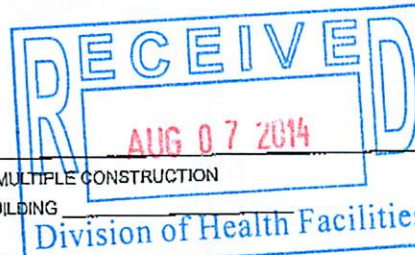


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES



PRINTED: 07/14/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355033	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/19/2014
NAME OF PROVIDER OR SUPPLIER ST CATHERINES LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1307 N 7TH ST WAHPETON, ND 58075		
(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	F 000	1. For Resident #19 and #20 the facility will provide the resident and/or representative a SNF Determination on Continued Stay form (Medicare denial notice including the option to request a demand bill).		
F 156 SS=C	For the standard Medicare/Medicaid recertification survey, started on 06/16/14 and completed on 06/19/14, the sample included 4 residents for complete review, 10 residents for focused review, and 3 closed records for review. The sample included 7 additional residents to verify specific concerns during the survey. 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	2. All residents who have Medicare Part A services ended and remain in the facility will receive a SNF Determination on Continued Stay form back to October 1, 2013 (Medicare denial notice including the option to request a demand bill). 3. The current policy for Medicare Beneficiary Notices is being reviewed by the Business Office Manager. All business office staff will be educated regarding the policy on Medicare Beneficiary Notices. 4. 08/04/2014 5. Audits will be completed initially by the Business Office Manager and/or delegate to assure all residents and/or representatives who have Medicare Part A services ended and remain in the facility will receive a SNF		
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE
			M. D. A.		8/01/14

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 156 SS=C	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	2. All residents who have Medicare Part A services ended and remain in the facility will receive a SNF Determination on Continued Stay form back to October 1, 2013 (Medicare denial notice including the option to request a demand bill). 3. The current policy for Medicare Beneficiary Notices is being reviewed by the Business Office Manager. All business office staff will be educated regarding the policy on Medicare Beneficiary Notices. 4. 08/04/2014 5. Audits will be completed initially by the Business Office Manager and/or delegate to assure all residents and/or representatives who have Medicare Part A services ended and remain in the facility will receive a SNF		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 60 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 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 the advance directives requirements. The facility must inform each resident of the	F 156	Determination on Continued Stay form (Medicare denial notice including the option to request a demand bill). Audits will then be completed monthly for the first quarter, then quarterly for one year. Results of monitoring will be reported to the QA Committee at each schedule meeting (at least quarterly). The Business Office Manager will follow up on further education/training on an as needed basis.		

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F 156	Continued From page 2 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 Medicare billing records, facility policy and procedure, and staff interview, the facility failed to the resident and/or representative a Medicare denial letter for 2 of 2 supplemental residents (Resident #19 and #20) Medicare records reviewed. Failure to provide a denial letter explaining demand billing and the option of submitting a demand bill is a violation of resident rights. This failure has the potential to affect all Medicare beneficiaries in the facility. Finding include: Review of the facility's policy titled "Medicare Beneficiary Notices" occurred on the morning of 06/19/14. The policy, dated December 2011, stated, "... When the beneficiary meets the technical requirements but does not need daily skilled services, Part A services are ending and the beneficiary will remain in the facility or when the need for daily skilled service is no longer necessary but they will received Part B therapy services issue the SNF[skilled nursing facility] ABN [advanced beneficiary notice] ... or one of	F 156			

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F 156	Continued From page 3 the 5 approved denial letters . . ." Review of the facility's Medicare billing records occurred on 06/18/14. The records identified Resident #19 and #20's Medicare coverage ended on the following dates: *Resident #19: 05/30/14 *Resident #20: 06/05/14 The above residents did not receive a "SNF Determination on Continued Stay form (a denial notice - including the option to request a demand bill). This form includes the following two options: *"I do want my bill for services I continue to receive to be submitted to the intermediary for a Medicare decision. You will be informed when the bill is submitted . . ." *"I do not want my bill for services I continue to need to be submitted to the intermediary for a Medicare decision. I understand that I do not have Medicare appeal rights if a bill is not submitted." During an interview on 06/18/14 at 3:30 p.m., business office staff members (#17 and #18) stated the business office had not provided this form to residents or their representatives since October 2013.	F 156			
F 225 SS=B	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide	F 225			

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F 225	Continued From page 4 registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, facility policy and procedure review, and staff interview, the facility failed to report an allegation of abuse for 1 of 1 sampled resident (Resident #6) to the state survey and certification agency promptly (24	F 225	1. Director of Nursing reported allegation of abuse to the state survey and certification agency for resident #6 (36 hours after allegation). 2. The facility will report all allegations of abuse to the state survey and certification agency promptly (within 24hrs). 3. The Director of Nursing will review and revise the Abuse Prevention Policy to assure timely notifications occur. All staff will be trained on the Abuse Prevention Policy (including timely notifications). All new employees will be trained with new employee orientation on the Abuse Prevention Policy (including timely notifications). 4. 08/04/2014 5. Audits will be completed initially by nursing administration to ensure all allegations of abuse are reported as required. Audits will then be completed		

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F 225	Continued From page 5 hours). Failure to report allegations of mistreatment places all residents at risk of abuse or neglect. Findings include: Review of the facility's policy titled "Abuse Prevention Plan" occurred on the morning of 06/17/14. The policy, dated December 2002, stated, "... B. All persons, whether required to report or those who are not required to report MAY do so as described below: 1. After safeguarding the resident, report the information to their supervisor. The supervisor in turn must immediately report all suspected maltreatment to either or both the Director of Nursing or the Administrator. The Director of Nursing or Administrator will process the report ... In the absence of the Director of Nursing, the Clinical Manager will perform the duties of the Director of Nursing. ... C. 1. The Administrator, Director of Nursing/Designee (Others as identified) are responsible for prompt (within 24 hours) review, investigation and reporting all suspected cases of maltreatment. 2. Once it has been determined that the incident is reportable, an oral report will be made immediately by telephone to the reporting agency (i.e. Health Department ...) Review of an "Initial Allegation of Mistreatment, Abuse, Neglect, or Theft Reporting Form" occurred on the morning of 06/17/14. The form identified the date and time of an allegation involving Resident #6 as 04/12/14 at approximately 8:00 p.m. and the date and time of the call to the Health Department as 04/14/14 at 8:30 a.m. (36 hours later). During an interview on 06/17/14 at 11:10 a.m., an	F 225	monthly for the first quarter, then quarterly for one year. Results of monitoring will be reported to the QA Committee at each schedule meeting (at least quarterly). Administrative nursing staff will follow up on further education/training on an as needed basis.		

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F 225	Continued From page 6	F 225			
F 226 SS=D	administrative nursing staff member (#2) confirmed she had not reported the alleged violation of abuse within 24 hours. 483.13(c) DEVELOP/IMPLEMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to thoroughly investigate potential incidents of abuse/neglect for 1 of 1 sampled resident (Resident #12) with a fall from a wheelchair. Failure to implement written abuse prevention policies and procedures and ensure a thorough investigation placed residents at risk for abuse and mistreatment. Findings include: Review of the facility policy titled "Abuse Prevention Plan" occurred on 06/19/14. This policy, dated December 2002, stated, "... REPORT and INVESTIGATE ... Any employee or volunteer MUST report suspected maltreatment if: ... Has knowledge that a vulnerable adult has sustained an injury no [sic] reasonably explained by a history of such injury ... All persons, whether required to report or those who are not required to report MAY do so as described below: 1. After safeguarding the resident, report the information to their	F 226			

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F 226	Continued From page 7 supervisor. The supervisor in turn must immediately report all suspected maltreatment to either or both the Director of Nursing or the Administrator. . . . Internal facility investigation of reports of resident maltreatment will occur as follows: 1. A preliminary investigation of the incident is conducted with appropriate interim measures taken to safeguard residents until a final determination can be made. . . . The investigation will be well documented and will focus on whether the abuse or neglect occurred. . . ." Review of Resident #12's medical record occurred on June 18-19, 2014. Diagnoses included dementia with behaviors and a history of hip fracture. Resident #12's care plan stated, ". . . Problem Start Date: 09/20/2012 ADL [activities of daily living] FUNCTION; Resident requires assist of 1 for ADLs related to severely impaired cognitive status, confusion, unsteady gait secondary to dx [diagnosis] hip fx [fracture] and dementia. . . . Approach Start Date: 09/20/2012 Foot pedals: W/C [wheelchair] with pedals for transport. . . . Locomotion: . . . w/c with pedals for transport and when gait unsteady. . . ." An "Event Report," dated 06/03/14 at 3:08 p.m., stated, ". . . Resident attempted to stand per self and lost his balance and fell to the floor. . . . Does resident exhibit or complain of pain related to the fall? . . . Yes . . . head ache . . . Location Of Injury: Bridge of nose and on staples on forehead. . . . Notes: . . . Resident was assisted out of bathroom via w/c when resident put his feet down to stop w/c and tried to stand. Resident was unstable and landed on the floor before aid could	F 226	1. The Director of Nursing will complete another investigation of the fall incident regarding resident #12. 2. Nursing Administration will investigate all fall incidents with suspected abuse allegation. 3. The current Abuse Prevention Policy and the Accident/Incident Occurrence Policy are being reviewed and revised by the Director of Nursing to assure a thorough investigation of all fall incidents. All licensed nursing staff will be trained to thoroughly investigate all fall incidents as a potential incident of abuse allegation per Abuse Prevention Policy and the Accident/Incident Occurrence Policy (this training will be included in new nurse orientation). 4. 08/04/2014 5. Audits will be completed initially by nursing administration to ensure all licensed nurses investigate all fall incidents with suspected abuse allegation. Audits will then be completed monthly for the first quarter, then quarterly for one year. Results of monitoring will be reported to the QA Committee at each schedule meeting (at least quarterly). Administrative nursing staff will follow up on further education/training on an as needed basis.		

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F 226	Continued From page 8 get around the chair to catch him. Resident's wound on forehead with staples was bleeding and dressing was changed. Resident also received a wound on the bridge of his nose. Family and physician notified. . . ."	F 226			
F 241 SS=D	During an interview on 06/19/14, a supervisory nurse (#14) stated staff did not use foot pedals because Resident #12 does not normally use a wheelchair, so the staff did not know Resident #12 would try to put his feet down on the floor. On the morning of 06/19/14, when asked to provide evidence of an investigation into the above incident as possible neglect, facility staff provided no further information. 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: THIS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 06/06/13. Based on observation and staff interview, the facility failed to maintain and enhance resident dignity for 2 of 5 sampled residents (Resident #8 and #12) residing in the special care unit. Failure to ensure residents' clothing is clean and failure to honor residents' requests does not promote residents' self esteem and self worth and may negatively impact their quality of life.	F 241	1. All staff will maintain and enhance dignity for Resident #8 by ensuring clothing is clean and Resident #12 by honoring requests that are reasonable and within guidelines of resident rights. 2. All staff will maintain and enhance dignity for all residents by ensuring clothing is clean and honoring requests that are reasonable and within guidelines of resident rights. 3. Resident Rights Guidelines will be followed by all staff to ensure all residents clothing is clean and honoring all requests that are		

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F 241	Continued From page 9 Findings include: Observation on the morning of 06/17/14 showed Resident #12 finished his breakfast in the dining room. An unidentified staff member assisted Resident #12 from the dining room in his wheelchair. The resident stated, "I'm so hungry. I'm so hungry I could eat a hog." The staff member did not respond. The staff member then assisted Resident #12 into a recliner in the TV lounge. Resident #12 sat in the recliner for a few minutes, then got up and ambulated down the hallway. The resident again stated, "I'm so hungry I could eat a hog." A nursing staff member (#9) stated, "You did eat a hog. You just had breakfast," and assisted Resident #12 back into the recliner. The resident stated, "I'm so hungry," to which the staff member (#9) replied, "I'll get you a snack in a little while." Observation showed staff failed to provide a snack for Resident #12, and he eventually fell asleep in the recliner. Later in the morning, two staff members (#9 and #23) commented that Resident #12 was still hungry after breakfast and laughed. - Observations on 06/18/14 from 9:00 a.m. to 3:00 p.m. showed Resident #8 wore sleeve protectors on both arms with multiple stains covering them. The stained sleeve protectors were visible to Resident #8's son, visitors, staff, and other residents. Observations showed no staff members changed Resident #8's sleeve protectors.	F 241	reasonable. All staff will be trained on Resident Rights to ensure all residents clothing is clean and honoring all requests that are reasonable (this training will be included in new employee orientation). 4. 08/04/2014 5. Audits will be completed initially by nursing administration or social worker to ensure staff provides care in a manner that enhances each resident's dignity which will be addressed through resident council. Audits will then be completed monthly for the first quarter, then quarterly for one year. Results of monitoring will be reported to the QA Committee at each schedule meeting (at least quarterly). The Departmental Supervisor will follow up on further education/training on an as needed basis.		
F 248 SS=E	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program	F 248			

