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 _____	08/25/2011

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 08/22/11 and completed on 08/25/11, the sample included 2 residents for complete review, 7 residents for focused review, and 1 closed record for review. The sample included 2 additional residents to verify specific concerns during the survey.	F 000		
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to post the results of the most recent survey in a place readily accessible to residents for 4 of 4 days (August 22-25, 2011) of survey. Findings include: Observations on August 22-25, 2011 showed the results of the most recent Health and Life Safety Code surveys posted on a wall behind a recliner near the front entrance. Observation showed a resident would have to move the recliner to access the survey results.	F 167	All residents have the right to ready access to the most recent survey results without having to ask for assistance. The most recent survey has been moved to a high traffic area providing easy access to this information by all residents without having to require assistance. To insure survey results are maintained in this area, the QI Director will add this task to her weekly facility walkthrough for one month. Any problems will be addressed immediately.	08/26/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Pres/CEO — (X6) DATE: 09/22/2011

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 _____	08/25/2011

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 167	Continued From page 1 During interview on 08/25/11 at approximately 9:20 a.m. an environmental staff member (#1) confirmed staff had posted the survey results in a location not readily accessible to residents.	F 167		
F 278 SS=D	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. This REQUIREMENT is not met as evidenced	F 278	Spoke to State RAI Coordinator regarding changing/updating MDS assessments. Her instructions were to change only the most recent MDS assessments, and not the deceased MDS assessment. Resident #10 is deceased so MDS was not changed. Resident #1's recent MDS was not changed, but a note was added. Resident #4's recent MDS identifies her at risk for developing pressure ulcers. All residents have the potential to be affected by an inaccurate MDS assessment. CMS Form 2567, including POCs and staff education was provided at the 09/19/11 mandatory nursing staff meeting. This information will be posted as required reading for all staff unable to attend this meeting. Staff will be re-educated on admission policy for accurate weights and re-weighing residents weekly x1 month for a weight loss of 5% in a quarter. (cont. on page 3)	09/29/11

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 _____	08/25/2011

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 2 by: Based on record review, review of professional reference, and staff interview, the facility failed to ensure the Minimum Data Sets (MDSs) accurately reflected the resident's status for 2 of 9 sampled residents (Resident #1 and #4) and 1 of 1 closed record resident (Resident #10). Findings include: The Centers for Medicare and Medicaid Services Long-Term Care Facility Resident Assessment Instrument User's Manual, Version 3.0, revised July 2010, page K-3 stated, ". . . Height and weight measurements assist staff with assessing the resident's nutrition and hydration status by providing a mechanism for monitoring stability of weight over a period of time. The measurement of weight is one guide for determining nutritional status . . . On admission, weigh the resident and record results. . . ." Page M-2 stated, "Pressure Ulcer Risk Factor: Examples of risk factors include . . . a healed pressure ulcer." Page M-4 stated, "Unhealed Pressure Ulcer(s) . . . An existing pressure ulcer identifies residents at risk for further complications or skin injury . . . Steps to Assessment 1. Review the medical record, including skin care flow sheets or other skin tracking forms. 2. Speak with direct care staff and the treatment nurse . . . 3. Examine the resident and determine whether any ulcers are present. . . ." - Review of Resident #10's closed medical record occurred on 08/25/11. An admission Minimum Data Set (MDS), dated 02/23//11, and a quarterly MDS, dated 06/24/11, identified the resident at risk for pressure ulcers, and had no unhealed	F 278	(cont. from page 2) LTC risk management committee will review one random MDS charting focusing on weights (section K) and pressure sores (section M) monthly x6 months. The MDS coordinator is responsible to make necessary changes to reflect an accurate assessment in accordance with state and federal regulations. The LTC risk management committee includes the QI Director, DON, MDS Coordinator, Dietary, Wound Specialist and Social Services.	

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 _____	08/25/2011

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 3 pressure ulcers. A Progress Note, dated 02/14/11 at 1:45 p.m., stated, "Does have a reddened area on left upper inner buttock that looks as though the skin was rubbed off . . . area approx. [approximately] .5 x .5 cm. [centimeters]." The record lacked documentation regarding the reddened area for the following three weeks. On 03/02/11 at 3:41 p.m., Resident #10's Progress Notes stated, ". . . resident was examined and noted to have 1.2 cm x 1.6 cm dark colored blister to coccyx area. . . ." The record identified the facility transferred Resident #10 to the hospital on 06/14/11. The resident returned to the facility on 06/17/11 at 3:59 p.m. An admission note stated. ". . . Resident has a 3 cm by 3.3 cm red area with a blister in left upper buttocks area . . ." A note dated 06/25/11 at 3:24 p.m., stated ". . . No open areas noted at this time. . . ." Although Resident #10's medical record identified current pressure ulcers during the assessment period for both the 02/23/11 and 06/24/11 MDSs, neither MDS identified an unhealed pressure ulcer. Failure to accurately identify pressure ulcers on the MDSs contributed to the lack of care planning and lack of nutritional interventions to promote healing and prevent recurrence of the pressure ulcers. - Review of Resident #1's medical record occurred on all days of survey. An Admission Nursing Assessment, dated 01/27/11, identified Resident #1's weight as 191 pounds (lbs). The facility's Weekly Weight Chart for 2011 identified staff weighted Resident #1 on 01/27/11 (three	F 278		

