STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355070	A. BUILDING _____ B. WING _____	09/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHEL LUTHERAN NURSING & REHABILITATION CENTER	**1515 2ND AVE WEST WILLISTON, ND 58801**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey started on September 21, 2015 and completed on September 24, 2015, the sample included five (5) residents for complete review, sixteen (16) residents for focused review, and three (3) closed records for review. The sample included eight (8) additional residents to verify specific concerns during the survey.	F 000		
F 156	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		10/29/15

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

Electronically Signed | 10/19/2015

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

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F 156	Continued From page 2 the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on review of the facility's Medicare billing notices/records, the facility failed to confirm a request for a demand bill for 2 of 4 (Resident #25 and Resident #25) billing records reviewed which required a notice of non-coverage of Medicare services. Failure to confirm a resident and/or their responsible party requested a demand bill is a violation of resident rights. Findings include: Review of the facility's Medicare billing records occurred on 09/23/15 and showed the following: - Resident #25's responsible party received notification of the non-coverage of Medicare services via telephone on 08/25/15. An administrative staff member (#4) signed for the responsible party and failed to check the box to indicate a request for a demand bill or not.	F 156	Correction: Page #3 of 43 line 17 should read "#25 and Resident #26). 1. For Resident #25 and #26, the notification of non-coverage of Medicare services will be corrected by contacting the responsible party and checking the box to indicate a request for a demand bill or not. 2. All residents who receive notification of non-coverage of Medicare Services via telephone and do not return mailed copy have the potential to be affected. 3. A new procedure for reviewing notification of the non-coverage of Medicare service will be developed. 4. October 29, 2015. 5. The Director of Finance will be responsible to monitor notifications of the non-coverage Medicare service weekly	

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F 156	Continued From page 3 - Resident #26's responsible party received notification of the non-coverage of Medicare services via telephone on 07/03/15. An administrative staff member (#1) signed for the responsible party, but failed to identify, by checking a box, whether the responsible party requested a demand bill or not.	F 156	for four weeks, monthly for three months, and quarterly for three quarters. Results will be reported to the Administrator. If concerns are identified, immediate corrective action will be implemented. The Director of Finance will submit a report of the monitoring results to the QA committee monthly for three months, then quarterly for three quarters.	
F 225	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 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	F 225		10/29/15

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F 225	Continued From page 4 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, review of facility policy, and staff interview, the facility failed to ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown origin, were reported immediately to the administrator for 1 of 3 sampled residents (Resident #1) with an injury of unknown origin. Failure to identify, report, and investigate injuries of unknown origin placed all residents at risk for mistreatment and abuse. FINDINGS INCLUDE: - Review of facility policy titled "Investigation of Injury of Unknown Origin" occurred on 09/24/15. This policy, dated 09/15, stated "Policy: To report and investigate all injuries of unknown origin . . . Procedure 1. The daily report by the Neighborhood Nurse Manager is to include all injuries of unknown origin . . . 2. A progress note will be completed . . . to include information, but not limited to date and time identified, description of identified injury, interventions/treatment	F 225	1. Resident #1 May 25, 2015 bruise was investigated. Staff interviewed do not recall any incident. Staff members involved in the care provided to Resident #1 were re-educated in process of investigating bruises. 2. Any resident has the potenital to be affected. 3. Mandatory nursing in-services were held on October 14 & 15, 2015 and will be on October 27 & 28, 2015 to re-educate staff on Abuse and neglect and investigation of injury of unknown origin. Reviewed policy and procedure on Abuse Prohibition, Abuse Reporting, Abuse Investigation, and Investigation of Injury of Unknown Origin. In addition to verbal communication, a new alert was added to point click care for Certified Nursing Assistants to notify the Charge Nurse of a bruise. The Charge Nurse's were instructed to address alerts by the end of the work shift. Nurse Managers have	

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F 225	Continued From page 5 administered, and notification of family (and physician if required). . . " Review of Resident #1's medical record occurred on all days of survey, and identified a diagnosis of Dementia. The resident's quarterly Minimum Data Set (MDS), dated 06/10/15, identified moderate cognitive impairment, and extensive assist of one staff for activities of daily living (ADLs). Review of Resident #1's physician fax form, dated 05/26/15, stated, "Bruise noted to right upper thigh area measures 4 cm [centimeters] X 1 cm purple in color." A weekly skin integrity assessment completed 05/29/15 showed skin intact, and no bruises. During an interview on 09/23/15 at 3:52 p.m., an administrative staff member (#1), failed to provide documentation that the facility investigated Resident #1's bruise of unknown origin. This staff member expected all bruises of unknown origin to be reported and investigated to determine the cause.	F 225	been instructed to review alert report daily. Will continue with requirements that staff complete upon hire and at least annual reviewing of the Policy and Procedures for Abuse and Neglect and complete the abuse health care academy course. 4. October 29, 2015. 5. The Nurse Manager (or designee) will review alert report of bruises daily. The Director of Nursing Services will run a report of the alerts daily for 4 weeks, then one time per week for 4 weeks, then monthly for 10 months. The Director of Nursing Services (or designee) will report results of the monitoring to the QA committee monthly for 12 months.	
F 241	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed	F 241	A. 1. Staff member caring for Resident #4 was re-educated to sit when assisting	10/29/15

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F 241	Continued From page 6 to provide care in a manner that enhanced dignity/self-esteem for 7 of 29 sampled residents (Resident #4, #16, #27, #28, #29, #30, and #31). Failure to ensure dignity and respect during personal cares does not recognize the individuality of each resident or enhance the quality of life for each resident. Findings include: Review of facility policy titled "Activities of Daily Living" occurred on 09/24/15. This policy, dated July 2014, stated, " . . . 2. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene." - Review of Resident #4's medical record occurred on September 21-24, 2015. The quarterly Minimum Data Set (MDS), dated 06/13/15, identified severely impaired cognitive skills and total assistance required for eating. Observation on 09/22/15 at 8:02 a.m., showed a nurse (#3) standing over Resident #4 as she attempted to feed her. The resident was resistive to all feeding attempts, turning her head away from the nurse (#3). During an interview on the morning of 09/24/15, two administrative staff members (#1 and #2) confirmed staff should be seated when feeding a resident. - Observation during breakfast on 09/22/15, in the Harmony dining room, showed an unidentified certified nurse aide (CNA) provided	F 241	Resident with eating and if resident resists feeding attempts to leave and return, attempt other food, attempt another staff member, or offer nutritional supplement at a later time. Staff member caring for Resident #31 was re-educated to not utilize an eating utensil or clothing protector to clean face, but to utilize a napkin. 2. All resident who require the assistance for eating have the potential to be affected. 3. Mandatory nursing in-services were held on October 14th & 15th, 2015 and will be held on October 27th & 28th, 2015 to re-educate on proper assistance for residents who require assistance with eating. 4. October 29, 2015. 5. Assistant Director of Nursing Services (or designee) will monitor dining rooms (i.e. staff sitting while assisting residents with eating and use of napkin to clean face) weekly for one month, then monthly thereafter. If concerns are identified, immediate corrective action will be implemented. The Assistant Director of Nursing Services (or designee) will report results of monitoring to the QA committee monthly. B. 1. For Resident #27 & #28 staff were re-educated on shaving of female resident faces. Care plan for Resident #27 was updated to include that Resident at times refuses to have face shaved. Care plan for Resident #28 was updated to include family requests to not shave	

