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 _____	08/31/2010

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 August 29, 2010 and completed on August 31, 2010, the sample included 2 residents for complete review, 7 residents for focused review, and 1 closed record for review. In addition, 1 resident was added to the sample to verify specific concerns during the survey.	F 000		
F 250 SS=E	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to ensure the provision of medically-related social services regarding resident behaviors for 4 of 4 sampled residents (Resident #2, #7, #8, and #9) identified with behavioral symptoms. Record review identified a deterioration in behavioral symptoms occurred for Resident #2 and #9. Failure to identify all behaviors, monitor the behaviors for potential causes, and implement measures to prevent or change these behaviors, has the potential to affect the safety of these residents, and cause harm to these residents and/or other residents. Findings include: Review of the facility policy and procedure titled	F 250	1. The residents identified (#2,7,8 & 9) are being reviewed by the Social Service Department. Social Services will review the documentation and document problem areas requiring review and additional assessments for delirium, cognitive loss, psychosocial well-being, mood state and behavior symptoms. These areas will be addressed and noted in residents charts. Based on these reviews and assessments, their care plans will be continued or revised. Their behaviors will be identified in the newly developed Behavior Tracking Log. This log includes date, time, initials, behavior and risk of injury to self, to others, interference with cares, activities or interactions to self and others, plus what preceded the behavior, approach used and response to approach. These issues will be brought up during our newly started Behavior Committee, which is interdisciplinary and (cont. on page 2)	10/04/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Randall K. Pederson | TITLE: President/CEO | (X6) DATE: 9/23/2010

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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 _____	08/31/2010

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 250	Continued From page 1 "Resident Behavior" occurred on 08/31/10. This policy, undated, stated: "POLICY STATEMENT: To designate responsibilities of the interdisciplinary team when residents exhibit inappropriate, problematic or disruptive behavior which is potentially harmful to the health or welfare of the resident or other residents or staff and address guidelines for facility staff interventions. . . . All residents shall be observed for mental, emotional and behavioral changes as well as physical condition and staff shall initiate appropriate interventions. Staff actions will be directed toward problem awareness, problem description and observation in order to identify goals, interventions, and approaches. Any resident who exhibits inappropriate and problematic behavior which is potentially harmful to the residents or others will have all appropriate assessments, notifications, and an individualized plan of care. . . . Tracking of inappropriate and problematic behavior may be initiated to determine frequency and severity of the behavior as a means of ensuring residents needs are met and providing for safety of others. Identifying problematic behavior and planning interventions is an important aspect in abuse prevention." Review of the job description for the "Social Service Director" occurred on 08/31/10. This document, dated 04/09/10, stated: ". . . MAIN FUNCTION: To assist each resident to adjust to the social and emotional aspects of their illness, treatment and stay in the extended care facility; To assist in the maintenance or improvement of each resident's ability to control everyday physical, mental, and psychosocial needs. ESSENTIAL FUNCTIONS: 1. To identify the	F 250	(cont. from page 1) will meet at least monthly after TMC's weekly scheduled care conferences. As a team, using a variety of disciplines, we can decide what other actions need to be implemented, identify goals, interventions and approaches. 2. The newly developed Behavior Tracking Log will assist in identifying other resident behaviors that can cause potential harm to self or others. The nursing staff will continue to use their daily Nursing Report Booklet and will start noting that a behavioral issue was documented in the resident chart. This will assist in the flow of communication for other departments and behavior issues can be addressed ~~at that time~~. daily. Behavior Committee Meetings have been started and will meet at least monthly discussing behavior issues, interventions and goals. Social Service Director will update her Job Description. Social Services will document pertinent information into the residents chart and will also document according to the A2300 reference date using the MDS 3.0 schedule. Mandatory assessments will be updated according to the MDS schedule with results being found in the (cont. on page 3)	Per T.C. with R. Pedersen + K. Enderson, LSW 10/4/10 @ 11:25 a.m.

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 _____	08/31/2010

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 250	Continued From page 2 medically related social service & [and] emotional needs of each resident, such as their sense of identity, coping abilities, and sense of meaningfulness or purpose. . . . 6. To assist with careful assessment of the need for psychotropic drug use. Will make recommendations to the [name of facility] medical director the need for psychiatric consultation. Will help monitor for symtoms [sic] of decline and functional status and the potential side effects from the use of psychotropic drugs and the interaction with other medications resident may be on through care planning and resident chart documentation. . . . 11. Records in residents charts any pertinent information. . . 15. Develops a pertinent care plan for each resident and review that care plan quarterly thereafter unless a hospital stay or drastic change of care is observed. 16. To write progress notes quarterly on each resident. . . . Information is recorded as pertinent incidents occurs also. 17. Comment in the residents charts any problems, concerns or questions they may have. 18. Visit with each resident on a 1 to 1 basis at least weekly, for support and help with the potentially negative effect on their psychosocial functioning, which would include their institutional attitudes and practices which affect . . . problems of coping with grief, . . . behavior problems, which can include confusion, anxiety, loneliness, depressed moods, anger, fear, etc., and poor interaction and socialization skills, financial needs or problems, legal service needs, substance abuse, and need for death or dying or bereavement services. . . ." Review of the facility policy titled "Social Services	F 250	(cont. from page 2) MDS documentation. To insure historic and up to date documentation, a MDS Monitoring Log used by the MDS Coordinator (RN) will detail mandatory documentation completed, put in chart and coordinator's completion signature. 3. Items put into place to insure the deficient practice will not recur are: a. Behavior Monitoring Log. The log will be used by all departments to assist in assuring communication between shifts and departments. TMC will use the paper form starting 10/04/10. The form will be adapted to electronic records when our program is working and installed. The paper log will be continued to be used by other departments who do not have access to the "Thin Client".(electronic record). The paper log documentation will be located by the time clock at the nurses station and social services will input into Thin Client when needed. b. TMC has started a Behavior Committee that will meet at least monthly after their weekly scheduled care conferences. The meeting will assist in identifying behavior issues and specific approaches, injury/harm to self (cont. on page 4)	