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 _____	08/25/2011

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 4 days after admission) and recorded a weight of 176 lbs. The admission MDS, dated 01/31/11, identified a weight of 191 lbs. During an interview on the afternoon of 08/24/11, an administrative nurse (#2) and a dietary staff member (#3) stated staff obtained the 191 lbs recorded on Resident #1's Admission Nursing Assessment from "hospital records" and stated the weight obtained by facility staff on 01/27/11 was the correct weight of 176 lbs. Although facility staff did weigh Resident #1 during the the MDS assessment period and recorded that weight on the Weekly Weight Chart, staff used a weight obtained during a hospital stay when completing the admission MDS, resulting in an inaccurate weight recorded on the MDS. - Review of Resident #4's medical record occurred on all days of survey. An annual MDS, dated 07/27/11, identified the resident not at risk of developing pressure ulcers. Review of the Progress Notes showed the resident with a recurring pressure ulcer on 06/20/11 and 08/09/11. The facility failed to accurately identify the resident at risk of developing pressure ulcers on the 07/27/11 annual MDS, which may have contributed to the lack of nutritional interventions to promote healing and recurrence of the pressure ulcer, reopening on 08/09/11.	F 278		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES	F 314	Resident #10 is deceased. Resident #4 was placed on Arginaid. Wound healed 08/30/11. (cont. on page 6)	09/29/11

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 _____	08/25/2011

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 314	Continued From page 5 Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policies, and staff interview, the facility failed to implement nutritional interventions to promote healing and prevent recurrence of pressure ulcers, and failed to consistently monitor the pressure ulcers for 1 of 2 sampled residents (Resident #4) with a current pressure ulcer and 1 closed record resident (Resident #10). Failure to implement nutritional interventions resulted in delayed healing and recurrence of pressure ulcers. Findings include: Review of the facility's "Pressure Ulcer Treatment" policy occurred on 08/25/11. The policy, revised August 2003, stated, "Assessment is the starting point in preparing to treat or manage an individual with a pressure ulcer. Assess the pressure ulcer(s) initially and weekly thereafter for location, stage, size (length, width, and depth), sinus tracts, undermining, tunneling, exudate, necrotic tissue, and the presence or absence of granulation tissue or epithelialization . . . If no progress, reevaluate the adequacy of the	F 314	(cont. from page 5) All residents who have pressure sores or have the potential for pressure sores can be affected. All pressure ulcer policies and nutrition policies will be reviewed and modified. A mandatory educational staff meeting was held 09/19/11. CMS Form 2568, including POCs were reviewed as well as the policies and procedures related to prevention and treatment of pressure sores. A weekly LTC risk management committee is held to monitor all residents with skin issues, nutritional interventions, as well as appropriate documentation by the wound specialist. The committee monitors that family, dietary and physician were notified and notification is documented. Residents with pressure sores will also be monitored for nutritional interventions on the care plans. The QI audit has been implemented for all residents with pressure sores. The DON/designee will do QI weekly audits x4 weeks, then monthly audits x6 months, unless determined otherwise by the QI committee. The QI monitoring will be brought to the QI meetings monthly.	

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 _____	08/25/2011

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 314	Continued From page 6 overall treatment plan as well as adherence to this plan, make modifications if necessary . . . Nutritional assessment and management is important to ensure that the diet of the individual with a pressure ulcer contains nutrients adequate to support healing . . . All individuals with pressure ulcers will have an on going nutritional assessment through the Nutritional Risk Committee. . . ." Review of the facility's "Prevention Pressure Sores" policy occurred on 08/25/11. The policy, revised October 2005, stated, ". . . It is our policy to identify adults at risk of pressure ulcers and to define early interventions for prevention. Our goals are to: 1) identify at risk individuals who need prevention and the specific factors placing them at risk . . . All individuals at risk will have a daily systematic skin inspection during routine AM cares provided by the CNA [certified nursing assistant], with particular attention to bony prominences. All skin problems . . . are reported to the charge nurse for assessment and investigation . . . The Braden scale will be used for predicting pressure sore risk. Bed or chair bound individuals or those whose ability to reposition is impaired should be considered at risk for pressure ulcers . . . Risk should be periodically reassessed. Care should be modified according to the level or risk. Frequency of reassessment depends on patient status. Periodic reassessment is required for individuals with changes in activity and mobility status . . . An immediate prevention plan should be instituted for those 'at risk' when areas of potential pressure areas are identified. This plan should be reassessed and changes made as needed. . . ."	F 314		