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F 241	Continued From page 7 feeding assistance to Resident #31. The CNA used a spoon, scraped food off the resident's lower lip/chin twice, returned the spoon to the cereal bowl, and re-fed the food to the resident with the next bite of food. On approximately four occasions, rather than wiping Resident's #13's mouth with a napkin, the CNA used the resident's clothing protector. - Observation on 09/22/15 at 8:18 a.m., showed a female resident (Resident #27) with excessive facial hair on her upper lip and chin. - Observation on 09/22/15 at 11:16 a.m., showed a female resident (Resident #28) with excessive facial hair on her upper lip, chin, and cheeks. - Random observation on the afternoon of 09/22/15 showed an unidentified nurse administering insulin to an unidentified resident sitting in the Wheatland nurse's station partially concealed behind a curtain. The nurse raised the resident's shirt and exposed his abdomen to anyone approaching from the other side of the privacy screen. - Observation on 09/22/15 at 11:33 a.m. showed a staff nurse (#5) administered insulin to Resident #16 who was partially concealed with a privacy screen near the Wheatland lounge. The staff nurse raised the resident's shirt and exposed his abdomen to anyone in the lounge to view. -Observation on the afternoon of 09/23/15 showed a certified medication aide (CMA) (#5) administered insulin to Resident #16 who was partially concealed with a privacy screen, near	F 241	resident face. 2. All residents have the potential to be affected. 3. Mandatory nursing in-services were held on October 14th & 15th, 2015 and will be held on October 27th & 28th, 2015 to re-educate staff on shaving of female residents and if refusal is noted that this is documented and care planned. 4. October 29, 2015. 5. The Nurse Manager (or designee) will monitor female resident for shaving of facial hair. The monitoring will be conducted weekly for four weeks, monthly for three months, then quarterly for three quarters. If concerns are identified, immediate corrective action will be implemented. The Director of Nursing Services (or designee) will report results of monitoring monthly for three months, then quarterly for three quarters. C. 1. Staff caring for Resident's #16, #29, and #30 were re-educate to protect resident privacy by providing insulin injections in rooms with closed doors. 2. All resident who require injections have the potential to be affected. 3. Mandatory nursing in-services were held on October 14th & 15th, 2015 and will be held on October 27th & 28th, 2015 to re-educate staff to complete injections behind closed doors. Portable privacy screens were removed from the neighborhoods. 4. October 29, 2015. 5. The Nurse Manager (or designee) will monitor staff when providing injections to	

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F 241	Continued From page 8 the Wheatland dining room. The CMA raised the resident's shirt and exposed his abdomen for anyone in the dining room to view. -Observation on 09/22/15 at 11:37 a.m. showed a staff nurse (#5) administered insulin to Resident #29 who was partially concealed with a privacy screen near the Wheatland lounge. The staff nurse raised the resident's shirt and exposed her to anyone sitting in the lounge to view. -Observation on 09/22/15 at 11:43 a.m. showed a staff nurse (#5) administered insulin to Resident #30 who was partially concealed with a privacy screen near the Wheatland lounge. The staff nurse raised the resident's shirt and exposed her for anyone in the lounge to view. The privacy screen failed to appropriately conceal the residents while receiving treatment. During an interview on 09/23/15 at 5:30 p.m., an administrative staff member (#1) and a supervisory nurse (#2) stated the portable privacy screens are used to assure resident privacy and should conceal the resident from being viewed by other residents, staff, or family members.	F 241	residents. The monitoring will be conducted weekly for four weeks, monthly for three months, then quarterly for three quarters. If concerns are identified, immediate corrective action will be implemented. The Director of Nursing Services (or designee) will report results of monitoring monthly for three months, then quarterly for three quarters.	
F 278	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.	F 278		10/29/15

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F 278	Continued From page 9 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: THIS IS A REPEAT DEFICIENCY FROM THE SURVEYS COMPLETED ON 08/21/14. Based on record review and review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual (Version 3.0) the facility failed to ensure the Minimum Data Sets (MDSs) accurately reflected the residents' status for 17 of 21 sampled residents (Resident #1, #3, #4, #5, #7, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #20, and #21) and 2 of 3 closed resident records (Resident #23 and #24) reviewed. Failure to accurately code skin treatments does not allow the residents'	F 278	1. Last Omnibus Budget Reconciliation Act (OBRA) minimum data set (MDS)(and if Medicare A beneficiary Resident the last prospective payment system MDS assessment) for Resident #1, #3, #4, #5, #7, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #20, and #21 will be corrected for section M1200D. 2. All Residents MDS's have the potential to be affected. 3. Joan Coleman, State RAI Coordinator and State Training Coordinator, was contacted to review the requirements for item M1200D. Education was provided to	

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F 278	Continued From page 10 assessments to reflect their current status/needs, and has the potential to affect the care provided to these residents. Findings include: Section M1200D (Nutrition or Hydration Intervention to Manage Skin Problems) of the RAI Manual, October 2014, page M-38 and M-39, stated, "The determination as to whether or not one should receive nutritional or hydration interventions for skin problems should be based on an individualized nutritional assessment. . . . If it is determined that nutritional supplementation, i.e. adding additional protein, calories, or nutrients is warranted, the facility should document the nutrition or hydration factors that are influencing skin problems and/or wound healing and 'tailor nutritional supplementation . . . and obtain dietary consultation as needed, . . ." Review of the medical records for Resident #1, #3, #4, #5, #7, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #20, #21, #23, and #24 occurred on September 21-24, 2015. - Resident #9's annual MDS, dated 06/16/15, identified the resident not at risk for pressure ulcers and received nutrition/hydration interventions to manage skin problems. The medical record lacked an individualized nutritional assessment to indicate a need for nutrition or hydration interventions for the purpose of preventing or treating specific skin conditions. - Resident #7's admission MDS, dated 11/20/14, identified nutrition or hydration interventions to	F 278	the Dietitian and MDS Coordinator by Joan Coleman. The last OBRA MDS (and if Medicare A beneficiary Resident the last prospective payment system MDS assessment)for each Resident in the facility are being reviewed by the Registered Dietitian and if required corrected and re-submtted to the State and/or CMS. All dietary staff who complete section M1200D of the MDS have been educated to consult the dietitian (or designee) and/or the individualized nutritional assessment for proper coding. 4. October 29, 2015. 5. The Registered Dietitian (or designee) will monitor accuracy of 100% of the MDS's for section M1200D prior to submission. The Registered Dietitian (or designee) will report results of the monitoring to the MDS Coordinator on a weekly basis for one month, then monthly for 11 months. If concerns are identified, immediate corrective action will be implemented. The MDS Coordinator will submit a report of the monitoring results to the QA Committee monthly for 12 months.	

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F 278	Continued From page 11	F 278		

manage skin problems. The medical record lacked an individualized nutritional assessment to indicate a need for nutrition or hydration interventions for the purpose of preventing or treating specific skin conditions.

- Resident # 16's annual MDS, dated 03/12/15, and two quarterly MDS, dated 06/05/15 and 09/05/15, identified nutrition or hydration interventions to manage skin problems. The medical record lacked an individualized nutritional assessment to indicate a need for nutrition or hydration interventions for the purpose of preventing or treating specific skin conditions.