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 _____	08/31/2010

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 250	Continued From page 3 - Contacts/Requests" occurred on 08/31/10. This policy, undated, stated: "PURPOSE: To insure [sic] communication between social service department, staff, and patient/resident/family when there is a need/request. PROCEDURE: . . . 3. Social service contacts and requests include, but are not limited to: . . . d. Behavior concerns. e. Change or additions to psychoactive medications. . . ." - Review of Resident #2's medical record occurred on all days of survey. Resident #2's current diagnoses included dementia of Alzheimer's type, advanced dementia with psychosis, osteoporosis, generalized weakness, and confusion. Review of Resident #2's medication orders identified the resident on an antipsychotic medication, Zyprexa, twice a day; an antidepressant, Zoloft; and an antianxiety medication, Ativan, every six to eight hours as needed. Review of Resident #2's significant change Minimum Data Set (MDS), dated 06/19/10, identified Resident #2 with a short and long term memory problem, moderate impairment in daily decision making, usually able to make herself understood, and with behavioral symptoms four to six days per week including wandering, verbally abusive, and socially inappropriate/disruptive behavioral symptoms, and resistance to cares, daily, all not easily altered. The MDS identified the behavioral symptoms as a deterioration in symptoms. A previous significant change MDS, dated 04/22/10, and admission MDS, dated 11/03/09, identified the resident with no verbally or physically abusive behavioral symptoms.	F 250	(cont. from page 3) or others, what works and what does not will be addressed. The Behavior Committee will be inter-disciplinary with Social Services arranging and leading the meeting. Depending on the issue, some behaviors might be taken to the Safety Committee Meeting (monthly). c. TMC will continue using the daily Nursing Report Booklet as a means of communicating behaviors that were documented in the residents charts. Social Service has requested that the nursing staff make a note (ex: "see documentation on behavior in chart") to assist with social service awareness of issue. d. TMC has created a Behavior Tracking video for all staff to view. This will insure all staff and all departments are aware of the importance of behavior tracking and why the Behavior Log is a valuable tool in assisting the residents in living in the least restrictive environment and helping provide safety for the resident demonstrating the behavior and other residents and staff safety. TMC is also having an inservice for all staff going over the CMS 2567 deficiency list. e. To insure MDS CAA documentation in resident chart, MDS Director (RN) will use MDS Monitor Log (cont. on page 5)	

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 _____	08/31/2010

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 250	Continued From page 4 A "MDS & Social Service note," accompanying the 06/19/10 MDS, stated, ". . . makes statements like 'I want to die', anger at the care because unable to comprehend what is being said due to late stages of dementia. She refused medications and/or cares daily. . . . Since she started getting her strength back she does wander in halls aimlessly, she will swear and shake fist at you according to CNAs [certified nursing assistants] during cares. Due to her inability to comprehend she is not easily re-directed. It is best to let her wander and go where she wants. She doesn't attempt to hurt others, but she will become agitated when she is interrupted from her mission. It is best to let her establish her own goals. . . . Care plan updated and reviewed. . . . Continued to be monitored by mental health . . ." Review of Resident #2's significant change MDSs, dated 06/19/10, 04/22/10, 01/22/10; and admission MDS, dated 11/03/09 identified Resident #2 with mood and behavioral symptoms. The 01/22/10 and 06/19/10 MDSs identified a deterioration in mood and behavioral symptoms. Each MDS showed triggered areas included cognitive loss, psychosocial well-being, mood state, and behavioral symptoms. Record review identified each MDS, except the 06/19/10 MDS, lacked RAP documentation for the triggered areas. (Refer to F278). Review of Resident #2's current care plan identified the following problems, initially on 10/23/09, and no changes in approaches with reviews which occurred on 05/05/10 and 07/28/10: * "Psychotropic drug use R/T [related to] history of physical abuse to other residents" with approaches including "Meds [medication], as	F 250	(cont. from page 4) using a flow sheet addressing chart issues, when put in chart, and date MDS Director approved MDS. (see F Tag 278) 4. Quality Assurance monitoring tools are being developed and will be implemented on or by 10/04/10. The QA Director will review the monitored programs for effectiveness monthly for six months and quarterly thereafter if issues are being resolved. a. Behavior Monitoring Log developed and in use by 10/04/10. Monthly QA rounds will note if Behavior Log is being used. Responsible person is QA Director (RN). b. Behavior Committee Minutes starting 09/20/10, with minutes given to QA Director monthly by Social Services. Social Service Director will be responsible to give QA Director monthly minutes. The QA Director will decide monthly if any issues need to be brought up to the Safety Committee. It will be noted yes/no in the Safety Meeting Minutes. c. QA Director will add to monthly QA rounds the use of Nursing Report Booklet. This will start October 2010. d. Behavior Tracking Video will be available for staff viewing any time and will also be shown at the inservice reviewing CMS (cont. on page 6)	

