STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355109	A. BUILDING _____ B. WING _____	04/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOURIS VALLEY CARE CENTER	300 MAIN ST S VELVA, ND 58790

(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 April 10, 2016 and completed on April 13, 2016, the sample included two (2) residents for complete review, eight (8) residents for focused review, and one (1) closed record for review. The sample included five (5) additional residents to verify specific concerns during the survey.	F 000		
F 156 SS=B	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.	F 156		5/18/16

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

Electronically Signed | 05/05/2016

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F 156	Continued From page 1 The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with	F 156		

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F 156	Continued From page 2 the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on review of the facility's Medicare billing notices and Medicare billing records, the facility failed to provide required notices for 1 of 4 residents (Resident #16) reviewed for Medicare billing. Failure to provide evidence of follow-up regarding the demand bill is a violation of resident rights. Findings include: Review of Medicare billing records occurred on the afternoon of 04/12/16 with an administrative staff member (#3). Billing records for Resident #16 identified the facility failed to provide the required notices to the resident.	F 156	Preparation and execution of this response and plan of correction does not constitute an admission of agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed soley because it is required by the provisions of Federal and State law. For the purposes of any allegations that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the State Operations Manual. 1. Resident #16 requirements have been met by having Social Services reissue the form GSS #926 SNF Determination on	

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F 156	Continued From page 3	F 156	Continued Stay and 980 Notice of Medicare Non-coverage paperwork with the responsible family member. 2. All residents on Medicare have the potential of being affected. 3.Education on the procedure titled, "Non-coverage notification on Continued Stay" and "Notice of Medicare Non-coverage" will be provided for social service director and DNS on 5/12/16. System change: The HIM or designee will develop a tracking record of all residents admitted under a Medicare A benefit. will track resident name, date when the form GSS # 926 SNF Determination on Continued Stay and 980 Notice of Medicare Non-coverage were issued. Social Services or designee will monitor the form GSS # 926 SNF Determination on Continued Stay and 980 Notice of Medicare Non-coverage paperwork weekly during the Medicare meeting and ensure the forms are scanned into the legal medical record. 4. An audit will be developed to ensure compliance with Medicare A discharge notices includling GSS # 926 SNF Determination on Continued Stay and 980 Notice of Medicare Non-coverage. Social services director, or desginee, will be responsible for the completion of the	

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F 156	Continued From page 4	F 156	audit. An audit report will be provided quarterly for one year to the Quality Assurance committee for further recommendations.	
F 241 SS=C	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 and staff interview, the facility staff failed to provide care for residents in a manner and in an environment that maintained or enhanced each resident's dignity/self-esteem on 4 of 4 days of survey (April 10-13, 2016). Failure to remove cloth incontinence protector from residents' chairs in the activity room and hallway does not promote residents' dignity or enhance their quality of life. Findings included: Observation on 04/10/16 at 9:54 a.m. showed a cloth incontinence protector placed on a chair in the hallway near the dining room. Observation on 04/11/16 at 11:00 a.m. showed a cloth incontinence protector placed on six chairs in the activity room. A random observation on the morning of 04/11/16 showed a visitor sitting on a chair with a cloth incontinence protector.	F 241	1 No residents were cited for correction. 2. All residents have potential to be affected in this area. 3. System change: The facility removed all cloth proectors from the funiture. Staff education was provided on 4/18/16 thru 4/25/16/ about the need to provide an enviroment that enhance resident's dignity. 4.An audit will be developed to monitor the furniture in the facility does not have cloth protectors. The Activity Staff or designee will be responsible to complete the audit weekly for one month and monthly for one quarter. A report will be provided to the QA committee for further recommendations on achieving and maintaining compliance.	5/18/16

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F 241	Continued From page 5 Observation during the environmental tour on 04/12/16 at 2:15 p.m. showed a cloth incontinence protector placed on numerous chairs in the activity room. During this tour, the environmental supervisor (#5) stated staff placed the cloth protector on the chairs in case a resident has an accident. Observation on the afternoon of 04/12/16 showed a cloth incontinence protector placed on three chairs located in the hallway near the activity room. Observation on 04/13/16 at 8:30 a.m. showed a cloth incontinence protector on two chairs near the nurses station, and on ten chairs and six recliners in the activity room. These chairs are available for use for all residents of the facility and publicly viewed by the residents, staff, and family members.	F 241		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review, and staff interview, the facility failed to assess specific socially inappropriate behaviors exhibited, develop and implement individualized	F 250	1) Resident #5 individual needs have been met by updating the behavior care plan interventions to addresses evening restlessness.	5/18/16

