contained a list with some names, mailing addresses, and telephone numbers, such as the State Long-Term Care Ombudsman program, the State Survey Agency, etc. However, the list contained inaccurate information (i.e. names, addresses, etc.) and failed to include all the pertinent required agencies. In addition, the bulletin board lacked a statement informing residents that they may file a complaint with the State Survey Agency concerning any suspected violation of nursing facility regulations, non-compliance with the advance directives requirements, and requests for information regarding returning to the community. During an interview on the morning of 12/07/17, two administrative staff members (#4 and #5) verified the facility failed to post a complete and/or accurate list of names, addresses, and/or telephone numbers of all the pertinent State agencies and advocacy groups.	F 575	2. All residents have the potential to be affected by failure to have complete and accurate contact information to file a complaint with the State. 3. The correct contact information along with a statement notifying residents how to file a complaint with the State was posted. Staff will be re-educated on required notices and contact information and where it can be found at the mandatory all staff meeting held on 12/27/2017. 4. QI monitoring will be implemented on postings/binder to ensure accurate state agency information is provided so residents/families have information needed to file a complaint if desired. QI monitoring will be completed by DON/QI Designee weekly x 2 then monthly x3 and then quarterly x2, unless determined otherwise by the QI committee at the monthly meeting. 5. 1/11/2018	
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must--	F 582		1/11/18

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F 582	Continued From page 6 (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually	F 582		

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F 582	Continued From page 7 resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on review of Medicare Part A letters/notices and staff interview, it was determined the facility failed to provide a letter/notice (either the uniform denial letter or the Skilled Nursing Facility Advanced Beneficiary Notice Form CMS-10055, and the CMS 10123-NOMNC) with correct/accurate content to 2 of 2 residents (Resident #1 and #20) discharged in the last 6 months from Medicare covered Part A stay, with benefit days remaining. Failure of the facility to provide letters/notices that contained correct/accurate information limited the residents' ability to exercise their rights in regard to Medicare Part A services. Findings include: On the morning of 12/06/17, review of the Medicare Part A letters/notices for Resident #1 and #20 showed the facility altered the Centers for Medicare and Medicaid Services (CMS) uniform denial letters underneath the section of "Request for Medicare Intermediary Review." Altering the denial letters resulted in the content not being correct/accurate. The denial letters	F 582	1. The facility updated the Medicare Liability notice. Resident #1 & #20 were discharged from Medicare greater than 60 days ago. 2. All residents have the potential to be affected by failure to be given a letter/notice with correct/accurate content that were discharged from Medicare. 3. The Medicare Liability notice was updated and correct with the correct content. Staff will be re-educated on required notices and contact information and where it can be found at the mandatory all staff meeting held on 12/27/2017. 4. QI monitoring will be done on each resident issued a Medicare denial form; the QI will be done prior to the form being given to the resident/family to ensure the correct form/information is given. QI monitoring will be completed by the DON/QI designee weekly x 2, then monthly x 2, then quarterly	

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F 582	Continued From page 8 reviewed included the following: * Resident #1 - denial letter signed & dated 07/29/17. * Resident #20 - denial letter signed & dated 08/17/17. On the morning of 12/06/17, review of the CMS 10123-NOMNC (Notice of Medicare Noncoverage) forms for Resident #1 and #20 showed the facility used forms with an expiration date of 07/31/2011. The current CMS 10123-NOMNC notice has an approved date of 12/31/2011. Not using the current form resulted in the content not being correct/accurate. The CMS 10123-NOMNC forms reviewed included the following: * Resident #1 - denial letter signed & dated 07/29/17. * Resident #20 - denial letter signed & dated 08/09/17. During an interview on 12/06/17 at 11:00 a.m., an administrative nurse (#4) verified the denial letters and notices for Resident #1 and Resident #20 did not include the required content, as identified on the CMS website.	F 582	x 2, unless determined otherwise by the QI committee at the monthly meetings. 5. 1/11/2018	
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State	F 623		1/11/18

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F 623	Continued From page 9 Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged;	F 623		

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F 623	Continued From page 10 (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure	F 623		