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F 248	Continued From page 10 of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, record review, family and staff interviews, the facility failed to provide an ongoing, meaningful activity program to meet the physical, mental, and psychosocial needs for 5 of 5 sampled residents (Resident #1, #2, #8, #9, and #12) dependent on staff for activities who reside on the special care unit. Activities are a valuable component of residents' lives and vital to achieve their highest level of well-being. Failure to implement an individualized activity program to respond to the interests and current capabilities of the residents has the potential to affect their physical, cognitive, and emotional health. Findings include: - Review of Resident #8's medical record occurred on June 16-19, 2014 and diagnoses included Alzheimer's disease, dementia, psychosis, and depression. A quarterly Minimum Data Set (MDS), dated 05/08/14, identified the resident with severely impaired cognition, and extensive assistance for transfers and locomotion on the unit. An admission MDS, dated 08/17/13, identified music, groups, and religion as somewhat important to the resident. The current care plan stated, "... Problem ... ACTIVITIES ... Approach ... 1.Provide with 1-1 interactions through-out the day to her. 2.Invite and encourage participation at events of her	F 248	1. Resident #1 expired 7/21/2014. For residents #2, #8, #9, #12 – a review of their interests; past & present, abilities, strengths & problem areas will be reassessed by the activity staff to better meet their individual activity needs. 2. All residents who reside in Special Care will have a review of their interests; past & present, abilities, strengths & problem areas reassessed to better meet their individual activity needs. 3. The current policy and procedure for meeting the individualized social needs of residents is being reviewed by the Activity Director. All staff will be educated regarding the policy/ procedure on meeting the individualized needs of residents and on the importance of providing activity programming (group or individual) to help decrease of behaviors. Additional 1:1 activity sessions and group activities have been added to the Special Care Activity Calendar. 4. 08/04/2014		

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F 248	Continued From page 11 interest on/off unit. Verbal invites needed. 3.Rides to and from events as needed 4.Encourage social times with other residents and family 5.Invite to . . . Protestant Services 6.Invite to music entertainment & [and] special programs 7.Daily orientation and cueing to current situations/ goings [sic] on. 8. Offer baby doll for comfort when in high anxiety times. 9.Hair services as requested 10.Offer books on tape - past enjoyed Romances. . . ." Observations during the survey showed Resident #8 sat in her wheelchair or a recliner in the TV lounge near a bird aviary but was not actively engaged with the birds, the television played in the background during the afternoons, and music played in the background during meal times. The activity attendance record for 06/17/14 identified Resident #8 participated in "1:1 interaction," "Discussion Group/Reminiscence," "Independent Activity," "Movie/Television/Radio," "Pet/Birds/Fish," "W/Chair [wheelchair] Rides-Assisted," "Lounge Time," and "Baby". Facility staff failed to provide and engage Resident #8 in meaningful, individualized activities. - Review of Resident #9's medical record occurred on June 16-19, 2014 and diagnoses included Alzheimer's disease, dementia, mood disorder, and depression. A quarterly MDS, dated 04/22/14, identified the resident with severely impaired cognition, and extensive assistance for transfers and supervision for locomotion on the unit. An annual MDS, dated 01/22/14, identified her favorite activities as somewhat important to the resident. The current care plan stated, ". . . Problem . . .	F 248	5. Audits will be completed initially by the Activity manager/ designee to assure all residents individualized needs are being met, socially, spiritually, 1-1 visits and in group form. Audits will be then done monthly for the first quarter, then quarterly for one year. Results of the monitoring will be reported to the QA Committee at each scheduled meeting (at least quarterly). The Activity Manager will follow up on further education/ training on an as needed basis.		

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F 248	Continued From page 12 Activities . . . 5. Will take part in Music/ exercise with encouragement. 6. Will interact 1-1 when initiated [sic]. . . . Approach . . . 1. Verbal invites/ and assist to act. [activity] areas. 2. Encourage her to participate- using cues/supervision. 3. Daily orientation to present place/ situations will be done. 4. Monitor her when in group act. [activities] for episodes of anger and dislike of event. Allow to leave if she chooses to. 5. Hair services as requested/ needed will be provided. 6. 1-1 interaction/ visits by others will be offered. 7. Invite family/ friends to attend along with [name of Resident #9] at social events. 8. Assist with personal items needed- as family does not live by. 9. Offer spiritual services/ B. Study [bible study] to her. 10. Explain situations that you are wanting her to participate in before they happen. . . " Observations during the survey showed Resident #9 either in her room or in the dining room and not actively participating in any activities. Music played in the background during meal times. The activity attendance record for 06/17/14 identified Resident #9 participated in "1:1 interaction," "Independent Activity," "Music/Listening," "Music & [and] Movement/Hydration," "Lounge Time," and "Bed." The June attendance record showed these were the only types of activities that occurred, except for "Movie/Television/Radio" on eight days. Facility staff failed to provide and engage Resident #9 in meaningful, individualized activities. - Review of Resident #1's medical record occurred on June 17-19, 2014. Diagnoses included dementia and cerebrovascular disease. A significant change MDS, dated 02/25/14, identified music, spending time outdoors, and	F 248			

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F 248	Continued From page 13 religion as very important activities to Resident #1; reading materials, news, and groups as not very important; and animals as not important. Resident #1's current activity care plan stated, ". . . ACTIVITIES . . . 2. Visit on a one to one basis . . . 4. Offer magazines to read, 5. Catholic Services and Spiritual Care visits . . . 8. TV in room. . . . 10. Invite to music entertainment, encourage her to sing or play piano. 11. Outdoor visits in nice weather. 12. Invite to ladies groups, exercises, and other small group events. 13. Offer cocoa/1-1 interaction - when yelling/disruptive. 14. Offer 'baby doll' to comfort - relates/enjoys baby doll. 15. Spiritual music will be provided in room and other areas as able to comfort/distract from yelling out. . . . 14. Offer piano to play and sing with her when needs something she likes to do. . . ." An observation during the initial tour on 06/16/14 at 3:20 p.m. showed Resident #1 seated in a recliner in her room. The resident yelled "Hey" repeatedly, while scooting forward in the recliner and attempting to stand. An unidentified staff member brought another resident back to her room (located across the hall from Resident #1's room) in a wheelchair but failed to offer assistance to Resident #1, who was still yelling "Hey." A few minutes later, an unidentified certified nursing assistant (CNA) entered Resident #1's room and offered assistance. Observation showed no TV/music on in the resident's room. Observations throughout the day on 06/17/14 showed Resident #1 seated in a recliner in the TV lounge area near a bird aviary, but not actively engaged with the birds. Observation showed a	F 248			

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F 248	Continued From page 14 small group exercise activity held in the dining room at approximately 11:00 a.m., although Resident #1 did not attend. Resident #1 remained in the recliner between meals/toileting, except when staff brought her to the dining room for a snack at 2:32 p.m. At 3:08 p.m., staff transferred her back into a recliner in the TV area. Staff failed to offer/encourage Resident #1 to participate in individualized activities throughout the day on 06/17/14. The activity attendance record for 06/17/14 identified Resident #1 participated in "1:1 interaction," "Independent Activity," "Music/Listening," "Pets/Birds/Fish," "W/Chair [wheelchair] Rides - Assisted," and "Lounge Time." The June attendance record showed these were the only type of activities that occurred, except for "Visitors" on one day, "Music & Movement/Hydration" on one day, "Movie/Television/Radio" on nine days, "Bed" on 10 days, and "Baby" seven days. Observation throughout the day on 06/18/14 identified Resident #1 sat in her wheelchair in the dining room, or sat in a recliner in the TV lounge area. Resident #1 attended church services off the unit at approximately 9:30 a.m. Staff failed to offer/encourage other individualized activities the remainder of the day. Review of the Activity Attendance Log for 06/18/14 identified Resident #1 did not participate in any activities. The June 2014 log also showed no activity participation on June 1, 4, 12, 14, and 15. - Review of Resident #2's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease and vascular dementia. The admission MDS, dated 04/08/14,	F 248			

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F 248	Continued From page 15 identified music, groups, spending time outside, and religion as somewhat important activities; reading materials and news as not very important; and animals as not important. Resident #2's current care plan stated, ". . . Activities . . . Approach . . . Daily invites - verbal and with cueing to events. 3. Daily orientation several times through-out the day. 4. Supervision when off unit for safety. 5. Fall risk - monitor when at eventsss [sic]. 6. Invite family to join in social events. 7. Hair services as needed. 8. Reassurance often - explain goings on with resident. 9. Spiritual services affered [sic] (Catholic Faith) as scheduled. . . ." The activities care plan lacked individualized interventions specific to Resident #2's personal interests. Observation throughout the day on 06/17/14 and 06/18/14 showed Resident #2 napping in a recliner in the TV lounge between meals, wandering in the halls, wandering into other resident's rooms, or eating a snack in the afternoon. Resident #2 did not engage in any meaningful activities, and staff failed to provide individualized activities for Resident #2 that were consistent with his interests/preferences. Resident #2's activity attendance record for 06/17/14 showed Resident #2 participated in "1:1 interaction," "independent activity," "movie/television/radio," "pet/birds/fish," "visitors," and "lounge time." Observations showed Resident #2 slept in a recliner on and off throughout the day in the TV lounge, where the bird aviary is kept and the TV was turned on; however, Resident #2 was not actively engaged in these activities. The June attendance record showed these were the only type of activities that	F 248			

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F 248	Continued From page 16 occurred, except for "current events" on five days, "music/listening" on 11 days, "Music & Movement/Hydration" on one day, and "bed" on 10 days. The June 2014 log also showed no activity participation on June 1, 4, 12, 14, 15, and 18. During a family interview, family member (#1) stated, "No... Not really." when asked if staff provide activities for Resident #2. - Review of Resident #12's medical record occurred on June 17-19, 2014. Diagnoses included dementia and anxiety. The current care plan stated, "... Activities ... 2. Assist to events as he allows. 3. Involve in groups he attends. 4. Encourage Lutheran Church services ... 5. Outdoor visits when able. 6. Invite to music/Bible study/Exercise on unit. 7. Monitor for restlessness - fall risk. 8. 1-1 interaction/orientation daily by others. ..." Observations throughout the day on 06/17/14 and 06/18/14 showed Resident #12 sleeping in a recliner in the TV lounge, wandering in the hallway, and eating a snack in the afternoon. Resident #12 did not engage in any meaningful activities, and staff failed to provide individualized activities for Resident #12 that were consistent with his interests/preferences. Resident #12's activity attendance record for 06/17/14 showed Resident #12 participated in "1:1 interaction," "independent activity," "music/listening," "pet/birds/fish," "W/c rides - Assisted," and "lounge time." Observations showed Resident #12 slept in a recliner on and off throughout the day in the TV lounge (where the bird aviary is kept) and the staff played music	F 248			

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F 248	Continued From page 17 on a CD player during meals; however, Resident #12 was not actively engaged in these activities. The June attendance record showed these were the only type of activities that occurred, except for "movie/television/radio" on 10 days, and "worship service/Bible study" on one day. The June 2014 log also showed no activity participation on June 1, 4, 12, 14, 15, and 18. During an interview on the morning of 06/19/14 an administrative activity staff member (#26) stated there are morning exercises on the special care unit, one on one activities, and sometimes residents go to activities off the unit. The administrative activity staff member (#26) stated CNAs working in the special care unit provide the one on one activities. The administrative activity staff member (#26) agreed it is hard for the CNA to provide activities on the special care unit when there is only one CNA on duty and they are responsible for providing resident cares and activities. Staff failed to provide and engage residents in meaningful, individualized activities that were consistent with their unique needs/preferences. Providing activities may also help to effectively manage wandering and other resident behaviors. Refer to F250.	F 248			
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.	F 250			