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 _____	08/31/2010

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 250	Continued From page 5 order . . . Monitor target behaviors and for side effects . . Refer to social services, as needed. b) Psychiatric consult when appropriate." The nurses notes identified a psychiatric consult occurred on 08/20/10 with "no changes made." * "Becomes verbally/physically abusive as demonstrated by: agitated, wanders in hallways; rummages" with approaches of "a) Take precautionary combative measures 1. Assist of two. 2. Use RO (reality orientation) . . . 3. Gently hold hands. . . . 6. If situational, remove circumstances. 7. Permit to wander . . . Use principles of effective verbal communication . . . " Review of nursing progress notes identified the following: * 01/23/10 at 7:45 p.m.: "[Resident #2] wandered into resident room behind two other residents. [Resident #9] turned around et [and] said 'go home, you don't need to be here.' [Resident #2] responded by putting her hands up as if she was going to hit her et stated, 'Don't make me knock you on your [expletive word]!' I split the two ladies apart telling them this behavior was uncalled for. They both settled [down]. [Resident #2] was brought to her room et put into her bed [with] [no] further problems noted." * 02/10/10 at 2:00 p.m.: "Resident following roommate around. Telling roommate she shouldn't be messing around [with] that man. Upsetting roommate while roommate was visiting [with] staff. Diverted resident. . . . " * 05/20/10 at 10:30 a.m.: "Was found in room with her roommate holding her arms to prevent [Resident #2] from hitting [the roommate]. Redirected with much difficulty. Resident very irritable but is not agitated when allowed to wander on her own. . . ." * 06/03/10 at 5:30 p.m.: "Resident attempted to	F 250	(cont. from page 5) 2567 deficiency list on 09/29/10. Those attending the meeting and viewing of the video are required to sign attendance and knowledge at the time of attendance. e. Social Service job description will be updated by 10/04/10. A copy will be given to the TMC Board of Directors and QA Director for approval. Social Service job description will be reviewed yearly by governing bodies and Social Service Director. f. MDS Monitor Log will be developed and started by the MDS Director by 10/04/10. 5. All monitoring forms, inservice, video, new committees will be completed / formed and implemented starting 10/04/10. Thin Client (electronic records) is starting to be implemented at TMC-LTC in October 2010. Since this is a process, and depending on programming our tracking forms and documentation will be paper and flow to the Thin Client when available. Forms developed for paper flow might look different in the Thin Client. QA forms might also need to be changed due to MDS 3.0 requirements.	

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 _____	08/31/2010

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 250	Continued From page 6 take walker away from another resident. Resident started arguing [with] other resident that she can do anything with the walker that she wants to. [Resident #2] stated 'I am gonna kick you in the face.' Resident diverted away from resident." * 06/09/10 at 3:00 p.m.: "[Resident #2] was seen by [psychiatrist] . . ." The physician's orders identified the psychiatrist prescribed Resident #2 Zyprexa, an antipsychotic medication, 2.5 milligrams (mg) every morning on this date. Record review identified the resident also on Zyprexa 2.5 mg daily at bedtime as well (ordered upon admission on October 2009). * 07/01/10 at 8:30 p.m.: "Pt. [patient] combative [with] other resident over other resident's purse - ("tug of war" & [and] pushing). Distracted pt. & separated [sic] pts. Cont [continue] to observe." Record review included mood and behavior tracking forms (completed by direct care staff) between April through August 2010 which identified Resident #2 with frequent wandering, socially inappropriate and resistance to care behaviors; and occasional physical, and verbally abusive behavior. Record review lacked any social service progress notes and/or evidence of the potential causes of Resident #2's behaviors, which occurrences may have a potential for harm for the resident, recommendations for behavioral interventions, and an evaluation of those behavioral interventions. Failing to ensure the assessment, initiation of appropriate interventions, and the evaluation of inappropriate and problematic behaviors has the potential to affect the health and welfare of the resident, or other residents, or staff.	F 250		

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 _____	08/31/2010

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 250	Continued From page 7 - Review of Resident #9's medical record occurred on 08/31/10. Resident #9's medical diagnoses included Alzheimer's dementia, confusion, osteoporosis, depression and multiple cerebrovascular accidents (CVA) with right upper extremity weakness. Review of Resident #9's medication orders identified the resident on Lexapro, an antidepressant medication. Review of Resident #9's significant change MDS, dated 08/09/10, identified Resident #9 with a short and long term memory problem, moderate impairment in daily decision making, able to make herself understood, and with behavioral symptoms daily of wandering, easily altered; and resistance to cares four to six days per week, not easily altered. The MDS identified the behavioral symptoms as a deterioration in symptoms. A quarterly MDS, dated 05/09/10, and admission MDS, dated 11/18/09, identified the resident with no indicators of resistance to cares. The admission MDS summary stated, ". . . Please refer social [sic] notes for cognitive loss, mood state, and behavior symptoms. . . ." Both comprehensive MDSs (annual and significant change) lacked the completion of RAP documentation for delirium, cognitive loss, mood state, and behavioral symptoms. Mood and behavior tracking forms completed between June through August 2010 identified Resident #9 frequently wandered; occasionally resistant to cares; and infrequently displaying socially inappropriate behaviors. Review of Resident #9's current care plan lacked identification of the problem of resistance to cares, not easily altered, and staff approaches.	F 250		