- Resident #3's quarterly MDS, dated 07/14/15, and annual MDS, dated 01/14/15, identified nutrition or hydration interventions to manage skin problems. Both the quarterly and annual MDS indicated no risk for pressure ulcers and no wounds or skin problems. The medical record lacked an individualized nutritional assessment to indicate a need for nutrition or hydration interventions for the purpose of preventing or treating specific skin conditions.

- Resident #20's annual MDS, dated 07/15/15, and quarterly MDS, dated 04/15/15, identified nutrition or hydration interventions to manage skin problems. The medical record lacked an individualized nutritional assessment to indicate a need for nutrition or hydration interventions for the purpose of preventing or treating specific skin conditions.

- Resident #4's two significant change MDSs, dated 04/07/15 and 05/29/15, and one quarterly

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F 278	Continued From page 12 MDS, dated 06/13/15, identified nutrition or hydration interventions to manage skin problems. The nutritional assessments, dated 03/23/15 and 06/01/15, stated, ". . . No pressure ulcers . . ." The dietary progress note, dated 04/10/15, also stated, ". . . Skin intact . . ." The medical record lacked an individualized nutritional assessment indicate a need for nutrition or hydration interventions for the purpose of preventing or treating specific skin conditions. - Resident #5's quarterly MDS, dated 09/01/15, identified nutrition or hydration interventions to manage skin problems. The nutritional assessment, dated 09/01/15, stated, ". . . skin intact . . ." The medical record lacked an individualized nutritional assessment to indicate a need for nutrition or hydration interventions for the purpose of preventing or treating specific skin conditions. - Resident #17's annual MDS, dated 04/01/15, and quarterly MDS, dated 07/01/15, identified nutrition or hydration interventions to manage skin problems. The nutritional assessment, dated 04/01/15, stated, ". . . Hx [History] of pressure ulcers, skin is currently intact. . . ." The medical record lacked an individualized nutritional assessment to indicate a need for nutrition or hydration interventions for the purpose of preventing or treating specific skin conditions. - Resident #23's quarterly MDS, dated 01/22/15, identified nutrition or hydration interventions to manage skin problems. The medical record lacked an individualized nutritional assessment to indicate a need for nutrition or hydration interventions for the purpose of preventing or	F 278		

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F 278	Continued From page 13 treating specific skin conditions. - Resident #1's quarterly MDS, dated 06/10/15, identified nutrition/hydration interventions to manage skin problems. The medical record lacked an individualized nutritional assessment to indicate a need for nutrition or hydration interventions for the purpose of preventing or treating specific skin conditions. - Resident #18's quarterly MDS, dated 04/21/15, and annual MDS, dated 07/21/15, identified nutrition/hydration interventions to manage skin problems. The medical record lacked an individualized nutritional assessment to indicate a need for nutrition or hydration interventions for the purpose of preventing or treating specific skin conditions. - Resident 10's significant change MDS, dated 08/03/15, and quarterly MDS, dated 05/03/15, identified nutrition or hydration interventions to manage skin problems. The medical record lacked an individualized nutritional assessment to indicate a need for nutrition or hydration interventions for the purpose of preventing or treating specific skin conditions. - Resident 11's quarterly MDS, dated 08/27/15, and significant change MDS, dated 07/17/15, identified nutrition or hydration interventions to manage skin problems. The medical record lacked an individualized nutritional assessment to indicate a need for nutrition or hydration interventions for the purpose of preventing or treating specific skin conditions. - Resident 12's quarterly MDS, dated 07/24/15,	F 278		

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F 278	Continued From page 14 and admission MDS, dated 04/26/15, identified nutrition or hydration interventions to manage skin problems. The medical record lacked an individualized nutritional assessment to indicate a need for nutrition or hydration interventions for the purpose of preventing or treating specific skin conditions. - Resident 24's quarterly MDS, dated 08/20/15, identified nutrition or hydration interventions to manage skin problems. The medical record lacked an individualized nutritional assessment to indicate a need for nutrition or hydration interventions for the purpose of preventing or treating specific skin conditions. - Resident #13's annual MDS, dated 07/03/15, and quarterly MDS, dated 04/30/15, identified nutrition or hydration interventions to manage skin problems. Both the annual and quarterly MDS indicated no risk for pressure ulcers and no wounds or skin problems. The medical record lacked an individualized nutritional assessment to indicate a need for nutrition or hydration interventions for the purpose of preventing or treating specific skin conditions. - Resident #14's quarterly MDS, dated 06/25/15, and annual MDS, dated 12/25/14, identified nutrition or hydration interventions to manage skin problems. Both the quarterly and annual MDS indicated no risk for pressure ulcers and no wounds or skin problems. The medical record lacked an individualized nutritional assessment to indicate a need for nutrition or hydration interventions for the purpose of preventing or treating specific skin conditions.	F 278		

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F 278	Continued From page 15 - Resident #15's quarterly MDS, dated 07/1/15, and admission MDS, dated 01/28/15, identified nutrition or hydration interventions to manage skin problems. Both the quarterly and annual MDS indicated no risk for pressure ulcers and no wounds or skin problems. The medical record lacked an individualized nutritional assessment to indicate a need for nutrition or hydration interventions for the purpose of preventing or treating specific skin conditions. - Resident #21's quarterly MDS, dated 07/03/15, and significant change MDS, dated 04/25/15, identified nutrition or hydration interventions to manage skin problems. Both the quarterly and significant change MDS indicated no risk for pressure ulcers and no wounds or skin problems. The medical record lacked an individualized nutritional assessment to indicate a need for nutrition or hydration interventions for the purpose of preventing or treating specific skin conditions.	F 278		
F 281	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS 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, record review, review of facility policy, manufacturer's recommendations, and staff interview, the facility failed to provide services to meet professional standards of practice for 3 of 21 sampled residents (Resident #3, #5, and #6) and 2 of 2 supplemental residents (Resident #26 and #32). Failure to	F 281	A. 1. All Licensed Nursing staff were re-educated on the process for obtaining orders for Resident #5. 2. All Resident's have the potential to be affected. 3. Policy and Procedure for Physician Medication orders was reviewed and	10/29/15