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F 250	Continued From page 6 approaches/interventions, and monitor effectiveness for 1 of 2 sampled residents (Resident #5) with wandering behaviors. Failure to adequately assess specific socially inappropriate behaviors and respond appropriately placed Resident #5 and other residents in situations of potential harm. Findings included: Review of Resident #5's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease, dementia, anxiety disorder, and major depressive disorder. Review of an admission Minimum Data Set (MDS), dated 02/05/16, identified severely impaired cognition, wandering one to three days in the assessment period, and limited assist of one staff member with transfers. The current care plan stated, " . . . Focus: The resident has potential for elopement R/T [related to] poor safety awareness, was in a secured facility prior to admit, and wanders throughout the center. He has wandered into others rooms. . . . Interventions: Offer to take resident for a walk, Provide diversionary activity: Offer nuts and bolts to tinker with. Personal Alarm: Wander Guard used to alert staff to resident's movement . . ." Resident #5's nursing progress note identified the following: * 03/17/16 at 9:41 p.m."Resident very restless this evening. He paced up and down the hallway many times. He wandered into several other resident rooms. He was assisted to bed and with bedtime cares and toileting. He got out of bed after he had been sleeping and found to be in another residents room looming over her bed	F 250	2) Residents with cognitive imipairment who cannot locate their room have the potential to be affected in this area. 3) Education was provided 4/18/16 thru 4/25/16 to nursing staff on the procedure titled "Managing residents with difficult behaviors". Education included additional interventions that can be used or implemented for cognitively impaired residents with wandering behaviors. 4) An audit will be developed to monitor behavior documentation and care plan interventions with residents that are cognitively impaired and have restlessness and wander. The DNS, social worker, or designee will be responsible for the completion of the audit. The audit will be completed weekly for one month, then monthly for two months, and then every 3 months. A report will be provided to the QA committee for further recommendations on monitoring and achieving compliance.	

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F 250	Continued From page 7 while she was in it. Later on, resident was found to be in another resident room, standing by her bed with his pants down around his ankles. This resident was not yet in bed. A third time resident got out of bed and was starting to wander when he was redirected by staff back to bed. . . ." During an interview on 04/12/16 at 4:00 p.m., a social services director (#3) indicated no awareness of Resident #5's behavior on the evening of 03/17/16. She further stated she would investigate to find the cause of the resident's behavior, and Resident #5's care plan needed reviewing to add more interventions regarding behaviors. During an interview on 04/12/16 at 4:15 p.m. a supervisory nurse (#1) indicated no awareness of Resident #5's behavior on the evening of 03/17/15 and would expect follow-up after this behavior.	F 250		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.	F 278		5/18/16

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F 278	Continued From page 8 Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review, review of the Resident Assessment Instrument (RAI) User's Manual (Version 3.0), and staff interview, the facility failed to ensure the Minimum Data Sets (MDSs) accurately reflected the resident's status for 2 of 10 sampled residents (Resident #2 and #10). Failure to accurately code behaviors and turning/repositioning on the MDS does not provide as accurate assessment of the resident's current status and needs. Findings include: TURNING/REPOSITIONING The Long-Term Care Facility RAI User's Manual, October 2015, Page M-38, stated, "Definitions: Turning/Repositioning Program: Includes a consistent program for changing the resident's position and realigning the body. 'Program' is defined as a specific approach that is organized,	F 278	1. Resident #2's individual needs have been met by correcting the MDS sections EO100B and M1200C. Resident #10's individual needs have been met by correcting the MDS section M1200C. 2) All residents have the potential to be affected in this area. 3) Education was provided 5/12/16 to social services and MDS cordinator and any other staff who complete those sections of the MDS on RAI coding instructions for turning and repositiong program (M1200C) and residents that have documented delirium behaviors (E0100B). An resident identified as having the MDS scored inaccurately in	

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F 278	Continued From page 9 planned, documented, monitored, and evaluated based on an assessment of the resident's needs. . . . The turning/repositioning program is specific as to the approaches for changing the resident's position and realigning the body. The program should specify the intervention (e.g., reposition on side, pillows between knees) and frequency (e.g., every 2 hours). . . ." - Review of Resident #10's medical record occurred April 12-13, 2016. A quarterly MDS, dated 01/24/16, identified a turning and repositioning schedule. Resident #10's current care plan stated, ". . . Interventions, assist and remind to reposition at least every 2 hours . . . " During an interview at 04/12/16 at 5:00 p.m., an administrative nurse (#1), stated, the facility "just does the standard turning and repositioning, it's not individualized." - Review of Resident #2's medical record occurred all days of the survey. A quarterly MDS, dated 11/29/15, and a significant change MDS, dated 01/25/16, identified a turning and repositioning schedule. Resident #2's current care plan stated, ". . . Interventions . . . Remind/Assist to turn/reposition at least every 2 hours . . ." The resident's medical record failed to identify an individualized turning and repositioning program. During an interview at 04/12/16 at 2:06 p.m., an administrative nurse (#4), verified the facility lacked documentation identifying an individualized turning and repositioning schedule for Resident #2.	F 278	delirium and turning and repositioning schedules will be corrected and resubmitted. 4) An audit will be created and completed by the MDS Coordinator and/or Social Worker to monitor the accuracy of MDS sections M1200C and E0100B. The MDS Coordinator and LSW will monitor weekly for 1 month, monthly for 1 quarter or as Quality Assurance Committee deems necessary. A report will be provided to the QA committee for further recommendations for monitoring and acheiving compliance.	

