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 _____	10/27/2016

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 10/25/16 and completed on 10/27/16, the sample included two (2) residents for complete review, seven (7) residents for focused review, and one (1) closed resident record for review. The sample included one (1) additional resident to verify specific concerns during the survey.	F 000		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to provide housekeeping and maintenance services to maintain a clean environment in 2 of 2 resident care areas/units (north wing, west wing) 1 of 1 kitchenette, and 1 of 1 kitchen. Failure to ensure bathroom vents and walls, ice machines, and an oven are cleaned and repaired regularly does not promote a homelike environment and may negatively impact residents' quality of life. Findings include: Review of the facility policy titled "Maintenance and Cleaning" occurred on 10/27/16. This policy, dated 1988, related to the ice machines, stated, ". . . It is the USER'S RESPONSIBILITY to see that the unit is properly maintained. . . . Maintenance and Cleaning should be scheduled	F 253	1. Rooms 6,9,10,11,12,13, and 16 vents and all resident room vents were cleaned 10/20/2016. Rooms 11 and 12 bathroom walls were repaired 11/8/2016. Room 4 wall screws and screw holes were repaired 11/8/2016 Ice machine x 2 were cleaned 11/1/2016 Oven was cleaned 11/3/16 Facility will provide housekeeping and maintenance services to maintain a sanitary, orderly and comfortable interior. 2. All residents have the potential to be affected by failure to ensure that the facility is kept sanitary, orderly and comfortable. 3. Vents were added to the housekeeping	11/13/16

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

Electronically Signed | 11/11/2016

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 253	Continued From page 1 at a minimum of twice per year. . . ." - The initial tour of the facility occurred at approximately 12:30 p.m. on 10/25/16 and showed the following: *Dust and debris buildup on the bathroom vents in resident rooms 6, 9, 10, 11, 12, 13, and 16. *Scuffed and paint-chipped bathroom walls in resident rooms 11 and 12. *Screws and screw holes in the walls in resident room 4. - During the dietary tour on 10/27/16 at 8:30 a.m. the dietary manager (#1) stated the maintenance department cleans the ice machine. During this tour observation in the resident's kitchenette showed the lower area of the oven contained a large amount of black baked on food items. The dietary manger (#1) stated she did not know who is responsible to clean the oven. - The enviornmental tour of the facility occurred on 10/27/16 at 9:00 a.m. with the plant operations manager (#2). This manager stated the bathroom vents, scuffed, paint-chipped walls and screw holes are only cleaned/repaired when nursing or housekeeping staff put in a work order to his department. When asked about cleaning the ice machine, the manager (#2) stated it is the responsibility of the dietary staff to clean it.	F 253	daily checklist to check daily (Mon-Fri) and clean as needed. Room/bathroom walls will be checked on a quarterly basis and repaired as needed. Manufacturers guidelines for ice machine sanitation/cleaning was added to policy book and will be done twice a year. Oven cleaning was added to a daily check list and cleaned as needed. A mandatory all staff in-service was held 11/9/2016 with POC's reviewed. 4. QI monitoring will be implemented on the bathroom vents, room walls, ice machine cleaning/sanitation, and oven cleaning. The QI Dir/Designee will monitor oven and bathroom vents weekly X 4, then monthly X 2, then quarterly X 2, unless determined otherwise by the QI committee. The walls in bathrooms/rooms will be checked monthly X 3, then quarterly thereafter on facility walk-throughs, unless determined otherwise by the QI committee. Ice machine cleaning checklist will be audited every quarter to ensure that machines are cleaned/sanitized every 6 months/twice a year, unless determined otherwise by the QI Committee. All results will be reviewed at the monthly QI meeting. 5. 11/13/2016	

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F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES 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 observation, record review, review of facility policy, and staff interview, the facility failed to provide treatment and services to prevent skin breakdown and the development of pressure ulcers for 1 of 4 sampled residents (Resident #3,) at risk for pressure ulcers. Failure to consistently implement interventions for pressure relief may result in skin breakdown and pressure ulcers and may have delayed healing of Resident #3's open areas. Findings include: Review of the facility policy titled "Prevention Pressure Sores" occurred on 10/27/16. This policy, revised in 2005, stated, ". . . It is our policy to identify adults at risk of pressure ulcers and to define early interventions for prevention. . . . Bed or chair bound individuals or those whose ability to reposition is impaired should be considered at risk for pressure ulcers. . . . High Risk Factors: 1. Lack of mobility . . . 2. Lack of sensation/altered level of consciousness . . . 7. Lack of knowledge.	F 314	1. Resident #3 was placed on a every 2-3 turning schedule and placed in a Broda chair 11/3/16. 2. All residents have the potential to be affected by failure to ensure the resident receives necessary treatment to heal pressure sores and prevent new ones from developing. 3. A mandatory all staff in-service was held 11/9/2016 with POC's reviewed. 4. QI Dir/Designee will monitor resident #3 and 2 other residents weekly X 4, biweekly X 2, monthly X 3 then quarterly X 2 to ensure residents are being repositioned and charting matches what was done. All results will be reviewed at the monthly QI meetings. 5. 11/13/2016	11/13/16

