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 _____	10/15/2015

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 10/12/15 and completed on 10/15/15, the sample included 2 residents for complete review, 7 residents for focused review, and 1 closed record for review.	F 000		
F 309	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to provide the necessary care and services for 1 of 3 sampled residents (Resident #1) with insulin dependent diabetes. Failure to assess for signs and symptoms of hypoglycemia (low blood sugar), give insulin when ordered or obtain a physician's order to hold the insulin, provide interventions and recheck the blood sugar when indicated, and notify the physician in a timely manner of a pattern of low blood sugars does not allow for adjustments to treatment, has the potential to result in poorly controlled diabetes, and places other diabetic residents at risk for harm. Findings include: Review of Resident #1's medical record occurred	F 309	1.Resident #1 will have blood sugars rechecked in 30-45 minutes after blood sugars <60mg/dl and a provider will be notified if the blood sugar remains <60mg/dl per policy. 2.All resident with diabetes have the potential to be affected by inadequate monitoring and lack of notifying the provider. 3.The blood glucose monitoring policy was posted and reviewed. Staff will be re-educated on monitoring high and low blood sugars according to the new policy. A mandatory staff meeting will be held 11/3/2015 with POCs reviewed as well as the policies and procedures related to blood glucose monitoring. 4.QI monitoring will be implemented on	11/19/15

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

Electronically Signed | 10/30/2015

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 _____	10/15/2015

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 309	Continued From page 1 on all days of survey. Diagnoses included Type II diabetes mellitus. The care plan, dated 08/10/15, stated, "Problem: At risk for complications related to hyper/hypoglycemia . . . Approaches: . . . * observe & report sx [symptoms] of hypoglycemia (cold/clammy skin, LOC [level of consciousness] changes, c/o [complaint of] double vision, diaphoresis, rapid resp [respiration], n/v [nausea/vomiting] *fingerstick blood sugar per MD [medical doctor] order & PRN [as needed] . . . * if blood sugar < [less than] 60 give orange juice or milk . . ." Physician orders included NovoLog (fast-acting) insulin per sliding scale before meals and at bedtime, and Lantus (long-acting) insulin as follows: * 08/06/15 - NovoLog sliding scale: 0 units for blood sugar (BS) 0-150, 2 units for BS 151-200, 4 units for BS 201-250, 6 units for BS 251-300, 8 units for BS 301-350, 10 units for BS 351-400. This sliding scale lacked parameters to notify the physician for low or high BS levels. * 08/06/15 - Lantus 100 units daily at 8 a.m. * 08/17/15 - decrease Lantus to 85 units * 08/19/15 clinic visit, the physician added to the sliding scale for BS of 0-50 to give one ampule D50 (dextrose water) and call provider, for BS of 51-70 to give 4 ounces of fruit juice and call provider, and for BS greater than 400 to call provider. * 08/28/15 - decrease Lantus to 70 units * 09/15/15 - decrease Lantus to 60 units * 09/24/15 - NovoLog sliding scale: 0 units for BS 0-200, 2 units for BS 201-250, 4 units for BS 251-300, 6 units for BS 301-350, 8 units for BS 351-400, call physician for BS greater than 400.	F 309	random residents to observe that low/high blood glucose was rechecked in a timely manner and a provider was informed as per policy. The DON/QI designee will do weekly audits x4, then monthly x4, unless determined otherwise by the QI Committee and results will be brought to the QI meetings monthly. 5.Completion date 11/19/2015	