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 _____	08/31/2010

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 250	Continued From page 8 Record review lacked any social service progress notes and/or evidence of the potential causes of Resident #9's behaviors, which occurrences may have a potential for harm for the resident, recommendations for behavioral interventions, and an evaluation of those behavioral interventions. Failing to ensure the assessment, initiation of appropriate interventions, and the evaluation of inappropriate and problematic behaviors has the potential to affect the health and welfare of the resident, or other residents, or staff. An interview occurred with a supervisory social services staff member (#6) on 08/30/10 at 3:00 p.m. The staff member (#6) stated she was unaware of precipitating factors, surrounding events, staff interventions, and resident response for Resident #2's above identified behaviors, and effectiveness or lack of effectiveness of those interventions. The staff member stated nursing staff are expected to follow the care plan interventions. On the morning of 08/31/10, a supervisory social services staff member (#6) stated: * she was not aware of the reason direct care staff check various behaviors on the behavior tracking forms for each resident. * resident care plans are not always individualized for specific behaviors. * incidences between Resident #2 and #9 with a purse occurred only once (however identified in January 2010 on Resident #2's behavior monitoring log and on July 1, 2010 in Resident #2's nursing progress notes). The staff member stated she was aware of the incident with the purse as she saw it occur. * medication is used to control behavior.	F 250		

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 _____	08/31/2010

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 250	Continued From page 9 * she does not complete any social service progress notes on identified resident needs, except with comprehensive (admission, annual or significant change) MDSs. Record review identified these not always completed and/or available. * lacked awareness of the incidences in Resident #2's nurses notes on 01/23/10 (between Resident #2 and Resident #9); on 05/20/10; on 06/03/10, and 07/01/10. The staff member stated she does not always read the nurses notes, however nursing staff call her regarding an injury/occurrence due to resident behaviors.. * staff do not document all behaviors because they do not want to sign their name to them. - Review of Resident #7's medical record occurred on 08/31/10. Diagnoses included Alzheimer's dementia with behaviors, anxiety, depression, and insomnia. The resident's medication administration record (MAR) identified Pristique 50 mg daily (antidepressant), Seroquel 50 mg every evening (antipsychotic), and Namenda 10 mg twice daily (used to treat symptoms of Alzheimer's disease). Resident #7's significant change MDS, dated 07/04/10, identified a short and long term memory problem, severe impairment in daily decision making, usually able to understand others, and socially inappropriate/disruptive behavioral symptoms exhibited daily and not easily altered. The preceding quarterly MDS, dated 04/04/10, and significant change MDS, dated 02/28/10, identified the same daily socially inappropriate/disruptive behavioral symptoms. Resident #7's significant change MDS Summary, dated 02/28/10, stated, "This assessment is being	F 250		

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 _____	08/31/2010

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 250	Continued From page 10 completed due to significant change in status noted with an emergence of a sad or anxious mood pattern as a problem that is not easily altered and an increase in the number of areas where behavioral symptoms are coded as not easily altered. Please refer to Social Services notes for delirium, cognitive loss, psychosocial well-being, mood state, behavioral symptoms, and psychiatric [psychotropic] drug use." Review of Resident #7's record showed an absence of these referenced Social Services notes. During an interview on 08/31/10 at 11:00 a.m., a licensed staff member (#6) stated, "I don't have the notes [Social Services notes referred to above]." This staff member was unable to provide the Social Services notes (RAP assessment documentation) for the significant change MDS Summary related to delirium, cognitive loss, psychosocial well-being, mood state, behavioral symptoms, and psychotropic drug use. (Refer to F278). Resident #7's current care plan showed the following problems: * "Psychotropic drug use" with approaches including ". . . Meds [medications], as ordered & monitor target behaviors due to agitation, hollering, etc. [etcetera] and side effects. . . . Refer to social services, prn [as needed] & psychiatric consult prn." * "Psychosocial well-being/mood/behaviors" with approaches including "a) See Scope of Practice for behaviors/mood. b) Review Creative Solutions and document what works here:--place call light on her person (attach it)." * "Becomes verbally/physically abusive as demonstrated by: up at night hollering loudly, "help me"." Approaches included "a) Take	F 250		