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 _____	08/25/2011

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 314	Continued From page 7 Review of the facility's "Pressure Sore Nutritional Intervention" policy occurred on 08/25/11. The policy, dated April 2009, stated, "POLICY: The resident with skin breakdown will receive appropriate intervention to promote healing. PROCEDURE: 1. Appropriate form will be completed by nursing. This will be completed once a week until skin is healed. The dietitian and the director of dietary services will refer to this in charting progress of nutritional care. 2. LRD/CDM [licensed registered dietician]/[certified dietary manager] will complete a nutritional assessment including estimated protein needs, vitamin/mineral needs, weight history, and intake of meals. Protein will be increased in the resident's diet according to estimated needs and based on resident's food preferences . . . 4. Extra protein supplements will be outlined on the care plan . . . 6. For skin breakdown - 1 oz. [ounce] ProSource 3x/day [3 times per day]; Arginaid 8 oz. bid [twice a day]; 1 oz. extra meat, egg, or cheese." - Review of Resident #10's closed medical record occurred on 08/25/11. Diagnoses included congestive heart failure, chronic obstructive pulmonary diease, and Alzheimer's Disease. An admission Minimum Data Set (MDS), dated 02/23/11, identified the resident required extensive assistance with bed mobility, transfers, and personal hygiene. The MDS further identified Resident #10 as frequently incontinent of bladder, occasionally incontinent of bowel, not on a toileting program, at risk for pressure ulcers, and had no unhealed pressure ulcers. A quarterly MDS, dated 06/24/11, identified Resident #10 continued to require extensive assistance with Activities of Daily Living, always incontinent of	F 314		

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 _____	08/25/2011

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 314	Continued From page 8 bowel and bladder, at risk for pressure ulcers, and had no unhealed pressure ulcers. (Refer to F278) A Progress Note, dated 02/14/11 at 1:45 p.m., stated, "Does have a reddened area on left upper inner buttock that looks as though the skin was rubbed off . . . area approx. [approximately] .5 x .5 cm. [centimeters]." The record lacked documentation regarding the reddened area for the following three weeks. On 03/02/11 at 3:41 p.m., Resident #10's Progress Notes stated, ". . . resident was examined and noted to have 1.2 cm x 1.6 cm dark colored blister to coccyx area. . . ." The record showed staff assessed the area weekly until 04/19/11 at 11:40 a.m., when the notes stated, "Observed area of pressure sore to residents [sic] left buttock. Area is covered with a fragile layer of epithelial tissue. No open areas noted at this time. Outline of wound still visible. . . ." A note dated 05/02/11 at 3:20 p.m. stated, "Observed coccyx region and previous pressure ulcer has now healed. Will continue to monitor as needed." Although Resident #10's Progress Notes dated 02/14/11 identified a reddened area on the left buttock with "the skin rubbed off," an Initial/Annual Nutritional Assessment, dated 02/16/11, identified Resident #10's skin as intact. The Nutritional Assessment lacked interventions specified in facility policy (ProSource, Arginaid, extra meat, egg, or cheese) to promote healing of Resident #10's pressure ulcer. A Quarterly Nutritional Assessment, dated	F 314		

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 _____	08/25/2011

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 314	Continued From page 9 05/18/11, failed to identify the recently healed pressure ulcer and lacked nutritional interventions to address the resident's risk for recurrence of pressure ulcers. When requested, on 08/25/11 at 10:50 a.m., administrative nurses (#2 and #4) failed to provide information identifying care plan interventions in place during the time Resident #10 had the open area on her buttock (February - May 2011). The record identified the facility transferred Resident #10 to the hospital on 06/14/11. The resident returned to the facility on 06/17/11 at 3:59 p.m. An admission note stated. ". . . Resident has a 3 cm by 3.3 cm red area with a blister in left upper buttocks area . . ." A note dated 06/25/11 at 3:24 p.m., stated ". . . No open areas noted at this time. . . ." Resident #10's most recent care plan, dated 05/18/11, stated, "Potential skin integrity impairment due to: B&B [bowel and bladder] incontinence & impaired mobility." The care plan failed to identify the history of skin breakdown and/or the pressure ulcer which developed on 06/17/11, and lacked nutritional interventions implemented to promote healing and prevent recurrence of pressures ulcers for Resident #10. Failure to monitor Resident #10's pressure ulcer weekly and to implement nutritional interventions to aid healing, as per facility policy, contributed to the original pressure ulcer increasing in size from 0.5 x 0.5 cm on 02/14/11 to 1.2 x 1.6 cm on 03/02/11; slowed healing of the ulcer; and may have contributed to the development of a second	F 314		

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 _____	08/25/2011

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 314	Continued From page 10 pressure ulcer in the same area on 06/17/11. - Review of Resident #4's medical record occurred on all days of survey. Diagnoses included type II diabetes mellitus, congestive heart failure, depression, and anemia. A quarterly MDS, dated 08/16/11, identified the resident required extensive assistance of two staff members with bed mobility and transfers, and limited assistance of one staff member with personal hygiene. The MDS further identified Resident #4 as frequently incontinent of bladder, continent of bowel, and not on a toileting program. The MDS showed the resident was at risk for pressure ulcers, with one current Stage II pressure ulcer. An annual MDS, dated 07/27/11, identified the resident required extensive assistance with bed mobility, transfers, and personal hygiene, continent of bladder and bowel, not at risk of pressure ulcers, and had no current pressure ulcers. (Refer to F278) On the morning of 08/23/11 two certified nursing assistants (CNAs) (#7 and #16) assisted Resident #4 with toileting. Observation during cares showed an open ulcer to the left side of the resident's coccyx. Review of Progress Notes for Resident #4 revealed the following: * An initial wound assessment completed by the wound care specialist, dated 06/20/11, stated, "LOCATION OF WOUND: coccyx. STAGE OF WOUND: Stage 2 . . . WIDTH . . . 1.0 cm. LENGTH . . . 1.0 cm. DEPTH . . . 0.1 cm . . . TREATMENT: Calmoseptine applied liberally." * The second wound assessment completed by the wound care specialist, dated 06/28/11,	F 314		