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 _____	10/15/2015

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 309	Continued From page 2 Resident #1's blood sugar record and corresponding departmental notes showed the following BS levels in milligrams per deciliter (mg/dl) and interventions: * 08/07/15 at 8:15 a.m. - 65 * 08/08/15 at 6:44 a.m. - 66 * 08/09/15 at 7:18 a.m. - 52 The record lacked evidence staff provided a timely intervention, i.e. orange juice or breakfast immediately, rechecked the BS, or notified the physician of the low BS results. * 08/10/15 at 8:54 a.m. - 50. At 8:55 a.m. ". . . orange juice and breakfast given." 08/11/15 at 9:51 a.m. "LATE ENTRY: 8/10/15 Res. [resident] blood sugar 50 this morning, speech slurred, eye contact and response time slow. orange juice, toast, 2 milks, and sausage fed to him. Res. reports his hands and fingers feel funny. Blood sugar recheck 78, and Res. alert, setting up, and feeling better. . . ." The record lacked the time of the BS recheck, and lacked evidence staff notified the provider of the resident's symptoms and low BS. * 08/13/15 at 6:56 a.m. - 45. At 5:27 a.m. "BS this AM [morning] was 49, woke pt. [patient] up from sleeping and he was easy to alert [sic], milk and graham crackers and peanut butter were given . . ." The record lacked evidence staff rechecked the BS, or notified the provider of the low BS. * 08/15/15 at 7:06 a.m. - 58. At 8:34 a.m. "BS check 58 this morining [sic], orange juice and yogurt given. . . . BS recheck 78. Staff failed to recheck the BS in a timely manner (waited 88 minutes). The record lacked evidence staff	F 309		

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 _____	10/15/2015

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 309	Continued From page 3 informed the provider of the low BS. * 08/17/15 at 6:54 a.m. - 69. At 9:55 a.m. "Dr. . . . notified of resident's blood glucose levels. New order given to decrease lantus in AM to 85 units daily. . . ." The record lacked evidence staff provided a timely intervention, i.e. orange juice or breakfast immediately, or rechecked the BS. * 08/25/15 at 8:17 p.m. - 64. * 08/27/15 at 8:40 a.m. - 68. The record lacked evidence staff provided a timely intervention, i.e. fruit juice, rechecked the BS, or notified the provider of the low BS results. * 08/28/15 at 8:32 a.m. - "0715 [7:15 a.m.] - accu-check 49 and nurse gave resident glass of milk (mighty shake). . . ." At 8:34 a.m. "0815 [8:15 a.m.] - accu-check repeated and was 59. AM insulin held at this time. Resident did eat 100%, but also offered orange juice which he drank. . . ." At 9:56 a.m. "[Name of doctor] here . . . updated on condition. New orders received . . . Acuu-chek [sic] 140 at this time." Staff failed to recheck the BS in a timely manner after the resident received milk and after the repeat BS of 59 (waiting 60 minutes and 101 minutes respectively). * 08/30/15 at 7:34 a.m. - 66. At 5:12 a.m. "Resident's blood glucose is 57 this morning. He has been given a glass orange juice . . ." At 7:36 a.m. "Lantus . . . 70 Units . . . held per nursing judgement. . . . resident is complaining of shaking. Given orange juice and instructed to eat . . ." Staff failed to recheck the BS in a timely manner after the resident received orange juice at 5:12 a.m. (waiting 142 minutes). The record lacked evidence staff rechecked the BS after	F 309		

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 _____	10/15/2015

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 309	Continued From page 4 interventions were provided at 7:34 a.m, or informed the provider of the continued low BS or the decision to hold the Lantus insulin. * 09/04/15 at 7:22 a.m. - 57. At 7:24 a.m. "Lantus . . . not given . . . Resident is extremely lethargic. Orange juice given . . ." The record lacked evidence staff rechecked the BS after orange juice provided, or informed the provider of the low BS and lethargy or the decision to hold the Lantus insulin. Blood sugars prior to lunch, supper and at bedtime were 116, 163, and 149 respectively. * 09/05/15 at 9:10 a.m. - Low. At 10:10 a.m. ". . . spoke with [name of doctor] this a.m. as resident's blood sugar was 98 and resident had not had any insulin in over 24 hours. [Name of doctor] gave this writer orders to hold Lantus. . . ." Staff failed to contact the physician for over 26 hours after the Lantus was initially held. * 09/06/15 at 9:19 p.m. - 180. At 9:20 p.m. "NovoLog . . . not given . . ." * 09/07/15 at 5:40 a.m. - 160. At 8:23 a.m. - 193. At 8:28 a.m. "NovoLog . . . was held. . . ." * 09/07/15 at 5:17 p.m. - 186. At 5:18 p.m. "NovoLog . . . was held. . . ." On the above three dates, staff failed to administer 2 units of NovoLog insulin as ordered per sliding scale or contact the provider for his/her decision on appropriate treatment. The BS on 09/07/15 at bedtime was 197. * 09/11/15 at 6:32 a.m. - 61. At 6:33 a.m. ". . . orange juice given" * 09/13/15 at 8:28 a.m. - 63. At 8:29 a.m. ". . . no coverage [no insulin needed per sliding scale]"	F 309		