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F 250	Continued From page 18 This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to provide medically-related social services to 1 of 1 sampled resident (Resident #2) who displayed physical, verbal, and sexual behaviors; threatened to kill himself and other residents; and exhibited wandering. Failure to address these behaviors by developing and implementing individualized interventions placed the resident, other residents, and staff at risk for harm, and negatively impacted Resident #2's psychosocial well-being. Findings include: Review of Resident #2's medical record occurred on June 17-19, 2014. Diagnoses included Alzheimer's disease and cerebrovascular disease. Current medications included Trazodone (an antidepressant) 100 milligrams (mg) at bedtime (increased from 50 mg on 05/05/14) and Ativan (an anxiolytic) 0.25 mg every four hours as needed (prn). Information received on the initial tour (on 06/16/14 at 3:20 p.m.) identified Resident #2 with "sexual" behaviors, as well as wandering. Nurses' notes identified the following behaviors: *04/04/14 at 9:13 p.m.: "... Wandering all shift. Trying to get out of the doors randomly. ..." *04/06/14 at 10:52 a.m.: "... Resident wandering in hallways in SCU [special care unit] this shift. Resident trying to exit SCU through locked doors, hard to redirect throughout this shift. ... CNA [certified nursing assistant] reported that during	F 250	1. Resident #2 will have interventions in place for behaviors to prevent harm to the resident or other residents and staff. 2. All residents who at risk for behaviors that would harm the resident, other residents or staff will have interventions to prevent harm. 3. Guidelines for Managing Challenging Behaviors will be followed by nursing administration and/or social worker to ensure interventions are in place to prevent harm to residents and staff when any resident has behaviors. Nursing administration will train all staff the Alzheimer's Association Guidelines for Managing Challenging Behaviors to prevent harm to resident and staff when any resident has behaviors (this will also be included in new employee orientation). 4. 08/04/2014 5. Audits will be completed initially by nursing administration and/or social worker to ensure staff	

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F 250	Continued From page 19 AM [morning] cares resident was masturbating. Resident was making statements to CNA such as 'That feels so good' and 'Are they all as good as you are?' CNA redirected the resident and told him that was inappropriate and exited his room. Resident later came out in hallway and pulled down his pants. . . ." *04/08/14 at 8:05 p.m.: ". . . Resident continues to wander around unit. Did yell at another resident this afternoon and told her to 'shut up.' . . ." *04/07/14 at 9:00 a.m.: ". . . now is up wandering in halls and goes in and out of rooms so needs redirecting often with other res. [residents] c/o [complaining of] being [in] their room. . . ." *04/07/14 at 7:08 p.m.: ". . . He has been in and out of one female resident's room, and she became upset with this. . . ." *04/08/14 at 4:33 a.m.: ". . . Resident has been wondering [sic] throughout this shift until this time he is now asleep in a bed that is not his. Resident was in and out of other resident's rooms numerous times. . . ." *04/09/14 at 7:55 p.m.: ". . . Resident combative with staff and other residents. Verbally threatening to 'kill' other male resident and 'break staffs fingers'. Very difficult to redirect. Took over 1 hr [hour] to calm resident down. . . . Wandering in and out of other residents rooms. . . ." *04/10/14 at 4:02 a.m.: ". . . Res roams into other res rooms, and when trying to redirect him, he becomes angry, shaking fist at staff, yelling and swearing. . . ." *04/10/14 at 9:02 p.m.: ". . . Resident very anxious this shift. He has been wandering most of shift. Wandered into a female resident's room and female resident became very upset and started to yell at resident. . . ." *04/12/14 at 5:57 a.m.: ". . . resident is continuously in and out of other resident's rooms,	F 250	follows the interventions developed for residents with behaviors to prevent harm. Audits will then be completed monthly for the first quarter, then quarterly for one year. Results of monitoring will be reported to the QA Committee at each schedule meeting (at least quarterly). Administrative nursing staff and/or social worker will follow up on further education/training on an as needed basis. 1.		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355033	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/19/2014
NAME OF PROVIDER OR SUPPLIER ST CATHERINES LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1307 N 7TH ST WAHPETON, ND 58075		
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F 250	Continued From page 20 sitting on their beds and in their chairs demanding 'I own it!'. Unable to redirect resident and therefor [sic] when resident is in other resident's room and will not leave he is observed for safety of hisself [sic] and other residents until he chooses to leave room. . . ." *04/12/14 at 1:30 p.m.: ". . . garbled speech with swear words now and then, has been in and out of rooms laying in beds, female came down hall all confused as to whats [sic] going on with man in her bed. . . ." *04/12/14 at 9:16 p.m.: ". . . Resident wandering a lot [sic], into other resident's rooms, upsetting other residents particularly female resident. While attempting to redirect resident from other's rooms resident yelled for help, raised hists [sic] to staff and has yelled 'I just want to get out of here!' . . . was found digging through the garbage. . . ." *04/13/14 at 2:55 a.m.: ". . . Resident has sat on female resident's beds, while female resident's [sic] are sleeping- at one time sitting on one female resident's feet. . . . Resident has urinated in linen hampers throughout the unit. . . ." *04/14/14 at 1:47 p.m.: ". . . CNA reports from last eve [evening] that res. was found with trouser zipper down and going to void by kitchen cupboard, and later female res. in rm. 311 said res. stood in front of her and peed on floor. . . ." *04/16/14 at 6:29 a.m.: ". . . Res has been up most of this noc [night] shift, in other res rooms, physically bothering other res, to the point they get upset with him. . . ." *04/16/14 at 8:37 p.m.: ". . . Was uncooperative with cares, hollering out with cares, grabbing at staff. Wanders in halls and in other res rooms. Refused hs [bed time] med [medication], stated, 'I might just as well shoot myself.' . . ." *04/18/14 at 8:39 p.m.: ". . . Wandering constantly up and down hallways, going into peoples [sic]	F 250			

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F 250	Continued From page 21 rooms. not easily redirect [sic]. . . ." *04/22/14 at 9:11 p.m.: ". . . Resident wandering in and out of other residents [sic] rooms, and either sitting in their chairs or laying in their beds, was easily redirected. . . ." *04/24/14 at 9:40 p.m.: ". . . Wandering in and out of female residents [sic] rooms. Was found in the bed of a resident and she was yelling for him to get out. . . . Cotninues [sic] to wander in and out of room [sic] at this time. . . ." *04/27/14 at 6:29 a.m.: ". . . CNA was charting at kiosk and resident grabbed her shoulders from behind and shook her. CNA turned around and resident had his teeth clenched and he was growling at her. CNA was able to free herself and walk away. Resident stayed in place growling for about a minute before walking away. . . ." *04/29/14 at 12:47 p.m.: ". . . Assaultive behaviors at breakfast time. . . . Resident was hitting out at staff and swearing . . . tried to get out the doors. Wandering all over the facility. . . ." *04/30/14 at 9:57 p.m.: ". . . Resident has been 'weepy' all shift, having 3 crying spells, saying 'I just want to die', resident wondering [sic] continuously in and out of other residents [sic] rooms upsetting other residents- especially female residents. When attempting redirection resident becomes very verbally abusive to staff, yelling, and cursing. Resident not responding to redirecting and continuing to go in and out of other's rooms, while they are asleep he is turning their lights on and off as well as their TVs, waking the other residents and upsetting them. . . ." *05/02/14 at 5:06 a.m.: ". . . Res taking off clothes in the hallway. Res sleeping in another res bed for part of the night. . . ." *05/03/14 at 8:07 p.m.: ". . . Found climbing into another male resident's bed while resident was still in it. Redirected out of room. Wanders into	F 250			

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F 250	Continued From page 22 other resident's rooms often. . . ." *05/03/14 at 11:15 p.m.: ". . . CNA called for assistance with res, when res was found laying naked in bed with another male res. . . . Res was very resistant to cooperate. . . ." *05/04/14 at 10:40 p.m.: ". . . Resident up and down constantly and when up is in other resident's rooms upsetting them. . . ." *05/08/14 at 5:51 a.m.: ". . . Resident does not sleep much throughout the NOC, resident wonders [sic] in and out of other resident's rooms, often attempts to climb into bed with other residents. . . ." *05/09/14 at 8:58 p.m.: ". . . Very agitated and walking around the unit. In and out of peoples rooms, trying to get out the doors several times. . . ." *05/16/14 at 12:43 p.m.: ". . . Resident pulled his penis out of pants and was walking around. Staff took him to his room and was going to help him go to bathroom thinking that is what he wanted and he immediately placed himself on the floor. Staff gave him a blanket and pillow and periodically checked on him. RN [registered nurse] went back to assess resident and he was no longer in room on floor. He was wandering out of another resident's room. . . ." *05/20/14 at 12:46 p.m.: ". . . Ativan 0.5 mg given due to constant wandering in and out of rooms, going into other male res. room and that res. tried pushing him out . . ." *05/21/14 at 7:59 p.m.: ". . . Resident has been in and out of resident's rooms this shift. Easily redirected out, but resident's [sic] upset over this. . . ." *05/23/14 at 4:09 p.m.: ". . . Going into peoples [sic] rooms and very hard to redirect [sic] even with two staff. None [sic] stop yelling and throwing hands in the air. . . . gave prn ativan. . . ."	F 250			

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F 250	Continued From page 23 *06/02/14 at 6:30 p.m.: "... Resident wandering into women resident rooms, was not easily redirected and needed to be guided out of rooms, resident was cursing and raising his voice ..." *06/04/14 at 9:26 p.m.: "... Resident has been in and out [of] other resident's rooms and in other resident's beds. ..." *06/06/14 at 9:27 p.m.: "... resident approached a female resident and attempted to poke her in the face with his finger. Resident was redirected before contact with other resident was made. ..." *06/07/14 at 3:55 a.m.: "... Resident sleeps about 50% of the NOC, is usually up wandering and frequently in and out of other resident's rooms. ... may at times void on the floor in inappropriate areas. ..." *06/18/14 at 1:34 p.m.: "... Resident has been in and out [of] other resident's rooms and laying on other resident's beds. ..." During the initial tour on 06/16/14 at 3:20 p.m., observation showed Resident #2 asleep in another resident's bed (Resident #9). Resident #9 stood in the doorway of her room, looking at Resident #2. Resident #9 then approached the surveyor and stated, "Help me, can you help me please?" The resident also stated, "There's a man in my bed, and he won't get up." The surveyor located an unidentified CNA, who attempted several times to wake Resident #2. When Resident #2 woke up, the CNA directed him out of Resident #9's room, but left Resident #2 standing in the hallway outside Resident #9's room. Resident #2 approached Resident #9 and began speaking to her. Resident #9 stated, "I don't know you, sir, please go." Resident #2 moved closer to Resident #9, who raised her voice and stated, "I don't know you, and you don't know me. Now leave!" Observation showed no	F 250			

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F 250	Continued From page 24 staff in sight, and Resident #9 entered her room. Resident #2 remained in the hallway outside Resident #9's room and stated, "What do I do?" Observation on 06/17/14 at 9:41 a.m. showed Resident #2 was not in his room, other residents' rooms, or in any common areas of the SCU. When asked, a CNA (#23) stated, "He was in [Resident #1's] room." Upon entering Resident #1's room, Resident #2 was not in the room. The CNA entered the bathroom and then exited the bathroom into the adjoining (vacant) room. The bathroom door as well as the door to the hallway were both closed. Resident #2 was in the room, rummaging through a closet. The CNA directed the resident into the hallway, but left the resident standing alone outside Resident #1's room. The CNA proceeded down the hall, and Resident #2 remained at the end of the hall by himself. The CNA stated, "I'm glad you asked about him. I was on my way down, but then I got sidetracked and kind of forgot." The CNA also stated she "stays busy" trying to keep Resident #2 out of other residents' rooms. Observation on 06/18/14 at 4:30 p.m. showed Resident #2 asleep on Resident #9's bed. A nursing staff member (#12) attempted to wake up Resident #2, and then left the room. Resident #2 eventually exited Resident #9's room and resumed wandering down the hallway. During this time, observation showed Resident #9 seated in a recliner in Resident #2's room, with her eyes closed, listening to music. Resident #2's current care plan identified the following: ". . . MOOD/BEHAVIOR: DX of Alzheimer's/dementia with behaviors. Is resistive to cares, verbally abusive, and wanders. He gets	F 250			