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F 314	Continued From page 3 . . . Early interventions include: . . . *Reduce pressure over bony prominences *Individualize turning and repositioning plans for residents in bed or chair: every 2 hour turn scheduled for residents and every 1 hour repositioning in the chair when appropriate. . . . *Provide special attention to floating heels to keep them off the bed . . . Minimize skin exposure to moisture due to incontinence whenever possible . . ." - Review of Resident #3's medical record occurred on all days of survey. Diagnoses included failure to thrive, weakness, and protein/calorie malnutrition. Resident #3's quarterly Minimum Data Set (MDS), dated 08/12/16, identified extensive assistance for bed mobility and transfers and at risk for pressure ulcers. The care plan stated, "Potential for alteration in skin integrity . . . Report to charge nurse and [sic] redness or skin breakdown immediately. May apply Lantiseptic or Calmoseptine cream as needed to any noted reddened areas. Protect skin from moisture and effects of pressure, friction, and shearing . . . Skin is fragile, handle with care . . . Argenaid per dietary." A nursing progress note, dated 10/15/16, identified a small open area to Resident #3's right buttock and staff treated the area with Calmoseptine. The next nursing progress note related to the open area, dated 10/25/16, identified two small open areas to the resident's right buttock. Observation on 10/25/16 at approximately 12:30 p.m. showed Resident #3 positioned on her left side sleeping on her bed. The nurse (#4) stated	F 314		

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F 314	Continued From page 4 the resident has been more tired lately and "hasn't been herself." At 4:40 p.m., (approximately 4 hours later), two certified nursing assistants (#8 and #9) utilized a PAL lift (a sit to stand mechanical lift) and assisted Resident #3 to the bathroom. Observation showed two small open areas on her right buttock and the CNA (#8) applied a lanolin (barrier) cream to the area. Observation during pericares on 10/26/16 at 8:05 a.m. showed two open areas to Resident #3's right buttock and the CNA (#7) applied lanolin cream to the area. At 10:35 a.m., two CNAs (11# and #12) assisted the resident to bed and positioned her on her left side. Resident #3 remained in this position until 1:30 p.m. (approximately 3 hours) when two CNAs (#7 and #12) repositioned her to her right side. Record review and the above observations identified staff failed to develop and implement an individualized turning and repositioning schedule, float Resident #3's heels when in bed, and reduce pressure between bony prominences when in bed.	F 314		
F 323 SS=E	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.	F 323		11/13/16

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F 323	Continued From page 5 This REQUIREMENT is not met as evidenced by: FALL MATS 1. Based on observation and staff interview, the facility failed to ensure an environment free of accident hazards on 3 of 3 days of survey (November 26-27, 2016). Failure to remove fall mats from the floor, when a resident is not in bed, placed residents at risk for falls and injury. Findings include: - Observation during initial tour on 10/25/16 at 11:45 a.m. showed a fall mat on the floor next to Resident #5's bed and the resident not in the room. Observation on 10/25/16 at 3:00 p.m. showed a fall mat on the floor next to Resident #5's bed and the resident not in the room. Observation on 10/26/16 at 10:25 a.m. showed Resident #5 ambulated from the nurses station to her room with stand by assist and the fall mat remained on the floor next to the bed. During an interview on the morning of 10/27/16 an administrative nurse (#3) stated Resident #5's care plan does not include use of a fall mat as this would be a tripping hazard. - Observation on 10/25/16 at approximately 12:30 p.m. showed a fall mat on the floor next to Resident #11's bed and the resident not in the room. At 1:15 p.m., a staff nurse (#4) stated Resident #11 moves about the facility in a wheelchair which he self-propels.	F 323	1. Floor mat for resident #5 was removed 10/20/2016. Res. #11 floor mat was discontinued and removed on 11/7/2016. Chemicals were removed from kitchenette and utility room and placed in locked storage. Sharp objects/knives were removed from cupboard and locked in storage. 2. All residents have the potential to be affected or at risk for accident/injury related to improper floor mat usage, unlocked chemicals and unlocked sharp objects. 3. Staff were re-educated on accident risks of floor mats, chemicals and sharp objects. A mandatory all staff in-service was held 11/9/2016 with POC's reviewed. Chemical storage policy was reviewed. 4. QI Dir/Designee will monitor floor mat placement, chemical storage, and sharp object storage weekly X 4, then monthly on walk-throughs X 2, then quarterly X 3, unless determined otherwise by the QI Committee. Results will be brought to the QI monthly meetings. 5. 11/13/2016	