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F 281	Continued From page 16 ensure nursing staff followed the six rights of medication administration for Resident #3, #5, #6, and #32 and to correctly prime an insulin pen for Resident #26 may result in medication errors for all residents. Findings include: Review of the manufacturer's instructions for the "HUMALOG Mix 75/25 KwikPen" occurred on 09/24/15. The instructions stated, ". . . Preparing HUMALOG Mix75/25 KwikPen: . . . Step 4: Push the capped Needle straight onto the Pen and turn the Needle forward until it is tight. Step 5: Pull off the Outer Needle Shield. Do not throw it away. Pull off the Inner Needle Shield and throw it away. Priming your HUMALOG Mix 7/25 KwikPen: Prime before each injection. priming ensures the pen is ready to dose and removes air that may collect in the cartridge during normal use. If you do not prime before each injection, may may get too much or too little insulin. . . . Step 6: Turn the Dose Knob to select 2 units. Step 7: Hold your Pen with the Needle pointing up. Tap the Cartridge Holder gently to collect air bubbles at the top. Step 8: Hold your Pen with Needle pointing up. Push the Dose Knob in until it stops, and "0" is seen in the Dose Window. Hold the Dose Knob in and count to 5 slowly. A stream of insulin should be seen from the needle. If you do not see a stream of insulin, repeat steps 6-8, no more than 4 times. If you still do not see a stream of insulin, change the needle and repeat steps 6 to 8. . . ." - Review of Resident #5's medical record occurred on September 21-24, 2015. Diagnoses included traumatic head injury and history of	F 281	revised. Licensed Nursing Staff were re-educated on the process of obtaining medication orders (notify primary care physician, if required recall, call on-call physician if after hours, and if no response notify the Medical Director). This re-education was completed on October 14th & 15th, 2015 and will be on October 27th & 28th, 2015. 4. October 29, 2015 5. The Neighborhood Nurse Manager (or designee) will monitor electronic medication administration records for missed doses of medications weekly for four weeks, then monthly. The Neighborhood Nurse Manager will report monitoring results to the Director of Nursing Services. If concerns are identified, immediate corrective action will be implemented. The Director of Nursing Services (or designee) will report monthly at QA committee. B. 1. Resident #3's electronic medication administration record was changed from 0.5 mg to 1 mg tablet of resperidone. 2. All Resident's have the potential to be affected. 3. Re-educated Licensed Nursing Staff on process of one licensed nurse entering the paper physician order into the electronic medical record and the second nurse reviewing the entered order. Once the Licensed Nurse has completed the process each nurse will sign the paper order verifying the process has been completed. Licensed Nursing staff were re-educated on the process of entering	

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F 281	Continued From page 17 pulmonary embolism. The progress notes identified the following: * 06/05/15 at 10:50 a.m., "Phone call from [physician's] nurse . . . to d/c [discontinue] coumadin and start resident on xarelto 20 mg at supper. Script sent to pharmacy to be filled. Phone call from pharmacy prior authorization needed to fill Xarelto. Informed [physician's] nurse about this waiting on response." * 06/06/15 at 4:24 p.m., "awaiting from pharmacy needs prior authorization per pharmacy." * 06/07/15 at 4:43 p.m., "awaiting prior authorization from insurance to cover medication doctor aware" * 06/08/15 at 5:07 p.m., "med [medication] not available. insurance would not pay for prescription, physician called x [times] 2 today for any new orders. awaiting response." * 06/09/15 at 9:41 a.m., "Writer spoke with [physician's] nurse related to xarelto no [sic] being available as it is not covered by resident's insurance. Nurse stated [physician] is aware of this and is aware that resident has not had medication for three [four] days. She states that [physician] will be writing new orders. Waiting for return call." * 06/0915 at 3:37 p.m., "Received order for coumadin 6 mg [milligrams] PO [orally] daily. . . ." During an interview on 09/23/15 at 4:45 p.m., an administrative staff member (#2) reported staff should begin by contacting the resident's attending physician. If they do not receive a response, they should then contact the on-call physician and/or the medical director for assistance.	F 281	physician order in the electronic medical record. Re-education was completed on October 14th & 15th, 2015 and will be on October 27th & 28th, 2015. 4. October 29, 2015. 5. The Health Information staff will monitor all paper physician orders to check for two licensed nurse signatures. The results of monitoring will be given to the Director of Nursing Services weekly for review. If concerns are identified, immediate corrective actions will be implemented. These results will be reported to the QA committee by the Director of Nursing Services (or designee) monthly for 12 months. C. 1. Resident #6 order for when to administer ativan was clarified. 2. All Resident's have the potential to be affected. 3. The facility will continue process of comparing the physician order to the physician visit (dication) notes. All Licensed Nursing staff will be re-educated on process October 27th & 28th, 2015. 4. October 29, 2015. 5. The Health Information staff will monitor for the signature of the Nurse Manager (or designee) on all physician visit (dictation) note. The results of the monitoring will be given to the Director of Nursing Services weekly for review. If concerns are identified, immediate corrective actions will be implemented. These results will be reported to the QA committtte by the Director of Nursing Services (or designee) monthly for 12	

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F 281	Continued From page 18 Failure to ensure medication is available and administered per physician's order may result in adverse consequences for Resident #5. - Review of Resident #3's medical record occurred on all days of survey. Diagnoses included unspecified psychosis, Alzheimer's disease, and dementia with behavioral disturbances. Review of Resident #3's physician's order, dated 01/12/15, indicated an increase of risperidone from 0.5 milligrams (mg) to 1 mg every HS. Observation of the label on Resident #3's blister pac containing the risperidone tablets stated, "risperidone 1 mg every HS." Resident #3's September 2015 electronic medication administration record (EMAR) identified, "Risperidone Tablet 1 MG [milligram]. Give 1 mg by mouth one time a day related to UNSPECIFIED PSYCHOSIS . . . 0.5 MG Tablet Oral (By mouth) . . . 1 tab po [by mouth] Q [every] HS [hour of sleep]." During an interview on 09/22/15 at 4:55 p.m., a supervisory nurse (#10) verified the September 2015 EMAR failed to accurately reflect the physician's order for risperidone 1 mg every HS started on 01/12/15. Staff failed to clarify the order and delete the 0.5 mg dose from the EMAR. - Review of Resident #6's medical record occurred on all days of the survey. Review of the psychiatrist's progress note, dated 08/10/15, identified a diagnosis of "unspecified anxiety" and the treatment plan included to start Ativan 0.5 mg (milligrams) by mouth twice daily at 8:00 a.m. and	F 281	months. D. 1. Resident #32 Lipitor was re-entered into the electronic medical record for at bedtime. 2. All Residents have the potential to be affected. 3. Residents who are either admitted or re-admitted to the facility will have medication reconciliation completed. Worksheet to be utilized will be Interact II Version 4.0 tool "Medication Reconciliation Worksheet for Post-Hospital Care." All Licensed Nursing staff were educated on the use of the form on October 14th & 15th, 2015 and will be October 27th & 28th, 2015. Policy and Procedure for Medication Monitoring was reviewed and revised. Policy and Procedure was developed for Medication Reconciliation. 4. October 29, 2015. 5. Each Neghborhood Charge Nurse will record monitoring of accuracy of label of medication card to physician order for each medication card received from the pharmacy. The evening RN House Supervisor will re-check random medication card label with physician order two times per week on each neighborhood. Any discrepancies will be immediately report to the Neighborhood Nurse Manager. Monitoring results will be reported to the Director of Nursing Services (or designee) weekly for one month, then monthly for 11 months. The Health Information staff will monitor for the "Medication Reconciliation Worksheet	