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F 250	Continued From page 25 agitated when rushed. He resides in the SCU. . . . Approach . . . 1) Redirect resident during periods of wandering, verbally abusive, and during rejection of care with alternative activity (he enjoys talking about farming, 1:1 visits, enjoys country music, etc). 2) Redirect to his room when wandering. 3)If resistive to cares, verbally abusive, allow personal space to calm and reapproach at a later time. 4)Assure basic needs are met (such as toileting, repositioning, hunger) 5) Allow resident to express needs/concerns. 6) Follow familiar routine 7)Provide cues/reminders/redirect. 8) monitor for wandering in others room- redirect at those times . . ." The care plan failed to address specific behaviors Resident #2 exhibited, such as thoughts of self harm, sexual behaviors, physical aggression toward staff and other residents, and crawling into bed with other residents. Observations during the survey identified staff failed to implement care planned interventions during Resident #2's periods of wandering (such a providing activities, offer toileting, etc.). Psychiatric Progress Notes, dated 05/16/14 and 06/13/14, failed to address resident-specific behaviors of verbal/physical aggression, sexual inappropriateness, and thoughts of self harm. The medical record also lacked evidence of social services involvement and progress notes except social services notes dated 04/04/14 and 04/07/14 (shortly after admission). During an interview of the morning of 06/19/14, a social services staff member (#1) stated Resident #2 is "seen by psych [psychiatric doctor]," and staff try to "redirect" Resident #2 "when they can"	F 250			

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F 250	Continued From page 26 to manage Resident #2's behaviors. Staff failed to assess and track/trend behaviors in an attempt to determine patterns and precipitating factors; effectively manage Resident #2's wandering, physical/verbal aggression, and sexual behaviors; establish a comprehensive behavior management care plan that included resident-specific behaviors with individualized interventions; evaluate the effectiveness of the interventions in place; and recognize/assess the impact Resident #2's behaviors have on the well-being of other residents. When asked for evidence of behavior monitoring/tracking for Resident #2, the facility provided no further information.	F 250			
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term	F 274			

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F 274	Continued From page 27 Care Facility Resident Assessment Instrument (RAI) User's Manual, and staff interview, the facility failed to complete significant change in status assessments (SCSAs) for 2 of 3 sampled residents (Resident #3 and #8) within 14 days after a significant change occurred in the resident's physical or mental condition. Failure to complete a SCSA in response to the resident's decline limited the facility's ability to identify and implement appropriate care plan approaches. Findings include: The Centers for Medicare and Medicaid Services (CMS) "Long-Term Care Facility RAI User's Manual," Version 3.0, October 2013, pages 2-20 and 2-23 states, "... A 'significant change' is a decline or improvement in a resident's status that: 1. Will not normally resolve itself without intervention ... (for declines only); 2. Impacts more than one area of the resident's health status; and 3. Requires interdisciplinary review and /or revision of the care plan. ... A SCSA is also appropriate if there is a consistent pattern of changes, with either two or more areas of decline or two or more areas of improvement. This may include two changes within a particular domain (e.g. [example given], two areas of ADL [activities of daily living] decline or improvement). ..." - Review of Resident #8's medical record occurred on June 16-19, 2014. Diagnoses included Alzheimer's disease, dementia, and fall with a hip fracture (08/06/13). Resident #8's quarterly Minimum Data Set (MDS), dated 06/27/13, identified independent for bed mobility, transfers, walking in room, and locomotion on unit, supervision for eating,	F 274	1. Resident #3 and Resident #8 will have a significant change status assessment completed. 2. The MDS nurse will ensure that significant change status assessments are completed for all residents within 14 days after a significant change occurred in the resident's physical or mental condition. 3. The Long-Term Care Resident Assessment Instrument User's Manual will be followed by the MDS nurses to ensure that significant change status assessments are completed for all residents within 14 days after a significant change occurred in the resident's physical or mental condition. 4. 08/04/2014 5. Audits will be completed initially by the MDS nurse on all reentries to ensure that significant change status assessments are completed for all residents within 14 days after a significant change occurred in the resident's physical or mental condition. Audits will be then		

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F 274	Continued From page 28 toileting, and personal hygiene, and limited assist for dressing. The MDS, dated 08/17/13, indicated a decline in these areas with extensive assist for bed mobility, transfers, locomotion on unit, dressing, eating, toileting, and personal hygiene, and walking in the room did not occur. The record identified staff completed an admission MDS on 08/17/13 instead of a significant change MDS. - Review of Resident #3's medical record occurred on all days of survey. Diagnoses included dementia and fall with an ankle fracture (05/09/14). Resident #8's significant change MDS, dated 02/11/14, identified supervision for bed mobility and walking in room, and an assist of one for transfers and locomotion on/off the unit. The MDS, dated 05/15/14, indicated a decline in these areas with extensive assist of two or more staff for bed mobility, total assist of two for transfers, extensive assist of one for locomotion on unit, and total assist of one for locomotion off unit. Walking in the room or in the corridor did not occur. During an interview, on the morning of 06/18/14, a supervisory staff member (#3) verified she completed an admission MDS on 05/15/14 instead of a significant change MDS.	F 274	completed monthly for one year. Results of monitoring will be reported to the QA Committee at each schedule meeting (at least quarterly). The MDS nurse will follow up on further education/training on an as needed basis.		
F 278 SS=E	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status.	F 278			

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F 278	Continued From page 29 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. 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: ADMISSION ASSESSMENTS: 1. Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual (Version 3.0), and staff interview, the facility failed to complete Minimum Data Set (MDS) assessments which accurately reflected the resident's status for 4 of 5 sampled residents (Resident #3, #4, #11, and #13) and as identified in 1 of 3 closed records (Resident #16) who had an admission MDS	F 278	1. The MDS nurses will complete Minimum Data Set (MDS) Assessments which accurately reflect the resident's status for Resident #3, #4, #11, #13 and #16 who returned to facility after a discharge return anticipated assessment. The MDS nurses and licensed social workers will complete Minimum Data Set (MDS) assessments accurately to reflect the resident's status regarding the coding of delusions for Resident #6, #8, and #9. 2. The MDS nurses will complete Minimum Data Set (MDS) Assessments which accurately reflect the resident's status for all residents who return to facility after a discharge return anticipated assessment (back to June 2013). The MDS nurses and licensed social workers will complete MDS assessments accurately to reflect the resident's status regarding coding of delusions for all residents (back to June 2013).		

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F 278	Continued From page 30 completed after being discharged from the facility with return anticipated. Failure to complete the appropriate MDS may result in the inaccuracy of the facility's Resident Level Quality Measure Reports. Findings include: The Long-Term Care Facility RAI User's Manual, dated October 2013, on pages 2-18 and 2-19 states, "The Admission assessment is a comprehensive assessment for a new resident and, under some circumstances, a returning resident . . . if: * this is the resident's first time in this facility, OR * the resident had been in this facility previously and was discharged prior to completion of the Omnibus Budget Reconciliation Act (OBRA) Admission assessment, OR * the resident has been admitted to this facility and was discharged return not anticipated, OR * the resident has been admitted to this facility and was discharged return anticipated and did not return within 30 days of discharge. . . ." - Review of Resident #3's medical record occurred on all days of survey. Resident #3's record identified a hospital stay from 05/06/14 to 05/09/14. The facility completed a discharge assessment return anticipated MDS and upon return from the hospital, the facility incorrectly completed an admission MDS. - Review of Resident #4's medical record occurred on all days of survey. Resident #4's record identified a hospital stay from 10/08/13 to 10/23/13. The facility completed a discharge assessment return anticipated MDS and upon return from the hospital, the facility incorrectly completed an admission MDS.	F 278	3. The Long-Term Care Facility RAI User's Manual (Version 3.0), October 2013 and the ND Department of Health, Division of Health Facilities-MDS 3.0 Answers to Questions update regarding Hallucinations and Delusions (06/26/2014) will be followed by all facility staff completing the coding of delusions on the MDS. All MDS staff completing the coding of delusions on the MDS and the coding of the type of assessment upon resident's reentry into the facility will be trained on the updated state guidelines of 06/26/14 regarding Hallucinations and Delusions and to follow the LTC Facility RAI User's Manual. 4. 08/04/2014 5. Audits will be completed initially by the MDS nurse and/or social worker to ensure that all of the MDS assessments are coded accurately regarding delusions and accurately coding all returning resident assessments. Audits will be then completed		

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F 278	Continued From page 31 - Review of Resident #13's medical record occurred on June 18-19, 2014. Resident #13's record identified a hospital stay from 03/29/14 to 04/01/14. The facility completed a discharge assessment return anticipated MDS and upon return from the hospital, the facility incorrectly completed an admission MDS. - Review of Resident #11's medical record occurred on June 18-19, 2014 and identified a hospital stay from 02/21/14 to 02/14/14. The record identified staff completed a discharge return anticipated MDS on 02/21/14 and incorrectly completed an admission MDS on 03/02/14. The record showed Resident #11 hospitalized again from 04/21/14 to 04/29/14. The facility completed a discharge return anticipated MDS on 04/20/14 and incorrectly completed an admission MDS on 05/05/14. - Review Resident #16's closed medical record occurred on 06/19/14 and identified a hospital stay from 03/22/14 to 03/26/14. The facility completed a discharge assessment return anticipated MDS on 03/22/14 and upon return from the hospital, the facility incorrectly completed an admission MDS on 03/28/14. During an interview, on the morning of 06/18/14, an MDS nurse (#3) verified she completed an admission MDS after a discharge return anticipated MDS. During an interview on 06/18/14 at 2:45 p.m. two MDS nurses (#6 and #14) confirmed they have completed an admission MDS when residents returned from a hospital stay even when the return occurred less than 30 days after a	F 278	monthly for one year. Results of monitoring will be reported to the QA Committee at each schedule meeting (at least quarterly). The MDS Nurse and/or social worker will follow up on further education/training on an as needed basis.		

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F 278	Continued From page 32 discharge return anticipated. CODING OF DELUSIONS: 2. Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual (Version 3.0), and staff interview, the facility failed to complete Minimum Data Set (MDS) assessments which accurately reflected the resident's status for 3 of 3 sampled residents (Resident #6, #8, and #9) coded with delusions. Failure to accurately assess Resident #6, #8, and #9 regarding delusions and code the MDS correctly does not reflect the resident's current status and may affect the level of care provided to the residents. Findings include: The Long-Term Care Facility RAI User's Manual (Version 3.0), October 2013, pages E-2 - E-3 stated, "... E0100: Potential Indicators of Psychosis ... Coding Instructions ... Code based on behaviors observed and/or thoughts expressed in the last 7 days rather than the presence of a medical diagnosis. Check all that apply. ... *Check E0100B, delusions: if delusions were present in the last 7 days. A delusion is a fixed, false belief not shared by others that the resident holds true even in the face of evidence to the contrary. ... Coding Tips and Special Populations, *If a belief cannot be objectively shown to be false, or it is not possible to determine whether it is false, do not code it as a delusion. *If a resident expresses a false belief but easily accepts a reasonable alternative explanation, do not code it as a delusion. ..." - Review of Resident #8's medical record	F 278			

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F 278	Continued From page 33 occurred on June 16-19, 2014 and diagnoses included Alzheimer's disease, dementia, depression and psychosis. The quarterly MDS, dated 02/07/14, and the quarterly MDS, dated 05/08/14, identified the resident had delusions during the look back periods. The resident's medical record lacked evidence to support the coding of the delusions on both MDSs. - Review of Resident #9's medical record occurred on June 16-19, 2014 and diagnoses included Alzheimer's disease, dementia, depression, and psychosis. The quarterly MDS, dated 04/22/14, identified the resident had delusions during the look back period. The resident's medical record lacked evidence to support the coding of the delusions on the MDS. During an interview on 06/18/14 at 12:55 p.m., a social services staff member (#1) confirmed Resident #8's and Resident #9's records lacked evidence to support the coding of delusions. - Review of Resident #6's medical record occurred June 16-19, 2014 and diagnoses included dementia with behavioral disturbances, depression, and psychosis. The quarterly MDS, dated 12/20/13, identified the resident had delusions during the look back period. The resident's medical record lacked evidence to support the coding of the delusions on the MDS. During an interview on 06/18/14 at 3:15 p.m., a social services staff member (#11) confirmed Resident #6's record lacked evidence to support the coding of delusions.	F 278			
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS	F 281			