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F 278	Continued From page 10 BEHAVIORS Review of the Long-Term Care Facility RAI User's Manual Version 3.0, revised October 2015, pages E-1-E-2 stated, "Delusion: A fixed, false belief not shared by others that the resident holds even in the face of evidence to the contrary. . . . When a resident expresses a clearly false belief, determine if it can be readily corrected by a simple explanation of verifiable (real) facts (which may only require a simple reminder or reorientation) or demonstration of evidence to the contrary. . . . Check E0100B, delusions: if delusions were present in the last 7 days. . . ." - Review of Resident #2's medical record occurred all days of the survey. Diagnoses included agitation, insomnia, and anxiety. A significant change MDS, dated 01/25/16, identified the resident experienced delusions during the 7-day assessment period. Resident #2's medical record lacked evidence of the resident experiencing delusions during that time frame. During an interview on 04/12/16 at 2:22 p.m., the administrative staff (#3) confirmed Resident #2's record lacked documentation regarding delusional behaviors during the assessment period for the 01/25/16 MDS.	F 278		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality.	F 281		5/18/16

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F 281	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policies, and staff interview, the facility failed to follow professional standards of practice for 1 of 10 sampled residents (Resident #2) whose medication administration was documented incorrectly. Failure to directly observe residents take all medication and failure to ensure correct documentation of medication administration may result in negative outcomes and adversely affect the resident's physical, mental, and psychosocial well-being. Findings include: Review of facility policy titled "Documentation of Medication" occurred on 04/13/16. This policy, dated September 2012, stated, ". . . the documentation of each medication . . . will include: 1. Date and time given. . . . 3. The initials of staff administering medication . . . 4. Administration Details . . ." Review of Resident #2's medical record occurred on all days of the survey. Diagnoses included osteoporosis, Dorsalgia (back pain), pain of shoulder, and osteoarthritis. Medication included Tramadol HCL (pain medication) tablet 50 milligram (mg) one time a day. Review of Resident #2's electronic Medication Administration Record (eMAR) for January, February, March, and April 2016 showed a Tramadol tablet documented as administered at 6:00 a.m. on ten different days by a nurse but signed as "refused" by a different nurse at 6:00 a.m., the same date and time.	F 281	1. Resident # 2's individual needs have been met as staff now watch her swallow her medications and document acceptance after she swallows the medication. #2 all residents who receive oral medications have the potential to be affected by this practice. #3 Education provided on 4/18/16 thru 4/25/16 to review the procedure the procedure titled, Medication Administration and Scheduling" for all staff that pass medications. Educating our staff and using the quality assurance model for improvement will prevent recurrence and also prevent other residents form being affected in this area. #4 A medication administration audit will be developed to ensure staff watch residents swallow medications before they leave the residents and the timing of the documentation to be after the resident swallows medication, not before. The DNS and Staff development coordinator will be responsible to monitor for compliance. Audits will completed once a week for one month and then monthly for one quarter. A report will be provided to the QA committee for further recommendations.	

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F 281	Continued From page 12 During an interview on 04/12/16 at 2:45 p.m., an administrative nurse (#1) stated, after interviewing staff, one nurse administered the medication and signed it off before observing Resident #2 swallow the medication, then after the change of shift, a different nurse observed the resident had spit out or found the medication in the resident's room and documented the medications as refused. The administrative nurse (#1) stated staff should observe residents taking their medication before documenting it as administered. He further noted documentation by the nurse should state if a resident has not swallowed the medication, and the nurse should notify the physician if medications are repetitively discovered in the resident's room. The facility failed to ensure nurses observed Resident #2 swallow the medication, documented medication as administered after ensuring Resident #2 took the medication, and appropriately documented why medication was not administered.	F 281		
F 309 SS=E	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:	F 309		5/18/16

