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 _____	10/08/2014

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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 October 6, 2014 and completed on October 8, 2014, the sample included two (2) residents for complete review, seven (7) residents for focused review, and one (1) closed record for review. The sample included two (2) additional residents to verify specific concerns during the survey.	F 000		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to provide care in a manner that maintained or enhanced resident dignity for 3 of 9 sampled residents (Resident #1, #2, and #7) and 1 supplemental resident (Resident #13). Failure to knock on doors prior to entering residents' rooms or care areas (Resident #2 and #13) and failure to sit while assisting residents with their meals (Resident #1, #2, and #7) does not promote residents' dignity or enhance their quality of life. Findings include: Review of the facility policy titled "Dignity & Respect" occurred on 10/08/14. This undated policy stated, "POLICY: All residents will be treated with dignity and respect. This facility will	F 241	1. Residents #1, #2, and #7 will be provided dignity and respect by knocking on the door prior to room entrance and staff will sit at residents' level while assisting with meals. 2. All residents have the potential to be affected by inadequate privacy, dignity and respect. 3. The Dignity and Respect policy and Perineal Care policy was posted and reviewed. Staff re-educated on proper feeding techniques and knocking before entering. A mandatory staff meeting will be held on 11/03/14 with POCs reviewed as well as the policies and procedures related to Dignity and Respect and Perineal Care. 4. QI monitoring will be implemented on random residents to observe for staff knocking on doors prior to entering and feeding (cont. on page 2)	11/07/14

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

[signature] | President | 10-31-14

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.

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F 241	Continued From page 1 promote care for residents in a manner and environment that maintains or enhances each resident's dignity and respect in full recognition of their individuality . . ." Review of the facility policy titled "Perineal Care" occurred on 10/08/14. This undated policy stated, "STEPS IN PROCEDURE: 1. Knock on resident's door, wait for response to enter, identify resident and yourself. . . ." - Observation on 10/06/14 at 4:00 p.m. showed a nurse (#2) entered Resident #13's room without knocking or announcing him/herself. The nurse walked past Resident #13's roommate, also present in the room, and administered her medications. - Observation on 10/07/14 at 10:55 a.m. showed two certified nursing assistants (CNAs) (#5 and #6) assisted Resident #2 to the toilet in the central shower/bath room. On separate occasions during the observation, two other CNA (#3 and #4) entered the shower/bath room without knocking or announcing themselves. - Observation during the noon meal on 10/07/14 at 11:35 a.m. showed a CNA (#5) stood next to Resident #1 and fed him his meal. When another CNA (#6) arrived at the table and sat next to the resident, the CNA (#5) left the table, went to Resident #2's table, and stood next to him and fed him pudding. The CNA then moved to Resident #7's table, stood next to her, and fed her pudding. During an interview on the afternoon of 10/08/14, an administrative nurse (#7) stated she expected staff to knock and announce themselves before	F 241	(cont. from page 1) residents at eye level. The DON/ QI designee will do QI weekly audits x4, then monthly x5, unless determined otherwise by the QI Committee and results will be brought to the QI meetings monthly.	

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F 241	Continued From page 2 entering a resident's room or resident care areas.	F 241		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview, and resident interview, the facility failed to provide an ongoing program of activities designed to meet the physical, mental, and psychosocial well-being of 1 of 10 sampled residents (Resident #3) and one supplemental resident (Resident A). Failure to provide a program of activities designed to meet the needs of individual residents may result in increased behaviors, reduced socialization, and isolation of residents. Findings include: Review of the facility's Activity Calendars for the months of July, August, September, and October 2014 included the following: six days per week - morning stretches, ball, exercises, coffee, and story time; four days per week - current events; three days per week - sensory stimulation, bingo; two days per week - evening music; one day per week - beauty shop, bowling, chapel, mass, rosary, and bible study. - Review of Resident #3's medical record	F 248	1. Resident #3 will have an individualized program of activities designed to meet her needs. Care plans were updated according to resident #3's activity preferences and a program of activities of interest will be included. 2. All residents have the potential to be affected by not having a program of activities designed to meet their physical, mental and psychosocial well-being needs. 3. A mandatory staff meeting will be held on 11/03/14. Staff will be re-educated on maintaining activities of physical, mental and psychosocial well being needs. Activity staff will document three times a day of what activities were completed for all residents. The activity section of each care plan will be reviewed monthly to maintain current activity preferences. 4. The DON/QI designee will monitor activity charting and activity care plans for one or two random residents weekly x4, then monthly x5, unless determined otherwise by the QI Committee and results brought to QI meetings monthly.	11/07/14