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 _____	08/25/2011

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 314	Continued From page 11 stated, "LOCATION OF WOUND: coccyx. STAGE OF WOUND: Stage 2 . . . coccyx wound is 0.4 cm in width, 0.7 cm in length and 0.1 cm depth, superior to this a sacral wound noted at 0.2 cm width, 1.2 cm length and 0.1 cm depth . . . TREATMENT: Calmoseptine applied liberally. Not currently on any supplements, able to move and position herself at this time in bed or in chair. Encouraged resident to lie down on bed for naps if possible and to adjust position of recliner." * An entry made by a nurse, dated 08/09/11, stated, "Resident continues to have open area on buttocks Calmoceptine [sic] applied after peri cares. PT called and notified that open area on buttocks has not healed yet and message left." * A wound assessment completed by the wound care specialist, dated 08/10/11, stated, "TYPE OF WOUND: possible pressure sore. LOCATIONS OF WOUND: coccyx, 4 small superficial wounds noted, right sided coccyx 1.5 cm width and length, mid coccyx is 1.0 cm width and length, left sided coccyx is 0.8 cm width and length, and lateral left coccyx is 0.5 cm width and length. All open areas are superficial and less than 0.1 cm in depth . . . TREATMENT: Calmoseptine applied liberally. She is transferring over to hospital for pneumonia and we will continue to monitor the wound there." * An entry by a nurse, dated 08/12/11, stated, "[Resident #4] returned from the hospital . . . top of coccyx has approx [approximately] a 3.5 cm by 3 cm open area (Calmoseptine applied) . . . Resident has air pressure relieving mattress on bed, and a pressure relieving cushion in her WC and recliner . . ." * A wound assessment completed on 08/15/11 identified a "possible pressure sore" on the coccyx measured at "1.5 cm width and 2.1 cm	F 314		

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 _____	08/25/2011

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 314	Continued From page 12	F 314		

length and a superficial depth." The treatment remained the same with Calmoseptine applied liberally.

* The most recent wound assessment, completed on 08/22/11, identified a "possible pressure sore" to the coccyx measured at "0.1 cm width by 1.0 cm length." The assessment identified the treatment of Calmoseptine applied liberally.

Review of Resident #4's Long Term Care Nursing Assessment Summaries identified "no skin problems noted" during the assessment completed on 07/26/11; and "pressure ulcer present to coccyx, Calmoseptine being applied" during the assessment completed on 08/16/11.

Other than the Long Term Care Nursing Assessment Summary completed on 07/26/11, Resident #4's medical record lacked evidence the facility monitored the pressure ulcer and documented their assessment on a weekly basis from 06/28/11 to 08/09/11, as per facility policy.

During an interview on 08/23/11 at 3:35 p.m., a wound care specialist (#14) identified nursing staff notifies her when a resident has a new open area and then she completes an initial assessment, with weekly assessments thereafter until healed. The staff member (#14) confirmed the pressure ulcer developed on 06/20/11 and stated the pressure ulcer to Resident #4's coccyx was healed when she completed her weekly assessment during the week of 07/05/11 (staff member #14 unsure of exact date she saw resident). The staff member (#14) stated she "failed to document." The staff member (#14) stated the nursing staff notified her regarding the

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 _____	08/25/2011

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 314	Continued From page 13	F 314		

reopening of the pressure ulcer on 08/09/11 and she then completed her assessment on 08/10/11.

The most recent nutritional assessment completed since the resident's pressure ulcer originated on 06/20/11 included a Quarterly Nutritional Assessment, dated 08/03/11, which identified the resident with intact skin. This nutritional assessment failed to identify the resident's recent pressure ulcer and lacked nutritional interventions to address the resident's risk for recurring pressure ulcers.

An interview with a dietary staff member (#3) occurred on 08/24/11 at 8:35 a.m. The staff member (#3) stated nursing staff failed to notify the dietary department of Resident #4's pressure ulcer, identified on 06/20/11. The staff member (#3) stated she was first informed Resident #4 had a pressure ulcer during the resident's care conference on 08/10/11. The staff member (#3) identified she did not call the dietician and waited to notify her during her next visit scheduled on 08/24/11. The staff member (#3) confirmed the facility failed to assess Resident #4's increased nutritional needs and failed to implement nutritional interventions to promote healing of the pressure ulcer.

The facility last completed a Braden Scale (used for predicting pressure sore risk) for Resident #4 on 06/18/09, showing a score of 19, indicating high risk.

