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 _____	02/10/2022

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 The Standard Medicare/Medicaid recertification survey started on 02/07/22 and concluded 02/10/22.	F 000		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for	F 656		3/17/22

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

Electronically Signed | 03/04/2022

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F 656	Continued From page 1 future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, review of the facility policy, and staff interview, the facility failed to develop a comprehensive care plan for 5 of 14 sampled residents (Resident #15, #20, #21, #28, and #29). Failure to develop a comprehensive care plan that includes the care and services to the resident may negatively impact the resident's quality of care. Findings Include: Review of the facility policy titled "Care Plan" occurred on 02/10/22. This policy, dated 09/17/21, stated, ". . . Residents will receive and be provided the necessary care and services to attain or maintain the highest practicable well-being in accordance with the comprehensive assessment . . . The plan of care will be modified to reflect the care currently required/provided for the resident . . ." - Review of Resident #15's medical record occurred on all days of survey. Medical diagnoses included diabetes mellitus and physician's orders included long-acting insulin injections, metformin (anti-diabetic medication), and blood sugar checks, twice a day. The current	F 656	1. Resident #15, #28, and #29 care plan has been updated on 03/03/2022 to include Diabetes Mellitus. Resident #20 and #21 care plan has been updated on 03/03/2022 to include Anticoagulation medications. Resident #29 care plan was updated on 03/03/2022 to include oxygen and pain control. 2. All residents have the potential of being affected. 3. Licensed nurses will be re-educated by 03/14/2022 by DNS on care plans and how we need to ensure they are person-centered for each resident. Care plans are being reviewed Monday through Friday to ensure accuracy. Nursing Department is responsible to update care plans at an appropriate time to ensure problems/preferences are current. 4. Social Services Director and designee will audit/monitor five care plans weekly times one month; 5 care plans every month for 3 months to ensure compliance. The Care Plan audit will include the accuracy of diagnosis written within the care plan. The Quality Assurance committee will review and	

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F 656	Continued From page 2 care plan lacked information related to diabetes mellitus. During an interview on 02/09/22 at 3:18 p.m., an administrative nurse (#1) confirmed Resident #15's care plan lacked goals and interventions related to diabetes mellitus. - Review of Resident #20's medical record occurred on all days of survey. Medical diagnosis included atrial fibrillation and physician's order included Coumadin (a blood thinner). The current care plan lacked information related to Coumadin. During an interview on the morning of 2/10/22 at 10:30 a.m. an administrative nurse (#2) confirmed Resident #20's care plan lacked problem, goals and interventions related to blood thinner use. - Review of Resident #21's medical record occurred on all days of survey. Medical diagnoses included atria fibrillation and medications included Coumadin. The current care plan lacked information related to Coumadin. During an interview on 02/09/22 at 3:30 p.m., an administrative nurse (#2) confirmed Resident #21's care plan lacked goals and interventions related to the use of a blood thinner. - Review of Resident #28's medical record occurred on all days of survey. Physician's orders included long- acting and short-acting insulins and blood sugar checks four times a day for diabetes. The current care plan lacked	F 656	monitor Care Plan audits during monthly quality meetings. The quality assurance committee will ensure compliance. 5. Completion date March 17th, 2022.	

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F 656	Continued From page 3 information related to diabetes. During an interview on the morning of 02/10/22 at 10:30 a.m., an administrative nurse (#2) verified Resident #28's care plan lacked goals and interventions related to diabetes. - Review of Resident #29's medical record occurred on all days of survey. Diagnoses included Type 2 diabetes mellitus, chronic obstructive pulmonary disease (COPD), and chronic pain. Physician's orders included long-acting insulin injections and blood sugar checks twice a day for diabetes, oxygen continuously at three liters per nasal cannula for COPD, and Oxycodone (narcotic for pain) and Tylenol for chronic pain. The current care plan lacked information related to diabetes mellitus, oxygen use, and chronic pain. During an interview on the morning of 02/10/22 an administrative nurse (#2) confirmed Resident #29's care plan lacked goals and interventions related to diabetes mellitus, oxygen use and chronic pain.	F 656		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, review of professional reference, and staff interview, the facility failed to ensure staff followed standards of practice for 1	F 658	1. Licensed nurses for resident #15 will be re-educated by 03/14/2022 by DNS to ensure understanding/competency of	3/17/22