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F 623	Continued From page 11 to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on review of transfer/discharge notices and staff interview, the facility failed to provide a written notice of discharge that included all the required content, for 2 of 2 residents (Resident #3 and #28) discharged home in the past 90 days. Failure of the facility to provide discharge notices with all the required content limited the residents' ability to exercise their resident rights. Findings include: On the morning of 12/07/17, review of discharge notices for Resident #3 and #28 showed the facility failed to include all the necessary contents. The discharge notices contained the first and last name of a previous State Long-Term Care Ombudsman and lacked the following contents: * The email address of appeals supervisor. * Information on how to obtain an appeal form, and assistance in completing the form and submitting the appeal hearing request. * The email address of the Office of the State Long-Term Care Ombudsman. * The email address of the Office of Protection and Advocacy. The discharge notices reviewed included the following: * Resident #3's discharge notice signed &	F 623	1. The facility updated the Notice of Transfer/Discharge notice. Resident #3 and #28 were discharged greater than 30 days ago. 2. All residents have the potential to be affected by failure to include all the necessary content of discharge notices. 3. The Notice of Transfer/Discharge notice was updated with necessary and correct information. . Staff will be re-educated on required notices and contact information and where it can be found at the mandatory all staff meeting held on 12/27/2017. 4. QI monitoring will be completed by the DON/QI designee to ensure correct and accurate forms/content is provided to each resident that is discharged or transferred. QI monitoring will be completed weekly x 2, then montly x 2, then quarterly x 2 unless determined otherwise by the QI committee at the monthly meeting. 5. 1/11/2018	

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F 623	Continued From page 12 dated 09/01/17; and * Resident #28's discharge notice signed & dated 11/07/17. During an interview on the morning of 12/07/17, an administrative staff member (#5) verified the discharge notices for Resident #3 and Resident #28 did not include the required content.	F 623		
F 657 SS=D	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.	F 657		1/11/18

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	355034	A. BUILDING _____ B. WING _____	12/07/2017

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F 657	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to review and revise the comprehensive care plan to reflect the residents' current status for 2 of 12 sampled residents (Resident #14 and #22). 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 the facility policy titled "Baseline Care Plan" occurred on 12/06/17. This policy, dated November 2017, stated, ". . . 4. In the event that the comprehensive assessment and comprehensive care plan identified a change in the resident's goals, or physical, mental, or psychosocial functioning, which was otherwise not identified in the baseline care plan, those changes shall be incorporated into an updated summary provided to the resident and his or her representative, if applicable." - Observation on 12/04/17 from 12:02 p.m. to 1:00 p.m., showed Resident #22 received tortellini with meat sauce, cake, green beans, a bread stick, juice and water. During the observation Resident #22 had consumed less than 25% of her meal independently. Resident #22 began to doze and then perked up and ate her cake. Staff did not encourage and or cue Resident #22 to eat. Review of the meal intake record showed Resident #22 ate 50% and drank 260 cubic centimeters (cc) of the liquids provided.	F 657	1. Resident #14 & #22 care plans were updated. Dietary/nursing staff was re-educated on resident likes/dislikes. Resident #14 dietary tray card was updated to ensure resident preferences. 2. All residents have the potential to be affected by failure to ensure the care plan addresses the residents current care needs; and dietary card reflects the resident□s current dining likes/dislikes and interventions. 3. Staff were educated on proper care planning along with dietary preferences and interventions. A mandatory all staff in-service will be held with POC□s on 12/27/2017. 4. QI monitoring will be implemented for residents #14 and #22, along with 3 random resident□s 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 implemented for residents #14 and #22, along with 3 random residents to ensure dietary tray cards are correct as well as meal being served is correct according to residents likes/dislikes. 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. 1/11/2018	

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F 657	Continued From page 14 Observation on 12/04/17 at 3:46 p.m., showed Resident #22 had a snack, coffee, and a four ounce drink. When asked, an activity staff member (#3) identified the drink as a supplement. Resident #22 independently drank all of the supplement, ate all the snack, and throughout the activity continued to sip her coffee. Review of Resident #22's medical record occurred on all days of survey and identified diagnoses including Alzheimer's disease. The current care plan stated, "Goal: Resident will maintain a healthy weight. Interventions: . . . Diet as ordered-requests small portions. Monitor percentage of meals. Report problem to nurse; I.E., choking, difficulty chewing. Provide mechanical soft diet per orders . . . Expected weight loss due to refusing to eat; aging/disease process. . . ." Review of nursing progress notes identified the following: * 11/07/17 at 12:21 p.m., "Resident was at feeding table today Resident did not allow staff to help her eat. Tried cueing resident to eat, resident was resistant. Only ate a few bites of her meal and small amount of her shake. Resident states that she doesn't want to eat because she isn't hungry." * 11/07/17 at 05:42 p.m., "Resident was agitated with being at the feeding table. Resident returned to normal table." * 11/27/17 at 02:44 p.m., "It was noticed that the resident has not eaten the past two days. Notified DON [Director of Nursing]. She advised to call resident's POA [power of attorney] to inform that resident has not been eating well . . ."	F 657		