During an interview on the afternoon of 08/24/11, an administrative staff member (#2) stated the facility's policy included completing a Braden Scale every week during the first month for new

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 _____	08/25/2011

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 314	Continued From page 14 admissions and again with a change in a resident's condition. Review of Resident #4's prior care plan, dated 06/21/11, showed the problem of "Impaired skin impairment at risk r/t [related to] incontinence, decreased mobility, decreased intake, red coccyx." Approaches for this problem included: "* Resident is toileted upon request with good peri cares after incontinence * Apply Colmoseptine [sic] to open areas after toileting hygiene * Encourage resident to continue to reposition herself in bed * Encourage fluids and balanced diet * Pressure relieving cushion in WC [wheelchair] * Notify PT [physical therapist] skin specialist of open areas * Pressure relieving [sic] mattress on bed * Encourage resident to change positions frequently, move to recliner etc." The resident's current care plan, dated 08/16/11, showed the problem of "Impaired skin integrity-open area to coccyx," with the goal of "Resident will have adequate care for existing skin breakdown and will remain free from further skin breakdown." Approaches for this problem included: "*Assess skin * Notify MD [medical doctor] of skin breakdown * Apply ointment * Reposition/provide comfort * Wound care consult * Pressure relieving bed device * Notify charge nurse of any skin breakdown,	F 314		

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 _____	08/25/2011

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 314	Continued From page 15 changes, etc. * Pillow to [left] side under covers to prevent sliding * Apply Calmoseptine to open area after good peri cares." The care plans lacked nutritional interventions implemented to promote healing of Resident #4's current pressure ulcer and to prevent recurring pressure ulcers from developing. During an interview on the afternoon of 08/24/11, two administrative nurses (#2 and #4) confirmed the lack of dietary interventions to promote the healing of Resident #4's pressure ulcer and identified the medical record lacked evidence the dietary department received notification of Resident #4's pressure ulcers in June 2011 and August 2011. The staff members (#2 and #4) confirmed the resident's medical record lacked evidence of assessment and monitoring of the pressure ulcer from 06/28/11 - 08/09/11. Failure to consistently and accurately assess and monitor Resident #4's pressure ulcer and to implement nutritional interventions to aid in healing, as per facility policy, contributed to recurrence and delayed healing of the pressure ulcer.	F 314		
F 315 SS=B	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident	F 315	Residents 1, 2, & 5 will receive proper pericare. The policy and procedure has been posted for staff to review and sign off. The policy and procedure was discussed at the 08/25/11 mandatory staff meeting. QI will continue watching pericares. (cont. on page 17)	09/29/1

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 _____	08/25/2011

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 315	Continued From page 16 who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to perform complete perineal cares following urinary incontinence for 3 of 6 sampled residents (Resident #1, #2, and #5) observed during personal cares. Failure to perform complete cleansing could result in the residents experiencing skin breakdown. Findings include: Review of the facility policy "Perineal Care" occurred on 08/25/11. The undated policy stated, ". . . Perineal care (pericare) is provided to aid in the prevention of infection and to aid in prevention of skin breakdown . . . Pericare is done with incontinent episodes between AM [morning] and HS [bedtime] cares by using a disposable pre-moistened cloth (or cloth washcloth as appropriate) . . . Male: . . . Cleanse the tip of the penis first (where the opening for the urine is). Cleanse the rest of the penis . . . Cleanse the scrotum. Dry the area - penis first, scrotum next. . . ." - On 08/22/11 at 3 p.m., observation showed two Certified Nursing Assistants (CNAs) (#8 and #9) assisted Resident #1 to the bathroom. Observation showed the resident incontinent of urine. After toileting, a CNA (#8) cleansed	F 315	Residents 1, 2 & 5 will be includes in these observations. All incontinent residents have the potential to be affected by improper pericare. A mandatory staff meeting was held 09/19/11. POCs were reviewed as well as the policies and procedures related to pericare. The QI monitoring will be implemented on random residents who receive pericare. The DON/ designee will do QI weekly monitoring on three residents x4 weeks, then monthly x6 months on incontinent residents to monitor that proper pericare is being provided. QI monitoring will be brought to the QI meetings monthly for further recommendations.	

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 _____	08/25/2011

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 315	Continued From page 17 Resident #1's perianal area and buttocks, but failed to cleanse the penis, scrotum, and groin area. - On 08/22/11 at 3:15 p.m. observation identified two CNAs (#8 and #9) assisted Resident #2 to the bathroom. Observation showed the resident's brief soaked with urine. Following toileting, a CNA (#8) cleansed the perianal area, buttocks, and groin, but failed to cleanse the penis and scrotum. - On 08/22/11 at 4:08 p.m., two CNAs (#7 and #9) assisted Resident #5 to the bathroom. Observation showed the resident's brief wet with urine. After the resident had a bowel movement and voided, a CNA (#7) cleansed the perianal area and buttocks, but failed to cleanse the penis, scrotum, and groin areas. - On 08/23/11 at 10:30 a.m., observation showed two CNAs (7 and #10) assisted Resident #2 to the bathroom. Observation showed the resident incontinent of urine. Following toileting, a CNA (#7) cleansed the perianal area, buttocks, and groin, but failed to cleanse the penis and scrotum. During an interview on 08/24/11 at 1:50 p.m., two administrative nurses (#4 and #12) stated they expect staff to cleanse the penis, scrotum, and groin when performing perineal cares for male residents. Failure to perform complete cleansing of the perineal area could result unpleasant odors and/or skin breakdown for the residents.	F 315		
F 319 SS=D	483.25(f)(1) TX/SVC FOR MENTAL/PSYCHOSOCIAL DIFFICULTIES	F 319	Resident #1 will be followed by our facility's designated psychiatrist. Resident #1 was (cont. on page 19)	09/29/11