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F 658	Continued From page 4 of 5 sampled resident (Resident #15) selected for unnecessary medication review. Failure to notify the physician of blood glucose levels that are out of range may result in untreated hyperglycemia (high blood glucose level). Findings include: The facility failed to provide a policy regarding hyperglycemia or following physician's orders. Berman, Snyder, and Frandsen's "Kozier & Erb's Fundamentals of Nursing: Concepts, Process, and Practice," 11th ed., Pearson Education, Inc., Massachusetts, page 64, stated, ". . . It is the nurse's responsibility to seek clarification of ambiguous or seemingly erroneous orders from the prescriber . . . If the order is neither ambiguous nor apparently erroneous, the nurse is responsible for carrying it out. . . ." Review of Resident #15's medical record occurred on all days of survey. Diagnoses include Type 2 diabetes mellitus. The quarterly Minimum Data Set (MDS), dated 11/11/21, identified Resident #15 required insulin injections for all seven days of the assessment period. The care plan failed to include blood glucose monitoring. The physician's orders identified, ". . . Check BS [blood sugar] bid [twice daily]. Notify MD [physician] if BS is . . . > [greater than] 400 [milligrams per deciliter [mg/dL] . . ." Review of Resident #15's blood glucose levels from November 8, 2021 - February 8, 2022 (three months), showed facility staff failed to notify the physician of blood sugars greater than 400 mg/dl on 10 occasions.	F 658	reporting hyperglycemic episodes and parameters to be set and followed. 2. All diabetic residents have the potential of being affected. 3. All Licensed Nurses will be re-educated by 03/14/2022 by DNS on the proper procedure of establishing parameters and when to notify the physician, if necessary, according to parameters. Re-education on policy named, Blood Glucose Monitoring, Disinfecting and Cleaning □ Rehab/Skilled. Will be done by 03/14/2022 by DNS. 4. DNS or designee will do a Blood Glucose monitoring audit three times a week for one month, weekly for one month, bi-monthly for four months. The Quality Assurance Committee will review and monitor Blood glucose monitoring audits during monthly quality meetings. The Quality Assurance Committee will ensure compliance. 5. Completion Date March 17th, 2022.	

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F 658	Continued From page 5 During an interview on 02/09/22 at 3:18 p.m., an administrative nurse (#1) confirmed staff failed to notify the physician of Resident #15's blood sugar results per physician's order.	F 658		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of the facility policy, and staff interview, the facility failed to provide proper respiratory care consistent with standards of practice and physician's orders for 1 of 1 sampled resident (Resident #8) receiving tracheostomy cares. Failure to change oxygen, humidity, and suction tubing per facility policy may complicate the resident's respiratory status. Findings include: Review of the policy titled "Tracheostomy, Suctioning Dressing Change and Reinsertion of Tube" occurred on 02/10/22. This policy, dated 10/20/21, stated, ". . . tracheostomy involves meticulous and careful management to avoid infection . . . suctioning will be performed . . . using sterile technique . . . When finished	F 695	1. Follow up provided by DNS on 02/10/2022 to exchange tubing. Licensed Nurses for resident #8 will be re-educated by 03/14/2022 by DNS to ensure understanding. 2. All tracheostomy and oxygen utilizing residents have the potential of being affected. 3. All Licensed Nurses will be re-educated by 03/14/2022 by DNS on proper suctioning techniques and oxygen administration/storage. Licensed Nurses will complete a suction and oxygen administration competency to show understanding by 03/14/2022 by DNS. 4. DNS or designee will do a suction/oxygen administration audit daily for one week, weekly for one month, bi-weekly for 4 months. The Quality	3/17/22