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 _____	10/15/2015

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 309	Continued From page 5 * 09/15/15 at 8:01 a.m. - 69. At 8:03 a.m. ". . . no coverage" At 10:43 a.m. "[Name of doctor] updated re: [regarding] low morning blood sugars and order received to decrease lantus to 60 units in a.m." * 09/17/15 at 7:24 a.m. - 68. At 7:24 a.m. ". . . no coverage, gave juice" * 09/19/15 at 8:07 a.m. - 62. At 8:11 a.m. ". . . no coverage" * 09/20/15 at 8:16 a.m. - 59. At 8:17 a.m. ". . . no coverage, gave juice" * 09/21/15 at 6:53 a.m. - 68. At 6:54 a.m. "None [NovoLog] per sliding scale." The record lacked evidence staff provided a timely intervention with four of the seven low blood sugars, rechecked the BS on all seven occasions, or notified the provider of the low BS results on six of the seven occasions. *09/24/14 at 7:06 a.m. - 72. At 1:19 p.m. "[Name of provider] . . . made aware low morning blood sugars, orders written [changed the sliding scale]. . . ." Resident #1's record revealed no further concerns with low blood sugars after this sliding scale order change. During an interview on 10/15/15 at 9:35 a.m., an administrative nurse (#1) stated the facility has no policy on hypoglycemia. When asked when staff should notify the physician of a low blood sugar, this nurse stated the physician order should be individualized, if not, then staff should notify the provider if the blood sugar is less than 60 or greater than 400. This nurse stated she would expect staff to give the resident juice for a low blood sugar, and to recheck the blood sugar if less than 60.	F 309		

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 _____	10/15/2015

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 309	Continued From page 6 Failure to have a policy to guide staff related to hypoglycemia, provide immediate intervention for low blood sugars, recheck the blood sugar in a timely manner after interventions were provided, document all interventions, give insulin as ordered or obtain an order to hold the insulin, and notify the medical provider of low blood sugars in a timely manner does not allow the resident to receive the highest practicable level of care and may result in poor blood sugar control.	F 309		
F 323	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation and record review, the facility failed to provide adequate assistive devices for 2 of 3 sampled residents (Resident #3 and #9) observed transferred with a gaitbelt. Failure to ensure staff properly used a gaitbelt placed the residents at risk for accident and/or injury. Findings include: - Review of Resident #3's medical record occurred on all days of survey. Diagnoses included anxiety. The significant change Minimum Data Set (MDS), dated 08/12/15,	F 323	1.Resident #9 will receive adequate supervision and assistant devices to prevent accidents/injury. Resident #3 is deceased. 2.All residents have the potential to be affected or at risk for accident/injury related improper gait belt use. 3.A gait belt policy was developed, posted, and reviewed. Staff will be re-educated on gait belt use according to the new policy. A mandatory staff meeting will be held 11/3/2015 with POCs reviewed as well as the policy and procedure related to gait belt use.	11/19/15

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 _____	10/15/2015

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 323	Continued From page 7 identified extensive assistance of two or more people for transfers. The current care plan stated, "Impaired ADL [activities of daily living] function/Rehab potential . . . Interventions . . . Pivots with 2 assist. . . ." Observation on 10/13/15 at 5:10 p.m. showed two certified nursing assistants (CNAs) (#6 and #2) transferred Resident #3 from her bed to the wheelchair and from the wheelchair to the toilet. Both CNAs held onto the gaitbelt with one hand and lifted under Resident #3's axilla with their other hand. - Review of Resident #9's medical record occurred on October 14-15, 2015. Diagnoses included osteoarthrosis with bone and cartilage disease. A significant change MDS, dated 09/22/15, identified extensive assistance of two or more people for transfers. The current care plan stated, ". . . Transfer with 1-2 assist and gait belt. . . ." Observation on 10/15/15 at 8:32 a.m. showed a CNA (#6) transferred Resident #9 from her wheelchair to the toilet, then from the toilet back to her wheelchair. The CNA (#6) held onto the gaitbelt with one hand and lifted under Resident #9's axilla with the other hand, lifting the resident's shoulder as the resident stood.	F 323	4.QI monitoring will be implemented on random residents to observe for proper gait belt use. The DON/QI designee will do weekly audits x 4, then monthly x4, unless determined otherwise by the QI Committee and results will be brought to the QI meetings monthly. 5.Completion date 11/19/15	
F 328	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids;	F 328		11/19/15