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 _____	08/31/2010

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 250	Continued From page 11 precautionary combative measures: 1. Assist of two. . . . 3. Gently hold hands. . . . 5. If resists cares, come back later. 6. If situational, remove circumstances. . . . Use principles of effective verbal communication: . . . 2. Isolate individual. . . . " Resident #7's nursing progress notes revealed the following: * 02/22/10 at 5:00 p.m. - "Resident hollering out for 'help.' Yells when no one is talking to her." * 02/27/10 at 6:30 a.m. - "Awake qhr [every hour] throughout the noc [night]. . . just hollers [without] specific c/os [complaints]." * 03/09/10 at 11:45 p.m. - ". . . hollering et [and] keeping roommate awake." * 03/10/10 at 3:55 a.m. - "Has not slept, continues to holler out, 'I want to go home.' . . ." * 04/09/10 at 4:40 a.m. - "Resident has not slept at all tonight. . . . Resident has gotten physically et verbally negative towards staff. She continues to call out comments 'look for my father' [and] 'Where are the children?' Redirection attempted [without] any success." * 04/13/10 at 3:00 a.m. - "Resident has not yet slept. Has become irritable [with] family et stated, 'I should kick you.' . . ." * 04/20/10 at 9:00 p.m. - ". . . patient is screaming/hollering to send the man in and attempting to crawl out of the bed. . . . Patient being very loud et disruptive to others. Other residents coming out from room wondering what all the hollering is about. . . ." 10:00 p.m. - ". . . Pt. [patient] pounding on doors, stomping feet et is very agitated. . . . " * 04/25/10 at 11:00 a.m. - "Resident attempting to get into kitchen, hollering, slapping at me [nurse], . . ." * 04/26/10 at 5:00 p.m. - "Resident wheeling	F 250		

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 _____	08/31/2010

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 250	Continued From page 12 herself about aimlessly - wheeled herself into another resident's room. Not easily redirected out of the room. . . ." * 05/01/10 at 6:00 p.m. - "Resident has been very agitated et hollering continuously . . . Did slap CNA [certified nurse aide] in the face this AM. Unable to be redirected." * 05/01/10 at 8:00 p.m. - ". . . Resident in DR [dining room] being very loud et disruptive. Hollering. Holding onto another EC [extended care] patient's w/c [wheelchair]. Arguing with patient when another resident tried to intervene et [Resident #7] attempted to hit [that] resident. . . ." * 05/02/10 - 6:00 p.m. ". . . As the day went on, resident became more et more agitated et unable to redirect. Did strike out @ [at] staff x [times] 1 when attempting to redirect her. . . ." * 05/03/10 at 11:00 a.m. - "Resident hollering out. Redirected to dining room. Resident starting swatting at staff. Resident ate lunch et started yelling out. 1200 [12:00 p.m.] pt talken [sic] to room to toilet. Resident grabbed on to the door, as staff tried to grab her hand off the door handle, resident bit staff on the hand. Redirected et toileted. 1220 [12:20 p.m.] Pt yelling in room to push her. Staff attempted to push her et resident grabbed onto rail outside of room et hit at staff. Staff left resident alone as she continued to yell." * 05/04/10 at 9:00 a.m. - "This AM at breakfast resident is yelling out - very disruptive. When nurse attempted redirection [of] resident, she became aggressive and abusive - swinging at nurse. . . ." * 05/05/10 at 9:55 p.m. - "Resident in bed yelling et screaming. IM [intramuscular] ativan given [with] relief. . . ." * 06/04/10 at 2:00 a.m. - "Pt sitting up - calling out - on the edge of bed x 6, toileted x 2. . . ." * 07/16/10 at 1:25 a.m. - ". . . Yelling out	F 250		

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 _____	08/31/2010

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 250	Continued From page 13 'momma, come here.' Unable to redirect. . . ." Resident #7's mood and behavior tracking forms from June 1 - August 30, 2010 identified the facility staff identified the resident asking repetitive questions; repetitive verbalizations, such as calling out for help; expressions of what appear to be unrealistic fears; repetitive arduous complaints/concerns, such as attention seeking; insomnia; repetitive physical movements; wandering behavior (August 2010); and socially inappropriate behavior, such as disruptive sounds or screaming. The facility failed to determine a pattern, develop specific interventions, and evaluate those interventions, to address Resident #7's mood and behaviors. This placed Resident #7, and other residents and staff, at risk of harm, and did not allow Resident #7 to reach her highest practicable level of physical, mental, and psychosocial functioning. - Review of Resident #8's medical record occurred on 08/31/10. Resident #8's current diagnoses included dementia, psychosis, depression, and agitation. Review of Resident #8's current medication orders identified the resident received an antipsychotic, Risperdal twice a day; an antidepressant, Celexa; and an antianxiety medication, Xanax, every twelve hours as needed. Review of Resident #8's quarterly MDS, dated 08/09/10, identified Resident #8 with behavioral symptoms of verbally abusive and socially inappropriate/disruptive behavioral symptoms, one to three days per week, not easily altered. A significant change MDS, dated 02/09/10,	F 250		