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SOURIS VALLEY CARE CENTER	300 MAIN ST S VELVA, ND 58790

(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 13 Based on record review, review of standing orders, review of facility policy and staff interview, the staff failed to follow the the facility policy/Standing Orders for 4 of 5 sampled residents (Resident #1, #4, #6, and #9) requiring interventions for constipation. Failure to monitor the residents' bowel status and follow the facility policy/Standing Orders to relieve constipation does not ensure regular bowel evacuation and may cause the resident unnecessary discomfort. Findings include: Review of the "Standing Orders", dated 08/12/15, occurred April 11, 2016. The standing orders stated, ". . . Senna-S Tablet 8.6 - 50 MG [milligrams] Give 2 tablets by mouth as needed for constipation. Give up to twice daily as needed; hold for loose stool. Contact provider/practitioner if there are three days without a significant BM [bowel movement]. . . . Dulcolax Suppository 10 MG (Bisacodyl) Insert 10 mg rectally as needed for constipation. Give daily as needed. Contact provider/practitioner if there are three days without a significant BM. . . . Milk of Magnesia Suspension 400 MG/5 ML [millimeter] Give 30 ml by mouth as needed for constipation. Give daily as needed. Contact provider/practitioner if there are three days without a significant BM. . . ." Review of the facility policy titled "Bowel Assessment" occurred April 11, 2016. This policy dated, September 2012, stated, ". . . Constipation: If the resident has two or fewer bowel movements during the seven-day look-back period . . . Possible Interventions . . . 1.	F 309	1. Residents #1, #4,and #6 individual needs have been met with the completion of a new bowel assessment, and their care plans have been updated. Resident #9 has been discharged. 2. All residents with a diagnosis of constipation have the potential to be affected in this area. 3.A list of resident with a constipation diagnosis will have their bowel assessment reviewed and care plans will be updated as needed. Education was provided to nursing staff on 4/18/16 thru 4/25/16 on the need to monitor residents constipation and bowel status and involving the physician if the resident hasn't had a substantial bowel movement for at least three days. Education was also provided to the nursing department on the importance of documenting bowel movements at point of care. System change: If resident has history of bowel issues dietary manager will be notified for dietary interventions. 4. An audit will be created and completed by the DNS, or designee, to monitor compliance. The audit will be completed daily for two weeks, weekly and then weekly for two months. A report will be provided to the QA committee for further recommendations for monitoring and acheiving compliance.	

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F 309	Continued From page 14 g. Medications: As ordered by the provider . . ." - Review of Resident #1's medical record occurred on all days of survey. Diagnoses included constipation. The annual Minimum Data Set (MDS), dated 07/26/15, indicated severely impaired cognitive skills, extensive assistance of two people for toileting, occasionally incontinent of bowel, and constipation. The care plan failed to address constipation. Physician orders included Standing orders, Dulcolax Suppository (Bisacodyl) as needed (PRN) and Colace Capsule PRN for constipation. Review of Resident #1's March 2016 electronic medication administration record (eMAR) and bowel movement record showed the following: * March 03-08: no bowel movement for six days, and Colace given on 03/06/16 the fourth day of no BM. * March 10-14: no bowel movement for five days, and Colace given on 03/12/16 and 03/14/16 the third and fifth day of no BM. * March 23-28: no bowel movement for six days, and Colace given on 03/27/16 and 03/28/16 the fifth and sixth day of no BM. - Review of Resident #9's medical record occurred on April 12-13, 2016. Diagnoses included constipation. The admitting MDS, dated 01/19/16, indicated severely impaired cognitive skills, extensive assistance of two people for toileting, and constipation. The care plan failed to address constipation. Physician orders included Standing orders, Docusate sodium capsule daily, and Docusate sodium capsules as needed for constipation.	F 309		

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F 309	Continued From page 15 Review of Resident #9's eMAR and bowel movement record for January, February, and March 2016 showed the following: * January 21-24: no bowel movement for four days, no as needed (PRN) medication given. * January 26-28: no bowel movement for three days, no PRN medication given. * February 1-3: no bowel movement for three days, no PRN medication given. * February 10-13: no bowel movement for four days, Docusate sodium given 02/14/16 the fifth day prior to having a BM. * February 21-25: no bowel movement for five days, Docusate sodium given 02/24/16 the fourth day of no BM. * February 27-March 1: no bowel movement for four days, no PRN medication given. * March 10-12: no bowel movement for three days, Docusate sodium given 03/13/16 the fourth day prior to having a BM. * March 18-22: no bowel movement for five days, Docusate sodium given 03/20/16 the third day of no BM. * March 24-28: no bowel movement for five days, Docusate sodium given 03/27/16 and 03/28/16 the fourth and fifth day of no BM. During an interview on 04/12/16 at 2:45 p.m., an administrative nurse (#1) stated after the second day of no bowel movement staff should be implementing interventions for constipation, utilizing standing orders for medications, and implementing physician orders for PRN medications. - Review of Resident #4's medical record occurred on all days of survey. Diagnoses included dementia and constipation. The	F 309		