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F 695	Continued From page 6 suctioning . . . Dispose of catheter . . . into trash . . ." Review of the policy titled "Oxygen Administration, Safety, Mask Types" occurred on 02/10/22. This policy dated 05/19/21, stated, "When oxygen [humidity system] is not in use, store . . . mask [tracheostomy] . . . and tubing in zip-lock bag/plastic bag . . ." Review of Resident #8's medical record occurred on all days of survey. Diagnoses included tracheostomy, acute and chronic respiratory failure with hypoxia, dysphagia (difficulty swallowing), and pleural effusion (the buildup of fluid that collects between the chest wall and the lungs). The current care plan identified, ". . . tracheostomy R/T [related to] Impaired breathing mechanics HAS HUMIDIFIER TO KEEP SECRETIONS MOIST . . ." A physician's order, dated 12/18/21, stated, ". . . Change Tubing and chamber to humidity system monthly . . . discard suction catheter after each usage . . . suction resident once a day in the am and PRN [as needed] if resident is not able to move secretions . . ." Progress notes identified the resident was hospitalized for pneumonia on October 20-28, 2021 and received antibiotics. Observation on 02/07/22 at 12:49 p.m. showed Resident #8's humidity system tubing and chamber bag labeled "10/16/21" (indicating the date the staff changed the tubing), one used, non-sterile suction cannula lying on the bedside stand connected to the suction machine, three non-sterile suction cannulas lying in the bedside drawer, and one lying on the floor. The tracheostomy mask was lying on the floor.	F 695	Assurance Committee will review and monitor suctioning/oxygen administration audits during monthly quality meetings. The Quality Assurance Committee will ensure compliance. 5. Completion Date March 17th, 2022.	

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F 695	Continued From page 7 During an interview on 02/10/22 at 10:00 a.m., an administrative nurse (#1) confirmed that facility staff failed to change respiratory supplies as ordered. The facility failed to change the humidity tubing and chamber bag, discard suction catheters after use, and place the tracheostomy mask in plastic bag when not in use per policy. This practice has the potential to increase the risk of infection	F 695		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors.	F 732		3/17/22

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F 732	Continued From page 8 §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility staffing reports, policy review, and staff interview, the facility failed to ensure posting of accurate and complete staffing information on 4 of 4 days of survey (February 7-10, 2022). Failure to post accurate staffing data does not allow residents and visitors to be aware of the number of licensed and unlicensed staff on duty each shift, and the daily census of residents. Findings include: Review of the facility policy titled, "Nursing Staff Daily Posting Requirements - Rehab/Skilled" occurred on 02/10/22. This policy, dated 01/25/22, stated, "POLICY . . . skilled care locations will post daily the staffing and resident census at the beginning of each shift and update as appropriate (for each shift). The location will post the following information on a daily basis: . . . Resident census; Total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff members directly responsible for resident care per shift. . . .	F 732	1. Licensed Nurses will complete the Nursing Staff Daily Posting requirements every day. On 02/10/2022 DNS was notified of the Nursing Staff Daily Posting requirements. A new location was selected to be posted in an area where visibility is not obscured and residents and families have access to see on 03/03/2022 by DNS. 2. All residents have the potential of being affected. 3. All Licensed Nurses will be re-educated by 03/03/2022 by DNS on the importance of accurately filling out the Nursing Staff Daily Postings and reflecting the census per shift and including all information required according to policy. The census sheet will be updated by 03/14/2022 by DNS to reflect changes. 4. DNS or designee will complete a Daily posting audit daily for one week, weekly for one month, and monthly for 4 months. The Quality Assurance Committee will review and monitor audits during monthly	

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F 732	Continued From page 9 Registered Nurses; Licensed practical nurses or licensed vocational nurses; Certified nursing assistants/restorative nursing assistants; Certified medication assistants. This information must be prominently displayed in a clear and readable format where residents, staff members and the public may view. . . ." Observation of the daily staffing report showed the following: * 02/07/22 at 1:44 p.m., no current report posted. * 02/08/22 at 10:05 a.m., no current report posted. * 02/09/22 at 3:02 p.m., staff posting, obscured by the medication cart, failed to identify the resident census. * 02/10/22 at 10:57 a.m., staff posting failed to identify the resident census and the total hours worked for the night shift. During an interview on 02/10/22 at 8:27 a.m., an administrative nurse (#1) confirmed the location for the posting of staff is blocked from view when the medication cart is not in use.	F 732	quality meetings. The Quality Assurance Committee will ensure compliance. 5. Completion Date March 17th, 2022.	
F 740 SS=D	Behavioral Health Services CFR(s): 483.40 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health 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. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders.	F 740		3/17/22