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F 281	Continued From page 19 4:00 p.m. for anxiety. Review of the August 2015 MAR identified the resident received the medication at 7:00 a.m. and 7:00 p.m., not as prescribed. The September 2015 MAR identified a administration time change to 4:00 p.m. and 9:00 p.m. Review of the psychiatrist's progress note, dated 09/01/15, identified, "Is Ativan causing daytime sedation? . . . [change] dosing times of Ativan to 1800 [6:00 p.m.] [and] HS . . ." A physician progress note, dated 09/01/15 at 4:27 p.m., stated, ". . . Resident seen by [physician] during rounds. Doctor was informed that per night nurse, she has been awake and talkative at night up until one or two in the morning. Seems sleepy in the morning after breakfast. New orders by [physician] to change dosing times to BID at 1600 and HS same dose of Ativan. . . ." The "Medication Review Report," signed by the physician that same day, had a hand written note stating, "Change dosing times to BID [twice daily] at 1600 [4:00 p.m.] [and] HS. . . ." The progress note lacked any indication staff clarified the discrepancy of administration times between the psychiatrist and the physician's order. During an interview on 09/24/15 at 10:20 a.m., an administrative nurse (#11) stated she expected staff to get clarification from physicians when they received unclear orders, and confirmed staff needed to administer medications at the times ordered by the physician. - Observation during medication pass on 09/22/15 at 8:35 a.m. showed a certified	F 281	for Post-Hospital Care" form completion for each resident admitted or re-admitted to the facility. The results of the monitoring will be reported to the Director of Nursing Services (or designee) weekly for 4 weeks, then monthly for 11 months. If concerns are identified, immediate corrective actions will be implemented. These results will be reported to the QA committee by Director of Nursing Services (or designee) monthly. E. 1. Staff member caring for Resident # 26 was re-educated on the process of priming a KwikPen prior to the administration of Insulin. 2. All Resident's receiving insulin via KwikPen have the potential to be affected. 3. Policy and Procedure for priminig of a KwikPen prior to insulin administration was developed. All Licensed Nursing Staff and Certified Medication Aides were re-educated on the process of priming a KwikPen prior to insulin administration. This education was completed on October 14th & 15th, 2015 and will be on October 27th & 28th, 2015. 4. October 29, 2015. 5. The Infection Control Nurse (or designee) will monitor priming of KwikPen prior to insulin administration weekly for 4 weeks, then monthly for 11 months. The results of the monitoring will be reported to the Director of Nursing Services. If concerns are identified, immediate corrective actions will be implemented. The Director of Nursing Services (or designee) will report monthly to the QA	

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F 281	Continued From page 20 medication aide (CMA) (#9) administered medications to Resident #32, including Lipitor (for high cholesterol) 20 mg. The EMAR identified, "Lipitor 20 mg PO daily." The medication blister pac containing the Lipitor stated, "Lipitor 20 mg PO daily HS." During an interview on 09/22/15 at 11:18 a.m., a nurse manager (#10) stated when a new resident comes into the facility, the nurse on duty checks the medication cards [blister pacs with the orders. The nurse manager also stated that Lipitor is typically given at night, and the nurse failed to clarify the discrepancy between the EMAR and the blister pac administration times. - Observation during medication pass on 09/22/15 at 7:50 a.m. showed a nurse (#14) administered insulin to Resident #26. After placing a new capped needle on the KwikPen, the nurse did not remove the outer needle shield (cover). The nurse (#14) primed the insulin pen holding the pen in a horizontal position and pressed the injection button as she held the insulin pen in a horizontal position. The nurse (#14) failed to remove the needle cover, hold the needle pointing upwards, tap the insulin reservoir to expel any air bubbles, expel the insulin in an vertical position, and visualize a stream of insulin. During an interview on 09/23/15 at 5:00 p.m., an administrative staff member (#1) confirmed staff should prime insulin pens in a vertical position and visualize the stream of insulin.	F 281	committe for 12 months.	
F 309	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must	F 309		10/29/15

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F 309	Continued From page 21 provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to provide the necessary care and services to manage behavioral symptoms related to anxiety for 1 of 6 sampled residents (Resident #20) receiving a PRN antianxiety medication. Failure to thoroughly assess the resident's behaviors, implement individualized interventions, including non-pharmacological interventions, and establish on-going monitoring of the behaviors before administering antianxiety medications may result in decreased physical, mental, and psychosocial well-being and negatively impact the resident's quality of life. Findings include: Review of the facility's policy titled "RESIDENT BEHAVIORS" occurred on 09/24/15. This policy, dated August 2014, stated, ". . . BEHAVIORAL INTERVENTIONS 1. Assess for any physical need the resident may have . . . Know your resident's care plan. Know their likes and dislikes and what approaches have worked in the past . . . AFTER A RESIDENT BEHAVIOR OCCURS . . . *Complete the behavior log. . . ." Review of Resident #20's medical record occurred on September 23-24, 2015. Diagnoses	F 309	1. Staff members caring for Resident #20 were re-educated on documenting non-pharmacological approaches prior to administration of as needed ativan. 2. All Residents on as needed antiaxiety medications have the potential to be affected. 3. Process for documentation of behaviors has been adjust from electronic medical record to paper behavioral logs with individualized non-pharmacological approaches to be utilized. The Licensed Nurse's have been re-educated on documentation of identified behavior, non-pharmacological approaches utilized, and effectiveness prior to administration of antiaxiety medications. All nursing staff were re-educated on October 14th & 15th, 2015 and will be on October 27th & 28th, 2015. 4. October 29, 2015. 5. Director of Social Services (or designees) will monitor weekly for four weeks, then monthly for 11 months for documentation of use of non-pharmacological approaches prior to administration of as needed antiaxiety medications. If concerns are identified,	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 22 included anxiety and dementia with behavioral disturbances. The annual Minimum Data Set (MDS), dated 07/15/15, and the quarterly MDS, dated 04/15/15, identified severely impaired cognition, verbal and/or physical behaviors or rejection of care. The current care plan identified interventions related to behaviors as "* Assess and address for contributing sensory deficits, * Assess and anticipate resident's needs: food, thirst. toileting needs, comfort level, body positioning, pain etc. * Give me as many choices as possible about care and activities. I at times refuse cares. * Medication as ordered for anxiety/agitation . . . * Offer to take me for a wheel chair ride . . . *When I become agitated: Intervene before agitation escalates; Guide away from source of distress; Engage calmly in conversation; If response is aggressive, staff to walk calmly away and watch from a distance, and approach later." Review of Resident #20's medication administration record (MAR) from April 2015 through September 22, 2015, showed staff administered Ativan 0.5 milligrams (mg) by mouth as needed for agitation related to anxiety 34 times. Staff failed to identify specific behaviors related to anxiety/agitation and non-pharmacological interventions attempted before administering the PRN Ativan. During an interview on the morning of 09/24/15, two administrative staff members (#1 and #2) confirmed staff should identify and document the residents' behaviors and attempt non-pharmacological interventions prior to administering PRN Ativan.	F 309	immediate corrective actions will be implemented. Results of the monitoring will be reported by the Director of Social Services (or designee) on a monthly basis to the QA committee.	
F 323	483.25(h) FREE OF ACCIDENT	F 323		10/29/15

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F 323	Continued From page 23 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: THIS IS A REPEAT DEFICIENCY FROM THE SURVEYS COMPLETED ON 08/21/14. Based on observation and staff interview, the facility failed to maintain an environment free of accident hazards in 3 of 5 units (Harmony, Legacy, and Wheatland). Failure to secure hazardous chemicals in three separate laundry rooms (Harmony, Legacy, and Wheatland) and one unlocked medication room (Harmony), and failure to secure hazardous materials of two maintenance carts (Wheatland) placed cognitively impaired and wandering residents at risk for accidents/injury. Findings include: - Observation on 09/21/15 at 1:40 p.m. showed an unattended maintenance cart located in the hallway (vestibule 3) of Wheatland unit outside resident rooms for over ten minutes. This area, located by the Wheatland resident lounge, allowed several residents access to this hallway. The cart contained a drill with drill bit, boxes of nails, a hammer, several screwdrivers, one can	F 323	A. 1. Maintenance staff were re-educated on September 30, 2015 to not leave the maintenance carts unattended. 2. All residents have the potential to be affected. 3. On September 30, 2015 Maintenance staff were re-educated to not leave tool carts, tool bags, paint carts, or ladders in resident areas unattended. New maintenance carts that provide locking capabilities will be purchased. 4. October 29, 2015. 5. The Maintenance Supervisor (or designee) will monitor to assure that maintenance cart are not left unattended (or unlocked) weekly for 4 weeks, then monthly for three months, then quarterly for three quarters. If concerns are identified, immediate corrective actions will be implemented. The results of monitoring will be reported to the QA committee by the Maintenance Supervisor (or designee) monthly for four months, then quarterly for three quarters.	