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 _____	10/15/2015

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 328	Continued From page 8 Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy review, and staff interview, the facility failed to ensure appropriate oxygen treatment and care for 3 of 5 sampled residents (Resident #1, #5, and #6) and 1 of 1 closed resident record reviewed (Resident #10). Failure to assess a resident's need for as-needed (PRN) oxygen (O2), monitor effectiveness, and document liter flow does not allow the facility or the health care provider to assess the effectiveness of the resident's oxygen therapy. Findings include: Review of the facility policy titled "Oxygen Therapy" occurred on 10/14/15. This policy, dated 08/01/96, stated, "PURPOSE: To relieve anoxemia and anoxia [deficiency of oxygen]. . . . STEPS IN PROCEDURE: . . . 6. Adjust liter flow as ordered. . . . 12. Chart in nurses notes - Liter flow; Time Started & discontinued; Patient Observations; and Signature." - Review of Resident #1's medical record occurred on all days of survey. Diagnoses included history of coronary artery disease. Physician orders for oxygen included the	F 328	1. Residents #1, #5, and #6 will receive proper treatment and care for respiratory care. Residents #1 and #6 had their orders changed to specific amount of oxygen to be given. Resident #5 is no longer on oxygen. Resident #10 was a closed chart review. 2. All residents have the potential to be affected by failure to ensure appropriate oxygen treatment and care. 3. The oxygen policy was updated and posted. A special requirement was added for the nurses to chart liters of oxygen and percentage of oxygen. Staff will be re-educated on oxygen assessment, usage, and documentation. A mandatory staff meeting will be held 11/3/2015 with POCs reviewed as well as the oxygen policy and procedure. 4 QI monitoring will be implemented on random residents receiving respiratory care to observe that the liters of oxygen are charted along with the oxygen saturation according to the orders for that resident per policy. The DON/QI designee will do weekly audits X 4, then monthly audits X 4, unless determined by the QI committee the need to continue.	

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 _____	10/15/2015

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 328	Continued From page 9 following: * 08/27/15 - "Oxygen at 3L [liters] via nasal cannula" * 09/24/15 - "Oxygen 1-15L as needed to keep O2 Sats [saturation] > [greater than] 90% [percent]" Observation throughout the survey showed Resident #1 either receiving no oxygen, or 2 to 3 liters via nasal cannula. Review of Resident #1's September 24 - October 14, 2015 treatment administration record (TAR) showed a licensed nurse initialed and placed a check mark in the column for oxygen (indicating oxygen administered) four times daily, except for the period of October 2 at 4:00 p.m. through October 3 at 10:00 a.m. when the resident was not in the facility. On 10/12/15 at 3:12 p.m., a licensed nurse documented "O2 set at 2 liters via nasal cannula." On the remaining 19 days, the nurse failed to document the liter flow of the oxygen on the TAR. Resident #1's vital sign record, dated October 1-14, 2015, showed O2 sats documented at 90% on one day, 93% on four days, 98% on four days, and no results recorded on the remaining five days. This record failed to show whether staff obtained the saturation with the resident on room air or on oxygen, including the liter flow. Resident #1's departmental notes, from 09/24/15 to 10/14/15, showed the following: * 09/25/15 at 5:39 a.m., ". . . resident did not have oxygen tubing on. . . . O2 sats were 95% . . ." * 09/26/15 at 3:50 a.m., ". . . Denies complains	F 328	Results will be brought to the monthly QI meetings. 5. Completion 11/19/15.	