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F 740	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to provide the necessary behavioral health care services to ensure each resident attained/maintained their highest practicable emotional/mental well-being for 2 of 2 sampled residents (Resident #21 and #29) with recent orders to consult with behavioral health services. Failure to provide behavioral health services as directed by the physician may result in emotional/mental distress for the residents. Findings include: Review of the facility policy titled "Behavioral Health Services-Rehab/Skilled" occurred on 02/10/22. This policy, revised on 08/30/21, stated, ". . . Residents will receive necessary behavioral health care and services to attain or maintain the highest practical physical mental and psychological well-being . . ." - Review of Resident #21's medical record occurred on all days of survey. Diagnoses included dementia without behavioral disturbances and agitation. Review of physician's orders showed Resident #21's medications included Seroquel (an antipsychotic) 12.5 milligrams (mg) started on 10/04/21 and increased to 25 mg on 12/16/21 due to increased agitation. A fax communication note, dated 12/16/21 to the FNP (family nurse practitioner), stated: "Resident has had a couple verbal altercations today with other residents. Resident M/B	F 740	1. Resident #21 and #29 were both seen on Mental Health Rounds in February 23rd, 2022 by Rural Psychology. 2. All residents who have behavioral health needs have the potential to be affected. 3. All Licensed Nurses and Social Services will be re-educated by 03/14/2022 by DNS on the proper process of submitting orders for Behavioral Health to the HIM director to ensure paperwork is initiated and services are received in a timely manner. Once the order is received, a scanned copy will be emailed to the Behavioral Health committee and HIM Director to be discussed at daily QI meeting and start the referral process timely. 4.Resident orders will be audited daily for a week, weekly for a month, bi-weekly for one month and a monthly for two months. The Quality Assurance Committee will review and monitor audits during monthly quality meetings to ensure compliance is sustained. 5. Completion Date March 17th, 2022.	

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F 740	Continued From page 11 [mood/behavior] have increased in the last weeks. Resident gets very upset and will have verbal outbursts often times upsetting other res. [residents] Resident did get physical today with another resident [resident name]. No injuries with either resident. May we look at increasing Seroquel current order states 12.5 mg PO [by mouth] daily. Physician comments: Increase Seroquel to 25 mg daily, consult behavior health" A note, dated 12/22/21 from Resident #21's Power of Attorney identified she would like the resident seen by mental health services. The medical record lacked evidence the facility completed the necessary paperwork and contacted behavioral health for a consult. - Review of Resident #29's medical record occurred on all days of survey. Diagnoses included depression, agitation, and restlessness. Review of physician's orders showed Resident #29's medications included Seroquel 75 mg and increased to 100 mg on 12/14/21 for increased agitation and restlessness. A fax communication note, dated 12/13/21 to the FNP, stated: "Resident c/o [complain of] frequent pain in BIL [bilateral] shoulders, states that due to pain, he is able to sleep only 2 hours at night, 2 hours after breakfast and 2 hours after lunch. He states that his pain medication oxycodone 7.5 mg [every] 6 hours is not helping. He also claims Seroquel 75 milligrams at HS [hour of sleep] is not helping his sleep. He requests an increase in dosage on	F 740		

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F 740	Continued From page 12 Seroquel and oxycodone if possible. Physician comments: Seroquel 100 mg daily at bedtime, consult behavioral health for further guidance if not already scheduled" The medical record lacked evidence the facility completed the necessary paperwork and contacted behavioral health for a consult. During an interview on 02/10/22 at 9:15 a.m., an administrative nurse (#1) confirmed the facility failed to complete the necessary paperwork for a behavioral health consult as ordered for Resident #21 and #29.	F 740		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a	F 756		3/17/22