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F 281	Continued From page 34 The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, review of professional reference, and staff interview, the facility failed to follow professional standards of practice during 2 of 2 observations of medication pass (the evening of 06/17/14 and the morning of 06/18/14). Failure to ensure residents take their medication and signing off medications as given prior to administration may result in medication errors. Findings include: Berman and Snyder, "Kozier & Erb's Fundamentals of Nursing: Concepts, Process, and Practice," 9th ed., Pearson Education, Inc., New Jersey, pages 862-863, stated ". . . Process of Administering Medications . . . 3. Administer the drug. . . 5. Record the drug administered. . . ." Page 869 stated, ". . . Administering Oral Medications . . . Stay with the client until all medications have been swallowed. . . ." Review of the facility policy titled "MEDICATION ADMINISTRATION" occurred on 06/19/14. This policy, dated 10/10/11, stated, ". . . PROCEDURE: . . . 5. Administer the medication. . . Never leave medication at the bedside. . . 6. Chart the medication given. . . ." - Observation during medication pass on 06/17/14 at 5:08 p.m. and 5:11 p.m. showed a nursing staff member (#15) signed off	F 281	1. No medications will be left unattended for any resident (unless resident assessed and ordered for self-medication administration). Medications will be signed off after complete administration of medications (not before) for every medication pass. 2. No medications will be left unattended for any resident (unless resident assessed and ordered for self-medication administration) and medications will be signed off after completing administration of medications (not before) for every medication pass. 3. The Director of Nursing will review the Medication Administration Policy. The Director of Nursing will train all licensed nursing staff that are administer medications regarding not leaving medication unattended (unless resident assessed and ordered for self-medication administration) and medications will be signed off after completing administration of medications (not before). Administrative nursing staff will observe all licensed nursing staff that administers medications to assure medications not left unattended (unless resident		

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F 281	Continued From page 35 medications as given in the medication administration record (MAR) prior to ensuring the residents actually took the medications. - Review of Resident #12's chart occurred on June 18-19, 2014. Diagnoses included dementia with behaviors. Current medications included Depakote (an anticonvulsant), Lopressor (an antihypertensive), Senna (a laxative), and Tylenol. Observation during the morning medication pass on 06/18/14 showed Resident #12 seated at the dining room table with several oral medications on the table in front of him, and no staff supervision. A nurse (#12) approached the resident after a few minutes and brought him a breakfast tray. Nursing staff failed to stay with the resident to ensure he took his medications. - Observation on 06/18/14 at 7:55 a.m. during the medication pass showed a nurse (#12) prepared a resident's medications and signed the MAR before administering the medication to the resident. During an interview on the morning of 06/19/14, a supervisory nurse (#14) agreed staff should not leave medications unattended.	F 281	assessed and ordered for self- medication administration) and medications are signed off after completing administration of medications (not before). 4. 08/04/2014 5. Audits will be completed initially by the administrative nursing staff to monitor all licensed nursing staff that medications are not left unattended (unless resident assessed and ordered for self- medication administration) and medications signed off after completing administration of medication (not before). Audits will then be completed monthly for the first quarter, then quarterly for a year. Results of monitoring will be reported to the QA Committee at each schedule meeting (at least quarterly). Administrative nursing staff will follow up on further education/training on an as needed basis.		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that -- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident 's clinical condition demonstrates that use of a naso gastric tube was	F 322			

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F 322	Continued From page 36 unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observation, professional reference review, facility policy and procedure review, record review, and staff interview, the facility failed to provide the appropriate treatment and services for 1 of 1 sampled resident (Resident #6) fed by a gastrostomy tube. Failure to keep Resident #6's head of bed at a minimum of 30 degrees while receiving continuous tube feedings may result in aspiration pneumonia. Findings include: Berman and Snyder, "Kozier & Erb's Fundamentals of Nursing: Concepts, Process, and Practice," 9th ed., Pearson Education, Inc New Jersey, page 1292, states, "... Administering a Tube Feeding ... Assist the client to a Fowler's position (at least 30 degrees elevation) in bed or a sitting position in a chair, the normal position for eating. If sitting position is contraindicated, a slightly elevated right side-lying position is acceptable. Rationale: These positions	F 322	1. Resident #6 will have head of bed elevated to meet the individualized needs of the resident while receiving enteral feeding to prevent aspiration pneumonia. 2. All residents (including admissions) who are receiving continuous enteral feeding will have head of bed elevated to meet the individualized needs of the resident to prevent aspiration pneumonia. 3. The Director of Nurse reviewed and revised The Enteral Feeding Protocol. The Director of Nursing will train all licensed nurses and CNAs to maintain head of bed elevation to meet the individualized needs of residents receiving continuous enteral feedings to prevent aspiration pneumonia (at all times). 4. 08/04/2014 5. Audits will be completed initially by the licensed nurses to ensure all residents who are receiving continuous enteral feeds have		

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F 322	Continued From page 37 enhance the gravitational flow of the solution and prevent aspiration of fluid into the lungs" Review of the facility's policy titled "Feeding - Continuous Feeding" occurred on the afternoon of 06/18/14. This policy, dated December 2002, stated, " . . . 4. Gather and bring equipment to bedside . . . 6. . . . Assist resident to semi fowler's position unless contraindicated . . . 25. I. Leave resident safe and comfortable in a semi-fowler's position. . . ." Review of Resident #6 medical record occurred on June 16 - 19, 2014 and identified diagnoses of dementia, dysphagia, history of pneumonia, and esophageal reflux. Physician's orders identified: *03/22/12 - HOB (head of bed) no lower than 30 degrees when in bed *06/13/14 - Osmolite 1.2 (supplemental or sole-source nutrition formula for tube feeding) at 45 milliliters an hour continuously per gastrostomy tube Resident #6's current care plan stated: *01/08/14 - "FEEDING TUBE/GJ [gastrojejunostomy] TUBE: Resident requires feeding tube R/T inability to swallow and risk of aspiration . . . APPROACH: . . . has dysphagia with NPO [nothing by mouth] . . . Position HOB at least 30 degrees at all times . . ." *03/07/14 - "NUTRITION: Tube Feeding as sole source of nutrition. Tube placed r/t aspiration pneumonia . . ." *03/10/14 - "PROBLEM: RESPIRATORY/ASPIRATION RISK: Resident is at risk for respiratory distress/obstructed airway R/T [related to] decreased cognition with poor	F 322	the head of their bed elevated to meet individualized needs of the resident to prevent aspiration pneumonia. Audits will then be completed monthly for the first quarter, then quarterly for a year. Results of monitoring will be reported to the QA Committee at each schedule meeting (at least quarterly. Licensed nurses will follow up on further education/training on an as needed basis.		

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F 322	Continued From page 38 safety awareness and is NPO [no food by mouth] D/T [due to] past aspiration risk with coughing at meals and pneumonia . . . APPROACH: Position resident in position for optimal breathing, with HOB [head of bed] elevated per MD [physician's] order. . . ." During observation of personal cares, on 06/17/14 at 8:10 a.m., a certified nursing assistant (CNA) (#22) lowered the head of Resident #6's bed to a flat position and stated to the resident "I'm gonna need your head down." After approximately five minutes, the CNA raised the head of the bed and lowered it to a flat position a second time for approximately five minutes. The resident repeatedly coughed on two occasions and with a loose wet cough on one occasion during this observation. Observation showed the tube feeding being administered by an infusion machine during this observation. When questioned, the CNA (#22) confirmed Resident #6 received "constant" tube feeding. Review of Resident #6's progress notes identified: *04/14/14, 1:22 a.m. - ". . . Exact cause of cough remains unclear. There is no sign of pneumonia on x-ray . . ." *05/17/14, 7:51 p.m. - "Coughing off and on throughout the shift . . . On ABX [antibiotic] for URI [upper respiratory infection] Cough is wet and nonproductive. . . ." *06/06/14, 2:26 p.m. - ". . . Resident continues to have NP [nonproductive] cough despite use of [three names of antibiotics] . . ." *05/25/14, 12:57 p.m. - ". . . persistant [sic] cough [physician's name] stated that it could possibly be regurgitation [sic] of feeding . . ." *05/25/14, 4:30 p.m. - ". . . Res [resident] c/o	F 322			

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F 322	Continued From page 39 [complain of] her abd [abdomen] aching from all the coughing . . . "06/17/14, 3:27 p.m. - ". . . she has been coughing a lot and at times we need to ask her to sit out of an activity as it is disruptive to others . . "	F 322			
F 323 SS=G	During an interview on 06/18/14 at 3:00 p.m., an administrative nursing staff member (#6) stated the "head of bed should be elevated per care plan" when administering the tube feeding. 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, review of policy and procedure, and staff interview, the facility staff failed to provide adequate supervision and assistive devices necessary to prevent accidents for 4 of 13 sampled residents (Resident #1, #7, #8, and #12,) and 2 supplemental residents (Resident #21 and #22) with unwitnessed falls and/or observed during transfers and/or wheelchair transportation. Four of these residents reside in the special care unit (Resident #1, #8, #12, and #21). Failure to provide adequate supervision (Resident #12), use gait belts appropriately (Resident #1 and #12),	F 323	1. Resident #1 expired 07/21/14. Resident # 12 will be provided with adequate supervision to prevent accidents. Resident #12 will have gait belt used appropriately with all hands on assisted transfers and will be ambulated per plan of care with walker and gait belt. Resident #7, #8, #12, #21, #22 will be reassessed regarding use of foot pedals with wheelchair locomotion by Restorative Therapy Department and/or Nurse Managers. 2. All residents will be provided with adequate supervision to prevent accidents. All certified nursing assistants that assist any residents with ambulation or		

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F 323	Continued From page 40 and use wheelchair foot pedals during transportation (Resident #1, #7, #8, #12, #21, and #22) placed the residents at risk for accidents and injuries and resulted in a head injury for Resident #12. Findings include: Review of the policy titled "Wheelchair Bag Codes" occurred on 06/19/14. This policy, revised 04/14/11, stated, "... A yellow bag on the back of this wheelchair, means that the pedals for this chair are used for transportation and stored in the bag when not being used. ..." Review of the policy titled "Transfer Belt Use" occurred on 06/19/14. This policy, reviewed/revised 07/10/13, stated, "... The purpose of a transfer belt (gait) is to provide support to residents who may be unsteady on their feet. The belt will protect the resident should they become weak or lose their balance when ambulating or transferring. POLICY: Nursing staff will use a transfer belt when ambulating or transferring a resident who requires hands on assistance. ..." - Review of Resident #12's medical record occurred on June 18-19, 2014. Diagnoses included dementia, anxiety, and history of a hip fracture. The current Minimum Data Set (MDS), dated 06/04/14, identified severely impaired cognition; extensive assistance from one person for transfers, locomotion, and toilet use; limited assistance from one person for ambulation; two falls without injury; and two falls with injury. Resident #12's current care plan identified: "... Problem Start Date: 09/20/2012 ADL [activities of	F 323	hands assistance with any resident transfers will use a transfer belt. All residents will be reassessed by Restorative Therapy Department and/or Nurse Manager regarding the use of foot pedals with wheelchair locomotion. 3. The policies for Transfer Belt Use, Wheelchair Locomotion and Fall Prevention are being reviewed/revised by the Director of Nursing. All staff will be in-serviced regarding transfer belt usage, assisted wheelchair locomotion and fall prevention strategies by the Director of the Nursing. All new employees will be trained with new employee orientation regarding transfer belt usage, assisted wheelchair locomotion and fall prevention strategies. 4. 08/04/2014 5. Audits will be completed by licensed nursing staff to assure all certified nursing assistants utilize a transfer belt with all resident hands on assisted transfers and assisted ambulation. Audits will		