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F 323	Continued From page 24 of WD40 (oil spray), and one tube of caulk. - Observation on 09/22/15 at 8:00 a.m. showed a pointed screwdriver sitting at eye level on the alarm box of an exit door located in (vestibule 3) hallway of Wheatland Unit. During an interview on 09/22/15 at 8:40 a.m., a supervisory nurse (#12) stated she was unaware of why there was a screwdriver sitting on the door alarm and agreed it was a risk for the residents. The supervisory nurse immediately removed the screwdriver. - Observation on 09/23/15 at 12:20 p.m. showed a maintenance cart located in the hallway of the Wheatland unit between rooms W23 and W21 left unattended for eleven minutes. The cart contained a drill, electrical supplies, screwdrivers, paint scrapers, one hammer, a tube of caulk, and boxes of nails. Several residents located in this hallway have severely impaired cognitive levels as indicated by their medical records. During an interview on 09/23/15 at 2:30 p.m., a maintenance supervisor (#13) stated he expected staff to not leave maintenance carts unattended for more than three to five minutes, and if staff need to be away from the cart for a longer period of time then the staff needs to put the cart away. During an interview on 09/23/15 at 5:30 p.m., an administrative staff member (#1) stated maintenance carts should not be left unattended with tools or equipment. - During an environmental tour on 09/23/15 at	F 323	B. 1. No Residents were identified. Laundry room door locks on Wheatland, Harmony, and Legacy Neighborhoods were checked to assure functionable. Neighborhood laundry staff were re-educated to lock laundry rooms when unattended. 2. All residents have the potential to be affected. 3. Laundry staff were re-educated on September 29, 2015 to lock laundry room door when unattened. Nursing staff were re-educate on October 14th & 15th, 2015 and will be on October 27th & 28th, 2015 to lock laundry room door when unattended. 4. October 29, 2015. 5. The Housekeeping/Laundry Supervisor (or designee) will monitor Wheatland, Harmony, and Legacy Neighborhood laundry room doors to assure locked daily for four weeks, weekly for four weeks, then monthly for three months, then quarterly for three quarters. If concerns are identified, immediate corrective actions will be implemented. The results of the monitoring will be reported to the QA committee by the Housekeeping/Laundry Supervisor monthly for four months then quarterly for three quarters. C. 1. No Residents were identified. The Pinesol and Turbo Clean were removed from the Harmony Neighborhood Medication Room. 2. All residents have the potential to be affected.	

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F 323	Continued From page 25 2:00 p.m. observation showed three unlocked laundry rooms located in the hallways of Harmony, Legacy, and Wheatland. Each laundry room on these units contained one five gallon container of Oxygen (name brand) chemical laundry detergent and one five gallon container of Oxybrite (bleach) chemical sitting on the floor. Cognitively impaired residents resided in these units and would have access to these unlocked laundry rooms. During an interview on 09/23/15 at 5:30 p.m., an administrative nurse (#1) stated that all laundry rooms are to be locked when no laundry staff member is in the room. - Observation on 09/23/15 at 5:14 p.m. showed an unlocked medication room on Harmony unit. Observation showed the cupboards under the sink unlocked and contained chemicals including Pinesol and Turbo Clean. The facility failed to ensure the resident environment remained as free of accident hazards as possible.	F 323	3. The locks on the Harmony, Wheatland, and Legacy Neighborhood Medication Rooms were changed to auto passage lock on September 24, 2015. Nursing staff were re-educate on October 14th & 15th, 2015 and will be on October 27th & 28th, 2015 to not store chemical under sink in medication room, all chemicals are to be secured and locked, and of new locks placed on Medication Rooms. 4. October 29th, 2015. 5. The Assistant Director of Nursing Services will monitor Harmony, Wheatland, Legacy, and Horizon Towers Medication Rooms for locking of door. This monitoring will be conducted daily for four weeks, weekly for 4 weeks, then monthly for three months, then quarterly for three quarters. If concerns are identified, immediate corrective actions will be implemented. The Assistant Director of Nursing Services will report the results of the monitoring to the QA committee monthly for four months, then quarterly for three quarters. The Assistant Director of Nursing Services (or designee) and Housekeeping/Laundry Supervisor (or designee) will monitor in facility to assure all chemicals are secured. This monitoring will be conducted daily for 4 weeks, three times per week for 4 weeks, weekly for 4 weeks, then monthly for three months, then quarterly for three quarters. If concerns are identified, immediate corrective actions will be implemented. The results of the monitoring will be reported by the Assistant Director of Nursing Services to	

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F 323	Continued From page 26	F 323	the QA committee monthly for 5 months, then quarterly for three quarters.	
F 329	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and facility policy review, the facility failed to ensure each resident's drug regimen remained free from unnecessary drugs for 2 of 10 sampled residents (Resident #4 and #10) and 1 of 2 closed resident	F 329	A 1. Paper behavioral monitoring log with individualized interventions was implemented on September 25, 2015 to monitor exhibited behaviors on Resident #10. On October 6, 2015 Resident #10	10/29/15