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F 756	Continued From page 13 minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to ensure the consultant pharmacist completed and reported the drug regimen reviews at least monthly for 2 of 5 sampled residents (Resident #15 and #21) selected for unnecessary medication review. Failure to complete and report drug regimen reviews may result in residents receiving unnecessary medications and experiencing adverse consequences related to the medications. Findings include: Review of the facility policy titled "Medication - Drug Regimen" occurred on 02/10/22. This policy, revised 01/25/22, stated, ". . . a drug regimen review is performed for each resident at least once a month by a licensed pharmacist. . .	F 756	1. Resident #15 and #21 medical records were reviewed monthly starting January 27th, 2022. The process is already in place to review all residents on a monthly basis. 2. All residents have the potential to be affected. 3. All Licensed Nurses will be re-educated by 03/14/2022 by DNS on the regulation and requirement for Drug Regimen Review and reporting irregularities to the attending physician. Systematic Change in place - DNS and pharmacist will work together to ensure monthly reviews of all residents are completed and documented and relayed to the provider to review recommendations from the pharmacist. Pharmacy educated on the process of completing reviews before the monthly	

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F 756	Continued From page 14 ." Review of Residents #15 and #21's medical records from January 2021 - December 2021, identified the licensed pharmacist failed to complete the following: * Resident #15 - 5 of 12 required drug regimen reviews. * Resident #21 - 3 of 6 required drug regimen reviews. During an interview on 02/09/22 at 3:18 p.m., an administrative nurse (#1) confirmed the licensed pharmacist failed to complete the required monthly drug regimen reviews.	F 756	QA process to ensure we are reporting the correct data. 4. DNS or designee will audit monthly for 6 months the facilities Drug Regimen Review provided by the Consultant Pharmacist. The audit will show that the attending physician reviewed and responded. The Quality Assurance Committee will review and monitor Monthly Pharmacy audits during monthly Quality meetings. The Quality Assurance Committee will ensure compliance. 5. Completion Date March 17th, 2022.	
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons	F 757		3/17/22

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F 757	Continued From page 15 stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to ensure the resident's medication regimen remained free of unnecessary medications for 1 of 5 sampled residents (Resident #21) selected for unnecessary medication review. Failure to establish a baseline by assessing for abnormal involuntary movements before starting an antipsychotic may result in the resident experiencing adverse consequences related to the antipsychotic?? Findings include: Review of the facility policy titled "Psychotropic Medications-Rehab/Skilled", occurred on 02/10/22. This policy, revised 12/01/21, stated. ". . . If the physician prescribes an antipsychotic for the resident, a registered nurse must complete the Initial Antipsychotic Medication Assessment and the Abnormal Involuntary Movement Scale [AIMS] . . ." Resident #21's electronic medication administration record (EMAR) and physician's orders identified the resident received Seroquel (antipsychotic medication) 25 milligrams (mg) daily started on 12/16/21. Resident #21's medical record lacked an AIMS assessment. During an interview on 02/09/22 at 3:30 p.m., an administrative staff member (#2) stated the facility failed to complete an AIMS before starting Resident #21 on Seroquel.	F 757	1. Resident #21 had an AIMS assessment completed on 02/23/2022 by DNS to reflect a baseline. 2. All residents who take psychotropic medications have the potential to be affected. 3. All Licensed Nurses will be re-educated by 03/14/2022 by DNS on policy and procedure “Psychotropic Medications – Rehab/Skilled” regarding completing an AIMS assessment before administrating an antipsychotic. 4. DNS or designee will complete AIMs assessment audit weekly for one month, bi-weekly for one month, and monthly for four months. The Quality Assurance Committee will review and monitor audits during monthly quality meetings. Quality Assurance committee will ensure compliance. 5. Completion Date March 17th, 2022.	