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F 657	Continued From page 15 During an interview on 12/06/17 at 11:16 a.m. an administrative nurse (#1) confirmed the residents reactions to assistance, identified during the facility observation completed on 11/07/17, were not integrated into the resident's care plan. The care plan failed to address the residents resistance to cueing, and the necessity to return to a normal table. - Observation on 12/04/17 during the noon meal and on 12/06/17 during the breakfast meal showed Resident #14 sitting in her wheelchair at the dining room table eating attempting to feed herself. The resident's tray consisted of three coffee cups with lids and straws containing water, 4 ounces cranberry juice, and coffee. The water and juice were too far away for the resident to reach, so at each meal she drank mostly coffee. The resident's hands were unsteady and during both meals, the process was very slow with much of the food ending up on the clothing protector. Staff occasionally walked by and asked the resident if she needed anything. The resident responded with a "no" on most of those occasions. Staff failed to assist by ensuring the fluids were within the resident's reach or by assisting when much of the food fell onto her clothing protector. Review of Resident #14's medical record occurred on all days of survey. Diagnoses included hemiplegia, anxiety, and a history of weight loss. The current care plan stated, ". . . Dislikes chicken, tomatoes, some spicy foods. Encourage Res. [resident] to drink fluids with meals . . . Provide fluids, encourage intake of recommended fluid amounts . . . Accommadate	F 657		

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F 657	Continued From page 16 [sic] dietary preferences/dislikes . . . Honor food preferences as able . . . Assist with meals as needed. . . ." The current dietary tray card stated, ". . . Dislikes: Milk, Hot Cereal, Breads . . . Chicken, All Fish, All Tomato, Plums, Cabbage, Burritos, BBQ [Barbeque]. . . ." Observation of the above two meals showed the noon meal included a bread stick and a tomato-like sauce for the entree, and the breakfast meal included cream of wheat and toast. Staff served Resident #14 food that was on her dislike list. Review of the meal intake roster showed: * 12/04/17 lunch 0% eaten and fluid intake of 120 cc * 12/06/17 breakfast 50% eaten and fluid intake of 480 cc During an interview on 12/06/17 at 1:30 p.m., two supervisory staff members (#1 and #2) agreed the care plan failed to specifically address Resident #14's nutritional and dining likes/dislikes and interventions. Both staff members stated Resident #14 has requested to eat independently, usually refused staff assistance, refused to eat at a dining room assist table, and changed her mind frequently regarding food likes/dislikes. The facility failed to ensure the care plan and dietary tray card reflected the resident's current dining likes/dislikes and interventions.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards 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,	F 658		1/11/18

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F 658	Continued From page 17 must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, review of professional standards, and staff interview, the facility failed to ensure standards of practice were followed for 1 of 1 sampled resident (Resident #2) who had a fall with head and leg injury/pain. Failure to establish guidelines and/or follow professional standards for monitoring a fall with possible head injury and/or pain has the potential to delay identification and treatment of further or worsening signs/symptoms of injury. Findings include: Review of the Agency for Healthcare Research & Quality (www.ahrq.gov) "The Falls Management Program: A Quality Improvement Initiative for Nursing Facilities, Chapter 2, Fall Response," stated, ". . . Residents should have increased monitoring for the first 72 hours after a fall. Each shift, the nurse should record in the medical record a review of systems, noting any worsening or improvement of symptoms as well as the treatment provided. Reference to the fall should be clearly documented in the nurse's note. . . ." Review of the facility policy titled "Falling Star Fall Prevention Program" occurred on 12/06/17. This policy, dated November 2017, failed to address monitoring a resident after a fall with possible head injury. Review of Resident #2's medical record occurred on all days of survey. Diagnoses included	F 658	1. The facility implemented a falls policy to include guidelines related to nursing assessments and documentation after a resident fall with possible head and/or other injuries. Resident #2 fall was on 9/17/2017. 2. All residents have the potential to be affected by failure to ensure standards of practice were followed for residents who have a fall with injury/pain. 3. Staff will be educated on the new Falls Policy at the mandatory all staff in-service that will be held on 12/27/2017. 4. QI monitoring will be implemented on all falls to ensure that adequate assessment, follow through and documentation of the fall is completed; this includes any further falls resident #2 would have. QI monitoring will be done by the DON/QI designee weekly X 2 then monthly x3 then quarterly x2, unless determined otherwise by the QI committee at the monthly meeting. 5. 01/11/2018	