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F 323	Continued From page 6 During an interview on 10/27/16 at 11:40 a.m. an administrative nurse (#3) stated she expected staff to remove floor mats from the floor when resident's are not in bed. Observation on 10/27/16 at 12:00 p.m. again showed the fall mat on Resident #11's floor next to the bed and the resident not present. UNLOCKED HAZARDOUS ITEMS 2. Based on observation, review of facility policy, and staff interview, the facility failed to maintain an environment free of accident hazards in 1 of 2 utility rooms (North Utility Room) and 1 of 1 kitchenette. Failure to secure hazardous chemicals and two large kitchen knives placed cognitively impaired and wandering residents at risk for accidents/injury. Findings include: Review of the facility policy titled "Storage of Chemicals" occurred on 10/27/16. This policy, dated 2010, stated, "POLICY: Chemicals are stored in locked cupboards away from resident/patients. . . . 2. The storage room is used to store any/all hazardous items. A. A locked cupboard is used to store potentially hazardous items. . . ." - The dietary tour occurred on 10/27/16 at 8:30 a.m. with a dietary manager (#1). Observation in the resident's kitchenette showed a spray bottle of TB disinfectant cleaner in an unlocked cabinet. The disinfectant bottle stated, "Keep Out of	F 323		

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F 323	Continued From page 7 Reach of Children. An unlocked cabinet above the refrigerator contained two large kitchen knives. The dietary manager removed the disinfectant and the knives from the kitchenette. - The environmental tour of the facility occurred on 10/27/16 at 9:00 a.m. with the plant operations manager (#2). Observation showed a can of Cavicide disinfectant spray and a can of glass cleaner in an unlocked cupboard in the soiled utility room on the north wing. Both cans of chemicals stated, "Keep Out of Reach of Children." The manager (#2) moved the chemicals to the locked cupboard in the soiled utility room.	F 323		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure 3 of 9 sampled residents (Resident #1, #6, and #5) had a complete and	F 514	1. Res. #1, 5, and 6 records were corrected. 2. All residents have the potential to be	11/13/16

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F 514	Continued From page 8 accurate medical record. Failure to ensure a complete and accurate medical record does not allow staff and/or providers to have accurate information necessary to provide care and treatment for the residents. Findings include: - Review of Resident #1's medical record occurred on all days of survey. The electronic medical record (EMR) nursing progress note dated, 05/05/16 at 10:14 a.m., stated, "Bruise on right shoulder coninues [sic] to be tender and purple and yellow color." During an interview on 10/26/16 at 3:20 p.m., an administrative nurse (#3) stated staff documented the above information on the wrong resident. - Review of Resident #5's medical record occurred on all days of survey. The EMR nursing progress note dated, 01/28/16 9:48 a.m., stated, "Bruise left shoulder remains purple with some pink. Skin intact, immobilizer in place." During an interview on the afternoon of 10/26/16 an administrative nurse (#3) stated staff documented the above information on the wrong resident. - Review of Resident #6's medical record occurred on all days of survey. The EMR nursing progress note dated, 05/03/16 at 11:26 a.m., stated, "Resident will transfer with assist of 2 for a pivot transfer and sit to stand transfers using nursing disgression [sic]."	F 514	affected by facilities failure to ensure records are complete and accurate to provide the necessary care and treatment needed. 3. Staff were educated on the importance of correct charting. A mandatory all staff in-service was held 11/9/2016 with POC's reviewed. 4. Residents #1, 5, 6 and 2 other residents charts will be audited weekly X 4, then monthly X 2, then quarterly, unless determined otherwise by the QI committee. All results will be brought to the monthly QI committee meetings. 5. 11/13/2016	

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F 514	Continued From page 9 During an interview on 10/26/16 at 4:48 p.m., an administrative nurse (#3) stated staff documented the above information on the wrong resident.	F 514		