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 _____	10/15/2015

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 328	Continued From page 10 [sic] of SOB [shortness of breath] or dyspnea. . . . O2 sats 96% on 3LPM/NC [liters per minute per nasal cannula]." * 09/27/15 at 6:25 a.m., ". . . O2 sats 95% on 3LPM/NC. No SOB or dyspnea noted. . . ." * 09/28/15 at 6:29 a.m., ". . . O2 at 3LPM/NC continuous. Sats 96%. . . ." * 09/30/15 at 3:38 a.m., ". . . O2 continuous at 3LPM/NC. . . ." * 10/01/15 at 5:05 p.m., "Spo2 [oxygen saturation] 89 to 90% on room air at rest. Oxygen on at 2L/nc with Spo2 95 to 97%. . . ." * 10/03/15 at 3:35 p.m., ". . . SpO2 93% with 3 Literes [sic] of oxygen per nasal canula [sic]. . . ." * 10/05/15 at 1:29 p.m., ". . . O2 @ [at] 3L/NC . . ." * 10/06/15 at 2:29 a.m., ". . . O2 sats 96% on P2 [sic] at 2LPM/NC. . . ." * 10/07/15 at 3:54 a.m., "O2 sats@ 91% @3 1/2L/MIN/NC, states he is tired but offered no other complaints. . . ." * 10/08/15 at 1:57 a.m., ". . . Offered no complaints. . . . O2 sat 91%@3 1/2 L/MIN/NC." * 10/12/15 at 1:11 a.m., "On 10/11/2015 at 2335 [11:35 p.m.] resident had complains [sic] of chest pain . . . 98% O2 sats on 2LPM/NC . . . NO SOB or dyspnea noted. . . ." * 10/12/15 at 1:59 p.m., "Resident has no complaints of chest pain today. Voiced, 'I always ache all over' . . . on O2 via NC at 2 liters. . . ." * 10/12/15 at 3:12 p.m., ". . . O2 set at 2 liters via nasal cannula." * 10/13/15 at 11:18 a.m., ". . . He used the parallel bars [Physical Therapy department] for support during standing. . . . During standing his oxygen sats dropped to 85%. Oxygen was placed NC at 3 L. . . ." * 10/14/15 at 3:54 p.m., ". . . O2 at 3L/nc	F 328		

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 _____	10/15/2015

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 328	Continued From page 11	F 328		

continuous. Res. [resident] sats 88-89[%] on room air."

Other than 10/01/15 with low O2 sat on room air, 10/12/15 with chest pain, 10/13/15 with therapy, and 10/14/15 with low O2 sat on room air, the record lacked evidence staff consistently assessed Resident #1's need for oxygen, identified the necessary liter flow, checked his O2 sat prior to applying oxygen, or monitored the effectiveness of the oxygen after application.

- Review of Resident #6's medical record occurred on all days of survey. Diagnoses included chronic obstructive pulmonary disease (COPD). A physician order, dated 01/31/15, stated, "Oxygen @ 1-15 liters TO KEEP O2 SATS GREATER OR EQUAL TO 90%."

Observation throughout the survey showed Resident #6 either receiving no oxygen, or 3 to 3.5 liters via nasal cannula.

Review of Resident #6's September 1 - October 14, 2015 TAR showed a licensed nurse initialed and placed a check mark in the column for oxygen (indicating oxygen administered) daily, except for 09/18/15 when the resident was "ambulating in the hall." On 10/14/15 at 3:52 p.m., a licensed nurse documented "O2 3l/nc as needed. Res. will apply oxygen at times when in room." On 43 of the 44 days, the nurse failed to document the liter flow of the oxygen on the TAR.

Resident #6's vital sign record showed O2 sats documented once in September and once in October 2015 with a result of 98% and 100% respectively. This record failed to show whether

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 _____	10/15/2015

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 328	Continued From page 12 staff obtained the saturation with the resident on room air or on oxygen, including the liter flow. Resident #6's Departmental Notes, from 09/15/15 to 10/14/15, showed the following: * 09/21/15 at 4:59 a.m., ". . . won't leaven [sic] oxygen on when she says she is having trouble breathing, SATS greater than 92%. . . ." * 10/01/15 at 10:57 p.m., "2100 [9:00 p.m.] Resident anxious and complaining of not being able to break [sic]. Oxygen put on and assisted with nebulizer. . . ." * 10/02/15 at 12:21 a.m., "10/1/2015 2355 [11:55 p.m.] Resident complained of SOB. Duoneb taken." * 10/03/15 at 10:03 a.m., " Resident voices 'I can't breathe.' This writer encouraged resident to put in place her oxygen . . . resident continues to refuse to keep her oxygen in place and receive her nebulizer treatments. . . ." * 10/14/15 at 3:52 p.m., ". . . O2 3L/nc as needed. Res. will apply oxygen at times when in room." The only notation of liter flow identified in Resident #6's record, from 09/01/15 to 10/14/15, occurred on 10/14/15. The facility staff failed to document the liter flow when Resident #6 complained of SOB, and failed to consistently assess the resident's oxygen saturation level during complaints of SOB to determine whether oxygen therapy was warranted or another type of treatment/intervention was needed. - Review of Resident #5's medical record occurred on all days of survey. Diagnoses included history of gastrointestinal bleed with hospitalization and anemia.	F 328		