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 _____	08/31/2010

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 250	Continued From page 14 identified the same as above, except the behavior episodes occurred up to six times during the seven day assessment period. Resident #8's social services RAP documentation, dated 02/11/09, stated, ". . . Significant change due to cognitive change. Has become more lethargic and speech is nonsensical. . . . She will cry and is unable to know what will comfort her. . . . Mood and Behavior: Triggered due to becoming angry during cares, wanting something completed and staff try to complete request and she reports they won't help her. Continues to have numerous complaints about routines, no one cares, swears, has a lot of pain in arm and will become irrational . . . She has a sad/angry facial expression. She will pick at skin or table. These indicators are present and not changed. . . . She continues to swear and become angry at staff. This is usually during care, but also when she is crying and unable to find anything that comforts her. She continues to cry/moan/scream loudly in dining room-at these times we will take her out. . . . Psychosocial well-being: . . . [Resident #8's relative] can not help calm her down and [Resident #8] will call her names and be verbally rude. . . . Activities: . . . At times she enjoys and responds other times there is nothing we can offer or say. Best is to leave her just cry [sic]." Review of Resident #8's current care plan identified the following problems: * "Psychotropic drug use R/T use of . . . Risperdal" with approaches of ". . . Administer medications as ordered (Xanax prn [as needed]) . . . Frequently found in room crying/wailing . . . Monitor target behaviors and for side effects . . . Refer to social services, as needed. . . .	F 250		

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 _____	08/31/2010

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 250	Continued From page 15 Psychiatric consult when appropriate on an antipsychotic." * "Cognitive loss; impaired; CVA and visual field defect. Wails. Cries out loudly. Negative talk (usually in room cries) . . . " with approaches of ". . . RO [reality orientation] and inform again if asks questions repeatedly. . . . If agitated/restless, redirect to a more quiet, less stimulus area. Try and change the subject - talk about the past. . . ." Review of nursing progress notes dated from 01/29/10 through 08/25/10 described incidences of the resident distressed, expressing feelings of worthlessness, hollering out, crying, and/or experiencing pain, and interventions by nursing staff included medicating Resident #8 with either pain medication, a prn (as needed) antipsychotic medication (Risperdal), or an antianxiety medication (Xanax). Mood and behavior tracking between June and August 2010 identified Resident #8 made negative statements; showed persistent anger with self/others; self-deprecation; showed sad, pained, worried facial expressions; crying/tearfulness; verbally abusive; and socially inappropriate. The June tracking included one narrative: "I brought [Resident #8] to her room after lunch - she was crying and yelling saying we're mean to her and leave her sitting in the hallway all day. I asked if she'd like to lay down for a rest and she said no just shoot me and leave me to die and rot. She was in her doorway and I was behind her moving her roommates chair out of the way when she started screaming very loud that I was pulling her hair. [Two staff members] came down and we had a hard time calming her down. She said she's been abused for 6 mo [months]."	F 250		

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 _____	08/31/2010

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 250	Continued From page 16 The facility failed to determine a pattern, develop specific interventions, and evaluate those interventions, to address Resident #8's moods and behaviors. This placed this resident, and other residents and staff, at risk of harm, and did not allow Resident #8 to reach her highest practicable level of physical, mental, and psychosocial functioning.	F 250		
F 278 SS=E	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement.	F 278	1. Since the old RAP documentation is unable to be located on several residents, a written Social Service documentation will be updated on sample residents #2, 4, 7 & 9. Documentation will include cognitive loss, psychosocial well being, mood state and behavioral symptoms. Care plans will be reviewed and updated on these residents. 2. A resident MDS flow sheet has been developed to be used by the MDS - RN - Coordinator. Social Service MDS RAP-CAA documentation will be put on the MDS Coordinator's desk and the MDS Coordinator will review and put documentation in resident chart. At that time, MDS Coordinator will review the care plan to insure needed updates are included. MDS Coordinator will continue to put the A3A/A2300 reference date on TMC's outlook calendar with all managers completing (cont. on page 18)	10/04/10

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 _____	08/31/2010

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 278	Continued From page 17 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to accurately complete the comprehensive Minimum Data Set (MDS) regarding the completion of Resident Assessment Protocol (RAP) documentation for 4 of 9 sampled residents (Resident #2, #4, #7, and #9). Failure to provide supporting documentation for each triggered RAP did not allow each resident the opportunity to receive care consistent with their individual needs, problems, and strengths, and retain/maintain their maximum level of function. Findings include: The Centers for Medicare and Medicaid Services Revised Long-Term Care Facility Resident Assessment Instrument User's Manual, Version 2.0, December 2008, pages 4-4 and 4-5, stated, ". . . There are various models for completing the RAP in-depth assessment process for a resident with a particular problem. . . . Facility staff use the RAI triggered mechanism to determine which RAP problem areas require review and additional assessment. . . . Based on the review of assessment information, the interdisciplinary team decides whether or not the triggered condition affects the resident's functional status or well-being and warrants a care plan intervention. 5. The interdisciplinary team . . . develop, revise, or continue the care plan based on this comprehensive assessment." - Review of Resident #2's medical record occurred August 29 - August 31, 2010, and included review of Resident #2's significant	F 278	(cont. from page 17) the RAP/CAA documentation. Medical Records will review several charts monthly to insure MDS documentation continues to be in resident's open chart. Social Service documentation will be dictated and saved under TMC's server (not save as in word "my documents"). In the future dictated notes will go directly into Thin Client electronic records. 3. To insure that MDS RAP/CAA documentation is in the residents chart and care plans updated accordingly, TMC will: 1. Develop and use MDS Flow Sheet for monitoring MDS documentation with Social Services putting RAP/CAA documentation on MDS Coordinator's desk by 10/04/10. 2. A3A/A2300 reference dates will be put on outlook calendar by MDS Coordinator as in the past. 3. Medical Records will review several resident charts monthly to insure MDS documentation is there. She will continue this review monthly. 4. All social service RAP/CAA documentation will be dictated and saved under TMC server starting 10/04/10. (cont. on page 19)	