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F 323	Continued From page 41 daily living] FUNCTION: Resident requires assist of 1 for ADLs related to severely impaired cognitive status, confusion, unsteady gait secondary to dx [diagnosis] hlp fx [fracture] and dementia. . . . Approach . . . Foot pedals: W/c [wheelchair] with pedals for transport . . . Locomotion: Ambulatory [with] FWW [front-wheeled walker], Assist of 1 when possible. Encourage use of gait belt, often refuses and gets agitated; w/c with pedals for transport and when gait unsteady. . . . Transfer: Self and at times needs 1 assist with gait belt and FWW. Unable to use call light appropriately. . . . BLADDER: Resident experiences bladder incontinence R/T [related to] urgency, frequency, bladder neck obstruction and dementia. Resident states is able to feel urge but dribbles on way to BR [bathroom]. . . . Resident often takes self to bathroom. 1 assist for transfers and toileting. Staff to encourage resident to void every 1-2 hours and prn [as needed] with staff assistance. Offer urinal at night prn. . . . FALLS: Resident at risk for falling R/T severely impaired cognitive status, impulsiveness, refusal of care when agitated and tired, unsteady gait, wandering secondary to dx. fx, right hlp, dementia. . . . Approach . . . FALL on 06/03/14 from w/c with staff after abruptly putting feet down, he does not normally use w/c and staff didn't anticipate him to act in that manner. . . . continue 30 minute safety checks . . . monitor for whereabouts to assure no injuries to self with restlessness. . . ." Review of facility "Event Reports" and nurses' notes identified the following related to falls: "04/16/14 at 8:16 p.m.: ". . . Description . . . Found on floor sitting on his buttocks, in other resident room. . . . Notes . . . Staff found resident in other resident room sitting on his buttocks and	F 323	be completed by licensed nursing staff to assure all nursing departmental staff that assistance residents with wheelchair locomotion are utilizing foot pedals per resident's individualized plan of care and assessment. Audits will be completed monthly for first quarter, then quarterly for one year. Results of monitoring will be reported to the QA Committee at each scheduled meeting (at least quarterly). Administrative Nursing staff will follow up on further education/training on an as needed basis.		

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F 323	Continued From page 42 holding onto his walker. kept saying get me up I have to find her. . . ." *04/21/14 at 7:05 p.m.: " . . . Description . . . Fall in another resident's room . . . Resident stated he was coming out of the bathroom. . . . Location of injury . . . None at this time . . ." *04/23/14 at 8:35 p.m.: " . . . Description . . . fell in his bathroom. pants were around his ankles. Gripper socks on and he was laying on his left side. Head facing out of the door of the bathroom. . . . Location of injury right eye brow and eye area, inside mouth. . . . Notes . . . Res is sitting in the TV room in recliner, eyes closed. Res right eye is swollen shut . . . Steri strips to right eye are intact, has dried blood around his lips and around his eye, with blood that has run down the side of his nose. . . . 4/24/2014 01:15AM Res has been up to the BR, with assist of 1, gait belt, and walker. Res slow to move, unsteady. . . . 4/24/2014 02:00AM Res c/o aching all over, Tylenol 650 mg [milligrams] given . . . 4/24/2014 04:15AM Res has had some relief from the Tylenol . . . c/o rib pain . . . 4/24/2014 09:03 AM . . . Staff instructed to toilet resident every hour in attempt to prevent self toileting . . . 4/25/2014 09:56PM Resident has bruising on the R) side of his face and throat from fall. 4/27/2014 02:00PM Resident has been c/o increased R) rib pain since fall on the evening of the 23rd. Also L) [left] elbow has a pocket of fluid on it. . . ." *05/26/14 at 2:12 p.m.: " . . . Notes . . . Resident was heard yelling for help @ 2:05 p.m. He was sitting on the floor in the living room, with his back against the recliner and legs outstretched toward the window. He had appropriate shoes on. His dk [dark] blanket was on the floor next to his feet. He possibly could have tripped on the blanket. . . . 5/27/2014 02:11AM CNA reports to this writer that res [resident] was c/o [complaining of] feeling	F 323			

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F 323	Continued From page 43 achy, and that she noticed an abraised area to res back. Res given Tylenol 650 mg [milligrams] at this time . . . 5/29/2014 09:43AM . . . Bruised area on his mid back, L) [left] side is healing slowly. It has a scab in the middle of the bruise. . . " *05/30/14 at 8:26 p.m.: " . . . Description . . . witnessed fall . . . Notes . . . Resident had fall this evening at 815pm. Witnessed by staff member. Resident was trying to sit in recliner and got walker tangled in blankets and fell to his R) [right] side. . . Resident very anxious to get up, moving legs around and kepts [sic] telling staff 'get me up.' Resident assisted to feet x 2 assist and gait belt. Gait unsteady, taken to recliner. . . " When asked why staff were not assisting Resident #12 into the recliner (as his care plan indicated assistance from one staff person for transfers and ambulation), staff provided no further information. *06/01/14 at 6:17 p.m.: "BEHAVIORS: Increased restlessness this shift. Not easily redirected. Increased up and down in recliner. To bathroom frequently. Forgets what he's doing. Appetite poor, distracted. Yelling at staff to help him. Staff ask him what he needs help with and he says 'my pants are getting fixed.' Does have pants on. Pacing up and down the hallway. Shakiness to hands. When trying to redirect resident becomes upset with staff." At 8:19 p.m. (after Resident #12's fall in the bathroom), the nurses' note was edited to include: "Voided in garbage can in nurse's station." *06/01/14 at 8:23 p.m.: " . . . Description . . . fall with injury . . . Pain assessment . . . Yes (location) - headache Location of injury . . . laceration to forehead, skin tear to R) elbow . . . Notes . . . 6/1/2014 07:34PM Resident found on the floor in bathroom. Resident bleeding from head and R)	F 323			

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F 323	Continued From page 44 elbow. Resident anxious and stating 'get me up. OH Lord help me. I'm going to die.' . . . Stated that he fell 'trying to use the toilet.' Resident sustained a laceration to forehead. Direct pressure applied. . . . Resident very shaky. . . . Ambulance called and hospital notifying transfer as resident may need possible stitches. . . . 6/2/2014 09:00AM Resident received 10 staples to forehead laceration last evening in ER [emergency room]. . . . Is slightly swollen and bruised/reddened. 6/2/2014 02:49PM . . . Resident continues to be unpredictable and due to severe cognitive impairments has no safety awareness and takes self to br. Staff do approach resident hourly and at times more often and assist when possible with transfers and toileting. . . . Review of toileting records for 06/01/14 identified toileting times of 12:26 a.m., 3:57 a.m., and 11:27 a.m. It is unknown the last time staff toileted Resident #12 prior to his fall. When asked for more information regarding the fall (i.e. evidence of 30 minute checks by staff, recent toileting, etc.), the facility provided no further information. Toileting records for other days also identified that staff failed to toilet Resident #12 every 1-2 hours as care planned. During an interview on 06/19/14 at 8:37 a.m., a supervisory nurse (#14) stated staff are supposed to document each time they toilet a resident, and if the resident is dry, the toileting records would indicate "none" (meaning no void). Event reports and nurses' notes further identified: *06/01/14 at 9:48 p.m.: ". . . Returned from ER. Staples in place in forehead. . . . Seemed in good mood. . . ." The medication administration record	F 323			

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F 323	Continued From page 45 (MAR) for 06/01/14 identified that at 10:15 p.m. (27 minutes after the nurse's note was written, staff administered Tylenol 650 mg for pain related to Resident #12's recent fall, as well as Seroquel (an antipsychotic) 25 mg for increased agitation and "at risk for self injury." When asked to provide more information regarding the simultaneous administration of a pain medication with an antipsychotic, the facility provided no further information. *06/03/14 at 3:08 p.m.: "... Description ... Resident attempted to stand per self and lost his balance and fell to the floor. ... Pain Assessment ... Yes (location) - head ache ... Location Of Injury ... bridge of nose and on staples on forehead. ... Notes ... 6/3/2014 03:52PM Resident was assisted out of bathroom via w/c when resident put his feet down to stop w/c and tried to stand. Resident was unstable and landed on the floor before aid could get around the chair to catch him. Resident's wound on forehead with staples was bleeding and dressing was changed. Resident also received a wound on the bridge of his nose. ..." During an interview on 06/19/14 at 9:54 a.m., a supervisory nurse (#14) stated staff did not use foot pedals because Resident #12 does not normally use a wheelchair, so the staff did not know Resident #12 would try to put his feet down on the floor. Observation on 06/17/14 at 7:56 a.m. showed Resident #12 seated in a wheelchair in the dining room. An unidentified certified nursing assistant (CNA) transported the resident from the dining room, down the hallway, and to the TV lounge without foot pedals in place. During the transport, Resident #12 put his feet on the ground, which	F 323			

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F 323	Continued From page 46 caused the CNA to stop abruptly. The CNA stated, "Keep 'em up [Resident #12] [referring to his feet]." The CNA then transferred Resident #12 from the wheelchair to the recliner using a walker and no gait belt. The CNA grabbed the back of Resident #12's pants and lifted under his arm. At 8:02 a.m., Resident #12 stood from the recliner and used his walker to ambulate down the hallway and back to the dining room. A nurse (#9) directed him to the TV lounge and ambulated beside the resident with her hand under his arm. She assisted the resident back into the recliner by grabbing the back of his pants and under his arm. Observation on 06/17/14 at 2:20 p.m. showed an unidentified CNA ambulating with Resident #12 from his room to the TV lounge. Resident #12 did not have a gait belt on, and the CNA assisted him into the recliner by holding on to the back of his pants and under his arm. Observation on the afternoon of 06/17/14 showed Resident #12 eating an afternoon snack in the dining room. After finishing his snack, he got up from the table and began ambulating with his walker. A certified medication aide (#15) directed the resident to the TV lounge, but failed to offer assistance/gait belt to Resident #12. The resident ambulated down the hall and to the TV lounge, where he then sat in a recliner. Observation on 06/17/14 at 4:54 p.m. showed Resident #12 ambulating in the hallway with his walker. A CNA (#27) passed by the resident but did not stop to offer assistance. At 5:04 p.m., the CNA (#27) approached Resident #12, applied a gait belt, and assisted the resident with ambulation.	F 323			

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F 323	Continued From page 47 Observation on the morning of 06/18/14 showed a staff nurse (#12) assisted Resident #12 up from the recliner by pulling under his arm and failing to apply a gait belt. The resident then ambulated down the hallway with his walker and no assistance from staff. Observation on 06/18/14 at 4:27 p.m. showed Resident #12 ambulating independently in the dining room with his walker. An unidentified CNA entered the special care unit and observed the resident ambulating. Without offering assistance, the CNA then left the unit. Observation on 06/18/14 at 4:59 p.m. showed a CNA (#13) pushing Resident #12 in a wheelchair down the hallway and to his room. Observation showed no foot pedals in place, and Resident #12's legs were crossed at the ankles with his heel brushing the floor. After toileting the resident, the CNA brought the resident to the TV area in his wheelchair without foot pedals in place. During an interview on 06/18/14 at 10:37 a.m., a CNA (#16) stated Resident #12 self transfers at times, but he is not supposed to ambulate independently, and staff are expected to assist him with ambulation and transfers. During an interview on 06/18/14 at 2:34 p.m., a CNA (#13) stated they are expected to ambulate with Resident #12 and use a gait belt and a walker. During an interview on 06/19/14 at 9:54 a.m., a supervisory nurse (#14) stated staff should ambulate with Resident #12 and offer/use a gait belt if resident allows. These staff interviews conflict with the most current care plan.	F 323			

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F 323	Continued From page 48 Although Resident #12 experienced multiple falls attempting to use the bathroom and self transferring, staff failed to develop/implement effective interventions to keep the resident safe from falls and injuries, and failed to provide appropriate supervision which resulted in a head wound, ER visit, and placement of staples. Failure to follow Resident #12's care plan related to the use of wheelchair foot pedals resulted in an avoidable fall with a head injury, and failure to use gait belts/provide assistance with ambulation may result in avoidable falls/injuries in the future. - Review of Resident #1's medical record occurred on June 17-19, 2014. Diagnoses included Alzheimer's disease, cerebrovascular disease, and a history of falls. The current MDS, dated 05/27/14, identified severely impaired cognition, extensive assistance from two or more people for transfers, extensive assistance from one person for locomotion, two falls without injury, and two falls with injury. Resident #1's current care plan stated, "... FALLS: Resident is at risk for falls R/T hx of falls, unsteady gait, medication use, impaired cognition, independence with ADLs, use of assistive device secondary to Dx. of CHF [congestive heart failure], CVA [cerebrovascular accident], Dementia unspec [unspecified] with behavior disturb., Disorder depressive ... Approach ... FALL on 6/11/14- FOF [found on floor] BR. If found in BR stay with resident until done. If resident found up walking, walk with resident and or assist her to safe sitting area. ... FALL - 5/31/14 - Continue to observe resident frequently, safety checks every 30 minutes. ... Observe frequently and place in supervised area when out of bed. Staff to monitor closely with [sic] and be	F 323			