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F 658	Continued From page 18 Alzheimer's disease, dementia, and anxiety. Review of the progress notes showed the following: * 09/17/17 - "[8:00 a.m.] Resident was found on the floor by staff . . . When asked resident stated she didn't know what happened but was on her way to the restroom. Physical examination showed that the resident had a huge goose egg on the back of her head. It was also observed that her left leg was rotated inward . . . [8:12 a.m.] ER [emergency room] called and notified of the situation. Patient was transfer to the ER shortly thereafter. Neuro checks were done until the resident left for the ER." * 09/17/17 - 11:10 a.m. "Resident returned to LTC [long-term care] from the ER. CT [computed tomography] scan of head and xrays were normal. . . . Will continue to monitor closely." * 09/17/17 - 2:05 p.m. "No c/o [complaints of] pain at this time. . . ." * 09/17/17 - 3:15 p.m. "Tylenol . . . 650 mg [milligrams] . . . c/o 5 of 10 backpain. . . . 4:08 p.m. Medication was not effective . . . 4:09 p.m. Tramadol HCL 50 mg . . . [for] 8 of 10 back pain. . . . 5:27 p.m. Medication was effective. . . . 8:53 p.m. Tramadol HCL 50 mg . . . [for] 8/10 pain to back and bilateral lower extremities . . . 9:28 p.m. Medication was effective. * 09/18/17 - 5:45 p.m. "No c/o pain today, resident walks with 1 assist and gait belt. . . ." * 09/19/17 - 9:41 a.m. ". . . able to ambulate and transfer with out difficulty. She complains of hip pain when seated on the toilet. She denies any other pain or injuries. . . . PTA [physical therapy assistant]." * 09/19/17 - 4:48 p.m. "Tylenol . . . 650 mg . . complains of pain 'all over'. . . . 5:21 p.m. Medication was effective."	F 658		

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F 658	Continued From page 19 During an interview on 12/06/17 at 11:15 a.m., a supervisory staff member (#1) stated she expected a neurological assessment completed by the nurse every 15 minutes times (x) 2, every 30 minutes x 2, and every hour x 2 after a fall with a possible head injury and expected nursing staff to monitor the resident per professional standards after returning from the ER. The staff member verified the facility had no written policy/procedure for neurological assessments or guidelines for monitoring residents after a fall with possible injury. Nursing staff failed to document a review of systems and/or a neurological assessment at least each shift for the first 72 hours after the resident's fall (09/17/17 at 8:00 a.m. to 09/20/17 at 8:00 a.m.). The progress notes lacked any further assessment of the "huge goose egg" found on the back of the resident's head or other bruising/injuries after the fall. The facility lacked a policy/procedure related to nursing assessments and documentation after a resident fall with possible head and/or other injuries.	F 658		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that:	F 676		1/11/18

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F 676	Continued From page 20 §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ¿ §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview, and review of policy and procedure, the facility failed to ensure 2 of 9 sampled residents who required supervision and setup help with eating (Resident #8 and #15) received the necessary services during their meals and/or tray set-up. Failure to provide the necessary services (encouragement and cueing) during meals placed these residents at an increased risk for weight loss, insufficient fluid intake, and/or	F 676	1. Staff were re-educated on cueing/encouragement of residents during meals. Residents #8 & #15 will be provided encouragement and cueing during meals. 2. All residents with the risk of weight loss, insufficient fluid intake, and/or constipation have the potential to be affected by failure to provide the necessary services (encouragement	

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F 676	Continued From page 21 constipation. Findings include: Review of the facility policy/procedure titled "Feeding Residents" occurred on 12/07/17. This policy, undated, stated, ". . . STEPS IN PROCEDURE: . . . Provide assistance when resident needs help with eating . . ." Review of the facility policy titled "Hydration Policy" occurred on 12/07/17. This policy, undated, stated, ". . . 3. Interventions to improve a resident's hydration status may include but not limited to the following: . . . b. Provide assistance with drinking . . . 1. Risk Factors for Dehydration may include: . . . Dementia in which resident forgets to drink or how to eat . . . Functional Impairments that make it difficult to drink, reach fluids, or communicate fluid needs . . . Some strategies to prevent dehydration, when possible, may include: . . . Remind residents to drink water/fluids . . ." Review of the facility "Hydration Protocol" occurred on 12/07/17. This protocol, undated, stated, "Policy: Since the elderly population is prone to dehydration it is important to offer fluids frequently throughout the day . . . Offer water frequently throughout the day during meals, activities, and cares . . ." - Review of Resident #8's medical record occurred on December 5-7, 2017. Diagnoses included dementia and constipation. Resident #8's quarterly Minimum Data Set (MDS), dated 10/06/17, identified severely	F 676	and cueing) during meals of residents. 3. Staff were educated on providing necessary services such as encouragement and cueing with residents at risk for weight loss, insufficient fluid intake, and/or constipation. A list of residents that need cueing/encouragement with meals will be provided and reviewed with nursing at report time daily. A mandatory all staff in-service will be held with POC□s on 12/27/2017. 4. QI monitoring will be implemented on resident #8 and #15 and 2 random residents to ensure they receive the proper cueing/encouragement needed at meal times. QI monitoring will be completed by the DON/QI designee at different meals times; 5 times a week X 2 weeks then weekly x4, then monthly x2, then quarterly x 2 unless determined otherwise by the QI committee at the monthly meeting. 5. 1/11/2018	