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 _____	08/31/2010

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 278	Continued From page 18 change MDSs, dated 06/19/10, 04/22/10, 01/22/10; and admission MDS, dated 11/03/09. Each of the four MDSs identified Resident #2 with mood and behavioral symptoms. Each MDS triggered RAP documentation for cognitive loss, psychosocial well-being, mood state, and behavioral symptoms. Record review identified all but the 06/19/10 MDS lacked RAP documentation for these triggered areas. An interview occurred with a supervisory social services staff member (#6) on 08/30/10 at 1:45 p.m. The staff member stated she is responsible for completing the RAP documentation for cognitive loss, psychosocial well-being, mood state, and behavioral symptoms, as well as delirium. The staff member (#6) verified no RAP documentation available for the MDSs completed on 04/22/10, 01/22/10, and 11/03/09. - Review of Resident #9's medical record occurred 08/31/10, and included review of Resident #9's significant change MDS, dated 08/09/10, and admission MDS, dated 11/18/09. The MDSs triggered RAP documentation for delirium (08/09/10 only), cognitive loss, mood state, and behavioral symptoms. Record review identified the comprehensive MDSs lacked RAP documentation for these triggered areas. - Review of Resident #4's medical record occurred August 29 - August 31, 2010, and included review of a significant change MDS dated 01/30/10. The MDS triggered RAP documentation for cognitive loss, psychosocial well-being, and mood state. On the morning of 08/31/10, a supervisory social	F 278	(cont. from page 18) 4 & 5. TMC will monitor the above solutions to their deficiency through the Quality Improvement/Assurance program. 1. MDS Flow Sheet will be given to QA Director for six months and quarterly thereafter if issues have resolved starting 10/04/10. 2. QA Director will be included in reference dates on her outlook calendar starting 10/04/10. 3. Medical Records will continue to give chart review outcomes to QA Director monthly. 4. All Social Service RAP/CAA documentation will be dictated starting 10/04/10 and saved on TMC server. MDS Flow Sheet will insure this is completed (see 4 #1).	

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 _____	08/31/2010

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 278	Continued From page 19 services staff member (#6) verified the lack of RAP documentation for the 01/30/10 MDS. - Review of Resident #7's medical record occurred on 08/31/10, and included review of the significant change MDS, dated 02/28/10. The MDS triggered RAP documentation for delirium, cognitive loss, psychosocial well-being, mood state, and behavioral symptoms. Record review identified a lack of RAP documentation for these triggered areas. On 08/31/10 at 11:00 a.m., a supervisory social services staff member (#6) verified the lack of documentation for the 02/28/10 MDS.	F 278		
F 286 SS=B	483.20(d) MAINTAIN 15 MONTHS OF RESIDENT ASSESSMENTS A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to maintain the entire resident assessment, including the assessment documentation for the Resident Assessment Protocols (RAPs), completed within the previous 15 months in the resident's active record for 4 of 9 sampled residents (Resident #2, #4, #7, and #9). Failure to ensure a copy of all triggered RAPs notes remained in each resident's active medical record for 15 months, or in a facility file accessible to facility staff, does not allow staff who need to review the information in order to provide care to the resident access to the	F 286	1. To insure up to date information, Social Services will document pertinent information on mood state, cognitive loss, psychosocial well-being and behavioral symptoms on the sample residents #2, 4, 7 & 9. All documentation will be completed through dictation and saved on the TMC server (not in work save as my document). When Thin Client (Electronic Records) are programmed and working in TMC computer system all historic records will be saved with no opportunities available for lost or misfiled documentation insuring 15 months of historic CAA documentation. 2. To insure 15 months RAP/CAA documentation for all residents, medical records will audit (cont. on page 21)	10/04/10

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 _____	08/31/2010

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 286	Continued From page 20 information. Findings include: - The medical record for Resident #2, reviewed on all days of survey, identified the resident triggered for cognitive loss, psychosocial well being, mood state, and behavioral symptoms on significant change MDSs, dated 06/19/10, 04/22/10, 01/22/10; and admission MDS, dated 11/03/09. Review of the record identified all but the 06/19/10 MDS lacked RAP documentation for these triggered areas within the medical record. On the morning of 08/31/10, a supervisory social services staff member (#6) verified the lack of RAP notes for the 04/22/10, 01/22/10, and 11/03/09 MDSs. - Review of Resident #9's medical record occurred 08/31/10, and included review of the significant change MDS, dated 08/09/10, and admission MDS, dated 11/18/09. The MDSs triggered RAPs for delirium (08/09/10 only), cognitive loss, mood state, and behavioral symptoms. Record review identified the comprehensive MDSs lacked RAP documentation for these triggered areas within the medical record. During an interview with a supervisory social services staff member (#6) on 08/30/10 at 1:45 p.m., the staff member verified the lack of RAP notes for the 08/09/10 and 11/18/09 MDSs. - Review of Resident #4's medical record occurred August 29-31, 2010, and included review of the significant change MDS, dated 01/30/10. The MDS triggered RAP documentation	F 286	(cont. from page 20) several charts monthly. If any documentation is missing, copies will be available through Medical Records typed dictation. Dictation is saved under TMC server. When a Thin Client electronic record is operating, that information will be available in each residents personal electronic record. 3. Systemic changes made to insure historic RAP/CAA documentation available for the last 15 months is: 1. All RAP/CAA documentation will be dictated and saved under TMC server. 2. Medical Records will continue to do resident chart audits - all open files with auditing for historic 15 months of RAP/CAA documentation. 3. In the future, Thin Client electronic records will insure historic 15 months CAA documentation. Electronic records will be a process started in October. 4. MDS Tracking Form, Behavioral Logs, Behavioral and/or Safety Meetings developed and start using October 4, 2010. 5. A3A-A2300 reference dates will continue to be updated and staff involved with MDS process on outlook calendar. 6. All Social Service RAP/CAA documentation will be dictated starting 10/04/10 and saved on (cont. on page 22)	