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F 323	Continued From page 49 sure to give resident frequent reminders not to self transfer as resident is observed at times attempting to do things for herself d/t [due to] decreased cognition and poor safety awareness. . . . ADL FUNCTION: Resident requires assistance with ADLs R/T decline in funtional [sic] status, increased agitation and agitation exacerbation, decreased strength and mobility, poor safety awareness . . . Approach . . . Ambulation: 1 assist PRN with FWW . . . Locomotion, On and Off Unit and Wheelchair: Pedals for transport as tolerates and 1 assist. . . . Transfer . . . 1 assist and 2 assist PRN . . ." Observation during the initial tour (on 06/16/14 at 3:20 p.m.) showed Resident #1 seated in a recliner in her room. The resident yelled "Hey" repeatedly, while scooting forward in the recliner and attempting to stand. An unidentified staff member brought another resident back to her room (located across the hall from Resident #1's room) in a wheelchair but failed to offer assistance to Resident #1, who was still yelling "Hey." A few minutes later, an unidentified CNA entered Resident #1's room and offered assistance. Observation on 06/17/14 at 7:51 a.m. showed Resident #1 ate breakfast in the dining room while seated in her wheelchair (which had a bag marked with a yellow label that contained foot pedals). After breakfast, a CNA (#23) took Resident #1 down the hallway and into her bathroom in the wheelchair without utilizing foot pedals. The CNA cued the resident, "Lift your feet, [Resident #1]" as the resident's feet dropped down on the floor. After toileting, the CNA took Resident #1 to the TV lounge in the wheelchair without utilizing foot pedals. The CNA asked the	F 323			

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F 323	Continued From page 50 resident if she would like to sit in a recliner. The resident responded, "Yes." The CNA then indicated she would be right back to transfer Resident #1. At 8:40 a.m., Resident #1 remained in her wheelchair in the TV lounge. At 9:21 a.m., Resident #1 was seated in a recliner in the TV area. A CNA (#23) indicated Resident #1 had transferred herself into the recliner at some point. Observation on 06/17/14 at 10:56 a.m. showed a CNA (#23) transported Resident #1 in her wheelchair (without utilizing foot pedals) from the TV lounge to her room to use the bathroom. After transferring Resident #1 to the toilet, the CNA left Resident #1 alone in the bathroom and exited her room to get an incontinence brief. Upon completion of toileting, the CNA brought Resident #1 back to the TV lounge in her wheelchair without utilizing foot pedals. Observation on 06/17/14 at 12:54 p.m. showed a CNA (#23) transported Resident #1 in her wheelchair (without utilizing foot pedals) from the dining room to her room. The CNA stated, "Pick up your feet, [Resident #1]," as Resident #1's feet brushed on the floor during transport. Observation on 06/17/14 at 2:32 p.m. showed a CNA (#27) transferred Resident #1 from a recliner to her wheelchair and transported her from the TV lounge to the dining room without utilizing foot pedals. Observation on 06/18/14 at 8:57 a.m. showed a CNA (#16) transported Resident #1 in her wheelchair (without utilizing foot pedals) from the dining room, down the hallway, and to the resident's room.	F 323			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355033	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/19/2014
NAME OF PROVIDER OR SUPPLIER ST CATHERINES LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1307 N 7TH ST WAHPETON, ND 58075		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 323	Continued From page 51 Observation on 06/18/14 at 3:05 p.m., showed a staff member (#12) transfer Resident #1 from a recliner into a wheelchair with no gait belt and transport Resident #1 down the corridor without utilizing foot pedals. Observation on 06/18/14 at 4:24 p.m. showed a nursing staff member (#12) assisted Resident to stand from her wheelchair without using a gait belt. The staff member then attempted to ambulate with Resident #1 and her walker. Resident #1 was resistive to ambulation, so the staff member (#12) assisted her to sit back in her wheelchair. The staff member failed to apply a gait belt during this observation, although a gait belt was available on a nearby medication cart. Observation on 06/18/14 at 5:02 p.m. showed Resident #1 in the dining room in her wheelchair. The resident yelled "Hey" repeatedly, although no staff were available to assist her. After several minutes, Resident #1 stood up from her wheelchair and attempted to walk. At that time, two surveyors approached Resident #1 and encouraged the resident to sit in her wheelchair. The resident handed one surveyor a magazine and stated, "I can't do this." Resident #1 eventually sat back down in her wheelchair. Observation showed no staff available to assist Resident #1 during this time. During an interview on 06/18/14 at 10:37 a.m., a CNA (#16) indicated Resident #1 frequently transfers herself and attempts to ambulate independently. The CNA stated Resident #1 is not supposed to ambulate without staff assistance, and the staff frequently check on Resident #1 (every 30 minutes).	F 323			

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F 323	Continued From page 52 - Review of Resident #21's medical record occurred on 06/19/14. Diagnoses included Alzheimer's disease and dementia. The current MDS, dated 06/10/14, identified severely impaired cognition and extensive assistance from one person for transfers and ambulation. Observation on 06/18/14 at 10:03 a.m. showed an unidentified staff member brought Resident #21 back to the special care unit from an off unit activity in her wheelchair. Observation showed no foot pedals in place, although a yellow bag on the back of the resident's wheelchair (indicating foot pedals used for transport) contained foot pedals. Observation on 06/18/14 from 2:38 p.m. until 3:04 p.m. showed Resident #21 awake and sitting up on the edge of her bed. The resident repeatedly attempted to stand from her bed during this time, but was unable to do so. Observation showed no staff available to assist the resident. At 3:07 p.m., a nursing staff member #12 assisted Resident #21 out of bed and brought her to the dining room in her wheelchair (without utilizing foot pedals). - Review of Resident #8's medical record occurred on June 16-19, 2014. Diagnoses included Alzheimer's disease, dementia, psychosis, and anxiety. The current MDS, dated 05/08/14, identified severely impaired cognition, extensive assistance for transfers, and extensive assistance for locomotion. Resident #8's current care plan stated, "... ADL FUNCTION ... Approach ... Wheelchair locomotion with assist of 1 ..." Observation on 06/17/14 at 2:35 p.m., showed a CNA (#15) transported Resident #8 into the dining room without utilizing foot pedals on the	F 323			

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F 323	Continued From page 53 wheelchair. The resident's wheelchair showed a bag with a yellow label on the back (indicating foot pedals used for transport). Observation on 06/18/14 at 7:42 a.m., showed a CNA (#16) transported Resident #8 into the bathroom, out of the bathroom, and down the corridor into the dining room with no foot pedals on the wheelchair. The resident's wheelchair showed a bag with a yellow label on the back of the wheelchair (indicating foot pedals used for transport). - Review of Resident #7's medical record occurred on June 19, 2014. Resident #7's current care plan states, "... Problem ... ADL FUNCTION ... Approach ... Wheelchair with pedals for transport ..." Observation on 06/19/14 at 8:37 a.m., showed an unidentified CNA transporting Resident #7 from the dining room into the lounge area with no foot pedals on the wheelchair. The resident's wheelchair showed a bag with a yellow label on the back of the wheelchair (indicating foot pedals used for transport). - Observation on 06/19/14 at 9:20 a.m., showed an unidentified CNA transporting Resident #22 from a North hallway to the South chapel with no foot pedals on the wheelchair. The resident's wheelchair showed a bag with a yellow label on its back. Resident #22's current care plan stated, "... PROBLEM: ADL FUNCTION ... APPROACH: Wheelchair with foot pedals for transport. ..." Facility staff failed to utilize assistive devices (gait belts and wheelchair foot pedals) as well as	F 323			

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F 323	Continued From page 54 adequate supervision to prevent falls and injuries for multiple residents. Failure to provide gait belts and wheelchair foot pedals and provide appropriate supervision to ensure resident safety placed residents at risk for continued harm related to falls and other avoidable accidents.	F 323			
F 353 SS=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to ensure sufficient, qualified staff were available on a daily basis to meet the needs of 11 of 11 residents residing on the Special Care	F 353	1. The licensed nurses will ensure sufficient, qualified staff is available on a daily basis to meet the needs of the residents residing on the Special Care Unit by adjusting daily nursing departmental (nurses, med techs, and CNAs) assignments as needed. 2. The licensed nurses will ensure sufficient, qualified staff is available on a daily basis to meet the needs of the residents residing on the Special Care Unit by adjusting daily nursing departmental (nurses, med techs, and CNAs) assignments as needed. 3. The Director of Nursing will review the current staffing ratios to the Special Care Unit to ensure		

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F 353	Continued From page 55 Unit. Failure to ensure availability of staff may have contributed to concerns regarding dignity (Refer to F241); lack of activities (Refer to F248); behaviors (Refer to F250); and falls (Refer to F323). Findings Include: - Review of Resident #18's medical record occurred on June 18-19, 2014. Diagnoses included Alzheimer's disease, dementia, and depression. A progress note, dated 06/04/14 at 8:03 p.m., stated, "BEHAVIOR: Resident went into another resident's room and laid down in his bed. When staff came to get him out of the bed he giggled about it. Resident went back to another resident's room and when aid [sic] went to assist him out of the room resident pushed aid [sic] on the bed." During an interview during the survey, a staff member stated on 06/04/14 she was sent to the emergency room after separating Resident #18 and another resident. Resident #18 grabbed the staff member's wrist and she fell back onto the bed. The staff member managed to get in the hallway and called another unit for help. - During a confidential interview during the survey, a staff member stated "One CNA on duty doesn't work and it is not safe. Accidents could happen." - Review of Resident 4's medical record occurred on June 11-12, 2014. Diagnoses included Alzheimer's disease, dementia, and altered mental status.	F 353	the needs of all the residents are met. All licensed nurses will continue to be educated on the staffing plan for the Special Care Unit including adjusting daily nursing department assignments, maintaining the dignity of all residents, importance of activity programming, appropriate behavioral interventions, and prevention of falls. 08/04/2014 - Audits will be completed initially by nursing administrative staff to ensure the needs are met for all residents on the Special Care Unit and a safe environment is provided. Audits will then be completed monthly for first quarter, then quarterly for one year. Results of monitoring will be reported to the QA Committee at each schedule meeting (at least quarterly). Administrative nursing staff will follow up on further education/training on an as needed basis.		