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 _____	10/15/2015

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 328	Continued From page 13	F 328		

Physician orders for oxygen stated:
07/23/15 - "Oxygen at 1-15 Liters to keep O2 sats equal to or > 90%"

Review of Resident #5's July, August, and September 2015 TARs showed a licensed nurse initialed and placed a check mark (indicating oxygen administered) or N (oxygen not administered) in the column for oxygen. Nursing staff documented Resident #5's use of oxygen twice on 07/23/15, four times a day 07/24/15 through 09/02/15, and twice on 09/03/15 before the physician discontinued the resident's oxygen therapy.

The TARS identified the administration of oxygen as follows:
* Eight times administered oxygen after an assessment showed a room air sat below 90%.
* 26 times administered oxygen after an assessment showed a room air sat > 90%.
* 141 times administered oxygen without an assessment.

The TAR documentation identified the liter per minute flow rate three of the 171 administrations of oxygen:
* 07/24/15, 9:43 p.m., ". . . Treatment was not effective: O2 increased to 3.5 O2 Sats 83 . . ."
* 07/25/15, 5:39 a.m., ". . . Treatment was effective: O2 saturation 95% with O2 on at 3.5 L per nasal cannula . . ."
* 07/25/15, 5:06 p.m., ". . . Treatment was effective: O2 sat 95% on 2 liters/nc . . ."

Departmental notes on 07/23/15, 07/24/15, and 07/25/15 identified oxygen flow rates of two liters

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 _____	10/15/2015

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 328	Continued From page 14	F 328		

per nasal cannula. A note on 07/28/15 identified an oxygen flow rate of three liters. Documentation failed to identify any further information on the oxygen administration rate.

Documentation showed facility staff failed to follow physician orders when administering oxygen after an assessment showed, failed to assess and document room air oxygen saturations, and failed to identify the flow rate.

During an interview on 10/15/15 at 9:15 a.m., an administrative nurse (#1) identified the facility chose to schedule prn oxygen so that nursing staff "have to look at it," meaning the nurse should assess the resident each time.

- Review of Resident #10's medical record occurred on October 14-15, 2015. Diagnoses included chronic obstructive pulmonary disease.

Physician orders included the following:
* 05/27/14 - Oxygen at 1-15 liters as needed, keep O2 Sats greater or equal to 90%

Review of the June 2015 TAR showed a licensed nurse initialed and placed a check mark in the column for oxygen six times a day. On 06/26/15 at 2:19 p.m. a licensed nurse documented "Treatment was effective: as long as he leaves O2 on, feels better, 2 [sic] sats 92%." The nurse failed to document the liter flow of the oxygen on the TAR for the 30 days in June.

Review of the July 01-22, 2015 TAR showed a licensed nurse initialed and placed a check mark in the column for oxygen as follows:
* July 01-07: six times a day

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 _____	10/15/2015

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 328	Continued From page 15 * July 08: five times a day * July 09-21: four times a day * July 22: two times a day The nurse failed to document the liter flow of the oxygen on the treatment record for July 1-22, 2015. During an interview on 10/15/15 at 9:35 a.m., an administrative nurse (#1) stated staff should check and chart the O2 saturation before applying oxygen. Failure to assess a resident's need for oxygen therapy prior to implementing the oxygen, document the O2 sats and the liter flow, develop a policy for appropriate and effective oxygen administration, and monitor the effect of the oxygen consistently, does not allow the resident to receive the maximum benefit from the oxygen therapy or provide the health care provider the information needed to manage the resident's care effectively.	F 328		
F 329	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	F 329		11/19/15