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 _____	08/31/2010

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 286	Continued From page 21 for cognitive loss, psychosocial well-being, and mood state. Record review identified the active medical record lacked RAP documentation for these triggered areas. - Review of Resident #7's medical record occurred on 08/31/10, and included review of the significant change MDS, dated 02/28/10. The MDS triggered for delirium, cognitive loss, psychosocial well-being, mood state, and behavioral symptoms. Record review identified the active medical record lacked RAP documentation for these triggered areas.	F 286	(cont. from page 21) TMC server. MDS flow sheet will insure this is completed in a timely manner and in the residents open chart. 4 & 5. Quality Assurance Program using audits and monitoring will ensure that there will be 15 months of RAP/CAA documentation on the residents open chart starting 10/04/10. (please see attached sheet, #22A, for continuation of F286)	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. 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. 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. The facility must provide separately locked,	F 431	The "hospital stock" insulin vial was disposed of immediately following review of the manufacturer's package insert stating unused portion should be discarded 28 days after opening the vial. All residents receiving insulin have the potential to be affected by facility staff failing to follow manufacturer's recommendations for disposal of multi-dose insulin. A list of frequently used multi-dose medications requiring disposal prior to 60 days after opening has been posted in the medication room (facility policy states, "dispose multidose vials 60 days after opening unless specified otherwise by the drug company"). (cont. on page 23)	10/04/10

(cont. from page 22)

1. All RAP/CAA documentation will be dictated and saved under TMC server. This was started on 09/23/10.
2. Medical Records will continue to do resident chart audits -- all open files with auditing for historic 15 months of RAP/CAA documentation.
3. MDS Tracking Form, Behavioral Logs, Behavioral and/or Safety Meetings developed and start using 10/04/10.
4. A3A/A2300 reference dates will continue to be updated for staff involved with MDS process on outlook calendar. MDS Coordinator responsible for A3A/A2300 reference date and input to outlook calendar.
5. All Social Service RAP/CAA documentation will be dictated starting 10/04/10 and saved on TMC server. MDS Flow Sheet will insure this is completed in a timely manner and in the residents open chart.
6. MDS and RAP/CAA documentation will continue to be kept in each residents chart under "consults".
7. In the future, thin client electronic records will insure historic 15 months CAA documentation. Electronic records will be a process started in October.

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 _____	08/31/2010

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 431	Continued From page 22 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 professional literature, and staff interview, the facility failed to provide insulin that was not past the expiration date for 1 of 2 residents (Resident #11) observed receiving insulin. Failure to dispose of insulin by the recommended expiration date may cause the resident to receive ineffective or contaminated insulin and contribute to poor control of the diabetes. Findings include: Review of the manufacturer's package insert for Humalog insulin occurred on 08/30/10. The insert stated, "Storage . . . Unrefrigerated (below 86 [degrees] F [Fahrenheit]) vials, cartridges, Pens and KwikPens must be used within 28 days or be discarded, even if they still contain Humalog . . . See table below:" The table identified, "In-Use (opened) Room Temperature, (Below 86 [degrees] F) - 10 mL [milliliter] Vial - 28 days, refrigerated/room temperature." On 08/30/10 at 11:25 a.m., observation showed a licensed nurse (#7) drew up four units of insulin from a 10 milliliter refrigerated vial of Humalog	F 431	(cont. from page 22) A staff meeting has been scheduled for 09/29/10 to review our policy for Multidose Vials and CMS Form 2567 deficiency list, including the plan of correction. A copy of the policy, CMS form 2567, and notes from the staff meeting will be posted as required reading for those unable to attend. The DON and/or QI Director will monitor our facility policy regarding multidose vials to ensure vials are dated when opened and discarded per manufacturer's recommendations. All medication vials will be checked monthly for six months, then quarterly for six months. Monitoring will be included on our existing QI tool for the monthly walk through. If any concerns are identified at any time, immediate corrective action will be implemented.	

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 _____	08/31/2010

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 431	Continued From page 23 insulin, dated "opened 07/19/10," and administered the insulin to Resident #11. This insulin expired on 08/16/10, 14 days prior. During an interview on 08/30/10 at 11:30 a.m., a licensed nurse (#7) stated, "We are using stock insulin from the hospital for [Resident #11], who was admitted here last week, until his medications arrive. Normally we dispose of insulin after 30 days, but let me check for sure."	F 431		