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F 309	Continued From page 16 admission MDS, dated 08/05/15, indicated short and long term memory loss, extensive assistance of two people for toileting, always incontinent of bowel, and constipation. The care plan failed to address constipation. Bowel medications included Colace 10 ml two times a day started 12/30/15, and Dulcolax suppository PRN for constipation. Pain medication included Norco 5-325 mg (Hydrocodone-Acetaminophen) every six hours PRN for pain started on 11/17/15 and changed to two times a day on 12/01/15. A side effect of Narco is constipation. Review of Resident #4's November 2015 - January 2016 electronic medication administration record (eMAR) and BM record showed the following: * November 20-27: no BM for eight days and no bowel medications administered. * November 29 - December 3 2015: no BM for five days and no bowel medications administered. * December 28 2015 - January 2 2016: no BM for six days Dulcolax suppository given on day six. A nursing progress note, dated 01/03/16, stated ". . . day 6 with no bowel movement. - Review of Resident #6's medical record occurred on all days of survey and diagnoses included constipation. A quarterly MDS, dated 02/27/16, identified impaired cognition and total assistance of two persons with toileting. Physician orders included: facility's standing orders and Docusate Sodium Liquid 50 MG/5 ML give 10 ml by mouth as needed.	F 309		

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F 309	Continued From page 17 Review of Resident #6's March - April 10, 2016 eMAR and bowel movement record showed the following: * March 06 -10, 2016: no bowel movement for five days, docusate sodium given on 03/10/16 the fifth day of no BM.	F 309		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure timely services and treatment for 1 of 2 sampled residents (Resident #7) with orders from the health care provider (HCP) for a urinalysis (UA). Failure to obtain a specimen in a timely manner after an order was received (11 days later) resulted in delayed treatment of a urinary tract infection (UTI). Findings include: Review of Resident #7's medical record occurred on all days of survey and diagnoses include dementia with behavioral disturbances,	F 315	1. Resident #7's individual needs have been met by having completed the urine collection and anaylsis. Resident was treated with an antibitic and is currently asymptomatic. Care plan updated to include history of UTI. 2. All residents with physician orders for a urinalysis have the potential to be affected in this area. 3. Education was provided 4/18/16 thru 4/25/16 for nursing staff on the procedure titled, "Urine Testing" with a focus on the	5/18/16

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F 315	Continued From page 18 psychosis, and UTI. A quarterly Minimum Data Set, dated 02/18/16, identified extensive assist of two persons for toileting. Review of Resident #7's nursing progress notes identified the following: * 03/25/16 at 10:43 a.m., "Fax sent to [name of physician] regarding [name of resident] behavior." * 03/25/16 at 2:40 p.m., "Received and observed new orders from [name of physician] to obtain a UA . . ." * 04/04/16 at 3:00 p.m., "Collected urine and it was taken to [name of the clinic]" The record showed the specimen collected 11 days after the order was received. Resident #7's record showed a UA report, dated 04/04/16, and a physician's order, dated 04/05/16, for Bactrim DS (an antibiotic medication) tablet 800-160 MG (milligrams) give 1 tablet twice a day for 7 days for a UTI. During an interview on 04/12/16 at 2:20 p.m., an administrative nurse (#1) stated, "If staff couldn't get the UA they should have called the MD [medical doctor] or NP [nurse practitioner] to ask what to do." The staff member reported the facility needs an order to obtain a specimen by straight catheter. The medical record failed to provide evidence for the delayed collection of the urine specimen for Resident #7. Failure of staff to obtain the specimen in a timely manner resulted in the delay in treatment for the resident. This failure increased the potential for complications from the infection.	F 315	importance of obtaining urine specimens in a timely manner and documenting their attempts if they are unable to obtain a specimen. If difficulties are encountered due to incontinence, dementia or other factors call the physician and obtain an order to insert I&O catheter to obtain specimen. 4. An audit will be developed to monitor physician orders for urinalysis orders, if positive, timely notification to the phsycian for treatment. The Infection control nurse or designee will be responsible for the completion of the audit. The audit will be completed wekkly for one month, then monthly for two months. A report on the audit results will be provided to the QA committee for further recommendations on monitoring and achieving compliance.	

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F 323 SS=D	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, record review, policy review, and staff interview, the facility failed to ensure each resident received adequate supervision and assistive devices to prevent accidents for 2 of 4 sampled residents (Resident #1 and #9) observed with a gait belt or walker. Failure to properly use a gait belt and/or walkers placed the residents at risk for sustaining a fall or injury. Findings include: Review of the facility policy titled "Gait (Transfer) Belt" occurred on 04/13/16. This policy, dated September 2012, stated, ". . . 2. Place belt around resident's waist over clothing. . . . 5. When holding the belt, an underhand grasp should be used. The belt should not be used for lifting. It is for support and stability only. . . . 7. Do not use the pants/slacks belt as a gait (transfer) belt. . . ." Review of the facility policy titled "Ambulation of Resident" occurred on 04/13/16. This policy, dated September 2012, stated, ". . . 4. Use gait	F 323	1. Resident #1's individual needs have been met by completing a new mobilization support data collection tool and updating her care plan. Resident #9 was discharged. 2. All residents who require assistance with transfers and ambulation are at risk of being affected by this practice. 3. On May 10th-12, 2016 all staff will be trained on the "Safe Resident Handling Program" by Prevent inc. The procedure titled, Gait (transfer)belt will be reviewed with staff with a focus on the proper positioning and use of gait belt, and walker while transferring or ambulating residents. 4. An audit will be developed to monitor and assure compliance with proper use of a gait belt with transfers and use of gait and walker for ambulation. The Staff development nurse or designee, will be	5/18/16