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 _____	10/15/2015

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 16 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. This REQUIREMENT is not met as evidenced by: Based on record review, review of professional reference, and staff interview, the facility failed to ensure a medication regimen free from unnecessary medications for 2 of 4 sampled residents (Resident #2 and #7) receiving antipsychotic or hypnotic medications. Failure to attempt a gradual dose reduction (GDR), unless contraindicated, in an effort to reduce or discontinue antipsychotic or hypnotic use may result in residents receiving unnecessary medications and experiencing adverse drug effects related to their use. Findings include: The Centers for Medicare and Medicaid Services has outlined the standards of practice regarding the tapering of a medication dose/Gradual Dose Reduction which states the purpose of tapering a medication is to find an optimal dose or to determine whether continued use of the medication is benefiting the resident. Tapering may be indicated when the resident's clinical	F 329	1.Resident #7 had a GDR done on 10/16/2015. Resident #2 hypnotic was reviewed and a contraindication was dictated by the physician. 2.All residents have the potential to be affected by having unnecessary medications. 3.A mandatory staff meeting will be held on 11/3/2015 with POCs to be reviewed as well as the policies and procedures related to the use of psychoactive medications. The medical director reviewed the policy on psychotropic drug use. 4.QI monitoring will be implemented on random residents who receive psychoactive medications; monitoring GDRs according to regulations. The DON/QI designee will do monthly audits x4 unless determined otherwise by the QI Committee and results will be brought to the QI meetings monthly. 5. Completion 11/19/2015	

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 _____	10/15/2015

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 17 condition has improved or stabilized or the underlying causes of the original target symptoms have resolved. Often, however, the only way to know whether a medication is needed indefinitely and whether the dose remains appropriate is to try reducing the dose and to monitor the resident closely for improvement, stabilization, or decline. For psychopharmacological medications (other than antipsychotics and sedatives/hypnotics), a tapering of the medication should be attempted annually, unless clinically contraindicated. For antipsychotics, a GDR must be attempted annually, unless clinically contraindicated. For sedatives/hypnotics, a GDR should be attempted quarterly unless clinically contraindicated. - Review of Resident #2's medical record occurred on all days of survey. Diagnoses included insomnia. Medications included Halcion (hypnotic) 0.25 milligrams (mg) at bedtime since admission on 02/09/15 and Melatonin 3 mg at bedtime since 02/21/15. Resident #2's medical record showed the facility failed to attempt a GDR or identify contraindications for a GDR for the hypnotic Halcion, quarterly as required. - Review of Resident #7's medical record occurred on October 14-15, 2015. Diagnoses included Alzheimer's disease and depressive psychosis. Medications included Abilify (antipsychotic) 5 mg at bedtime since admission on 02/27/14. Resident #7's medical record showed the facility failed to attempt a GDR or identify	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 _____	10/15/2015

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 18 contraindications for a GDR for the antipsychotic Abilify since admission on 02/27/14. During an interview on 10/15/15 at 9:35 a.m. an administrative nurse (#1) stated the facility does not have a policy regarding GDRs.	F 329		
F 428	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 record review and staff interview, the facility's consulting pharmacist failed to recognize and report medication irregularities and recommend a gradual dose reduction (GDR) for 2 of 4 sampled residents (Resident #2 and #7) on an antipsychotic or hypnotic medication. Failure to identify irregularities and recommend a gradual dose reduction may result in residents receiving unnecessary medications and experiencing adverse reactions. Findings include: - Review of Resident #2's medical record occurred on all days of survey. Diagnoses	F 428	1.The pharmacist reviewed Resident #7 and #2 medications on 10/26/2015. 2.All residents have the potential to be affected by failure to recognize and report medication irregularities through a monthly pharma logical drug review. 3.The consulting pharmacist was given the pharmacy regulations in reference to federal and state regulations for pharmacy consultants. The consulting pharmacist will perform a monthly medication review and report any irregularities to the director of nursing. 4.QI monitoring will be implemented on random residents who receive	11/19/15

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 _____	10/15/2015

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 19 included insomnia. Medications included Halcion (hypnotic) 0.25 milligrams (mg) at bedtime since admission on 02/09/15. Resident #2's medical record lacked evidence of a pharmacy recommendation for a quarterly gradual dose reduction of Halcion. - Review of Resident #7's medical record occurred on October 14-15, 2015. Diagnoses included Alzheimer's disease and depressive psychosis. Medications included Abilify (antipsychotic) 5 mg at bedtime since admission on 02/27/14. Resident #7's medical record lacked evidence of a pharmacy recommendation for a gradual dose reduction of Abilify since 02/27/14. During an interview on 10/15/15 at 9:35 a.m. an administrative nurse (#1) stated the facility does not have a policy regarding GDRs.	F 428	psychoactive medications; monitoring the pharmacist review according to regulations. The DON/QI designee will do monthly audits x4 unless determined otherwise by the QI Committee and results will be brought to the QI meetings monthly. 5. Completion 11/19/2015	
F 441	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and	F 441		11/19/15