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F 329	Continued From page 27 records reviewed (Resident #24) who received scheduled or as needed (PRN) medications to control/manage behavior. Failure to adequately assess, establish and implement individualized behavioral interventions and monitor the effectiveness of those interventions may result in residents receiving unnecessary medications and experiencing adverse consequences. Findings include: Review of the facility procedure titled, "Monitoring Of Antipsychotics", occurred on 09/24/15. This procedure, undated, stated, "Purpose: Resident receive antipsychotic medications only when medically necessary. Every effort is made to ensure that residents who use antipsychotic receive the intended benefit of the medications and to minimize the unwanted effects of the antipsychotic medications. Procedure: 1. Resident receive an antipsychotic medication only if one of the following diagnoses is documented in the resident's medical record or if the resident is under psychiatric care of a particular condition not included on the list: . . . k. Organic mental syndrome (including dementia) with associated psychotic or agitated features as defined by: 1. specific behaviors quantitatively documented (number of episodes) and objectively described (e.g., biting, kicking, scratching, etc.) by the facility that causes the resident to: a. represent a danger to themselves, or b. represent a danger to others, which may include staff, or c. interfere with the ability of the staff to provide care 2. psychomotor symptoms not exhibited as specific behaviors listed in 1. but that cause the resident subjective distress (e.g., excessive fear). 3. specific behavior (as in 1.)	F 329	was seen by psychiatrist and seroquel was decreased to 25 mg orally two times per day. 2. All Resident's on antipsychotics have the potential to be affected. 3. Reviewed and revised policy and procedure on "Monitoring of Antipsychotics." New process implemented prior to adding or increasing dosage of antipsychotic medications the Behavior Committee will meet and review resident record for indications of need. Behavior documentation has been changed from the electronic medical record to paper forms with individualized interventional approaches for Residents in facility. Residents on antipsychotic medications will have these logs reviewed by Social Services. All nursing staff have been education on above process on October 14th & 15th, 2015 and will be on October 27th & 28th, 2015. 4. October 29th, 2015. 5. Director of Social Services (or designee) will monitor for indication of either the addition of antipsychotic or increase in dosage. Monitoring will be conducted weekly for four weeks, then monthly. If concerns are identified, immediate corrective actions will be implemented. Results of this monitoring will be reported by the Director of Social Services (or designee) on a monthly basis to the QA committee. B. 1. Staff members caring for Resident #4 were re-educated on documenting non-pharmacological approaches prior to	

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F 329	Continued From page 28 and psychotic symptoms (as in 2) must be documented quantitatively (number of episodes) and described objectively (e.g., biting, kicking, scratching, etc.) at [sic] the medication therapy is started and must be monitored . . . 2. Upon initiation of antipsychotic medication therapy (or upon admission for new residents receiving antipsychotics) and every six (6) months thereafter, the Abnormal Involuntary Movement Scale (AIMS). Copy of AIMS sent to physician. . . ." Review of Resident #10's medical record occurred on September 21-24, 2015. Diagnoses included dementia with behavioral disturbances, paranoid state, Alzheimer's disease, delusional disorder, episodic mood disorder, and depression. A quarterly Minimum Data Set (MDS), dated 02/03/15, identified severe cognitive impairment and no behavioral symptoms. A significant change MDS, dated 08/03/15, identified severe cognitive impairment and verbal behavioral symptoms directed toward others. Resident #10's physician orders showed the facility admitted the resident in August 2014. On admission, the resident received an antipsychotic, Seroquel 12.5 milligrams (mg) every morning. The medical record failed to contain an admission AIMS assessment, as per facility policy. Staff completed an AIMS assessment on 02/20/15, six months later. A "Consultant Pharmacist's Medication Review," dated 02/24/15, stated, "Consider reducing Seroquel (12.5 mg) and monitoring patient's response. . . ." The physician responded, on	F 329	administration of as needed ativan. 2. All Residents on as needed antiaxiety medications have the potential to be affected. 3. Process for documentation of behaviors has been adjust from electronic medical record to paper behavioral logs with individualized non-pharmacological approaches to be utilized. The Licensed Nurse's have been re-educated on documentation of identified behavior, non-pharmacological approaches utilized, and effectiveness prior to administration of antiaxiety medications. All nursing staff were re-educated on October 14th & 15th, 2015 and will be on October 27th & 28th, 2015. 4. October 29, 2015. 5. Director of Social Services (or designees) will monitor weekly for four weeks, then monthly for 11 months for documentation of use of non-pharmacological approaches prior to administration of as needed antiaxiety medications. If concerns are identified, immediate corrective actions will be implemented. Results of the monitoring will be reported by the Director of Social Services (or designee) monthly for 12 months to the QA committee.	

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F 329	Continued From page 29 03/03/15, "Rejected" explaining, "Will try next appt. [appointment] - remind me." Review of Certified Nurse Aide (CNA) charting for the Month of March 2015 identified Resident #10 exhibit no behaviors for the entire month. Nursing documentation for March 2015 indicated the following: + 03/10/15, 2:38 p.m. "Sent fax to MD [medical doctor] as resident c/o [complains of] burning with voids, increased behaviors, falling asleep more frequently during the day and at meals, odor noted, increased incontinence, VS [vital signs] stable. No temp at this time." + 03/11/15, 10:26 a.m. "Obtained order to UA [urinalysis] with reflex to culture. Urine sample obtained . . . Behaviors continue. . . ." + 03/16/15, 9:05 a.m. "Resident seen today for 60 day review. Resident has no concerns this am. . . . No new orders today." + 03/22/15 12:59 p.m. "Resident verbally abusive towards staff and other residents that [sic] last week or so. Resident threatening to kill people because she is not getting feed [sic]. She doesn't get dressing [sic] and demanding her lawyer. Resident does get help with all these things. UA was testing [sic] and was negative results [sic]. Will have [psychiatrist] review behaviors." The record lacked any evidence/documentation to support these statements. + 03/30/15, 16:50 a.m. "Resident seen today per [psychiatrist] for f/u [follow-up]. Staff report that resident has been more verbally aggressive and hitting out on occasion. MD was updated that resident was recently checked for a UTI [urinary tract infection] which returned WNL [within	F 329		

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F 329	Continued From page 30	F 329		

normal limits]. [Psychiatrist] has increased residents Seroquel to 25 mg TID [three times a day] and added Namenda 5 mg every HS [hour of sleep]. Staff will update MD in one week on the effects of medication changes, family has also been notified." The record lacked any evidence/documentation to support these statements.

The facility failed to adequately assess Resident #10, who received antipsychotic medication to control behaviors and had a significant dosage increase without evidence of attempts by the facility to minimize the behavior through other approaches/interventions.

- Review of Resident #4's medical record occurred September 21-24, 2015. Diagnoses included intellectual disability, bipolar, explosive disorder, and anxiety. An quarterly MDS, dated 06/13/15, failed to identify behaviors as an area of concern.

Review of Resident #4's current care plan identified, "Goal: I will show signs of comfort during 1 to 1 Visits with staff. . . . Approach: . . . 1 to 1 visits 3 times a week: Read to/hand massage/wheelchair ride/outside when nice/look at books of birds and puppies. . . ."

Review of Resident #4's MAR from July 15, 2015 through September 20, 2015, showed staff administered Ativan 1 mg as needed for agitation/restlessness related to anxiety 21 times. Staff failed to assess/identify the resident's specific behaviors related to the anxiety/agitation/restlessness which resulted in the resident receiving Ativan without an

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F 329	Continued From page 31 opportunity to determine if other approaches/interventions (non-pharmacological) would have been effective in controlling/managing the behavior. - Review of Resident #24's medical record occurred on September 23-24, 2015. Diagnoses included anxiety, alcohol-induced persisting amnestic disorder, and psychotic disorder with delusions and hallucinations. The quarterly MDS, dated 08/11/15, identified severely impaired cognition, verbal behaviors, and rejection of care. The care plan identified interventions related to anxiousness "15 minute monitoring and redirection . . . Administer medications as ordered. Monitor/document for side effects and effectiveness. . . . Care givers to provided [sic] opportunity for positive interaction, attention. Visit about his interest in cooking. Listen to his concerns and provide reassurance as needed. . . . Provide a program of activities that is of interest and accommodates residents status. Offer work related tasks such as washing tables and sweeping. Likes tv shows and movies related to wildlife, nascar, and cooking. . . ." Review of Resident #24's MAR for April 2015 showed staff administered Ativan 1 mg as needed for anxiety 38 times and Ativan 2 mg as needed five times. Staff failed to assess/identify the resident's specific behaviors related to the anxiety which resulted in the resident receiving Ativan without an opportunity to determine if other approaches/interventions (non-pharmacological) would have been effective in controlling/managing the behavior. During an interview on the morning of 09/24/15,	F 329		