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F 323	Continued From page 20 belt, if necessary, around resident's waist to help resident maintain balance. . . ." - Review of Resident #1's medical record occurred on all days of survey. Diagnoses included dementia, history of falling, osteoporosis, osteoarthritis, low back pain, and muscle weakness. The annual Minimum Data Sheet (MDS), dated 07/26/15, indicated severely impaired cognitive skills and extensive assistance of two people for transfers. The current care plan stated, ". . . Focus . . . The resident has an ADL [activity of daily living] self care performance deficit R/T [related to] Dementia e/b [evidenced by] needs assist . . . is using wheelchair for mobility. . . . Interventions . . . TRANSFER: Resident requires 1 staff participation with transfers. . . ." Observation on 04/11/16 at 9:16 a.m. showed two certified nurse assistants (CNAs) (#8 and #9) transferred Resident #1 from the bed to her wheelchair utilizing a gait belt. One CNA (#8) grabbed under the resident's left axilla with one hand and reached under the gait belt with her other hand to grab the resident's pants. The other CNA (#9) grabbed under the resident's right axilla with her right hand and used her left hand to pull up the resident's pants as they assisted the resident into her wheelchair. Observation on 04/12/16 at 11:42 a.m. showed a CNA (#10) assisted Resident #1 to transfer from the bed to her wheelchair. The CNA (#10) applied a gait belt around the resident's waist and grabbed under the resident's left axilla with her right hand to assist the resident to a standing position and pivot turn into her wheelchair. The	F 323	responsible for the completion of the audits. The audit will be completed once a week for one month then monthly for one quarter. A report of the audit findings will be reported to the QA committee for further recommendations on monitoring and acheiving compliance.	

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F 323	Continued From page 21	F 323		

CNA (#10) failed to utilize the gait belt while assisting the resident with the transfer.

- Review of Resident #9's medical record occurred on 04/12/16. Diagnoses included dementia, osteoporosis, osteoarthritis, and pain. The admitting MDS, dated 01/19/16, indicated severely impaired cognitive skills and extensive assistance of two people for transfers. The current care plan stated, ". . . Focus . . . The resident has limited physical mobility R/T past Stroke e/b drags foot. unsteady gait . . . Interventions . . . MOBILITY: Resident requires a front wheeled walker for mobility. Ambulates independently with cuing to find locations. . . . TRANSFER: Resident can transfer with assist of one . . ."

Observation on 04/12/16 at 2:54 p.m. showed Resident #9 seated in a recliner in the activity room. A CNA (#11) placed a four wheel walker in front of the resident, Resident #9 grabbed the four wheel walker, pulled herself up, and started to walk. The CNA (#11) stood in front of the walker with her back to the resident and pulled on the walker with one hand as the resident ambulated to the dining room. The CNA (#11) failed to use a gait belt during transfer, and failed to stand to the side of the resident as she utilized the walker.

Observation on 04/12/16 at 3:30 p.m. showed Resident #1 seated at the dining room table. The CNA (#11) placed a gait belt around the resident's waist, assisted the resident to stand with a walker, stood in front of the walker with her back to the resident and pulled on the walker with one hand as the resident to ambulated to the

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F 323	Continued From page 22 bathroom. The CNA (#11) failed to stand to the side of the resident as she utilized the walker. - Observation on 04/11/16 at 9:32 a.m. showed an unknown CNA assisted an unknown resident with a walker from the dining room into the hallway. The CNA stood in front of the walker with her back to the resident and pulled on the walker with one hand as the resident ambulated in the hallway. During an interview on 04/13/16 at 8:48 a.m., an administrative nurse (#1) stated they expected staff to use gait belts with all residents who require the assist of one staff member during transfers or ambulation. Staff members are expected to hold the gait belt during transfers, and to walk alongside the residents who utilize walkers.	F 323		
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	F 329		5/18/16

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F 329	Continued From page 23 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 policies/procedures, and staff interview, the facility failed to identify and implement non-pharmacological interventions for 1 of 1 sampled residents (Residents #4) before administering as needed (PRN) anti-anxiety medications. Failure to implement non-pharmacological interventions before administering a PRN anti-anxiety medication may result in administering an unnecessary medication. Findings include: Review of the facility policy titled "Psychopharmacological Medications and Sedative/Hypnotics" occurred on 04/13/16. This policy, revised March 2015, stated, ". . . PROCEDURE . . . Non-Emergency Administration . . . 1. Before administration of non-emergency psychopharmacological and/or sedative/hypnotics, the following must be completed: a. Documentation in PCC [point click care] - POC [point of care] observation of mood symptoms or behaviors that cause the resident distress and/or endanger the resident or others	F 329	1. Resident #4's individual needs have been met by updating the physician□s orders to include supplemental documentation on the emar question: have non-pharmacological med intervention been attempted prior to administration of PRN? 2. All residents with physician orders for a PRN anti-anxiety/psychoactive medication have the potential to be affected in this area. 3. Education was provided to nurses on 4/18/16 thru 4/25/16 the procedure titled, "Unnecessary Medications" with a focus on the need to document non-pharmacological interventions prior to administering a PRN anti-anxiety/psychoactive medication. Education was also provided to the nurses on supplemental documentation. System change: Physician's orders will include the supplemental documentation for all PRN psychoactive medications	