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 _____	10/15/2015

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 441	Continued From page 20 (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to follow standard infection control practices for 3 of 8 sampled residents (Resident #2, #7, and #9) observed during perineal care. Failure to follow infection control practices has the potential to cause or spread infection within the facility. Findings include: Review of the facility policy titled "Perineal Care" occurred on 10/15/15. This undated policy stated,	F 441	1.Residents #9, #7, and #2 will receive standard infection control practices during perineal care. 2.All residents have the potential to be affected by staff failing to follow standard infection control practices during perineal care practices. 3.A mandatory staff meeting will be held on 11/3/2015 with POCs to be reviewed as well as the policy and procedure on perineal care/hand washing. A demonstration on proper hand washing	

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 _____	10/15/2015

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 441	Continued From page 21 "STEPS IN PROCEDURE . . . 6. General procedure is to gently wipe from front to back, using a clean area of the cloth for each stroke; Center first, sides after center; Cleanse the rectal area last. . . . 9. Remove gloves. 10. Use clean gloves to apply any cream . . . 14. Remove gloves. 15. Wash hands. 16. Reposition resident as appropriate for resting or resuming normal activities. 17. Place call light where it is accessible to resident . . . 20. Wash hands. 21. Remove soiled linen and garbage from room; wash hands after proper disposal. . . ." - Observation on 10/12/15 at 5:20 p.m. showed a certified nursing assistant (CNA) (#2) provided perineal cares for Resident #2, who voided in the toilet. The CNA (#2) applied lantiseptic skin protectant to the perineal area with the same gloves on. The CNA (#2) failed to change gloves prior to applying skin protectant. - Observation on 10/13/15 at 8:24 a.m. showed a CNA (#3) provided perineal cares for Resident #2, who was incontinent of urine and voided in the toilet. Wearing the same gloves, the CNA (#3) applied lantiseptic skin protectant to the perineal area. The CNA (#3) then guided the resident out of the bathroom by touching Resident #2's back, applied the resident's shoes, moved the bedside table closer to Resident #2, handed the call light to the resident, and made the bed before removing her gloves and performing hand hygiene. The CNA (#3) failed to change gloves prior to applying skin protectant and perform hand hygiene after completing perineal cares and prior to completing other tasks. - Observation on 10/14/15 at 4:40 p.m. showed	F 441	will be also completed at the in-service. 4.QI monitoring will be implemented on random residents who receive perineal care to observe that standard infection control practices during perineal care are completed according to policy. The DON/QI designee will do weekly audits x4, then monthly audits x4 unless determined otherwise by the QI Committee and results will be brought to the QI meetings monthly. 5.Completion 11/19/2015	

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 _____	10/15/2015

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 441	Continued From page 22 two CNAs (#3 and #4) provided perineal cares for Resident #7 who was incontinent of urine. One CNA (#4) performed perineal cares and removed her gloves. The other CNA (#3) performed perianal cares, applied an incontinent product, unhooked the sling from the sit to stand mechanical lift, and adjusted Resident #7's clothes wearing the same gloves. The CNA (#3) gathered the garbage, removed her gloves, and left the room without performing hand hygiene. She disposed of the garbage and used hand sanitizer. The CNA (#3) failed to remove her gloves and perform hand hygiene after completing perineal cares and prior to completing other tasks. - Observation on 10/14/15 at 3:48 p.m. showed a CNA (#7) provided perineal care for Resident #9, who voided and had a bowel movement while on the toilet. The CNA (#7) removed the gloves used for perineal care, assisted the resident to wash her hands, combed the resident's hair, and provided the resident a drink of water. The CNA failed to perform hand hygiene after completing perineal care and prior to completing other care for Resident #9. During an interview on 10/15/15 at 8:55 a.m. an administrative nurse (#1) stated her expectation is for staff to remove their gloves and perform hand hygiene after perineal care.	F 441		