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F 757	Continued From page 16 During an interview on 02/10/22 11:05 a.m., an administrative nurse (#1) stated she expected staff to complete an AIMS before starting a resident on an antipsychotic medication.	F 757		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of professional reference, review of facility policy, and staff interview, the facility failed to ensure a medication error rate of less than five percent during 2 of 9 observations of medication administrations (February 7-8, 2022). Two medication errors occurred during staff administration of 26 medications, resulting in a 7% error rate. Failure to ensure the minimum timing between administrations of a handheld inhaler and administration of two different eye drops may result in residents receiving an ineffective dose and experiencing subtherapeutic benefits. Findings include: The Geriatric Medication Handbook, 2005, page 78, stated "Technique for Proper Use of Metered Dose Inhalers . . . 7. Hold breath for 10 seconds to allow medication to reach deeply into lungs. 8. Repeat puffs as directed. (Waiting one minute between puffs may permit additional puffs to	F 759	1. MA #3 and #4 re-educated on 02/10/2022 by DNS on the importance of inhaler and eye drop administration. Re-education will be provided by 03/14/2022 by DNS to med aides on the timing of administration of medications. 2. All residents with inhalers and eye drops have the potential to be affected. 3. All Med Aides and Licensed Nurses will be re-educated by 03/14/2022 by DNS on policy “Medication Administration – North Dakota” on the proper administration of eye drops and inhalers. All Med Aides will be completing a med administration competency by 03/14/2022 by DNS. 4. DNS or designee will complete a medication administration audit daily for one week, three times a week for one month, bi-weekly for one month, and monthly for four months. The Quality Assurance Committee will review and monitor audits during monthly quality meetings. The Quality Assurance	3/17/22

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F 759	Continued From page 17 penetrate the lungs better)." The facility policy on the use of Dorzolamide (used for increased internal eye pressure), provided on 02/09/22, stated, ". . . topical ophthalmic drug products to lower intraocular pressure. If more than one topical ophthalmic drug is being used, the drugs should be administered at least five minutes apart." - Observation on 02/07/22 at 3:09 p.m. showed the Medication Aide (MA) (#3) held an albuterol (used to dilate the lung passages) inhaler to the resident's lips and gave one puff of the medication, then without waiting, gave the second puff of the medication. The MA (#3) failed to cue the resident to hold her breath and failed to wait one full minute between puffs of the inhaler. - Observation on 02/08/22 at 8:49 a.m., showed the MA (#4) administered artificial tears to both eyes for a resident, gave her the oral medications required, and then gave the Dorzolamide one drop to each eye. Two minutes passed between the instillation of the artificial tears and the Dorzolamide. The MA (#4) failed to wait five minutes between the two ophthalmic medications. During an interview on 02/10/22 at 8:27 a.m. an administrative nurse (#1) confirmed the timing was incorrect for both medications and the MA should have cued the resident to hold her breath.	F 759	Committee will ensure compliance. 5. Completion Date March 17th, 2022.	
F 921 SS=D	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional,	F 921		3/17/22

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F 921	Continued From page 18 sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to provide a safe environment for residents and staff during 2 of 2 observations of the nourishment center (February 9-10, 2022). Failure to secure a large knife in a locked location has the potential for injury to residents, staff, and visitors. Findings include: - Observation of the nourishment center on 02/09/22 at 1:30 p.m. showed a large kitchen knife (approximately 12 inches in length) in a drawer under the ice machine. The dietary manager (#5) identified the knife had been missing from the kitchen for a month, removed the knife, and returned it to the kitchen. - While in the nourishment center with the dietary manager (#5) on 02/10/22 at 1:30 p.m., observation showed the same kitchen knife if in a different drawer. The dietary manager (#5) removed the knife from the nourishment center. Observation showed the nourishment center is located off a short hall between the nurse's station and resident rooms. The door to the nourishment center stood open during random observations on all days of survey. The facility has wandering residents who would have access to the nourishment center each time they went into the short hall. During an interview on 02/10/22 at 10: 25 a.m.,	F 921	1. Dietary Manager #5 educated dietary staff on 02/09/2022 on proper placement of knife. On 02/10/2022 Dietary Manager re-educate dietary staff on the proper placement of knives. 2. All residents have the potential to be affected. 3. All dietary staff will be re-educated by Dietary Manager by 03/14/2022 on proper storage of sharp knives. All staff will be re-educated on policy and procedure, Safety Practices for Activity Services to securing knives safely. 4. Dietary Manager #5 will complete a knife storage and safety audit of activity/nourishment areas five times for one week, weekly for one month, bi-weekly for one month, and monthly for two months. The Quality Assurance Committee will review and monitor audits during monthly quality meetings to ensure compliance is sustained. 5. Completion Date March 17th, 2022.	

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F 921	Continued From page 19 the dietary manager (#5) and an administrative staff member (#1) identified staff required education on the handling and storage of knives.	F 921		