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F 329	Continued From page 24 and response to interventions used. b. The behavior committee and/or care plan team will ensure the care plan is updated. This update will reflect non-pharmacological interventions to be used . . . 7. While the use of prn psychopharmacological medications and sedative/hypnotics is not encouraged, if a prn physician's order is received, ensure that the order has clear parameters, i.e., severe agitation that does not respond to other care plan interventions. It is important to initiate other care plan interventions prior to the use of prn psychopharmacological medications and sedative/hypnotics. . . ." Review of Resident #4's medical record occurred on all days of survey. Diagnoses included dementia and anxiety. The admission Minimum Data Set (MDS), dated 08/05/15, identified short and long term memory loss, constant inattention and disorganized thinking. The current care plan stated, ". . . Focus: The resident has a mood problem R/T [related to] dementia E/B [evidenced by] tearfulness, angry responses to interaction. Talks repetitively and/ or calls out. . . . Interventions: Mood - Non Pharmacological: Attempt non-pharmacological interventions: move to quite area; enjoys soap operas and game shows on tv. . . ." Review of Resident #4's medication administration record (MAR) for March 2016 and April 1-11 2016, identified lorazepam (Ativan) (antianxiety medication) tablet 0.5 milligram (mg) by mouth PRN one time a day for anxiety. The MAR and nursing progress notes indicated nursing staff administered Ativan three times in March and four times in April without identifying	F 329	asking staff if they have attempted non-pharmacological interventions prior to the administration of a PRN anti-anxiety medication. 4. An audit will be developed to ensure compliance with the documentation of non-pharmacological interventions prior to the administration of a PRN anti-anxiety/psychoactive medication. The audit will monitor the physicians order, emar documentation, and progress notes written by the nurse describing what non-pharmacological interventions that were attempted prior to administration of the PRN anti-anxiety/psychoactive medication. The DNS, or designee, will be responsible for the completion of the audit. The audit will be completed weekly for one month, then monthly for one quarter. An audit report will be provided to the Quality Assurance committee for further recommendations on monitoring and achieving compliance.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOURIS VALLEY CARE CENTER	300 MAIN ST S VELVA, ND 58790

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 25 specific non-pharmacological interventions attempted prior to the administration of the antianxiety medication. During an interview on 04/12/16 at 11:50 a.m., an administrative staff member (#1) indicated he expected nursing staff to document in the nursing progress notes non-pharmacological interventions attempted before administering an anti-anxiety medication.	F 329		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the	F 431		5/18/16

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F 431	Continued From page 26 Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: MEDICATION LABEL 1. Based on observation, record review, review of facility policy, and staff interview, the facility failed to ensure 1 of 1 insulin vial label matched the physician's order and the Medication Administration Record (MAR). Failure to ensure the insulin vial label matched the physician order and the MAR has the potential to cause medication errors. Findings include: Review of the facility policy titled "Medication-Change of Direction Stickers" occurred on 04/13/16. This policy, dated December 2015, stated, ". . . a. If the prescriber's directions for use change, the nurse may place a direction change, change of order-check or similar sticker on the container indicating there is a change in directions for use . . ." Observation during medication pass on 04/11/16 at 8:20 a.m., showed Resident #15 received Lantus insulin. The label on the Lantus insulin vial stated to inject 40 units at bedtime. Resident #15's current MAR and physician's order stated to inject 20 units two times a day.	F 431	1. Residents #15 individual needs have been met by replacing the label on the bottle of Lantus insulin with the current physician's orders. Controlled substances will be reconciled every shift by two licensed nurses. 2. All residents that receive medications, including controlled substances, have the potential to be affected in this area. 3. Education was provided to nursing staff on 4/18/16 thru 4/25/16 regarding the need to order a new label for medications when a physician's order changes, and the need to reconcile Controlled substances" each shift. Education was provided based on the Policy Acquisition, receiving, dispensing and storage of medications. 4. An audit will be developed to ensure compliance with the application of a new label when a medication label needs to be changed or replaced and if all controlled substances are reconciled every shift by two licensed nurses. DNS, or designee,	