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F 248	Continued From page 3 occurred on October 06-08, 2014. The facility admitted the resident in November 2013. Current diagnoses included Alzheimer's disease, depression, and dementia. The annual Minimum Data Set (MDS), dated 10/02/14, identified severe cognitive impairment, verbal behaviors (threatening, screaming, or cursing) directed at others occurred on one to three days of the assessment period, behaviors significantly disrupted care or the resident's living environment, wandering occurred one to three days of the assessment period, and Resident #3's behaviors worsened since the prior assessment, dated 07/09/14. The MDS also identified independence in walking and locomotion on and off the unit. Resident #3's Activities Assessment, dated 10/01/14, stated ". . . *Resident's favorite Activities: She says her favorite activity is to watch TV. . . . *Comments and Activities Preferences: She likes to visit. . . . She enjoys talking about her children. . . ." Resident #3's current care plan, dated 09/27/14, stated "Problem, Needs Environmental Stimulation To Prevent Depression & [And] To Gain Strength . . . Approaches . . . Visit 1:1 [1 to 1] to find out hobbies/interests and record on Activity Attendance sheet . . . Encourage resident to be out of room and attend group activities and dining . . . Loves to do crafts . . . Likes to watch [named TV programs] . . ." Resident #3's care conference note, dated 06/04/14, identified the resident enjoyed visiting with "the apartment ladies" [residents in the attached independent living facility]. The care	F 248		

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F 248	Continued From page 4 plan lacked this approach as an activity for Resident #3. The plan of care provided no evidence of resident specific measurable goals to assist and measure Resident #3's progress toward maintaining/attaining her highest level of physical, mental, and psychosocial well-being. The goals established required Resident #3 to meet facility activity related goals, and not specific personal goals. The care plan provided no frequency Resident #3 would attend the planned activities and did not address any specific benefits Resident #3 would gain from attendance at the designated activities, and/or expected responses/reactions. Review of Resident #3's Individual Activity Attendance Logs for the period July through October 07, 2014 identified the following activities: 1:1 visits, TV, stimulation in room, beauty shop, reading, phone, ombudsman visit, music, sports, current events, and out on pass. Review of Resident 3's Group Activity Attendance Logs for the period July through October 07, 2014 identified the following: social settings, mental stimulation, music, games, religion, exercise, and outings. Many of the activities occurred simultaneously with another activity. Observation showed the following: *10/06/14, 4:05 p.m. - Resident #3 ambulating independently through the halls, intermittently seated in the Front Lobby watching television. 4:30 p.m. - Resident #3 remained seated in the Front Lobby watching television.	F 248		

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F 248	Continued From page 5 The Activity Calendar showed activities of Storytime and Exercises at 4:30 p.m. The resident's Individual and Group Activity Log show all activities the resident participated in on 10/06/14 occurred at 8:43 p.m. *10/07/14, 1:15 p.m. - Resident #3 laying on right side in bed. Activity Calendar showed Sensory Stimulation scheduled. 1:50 p.m. - An unidentified facility staff member preparing Resident #3 for her shower. The Activity Calendar showed Coffee Time scheduled at 2:30 p.m. 3:15 p.m. - Resident #3 seated in the Fireside Lounge watching television by herself. During interview, on 10/08/14 at 11:10 a.m., an activities management staff member (#8) reported Resident #3 has independent craft items in her room. This staff member also reported the resident no longer participates in craft activities as much as she did in the past. The "apartment ladies" identified in the care conference note on 06/04/14 are from the attached independent living facility and attend afternoon coffee at approximately 2:30 p.m. This staff member (#8) reported Resident #3 enjoys visiting with these residents, however, observation during survey did not show the resident attending the afternoon coffee. Observation showed Resident #3 having her shower in the afternoon of 10/07/14 instead of Coffee Time. Facility staff failed to provide Resident #3 with guidance/assistance for activities on the afternoons of October 06 and 07 and failed to ensure availability for "Coffee Time" on 10/07/14 instead of her shower. The plan of care lacked any evidence of coordination between activities, nursing, etc. to adjust Resident #3's daily routine	F 248		