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 _____	08/25/2011

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 319	Continued From page 18 Based on the comprehensive assessment of a resident, the facility must ensure that a resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure a resident received the appropriate treatment and services for 1 of 1 sampled resident (Resident #6) who displayed symptoms of mental or psychosocial adjustment difficulty. Failure to provide Resident #6 with the appropriate mental health services does not allow the resident to maintain the highest level of mental and psychosocial functioning. Findings include: - Review of Resident #6's medical record occurred on all days of survey. Diagnoses included depression, unspecified psychosis, and dementia. Medications included Seroquel (an antipsychotic) 50 milligrams (mg) every evening, initiated on 02/04/11. The annual Minimum Data Set (MDS), dated 08/09/11, identified the resident with disorganized thinking, feeling depressed, trouble falling or staying asleep, having little energy, feeling bad about herself, and being short-tempered and easily annoyed. This MDS showed the resident rejected care and wandered on a daily basis and experienced one fall without injury since the prior assessment. A physician's progress note, dated 02/04/11, stated, ". . . This is an elderly female with	F 319	(cont. from page 18) seen 09/17/11. All residents have the potential to be affected by not having appropriate mental health services to maintain the highest level of mental and psychosocial functioning. A spreadsheet with appointment scheduling has been developed to track psychiatric appointments and will be kept in the mental health booklet at the nurses station. Social services/ designee will monitor the list to make sure that the residents on the schedule are being followed by the psychiatrist. Nursing will document that social services has been notified. The QI monitoring will be implemented on all residents that are on psychotropic medications. The social worker/ designee will monitor the spreadsheet monthly to ensure that all the residents on psychotropics are being followed by a psychiatrist as ordered. We will continue monthly chart audits to ensure that psychiatric consults are completed.	

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 _____	08/25/2011

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 319	Continued From page 19 moderately advanced dementia. The patient currently has been having more agitation issues at night; the patient has been wandering, has been extremely confused, and does have some hallucinations. The patient otherwise has no other active medical issues that the nursing staff is concerned about . . . If she continues with the agitation, we will have [name of mental health physician] see her over [teleconference]. We will add Seroquel 25 [mg] at bedtime and increase it to 50 [mg] . . ." The physician wrote an order the same day, which stated, "Seroquel 25 mg PO [by mouth] [at] bedtime X [for] 1 week then Seroquel 50 mg PO [at] bedtime. Appt [appointment] [with] [name of mental health physician]." Review of Resident #6's medical record revealed facility staff failed to make an appointment with the mental health physician as ordered. Review of a physician's progress note, dated 06/08/11, stated, ". . . The patient . . . continues to wander and is psychiatrically being managed by [name of mental health physician] . . . Continue current treatment . . ." During an interview on 08/23/11 at 4:45 p.m., a social service staff member (#17) stated she contacted the mental health physician's office on the morning of 08/23/11 and discovered the physician never saw Resident #6. During an interview on the morning of 08/24/11, an administrative nurse (#4) stated "it was missed" regarding the physician's order written on 02/04/11.	F 319		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE	F 325	Resident #1 has requested com- fort measures only (does not (cont. on page 21)	09/29/11

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 _____	08/25/2011

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 325	Continued From page 20 Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to assess and implement nutritional interventions for 1 of 1 sampled resident (Resident #1) with an open draining wound. Failure to reassess Resident #1's nutritional status after he developed the wound could result in delayed healing and compromise his nutritional status. Findings include: On the afternoon of 08/24/11, facility management staff provided policies regarding weights/nutrition risk. The policy provided by a dietary staff member (#3) contradicted the policy provided by an administrative nurse (#2). When asked about the inconsistencies, on the morning of 08/25/11, the staff members confirmed each department had its own policy. The policy provided by the dietary staff member (#3), dated May 2008, stated, ". . . The	F 325	(cont. from page 20) want an abdominal fistula repair/ colostomy). Weight loss is expected due to his medical condition and intermittently refusing insulin. This problem has been addressed in his care plan as a nutritional problem. All residents with significant weight loss have the potential to be affected by a lack of documentation addressing their nutritional needs. Nutritional policies related to care plans were reviewed and revised to ensure policies are facility wide. The policies were reviewed at the mandatory nursing and dietary staff meeting on 09/19/11. This information as well as CMS Form 2567 will be required reading for anyone unable to attend the meeting. A weekly LTC risk management committee has been developed to address resident issues with weight loss, nutritional issues and pressure ulcers/wound care. The QI director will be an active member and provide a monthly report to the QI Committee. All identified problems will be addressed immediately.	

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 _____	08/25/2011

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 325	Continued From page 21	F 325		

multidisciplinary care plan team will address individual nutritional risks. The Certified Dietary Manager (CDM) will meet quarterly and make appropriate changes in the residents [sic] care plan. . . ."

The policy provided by the administrative nurse (#2), dated February 2002, stated, ". . . The multidisciplinary care plan team will address individual nutritional risk. The Certified Dietary Manager (CDM) or consulting dietitian and the charge nurse will meet weekly and document an assessment of the data and make appropriate changes in the residents [sic] care plan. . . ."