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F 431	Continued From page 27 Review of Resident #15's physician's orders identified on 03/17/16 the Lantus dose was changed to 20 units in a.m. and 20 units every p.m. to attempt better daytime control. During an interview on 04/11/16 at 08:22 a.m., a licensed nurse (#6) confirmed Resident #15's Lantus insulin order had changed and the vial needed a new label. CONTROLLED SUBSTANCES 2. Based on observation, review of facility policy, and staff interview, the facility failed to ensure periodic reconciliation (accurate account) of controlled medications for 1 of 2 medication carts (100 wing) and 1 of 1 medication refrigerator. Failure to periodically reconcile controlled medications has the potential to result in loss or diversion of medications. Findings include: Review of the facility policy titled "Controlled Substances" occurred on 04/13/16. This policy, dated June 2014, stated, "Purpose: To provide verification and correct count of all controlled substances on hand, to provide safe storage for all controlled substances. . . ." Review of the medication refrigerator occurred on 04/12/16 at 3:10 p.m. with a licensed nurse (#6). The refrigerator contained a 1 cc [cubic centimeter] of injectable Ativan (a controlled antianxiety medication) from the emergency kit. The licensed nurse (#6) stated the facility did not periodically reconcile the Ativan.	F 431	will be responsible for the completion of the audit. The audit will be completed weekly for one month, then monthly for one quarter. A report of the audit findings and analysis will be provided to the Quality Assurance committee for further recommendations on monitoring and achieving compliance.	

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F 431	Continued From page 28 On the morning of 04/13/16 a licensed nurse (#6) stated the 100 wing medication cart has two medication cards of oral PRN Ativan which the facility does not reconcile.	F 431		
F 441 SS=E	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 (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	F 441		5/18/16

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F 441	Continued From page 29 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 ensure staff followed appropriate infection control practices for 4 of 9 sampled residents (Resident #1, #2, #6, and #8) observed during personal cares. The facility staff failed to follow infection control practices when handling soiled linens/clothing. Failure to follow established infection control practices may result in the spread of infection within the facility. Findings include: Review of the facility policy titled "Collecting Soiled Clothes and Linens" occurred on 04/13/16. This policy, dated March 2016, stated, " . . . Procedure: . . . c. Clothes and linens should be placed directly into plastic bags . . . e. Bagged clothes and linens should be placed in a covered laundry hamper . . . " - Observation at 8:10 a.m. on 04/11/16 showed Resident #8 lying on the bed while a certified nurse aide (CNA) (#2) provided personal cares. After using a washcloth and towel the CNA failed to bag the soiled items and instead placed them directly on the nightstand. - Observation on 04/11/16 at 8:48 a.m. showed two CNAs (#8 and #9) providing personal care to	F 441	1. Resident's #1, #2, #6, and #8 individual needs have been met by educating staff on procedure for collecting solid clothes and linens. 2. All residents have the potential to be affected by this practice. 3.Education was provided for all staff on 4/18/16 thru 4/25/16 the procedure titled, Collecting Soiled Clothes and Linens" with a focus on the need to prevent the spread of infection by handling soiled clothes and linen properly. 4. An audit will be developed to ensure compliance with the handling of soiled clothes and linen.The audit will monitor how staff handles and removes soiled clothes and linens from resident care areas. The infection control nurse, or designee, will be responsible for the completion of the audit. The audit will be completed weekly for one month, then monthly for one quarter. A report of the audit findings and analysis will be provided to the Quality Assurance committee for further recommendations on monitoring and achieving compliance.	

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F 441	Continued From page 30 Resident #2. While Resident #2 laid on the bed, the CNA (#9) grabbed the incontinence bed pad soiled with bowel movement and laid it directly on the end of the resident's clean bed linen. After completing cares, the CNA (#9) obtained the resident's soiled clothing and incontinence bed pad, placed them in a ball and held them against her uniform as she exited the room. The CNA (#9) failed to bag the items and placed them directly on the resident's clean bed and against her own uniform. - Observation on 04/11/16 at 9:16 a.m. showed two CNAs (#8 and #9) providing personal care and assisting Resident #1 with dressing. After performing personal cares, the CNA (#9) obtained the resident's soiled clothing and placed them under her arm against her uniform. The CNA (#9) failed to bag the items and placed them directly against her own uniform. Observation on 04/12/16 at 8:35 a.m. showed a CNA (#10) check and change Resident #1's brief. After using a washcloth and towel, the CNA (#10) failed to bag the soiled items and instead laid them directly on the end of the resident's clean bed linen. - Observation on 04/12/16 at 8:57 a.m. showed a CNA (#7) providing personal cares and assisting Resident #8 with dressing. After performing personal cares, the CNA obtained the soiled washcloth, towel, bed linens, and clothing, placed them in a ball against her uniform and removed them from the room. The CNA failed to bag the items and instead placed them directly against her own uniform.	F 441		

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F 441	Continued From page 31 During an interview on on 04/13/16 at 8:48 a.m., an administrative nurse (#1) stated the expectation of staff handling soiled linens and clothing is for these items to be bagged and removed from residents' rooms.	F 441		