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F 676	Continued From page 22	F 676		

impaired cognitive skills, and supervision and setup help needed for eating. The current care plan stated, ". . . Nutritional Risk: Due to decreased appetite . . . Assist with meals as needed . . ."

Meal observation on 12/04/17 at 11:32 a.m., showed Resident #8 sitting at a table in the dining room with other residents. Resident #8 received her food tray containing a plate of food, a piece of cake, coffee, 4 ounces of supplement, and 8 ounces of milk. Throughout the meal, facility staff made no attempt to encourage or cue Resident #8 with eating/drinking. Resident #8 consumed her cake, a few bites of her food, and none of her fluids. At 12:05 p.m., a Certified Nursing Assistant (CNA #6) approached Resident #8 and asked her if she had enough to eat and drink. Resident #8 stated, "I think so" and the CNA removed the resident's food tray from the table.

Meal observation on 12/05/17 at 8:06 a.m., showed Resident #8 sitting at a table in the dining room with other residents. Resident #8 received her food tray containing pancakes, ham, blueberries, coffee, 4 ounces of juice, 8 ounces of milk, and 8 ounces of water. Throughout the meal, facility staff made no attempt to encourage or cue Resident #8 with eating/drinking. At 8:36 a.m., she had consumed approximately 50% of her food, 3 ounces of milk, no juice, no water, and pushed herself back away from the table. At 8:50 a.m. (approximately 45 minutes after receiving her morning meal), a staff member (#7) approached Resident #8, asked if she wanted to drink more, and Resident #8 responded no.

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- Review of Resident #15's medical record occurred on December 5-7, 2017. Diagnoses included constipation.

Resident #15's quarterly MDS, dated 09/15/17, identified severely impaired cognitive skills, and supervision and setup help needed for eating. The current care plan stated, ". . . Nutritional Risk . . . Encourage intake of daily fluid recommendations. Monitor nutritional needs . . ."

Meal observation on 12/04/17 at 11:32 a.m., showed Resident #15 sitting at a table in the dining room with other residents. Resident #15 received her food tray containing a plate of food, coffee, milk, juice, and water. Soon after receiving her tray, observation showed Resident #15 eating her green beans with her fingers. Throughout the meal, facility staff made no attempt to encourage or cue Resident #15 with eating/drinking, and paper covers remained on her glass of juice and water. Resident #15 consumed most of her food, all of her coffee, a small portion of milk, 0% of her juice, and 0% of her water.

Meal observation on 12/05/17 at 8:42 a.m., showed Resident #15 in her room, in a recliner chair with her eyes closed, and a food tray on her over-the bed table in front of her. Her food tray contained pancakes, ham, cold cereal, a small carton of milk, juice, water, and coffee. Resident #15 had consumed less than 25% of her food, all of her coffee, 0% of her milk, 0% of her juice, and 0% of her water. At 8:53 a.m., observation showed Resident #15 remained in her recliner chair with her eyes closed; and at 9:01 a.m. she was awake, but not eating/drinking. Throughout

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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 676	Continued From page 24 the meal in her room, facility staff made no attempt to encourage or cue Resident #15 with eating/drinking. At 9:13 a.m., a CNA (#8) removed the food tray from Resident 15's room. As CNA (#8) passed by the nurses station with the food tray, she informed another CNA (#6) that Resident #15 had consumed 60% of her milk. Observation of the food tray showed Resident #15 did not consume 60% of her milk from the carton, rather this portion of milk remained in the unconsumed bowl of cereal. During an interview on the afternoon of 12/06/17, an administrative nurse (#9) stated the expectation is for staff to encourage, cue, and assist residents, as needed, during meals.	F 676		