Review of the facility policy "Pressure Sore Nutritional Intervention" occurred on 08/25/11. The policy, dated April 2009, stated, "POLICY: The resident with skin breakdown will receive appropriate intervention to promote healing . . . LRD [Licensed Registered Dietician]/CDM will complete a nutritional assessment . . . Protein will be increased in the resident's diet according to estimated needs and based on the resident's food preferences . . . Extra protein supplements will be outlined on the care plan . . ."

- On 08/23/11 at 10 a.m., observation identified a licensed nurse (#11) changed the dressing to a wound located on Resident #1's right flank. Observation showed the dressing saturated with tan, foul smelling drainage.

Review of Resident #1's medical record occurred on all days of survey. The record identified diagnoses including diabetes mellitus, colon cancer, failure to thrive, and colon perforation with fistula (an opening from the colon to the

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 _____	08/25/2011

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 325	Continued From page 22 outside of the body). On 07/19/11 at 3:56 p.m., the record identified a 3 centimeter open wound located on Resident #1's right flank with thick purulent drainage. A quarterly Minimum Data Set, dated 08/21/11, identified an open lesion. The record identified an Initial/Annual Nutritional Assessment, date 02/16/11, which indicated staff implemented ProSource and Arginaid supplements for a stage 2 pressure ulcer. A Quarterly Nutritional Assessment, dated 05/04/11, indicated Resident #1's skin intact and identified a plan to discontinue the Arginaid supplement. The record lacked evidence of a nutritional assessment completed after Resident #1 developed the fistula. Resident #1's comprehensive care plan, dated 05/02/11, identified a problem, "Potential for alteration in skin integrity." An undated, handwritten notation stated, "Fistula on R) [right] side just above hip." The care plan included several nursing approaches for the problem, but lacked nutritional interventions to promote healing of the fistula. During interviews on 08/24/11 at 1 p.m. and 2:50 p.m. a dietary staff member (#3) stated the LRD would be attending Resident #1's care conference that day and would assess the resident. The staff member stated, in the past, nursing staff communicated with the dietary department by sending paper communication slips, and stated after the facility switched to an electronic medical record (in November 2010), she no longer received notifications regarding changes for residents.	F 325		

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 _____	08/25/2011

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 325	Continued From page 23 The record lacked evidence dietary and nursing staff met weekly to assess and make appropriate changes to the care plan (as per the nursing policy) or that the CDM met quarterly to make appropriate changes to the care plan (as per the dietary policy) regarding Resident #1's nutritional risks. The record also lacked evidence the LRD assessed and/or documented a nutritional assessment for Resident #1 on 08/24/11, as stated by the dietary staff member (#3) during the interview on 08/24/11. Failure to reassess Resident #1's nutritional status after he developed an open draining wound could result in delayed healing of the wound. Failure to ensure the dietary and nursing departments followed the same policies and procedures and had a reliable communication system could lead to confusion and lack of appropriate treatment/interventions for nutritional issues.	F 325		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug	F 329	Resident #6 is no longer taking an antipsychotic medication and resident #8 is no longer taking a hypnotic medication. Staff is monitoring behaviors/reactions to withdrawing these medications. All residents receiving hypnotics or antipsychotics have the potential to be affected by receiving an unnecessary drug without adequate monitoring or not having a gradual reduction within a quarter unless contraindicated. A mandatory staff meeting was (cont. on page 25)	09/29/11

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 _____	08/25/2011

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 329	Continued From page 24 therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review, review of professional reference, and staff interview, the facility failed to ensure 1 of 1 sampled resident (Resident #8) with a scheduled hypnotic received a gradual dose reduction (GDR) and failed to ensure 1 of 2 sampled residents (Resident #6) with a scheduled antipsychotic received adequate monitoring. Failure to attempt a GDR (unless contraindicated) and failure to adequately monitor residents receiving antipsychotic medications may result in residents receiving unnecessary medications and experiencing adverse drug reactions related to these medications. Findings include: Lippincott, Williams, and Wilkins, "Nursing 2011 Drug Handbook," 31st edition, page 677, stated, "Seroquel . . . NURSING CONSIDERATIONS . . . Black Box Warning- Drug isn't indicated for use in elderly patients with dementia-related psychosis because of increased risk of death from CV [cardiovascular] disease or infection. . . ." Page 788, stated, "Ambien . . . Alert: . . . Use drug only	F 329	(cont. from page 24) held on 09/19/11. The policy for psychotropic drug use will be reviewed by all staff. The physicians will also review the psychotropic drug use policy. All residents on psychotropic medications will be followed by a psychiatric consultant (if available), unless family/resident refuses. In case of refusal, the ordering physician will monitor and follow federal guidelines for dose reduction of psychotropic medication unless: clinically contraindicated (providing appropriate documentation). A QI tool will be implemented to monitor that all residents on psychotropic medication are being followed by a physician or psychiatric consultant as ordered. The DON/designee is responsible for this monitoring as well as monitoring that a gradual dose reduction was attempted or physician documentation of contraindication for dose reduction for resident taking these medications. The QI monitoring will be submitted to the QI committee quarterly for one year for review and further recommendations. Any identified problems will result (cont. on page 26)	monitoring monthly x 1yr per T.C. w/m Shelly E. Amb Nelson Am Nelson 3 pm 9/11