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F 248	Continued From page 6 to accommodate attendance/participation at activities determined important/beneficial to the residents physical, mental, and psychosocial well-being. - During confidential interview, Resident A reported the facility's activities program "could be more" and the resident participates in "Bingo." Review of Resident A's care plan occurred on 10/08/14. The care plan identified "Problem, Needs Environmental Stimulation To Prevent Depression & [And] To Gain Strength] . . . Approaches . . . Visit 1:1 [1 to 1] to find out hobbies and interests and record on Activity Attendance sheet . . . Likes to attend Bingo and music . . ." Review of Resident A's Individual Activity Attendance Logs for the period July through October 07, 2014 identified the following activities: 1:1 visits, family visits, TV, stimulation in room, sports, beauty shop, current events, reading, phone, ombudsman visit, and music. Review of Resident A's Group Activity Attendance Logs for the period July through October 07, 2014 identified the following: social settings, mental stimulation, music, games, religion, and outings. Many of the activities occurred simultaneously with another activity. Facility staff failed to determine activities of interest to Resident A, relying on family members and self directed activities. The facility's Activity Calendar shows multiple activities repeated throughout the month. The	F 248		

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F 248	Continued From page 7 attendance logs for Resident #3 and Resident A show multiple entries, most of which are not consistent with the Activity Calendar. The entries include examples such as "mental stimulation, music, social settings" for the same time as another scheduled activity and then failed to identify which activity the resident actually participated in. Observation and resident interview identified the facility failed to make available a program of activities of interest to the residents and failed to assure Resident #3 attended coffee time with the "apartment ladies," a preferred activity she enjoys.	F 248		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, and staff interview, the facility failed to complete significant change in	F 274	1. MDS for resident #1 unable to be corrected as subsequent quarterly MDS completed and accepted. 2. All residents have the potential to be affected by an inaccurate MDS assessment. 3. A MDS staff meeting was held on 10/30/14 and all MDS staff re-educated on identifying significant changes of a resident status. 4. LTC Risk Management Committee will review weekly all resident's status weekly x4, then monthly x5, unless determined otherwise by the QI Committee and results brought to the QI meetings monthly.	11/07/14

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F 274	Continued From page 8 status assessments (SCSA) for 1 of 9 sampled residents (Resident #1) within 14 days after a significant change occurred in the resident's physical or mental condition. Failure to complete a SCSA in response to the resident's decline limited the facility's ability to identify and implement appropriate care plan approaches. Findings include: The Centers for Medicare and Medicaid Services (CMS) "Long-Term Care Facility RAI User's Manual," Version 3.0, October 2013, pages 2-20 and 2-23 stated, ". . . A 'significant change' is a decline or improvement in a resident's status that: . . . 2. Impacts more than one area of the resident's health status; and 3. Requires interdisciplinary review and /or revision of the care plan. . . . A SCSA is appropriate when: There is a determination that a significant change (either improvement or decline) in a resident's condition from his/her baseline has occurred as indicated by comparison of the resident's current status to the most recent comprehensive assessment and any subsequent Quarterly assessments . . . A SCSA is also appropriate if there is a consistent pattern of changes, with either two or more areas of decline . . ." Review of Resident #1's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease. The annual Minimum Data Set (MDS), dated 11/02/13, identified the resident required supervision for bed mobility, walking in his room, and bathing, and no weight loss. The quarterly MDS, dated, 05/02/14, identified supervision required for walking in his room and a weight loss. The quarterly MDS, dated 08/02/14, indicated the resident required extensive	F 274		

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F 274	Continued From page 9 assistance for bed mobility, walking in his room, and bathing, and weight loss. The record lacked evidence staff completed a SCSA following Resident #1's decline in functional status. During an interview on 10/08/14, an administrative nurse (#1) agreed a significant change MDS should have been completed on 08/02/14 instead of a quarterly MDS.	F 274		
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 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.	F 329	1. Resident #10 is deceased, so we are unable to document non-pharmacological interventions. 2. All residents have the potential to be affected by having un-necessary medications. 3. A mandatory staff meeting will be held on 11/03/14 with POC to be reviewed as well as the poli-cies and procedures related to the use of psychoactive medica-tions. TMC's Antipsychotic Flow Sheet will be used to document non-pharmacological interventions prior to PRN antipsychotic medi-cation administered. 4. QI monitoring will be implemen-ted on random residents who receive PRN antipsychotic medi-cations; monitoring non-pharma-cological interventions are being tried and documented prior to (cont. on page 11)	11/07/14