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F 353	Continued From page 56 Review of a progress note, dated 04/10/14 at 12:20 p.m., stated, "Resident was very restless, walked down to special care as we have an PRN [as needed] order to do so when restless." At 2:20 p.m. a progress note stated, "... incident in SCU [Special Care Unit] earlier reported ... staff filling water pitchers ... went into room 304 to fill ice pitcher and res. [resident] from south ... was back there napping in first bed woke and got right up from bed and walked over and grabbed staff by chest blouse neckline, saying "What are you doing in my house!, staff ... called for assist ... saying she was hollering for help for 5 min. [minutes]! approx. [approximately] and no one came ... then [a] male staff went and opened door of SCU to get help but was not heard yelling. south cna [certified nurse aide] was coming up the hall already to go and assist with settling residents in SCU ... incident report filled out." During an interview, on 06/19/14 at 8:35 a.m., two nurse managers (#2 and #14) verified Resident #4 had a PRN order to go back to the SCU when restless. When asked for an incident report staff provided no further information. - Interviews with licensed nurses (#8 and #9) regarding staffing in the Special Care Unit (SCU) occurred on 06/18/14 at 3:35 p.m. and 06/19/14 at 8:45 a.m. The nurses stated the unit is staffed with one Certified Nursing Assistant (CNA) to provide care for all 11 residents. If the CNA needed assistance he/she would call a nurse from the 200 unit.	F 353			
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must -	F 371			

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F 371	Continued From page 57 (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, review of policy and procedure, and staff interview, the facility failed to prepare and store food in a safe and sanitary manner in 1 of 2 kitchens (South kitchen), 1 of 1 activity kitchenette, and 1 of 1 special care unit kitchenette. Failure to properly sanitize food contact surfaces and store food in a sanitary manner placed all residents who eat food prepared in the facility at risk for foodborne illness. Findings Include: Review of the facility policy titled "Sanitizer Dispensing" occurred on 06/19/14. This policy, dated 11/13/09, stated, "... Procedures: 1. Fill third compartment with water (approximate water temperature should be 75 [degrees] F [fahrenheit]). As sink is filling, press the UltraActive Sanitizer 3 chemical button 1 time and fill to line designated on outside of sink. This chemical has been calibrated by the designated chemical company for proper concentrate. 2. Once sink is filled to line, tear off a section of the pH test strip and dip paper into the test solution. Remove at once. Immediately compare to color chart on the front of the pH test strip dispenser. 3. Proper pH level	F 371	1. Scoops will not be left in any food product containers within the facility to ensure food is stored, prepared, distributed and served under sanitary conditions. Culinary staff will properly mix sanitizer to 200ppm to ensure food contact surfaces are properly sanitized and that food is stored in a sanitary manner so that residents who eat food prepared in the facility are not at risk for foodborne illness. 2. Scoops will not be left in any food product containers within the facility to ensure food is stored, prepared, distributed and served under sanitary conditions. Culinary staff will properly mix sanitizer to 200ppm to ensure food contact surfaces are properly sanitized and that food is stored in a sanitary manner so that residents who eat food prepared in the facility are not at risk for foodborne illness. 3. The current policy/procedure for food storage and sanitizer dispensing has been reviewed by culinary supervisor. All staff will		

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F 371	Continued From page 58 for this chemical sanitizer is 200 ppm [parts per million] not to exceed 1000 ppm. 4. To fill a bucket with UltraActive Sanitizer 3, dip bucket into full sink and test with PH test strip by following directions outlined above or measure 1/4 teaspoon of UltraActive Sanitizer 3 solution and mix with 1 gallon water . . ." - During the Initial tour of the south kitchen on 06/16/14 at 2:45 p.m., an administrative dietary staff member (#24) tested a sanitization bucket used for food contact surfaces. The concentration of the solution measured 100 ppm. The administrative dietary staff member (#24) confirmed the concentration of the solution was lower than 200 ppm and discarded the solution. A dietary staff member (#25) attempted to prepare the sanitizing solution in the bucket. An administrative dietary staff member (#24) instructed the dietary staff member (#25) on how to properly prepare the sanitizing solution by filling the sink, dispensing the sanitizer, dipping the bucket into the sink, and testing the concentration of the solution with a pH strip. The administrative dietary staff member (#24) confirmed the concentration of the solution was 200 ppm. During an interview on 06/16/14 at 2:45 p.m., an administrative dietary staff member (#24) stated the sanitization buckets are changed twice a day. During the tour of the kitchen on 06/16/14 at 3:30 p.m., an administrative dietary staff member (#24) tested a sanitization bucket used for food contact surfaces (countertops). Observation showed an unidentified dietary staff member preparing buttered bread (ready to eat food) on the counter. The concentration of the solution measured 100 ppm. The administrative dietary	F 371	be in serviced regarding food storage on 7/30/2014 and culinary staff will be in serviced regarding sanitizer dispensing on 7/31/2014. 4. 8/4/2014 5. Audits will be completed initially by the culinary supervisor to assure all food product containers within the facility are free of scoops and sanitizer dispensing at proper chemical levels to ensure all food contact surfaces are properly sanitized and food is stored, prepared, distributed and served under sanitary conditions so that residents who eat food prepared in the facility are not at risk for foodborne illness. Audits will then be completed monthly for the first quarter, then quarterly for one year. Results of monitoring will be reported to the QA Committee at each scheduled meeting (at least quarterly). Culinary supervisor will follow up on further education/training on an as needed basis.		

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F 371	Continued From page 59 staff member (#24) confirmed the concentration of the solution was lower than 200 ppm.	F 371			
F 431 SS=D	- Observations on 06/18/14 at 4:20 p.m. showed a scoop left in the flour container and the coffee container in the activity kitchenette. In the special care unit kitchenette, a scoop was left in the thick-it container, the coffee container, and the flour container. The handles of all of the scoops were in direct contact with the food products. 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	1. Resident #13 discharged. 2. All licensed nursing staff that check-in medications will assure the contents of a medication cassette match the label and physician's order for all residents. 3. The Director of Nursing will review/revise the policy for Checking in Ordered Medications from Pharmacy. The Director of Nursing will train all licensed nursing staff the check-medications in to assure the contents of each medication cassette match the label and physician's order. 4. 08/04/2014		

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F 431	Continued From page 60 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: Based on observation, record review, and staff interview, the facility failed to ensure contents of a medication cassette matched the label and physician's order for 1 of 1 sampled resident (Resident #13) reviewed during an observation of the South unit medication cart. Failure to correctly label the contents of medication cassettes may result in the wrong dose of medication administered to residents. Findings include: An observation, on 06/18/14 at 4:25 p.m., of the South unit medication cart identified a medication cassette for Resident #13. The cassette's label, dated 05/25/14, identified Ativan 0.5 milligrams (mg), 1 tablet every 6 hours as needed (PRN). Four of the cassette compartments contained two 0.5 mg tablets, and one compartment contained one 0.5 mg tablet. Review of Resident #13's Individual Narcotic Record indicated "Directions for Usage - Lorazepam [Ativan] 1 mg TID [three times daily] (give 2 [two] 0.5 mg Tabs)." Review of Resident #13's most current physician's order, dated 05/24/14, verified Ativan 0.5 mg tablet every six hours as needed.	F 431	5. Audits will be completed initially by the administrative nursing staff to monitor all licensed nursing staff that check-in medications from pharmacy assure the contents of each medication cassette match the label and physician's order. Audits will then be completed monthly for the first quarter, then quarterly for a year. Results of monitoring will be reported to the QA Committee at each schedule meeting (at least quarterly). Administrative nursing staff will follow up on further education/training on an as needed basis.		

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F 431	Continued From page 61 During an interview on 06/19/14, a nursing staff member (#19) verified the contents of the Ativan medication cassette did not match the pharmacy label. The cassette should contain single doses of Ativan 0.5 mg in each compartment not the observed two 0.5 mg tablets. She agreed the Narcotic Record sheet incorrectly identified an Ativan 1 mg dose instead of the correct 0.5 mg dose. Staff did not administer any doses from the cassette since the 05/24/14 physician's order.	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.	F 441	1. The glucometer will be cleaned appropriately and per facility policy and manufacturer's recommendations to prevent spread of infections. 2. Each time the glucometer is used, it will be cleaned appropriately and per facility policy and manufacturer's recommendations to prevent the spread of infections. 3. The Director of Nursing will create a new policy/procedure for Glucometer Cleaning. All licensed nursing staff that uses the glucometer will be trained regarding Glucometer Cleaning by the Administrative nursing staff.		

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NAME OF PROVIDER OR SUPPLIER ST CATHERINES LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1307 N 7TH ST WAHPETON, ND 58075		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 441	Continued From page 62 (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, review of policy and procedure, and staff interview, the facility failed to ensure staff followed infection control practices for cleaning the blood glucose monitor during observations of blood glucose monitors on 3 of 4 medication carts (Units 100, 200 [and special care unit (SCU)], and 500). Failure to disinfect the glucometer after each resident use has the potential to spread infection to residents and staff. Findings include: Review of the facility policy titled "Glucometer Cleaning" occurred on 06/19/14. This undated policy stated, "... If a glucometer that has been used for one resident must be reused for another resident, the device must be cleaned and disinfected. Glucometers single or multiple use, need to be cleaned according to the manufacturers recommendations for each brand/model the facility utilizes. PROCEDURE . . . 3. Ensure the glucometers are cleaned in the resident's room. . . ." Review of the manufacturer's guidelines for the	F 441	4. 08/04/2014 5. Audits will be completed initially by the administrative nursing staff to monitor all licensed nursing staff that uses the glucometer to assure the glucometer is cleaned appropriately to prevent the spread of infections. Audits will then be completed monthly for the first quarter, then quarterly for a year. Results of monitoring will be reported to the QA Committee at each schedule meeting (at least quarterly). Administrative nursing staff will follow up on further education/training on an as needed basis.		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 441	Continued From page 63 facility's blood glucose monitoring system occurred on 06/19/14. The guidelines stated, "... Cleaning & Disinfecting Guidelines ... clean and disinfect meters between each patient test to avoid cross-contamination issues ... To clean the meter, clean the outside of the meter with a lint-free cloth, dampen with soapy water or isopropyl alcohol (70% - 85%), and wipe down the meter ... To disinfect the meter ... bleach ... 1:10 dilution ... Super Sani-Cloth and Sani-Cloth HB Germicidal Disposable Wipe. ..." During an observation, on 06/17/14 from 5:20 p.m. to 6:00 p.m., a nursing staff member (#21) took the glucometer from the 100 unit medication cart into Resident #23's room, laid it on the bed, completed the blood glucose check, left the room, and placed the glucometer on top of the medication cart. The nurse did not clean or disinfect the glucometer before or after leaving the resident's room. - Review of the 500 unit medication cart occurred on 06/18/14 at 3:05 p.m. with a licensed nurse (#7). When asked how staff clean the blood glucose monitor after use, the nurse (#7) pointed to a supply of alcohol wipes, located in the medication cart next to the monitor, and stated staff clean the monitor with the alcohol wipes. During interviews on 06/18/14 at 11:05 a.m. and 4:15 p.m., two nursing staff members (#19 and #22) verified each medication cart contained one glucometer staff used for all resident blood glucose checks. Staff did not consistently clean the glucometer between each resident use and used only alcohol wipes to clean the glucometer. - Review of the medication cart, used for the 200	F 441			

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F 441	Continued From page 64 unit and the SCU, occurred on 06/19/14 at 8:45 a.m. with a licensed nurse (#9). When asked how staff clean the blood glucose monitor after use, the nurse (#9) stated staff clean the monitor with alcohol wipes. During an interview on 06/19/14 at 9:00 a.m., an administrative nurse (#2) indicated staff use the disinfectant wipes recommended by the manufacturer to disinfect the glucometer between each resident use. A nursing staff member (#19) verified the 100 unit had none of the required disinfectant wipes in stock.	F 441			
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to implement a system to ensure call lights functioned in the tub and shower rooms in 1 of 3 resident care units (North Unit). Failure to ensure a functioning call system in the tub and shower rooms placed residents and staff at risk of not receiving assistance when needed. Findings include: A tour of the environment occurred on 06/18/14 at 9:30 a.m. with two environmental managers (#4 and #5). Observation showed a shower room at the west end of the 600 hallway and a tub room	F 463	1. 2. Facility bathing rooms, showers and resident public toilet rooms will be monitored to assure operation of an emergency call light system. An audit/ checklist will be completed daily by facility bath aid. 3. A policy & procedure will be created and educated to staff responsible for the completion of this audit. This audit will be reviewed/monitored weekly x2, monthly x2, and then quarterly by the director of Plant Operations.		

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F 463	Continued From page 65 located across the hall from the shower. Observation in the tub and shower rooms identified the call system at the shower, tub, sink, and toilet not functioning. On 06/18/14 at 10:47 a.m., an interview occurred with a Certified Nursing Assistant (CNA) (#20) assigned to assist with bathing on the North Unit that morning. The CNA (#20) stated she was not aware the call system in the North tub and shower rooms was not functioning. On 06/18/14 at 12:30 p.m. observation in the tub and shower rooms with an administrative nurse (#2) identified the call system functioning. An interview occurred with the manager (#4) at 12:45 p.m. The staff member (#4) stated, when reviewing the system, he found a "power surge" had occurred on 06/18/14 at 12:45 a.m. He stated he "reset" the system and the call lights again functioned. Failure to implement a system for monitoring call light function in tub and shower areas placed residents at risk of not receiving necessary assistance.	F 463	This documentation will be filed for reference. Audits will be reported and reviewed quarterly by Quality Council. 2 4. Completion Date: 08/04/2014		