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 _____	08/25/2011

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 329	Continued From page 25 for short-term management of insomnia, usually 7 to 10 days. . . ." - Review of Resident #8's medical record occurred on August 24-25, 2011. Diagnoses included depression and insomnia. Medications included Ambien (a hypnotic) 5 milligrams (mg) at bedtime, initiated on 02/01/11. The resident's quarterly Minimum Data Set (MDS), dated 05/07/11, and annual MDS, dated 08/03/11, identified the resident without sleep disturbances. The physician's progress notes since February 2011 failed to identify Resident #8's use of Ambien, clinical rationale for continued use, or contraindications for attempting a quarterly GDR. - Review of Resident #6's medical record occurred on all days of survey. Diagnoses included depression, unspecified psychosis, and dementia. Medications included Seroquel (an antipsychotic) 50 milligrams (mg) every evening, initiated on 02/04/11. The annual MDS, dated 08/09/11, identified the resident with disorganized thinking, feeling depressed, trouble falling or staying asleep, having little energy, feeling bad about herself, and being short-tempered and easily annoyed. This MDS showed the resident rejected care and wandered on a daily basis and experienced one fall without injury since the prior assessment. A physician's progress note, dated 02/04/11, stated, ". . . This is an elderly female with moderately advanced dementia. The patient currently has been having more agitation issues at night; the patient has been wandering, has been extremely confused, and does have some	F 329	(cont. from page 25) in immediate corrective action/ education for the involved staff members.	

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 _____	08/25/2011

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 329	Continued From page 26	F 329		

hallucinations. The patient otherwise has no other active medical issues that the nursing staff is concerned about . . . If she continues with the agitation, we will have [name of mental health physician] see her over [teleconference]. We will add Seroquel 25 [mg] at bedtime and increase it to 50 [mg] . . ." The physician wrote an order the same day, which stated, "Seroquel 25 mg PO [by mouth] [at] bedtime X [for] 1 week then Seroquel 50 mg PO [at] bedtime. Appt [appointment] [with] [name of mental health physician]."

Review of Resident #6's medical record revealed facility staff failed to make an appointment with the mental health physician as ordered.

Review of a physician's progress note, dated 06/08/11, stated, ". . . The patient . . . continues to wander and is psychiatrically being managed by [name of mental health physician] . . . Continue current treatment . . ."

During an interview on 08/23/11 at 4:45 p.m., a social service staff member (#17) stated she contacted the mental health physician's office on the morning of 08/23/11 and discovered the physician never saw Resident #6.

The primary physician's progress notes indicated a mental health specialist managed Resident #6's psychiatric care; however, the mental health specialist had not evaluated Resident #6 at any time.

Failure to attempt a GDR of Resident #8's Ambien and ensure adequate medication management/monitoring of Resident #6's Seroquel may have resulted in these residents

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 _____	08/25/2011

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 329	Continued From page 27 receiving unnecessary medications.	F 329		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on review of facility documentation, record review, and staff interview, the facility's consultant pharmacist failed to identify medication regimen irregularities for 1 of 1 sampled resident (Resident #8) receiving a scheduled hypnotic. Failure to recognize and report medication irregularities may result in residents receiving unnecessary medications and experiencing adverse consequences related to these medications. Findings include: Review of Resident #8's medical record occurred on August 24-25, 2011. Diagnoses included depression and insomnia. Medications included Ambien (a hypnotic) 5 milligrams (mg) at bedtime, initiated on 02/01/11. Review of the facility document titled "Pharmacist	F 428	Resident #8 was taken off the scheduled hypnotic; the psychiatric consultant ordered a prn hypnotic. All residents have the potential to be affected by a failure to recognize and report medication irregularities through a monthly pharmaceutical drug review. Lack of this check system may result in the residents receiving unnecessary medications and experiencing adverse consequences related to these medications. The consulting pharmacist was given the pharmacy regulations for Appendix PP in reference to the Federal and State Reulations for pharmacy consultants. The consulting pharmacist will perform a monthly medication review and report any irregularities to the attending physician and the director of nursing. The QI Direcotr will monitor three random charts of residents that are on psychopharmacological medications monthly x6 months. A quality improvement form will be developed to monitor the pharmacist monthly medication (cont. on page 29)	09/29/11

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 _____	08/25/2011

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 428	Continued From page 28 Mthly [Monthly] Medication Chart Review" occurred on 08/25/11. The document listed 29 indicators for review by the pharmacist and included the following: ". . . 6. Sedative/hypnotic used [greater than] 7 consecutive nights. 7. A hypnotic dose in excess of listed range . . . 10. Hypnotic/sedative/anxiolytic gradual dose reduction attempted . . ." Although the facility's consultant pharmacist reviewed Resident #8's medications monthly, the pharmacist failed to identify the drug regimen irregularity (the continued use of Ambien 5 mg since 02/01/11) and recommend a quarterly dose reduction attempt. During a telephone interview on the morning of 08/25/11, the consultant pharmacist (#15) stated he failed to review psychopharmacological medications for possible gradual dose reductions when he reviewed the residents' medication regimens each month. The pharmacist (#15) stated he "didn't realize he should be doing that."	F 428	(cont. from page 28) chart review to ensure that Federal and State regulations are being followed.	