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F 329	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to ensure a medication regimen free from unnecessary medications for 1 of 1 closed record resident (Resident #10) who received as needed (PRN) antipsychotic medication. Failure to attempt non-pharmacological interventions prior to administering an antipsychotic medication placed Resident #10 at risk of receiving an unnecessary medication. Findings include: Review of the facility policy titled "Use of Psychoactive Medication" occurred on 10/08/14. This undated policy, stated, "1. Antipsychotics: . . . K. The use of a prn antipsychotic medication will be specifically documented on the behavior assessment sheet, as well as the patient/residents MAR [medication administration record]. Documentation should include, assessment, other interventions utilized prior to administration of medication, and evaluation of effectiveness. . . ." Review of Resident #10's medical record occurred on 10/08/14. Resident #10's medical diagnoses included anxiety. Resident #10's medications included Haldol 3 milligrams (mg) intramuscularly once daily PRN. Haldol is an antipsychotic medication. Resident #10's careplan stated, "Problem: Alteration in Behavior Patterns Goals: Resident will be cooperative and not be combative towards	F 329	(Cont. from page 10) antipsychotic medication use. The DON/QI designee will do QI weekly audits x4, then monthly x5, unless determined otherwise by the QI Committee and results will be brought to the QI meetings monthly.	

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F 329	Continued From page 11 staff and other residents Approaches: Take precautionary combative measures . . . gently hold hands, approach from side in calm manner, if resists cares, come back later, if situational, remove circumstances, use principles of effective verbal communication, remain calm, move slowly, maintain eye contact, isolate individual (onlookers tend to fuel the escalating behavior), watch your body language, use silence, . . . " Review of Resident #10's June, July and August 2014 PRN medication administration record identified staff administered Haldol as follows: *06/24/14 at 3:36 a.m. - "given for agitation . . ." *07/01/14 at 5:41 p.m. - "resident restless attempting to leave DR [dining room], hollering, verbally disruptive . . ." *07/06/14 at 11:47 p.m. - No documentation on the MAR regarding reason for giving medication or response to medication *07/13/14 at 4:45 p.m. - "PRN administered. combative. pushing away caregivers. Refusing cares while trying to get out of chair. . ." *07/22/14 at 4:45 p.m. - "Resident restless, agitated and unable to redirect. . . . " *07/26/14 at 6:35 p.m. - "PRN administered. combative. Resident yelling and hitting at staff. . . ." *07/27/14 at 8:52 p.m. - "PRN administered due to agitation, swearing at staff, making rude comments, bit nurse. . . ." *07/29/14 at 4:06 p.m. - "PRN administered. Resident combative, hitting at staff. Resident was yelling at staff, 'get out of here!' Resident can be heard from own room to nurses station. Resident stated 'I ain't taking that crap, . . .' Resident attempted to kick at, hit, and swore at this nurse. Will continue to monitor. . . ." *08/01/14 at 4:21 p.m. - ". . . Resident is	F 329		

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(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 12 beginning to have behaviors such as difficulty redirecting and put her Kleenex in the sink and run water on the whole box. Is becoming more difficult to redirect and wheeled self up to recliner as if to attempt to transfer herself. Right now is attempting to remove decorations from her sweatshirt, but is calm. . . ." *08/02/14 at 4:32 p.m. - "Administered haloperidol 3 mg . . . intramuscularly . . . Resident's behavior beginning to escalate at this time such as attempting to go into soiled linen room and not wanting to come out, grabbing unto [sic] siderails and attempting to get out of chair . . . unable to be redirected." *08/05/14 at 4:36 p.m. - " PRN administered. Resident is aggitated [sic] and combative towards staff. Resident is swinging hands at staff and stating 'get the hell out of here!' Resident also stated 'I am going home now!' This nurse attempted to offer resident to do activities or if resident needed to use rest room. Resident stated 'I will go to the bathroom in my own home.' . . ." *08/07/14 at 11:57 p.m. - "PRN administered. combative. Resident hitting at staff during cares. . . ." Resident #10's Departmental Notes corresponding with the above dates/times identified nursing staff administered PRN Haldol on 9 of 12 occasions without prior attempts of non-pharmacological interventions. During an interview in the afternoon on 10/08/14, a supervisory nurse (#7) stated staff are expected to attempt (and document) non-pharmacological interventions prior to administration of PRN medications.	F 329		

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 _____	10/08/2014

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F 329	Continued From page 13 Failure of staff to attempt non-pharmacological interventions or alternative approaches prior to administering Haldol placed Resident #10 at risk of receiving an unnecessary medication.	F 329		