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F 329	Continued From page 32 two administrative staff members (#1 and #2) confirmed staff should attempt non-pharmacological interventions prior to administering the prn Ativan.	F 329		
F 333	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, review of professional standards, and staff interview, the facility failed to ensure 1 of 4 sampled residents (Resident #16) receiving insulin remained free of significant medication error. Failure to administer insulin for six consecutive days affected Resident #16's health and may result in a negative outcome. Findings include: Review of the facility policy titled "Medication Administration" occurred on 09/24/15. This policy, dated May 2013, stated, ". . . The Licensed Nurse will start at the top of the eMAR/eTAR [electronic medication administration record/electronic treatment administration record], checking each medication order against the medication card. . . . Electronically signs eMAR/eTAR immediately after administration of medications. . . . Medications are to be administered within time frames as per policy . . ." Nursing 2015 Drug Handbook, "35th edition,	F 333	Correction on page 32 of 43 line 18 and 19 should read "Levemir (long acting insulin) 7 units two times a day," Please remove the statement with meals. 1. Resident #16's order for prescribed insulin to be administered after meal was reviewed. Medication order was re-entered into the electronic medical record to be administered after meals. Licensed Nursing staff members were re-educated on the process of entering physician orders. Licensed Nursing Staff and Certified Medication Aides were re-educated on the six rights of medication administration. 2. All Residents have the potential to be affected. 3. Re-educated Licensed Nursing staff on process of one licensed nurse entering the paper physician order into the electronic medical record and second nurse reviewing the entered order. Once the Licensed Nurse has completed the process each nurse will sign the paper	10/29/15

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F 333	Continued From page 33 Wolters Kluwer, Philadelphia, page 759 stated, ". . . Control of hyperglycemia in patients with diabetes . . . divided in a meal-related treatment regimen. . . . Give 5 to 10 minutes before start of meal by subcutaneous injection . . ." Review of Resident #16's medical record occurred on all days of survey. Diagnoses included diabetes type 2, hypoglycemia, and diabetic with ketoacidosis. Current medications included Levemir (long acting insulin) 7 units two times a day with meals, in addition with Novolog (short acting insulin) 5 units after each meal. - Observation on 09/22/15 at 11:33 a.m. showed a certified medication aide (CMA) (#5) administer insulin per sliding scale. The CMA (#5) failed to administer the scheduled Novolog after the meal. Review of Resident #16's September 2015 eMAR identified staff failed to administer Novolog for six consecutive days (September 16, 17, 18, 19, 20, and 21), totaling eighteen missed doses. Review of Resident #16's Medication Administration Record identified blood sugar readings between 49 and 534 from 09/16/15 to 09/21/15. During an interview on 09/22/15 at 5:20 p.m. a supervisory nurse (#12) confirmed staff failed to administer Resident #16's Novolog insulin medication after meals on September 16, 17, 18, 19, 20, and 21.	F 333	order verifying the process has been completed. Licensed Nursing Staff were re-educated on process of entering orders in the electronic medical record. Re-education was completed on October 14th & 15th, 2015 and will be on October 27th & 28th, 2015. 4. October 29, 2015. 5. The Health Information staff will monitor all physician order to check for two licensed nurse signatures. The results of monitoring will be given to the Director of Nursing Services weekly for review. The Director of Nursing Services (or designee) will monitor thirty percent of physician orders entered into the electronic medication administration record. This monitoring will be conducted weekly for 8 weeks, then monthly for 10 months. If concerns are identified, immediate corrective actions will be implemented. These results will be reported to the QA committee by the Director of Nursing Services (or designee) monthly for 12 months.	
F 364	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides	F 364		10/29/15

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	355070	A. BUILDING _____ B. WING _____	09/24/2015

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F 364	Continued From page 34 food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEYS COMPLETED ON 08/29/13 and 08/21/14. Based on observation, staff interview and review of professional reference, the facility failed to store food and milk/supplementsa by methods that held the proper temperature, and conserved flavor of food in 4 of 5 kitchens (Wheatland, Harmony, Pine View, and Horizon). Failure to ensure foods served to residents are only stored frozen for appropriate lengths of time, or are held at appropriate serving temperatures may impact food consumption related to palatability. Findings include: Review of the U.S. Department of Health & Human Services' Food Safety web site, http://www.foodsafety.gov/keep/charts/storagetimes.html, occurred on 09/29/15. It identified the following recommendations for lengths of time to store frozen foods to preserve food quality: *soups and stews 2 to 3 months *cooked meat or poultry 2 to 6 months - Observation during the initial kitchen tour on 09/21/15 at 1:50 p.m. of the main kitchen showed a large covered pan on the top shelf of the walk-in freezer labeled "chicken 11/24". At that	F 364	1. There were no Resident's identified. The chicken, three egg and cheese biscuit sandwich, low sodium chicken vegetable soup, and unlabeled sausage patty in the freezer were removed and thrown. Re-education was completed with staff member in Pine View kitchenette, who did not complete temperature check prior to serving. 2. All Residents have the potential to be affected. 3. New policy and procedure was developed for frozen foods. All Dietary staff were re-educated on the process of storage and dating of frozen foods. Cold foods will be removed from cooler just prior to serving time and placed on ice. Temperature of cold food will be checked at the start and end of service. If the temperature at the begining end of service is above 41 degrees these items will be disposed. All dietary staff have been re-educated by memo on September 24, 2015 and on one on one basis by the Director of Food Services. 4. October 29, 2015. 5. The Director of Food Service (or designee) will monitor all daily temperature sheets and complete direct observation of temperatures being	

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F 364	Continued From page 35 time, an administrative dietary staff member (#7) identified it was a hot dish that the staff prepared on 11/24/14 and needed to be thrown away. The staff member stated she preferred leftovers to be in the freezer for no longer than 90 days after preparation. On 09/23/15 at 10:55 a.m., observation showed a dietary staff member (#6) in the Pine View kitchenette placed pans of food into the steam tray table. She placed a thermometer in each pan of food, and documented the temperatures in a binder. She then stated milk and juice usually tested at 32 degrees, documented a temperature in the binder without taking a temperature, and continued to set up for the noon meal. At 11:32 a.m., the staff member (#6) removed trays of drinks out of the refrigerator and placed them on the counter for service. After requesting a temperature of the milk and chocolate Ensure supplement, the staff member (#6) tested the drinks and confirmed the thermometer read 47 degrees. She stated she thought the prepared drinks had been in the refrigerator since 9:15 a.m., but confirmed the temperatures were high. The staff member left the drinks on the counter, and provided them to residents with meals. On 09/24/15 at 8:00 a.m., observation in the Horizon Towers kitchenette showed three egg and cheese biscuit sandwiches in the freezer labeled "3/3 [03/03/15]." On 9/24/15 at 8:15 a.m., observation in the Wheatland kitchenette showed a Styrofoam container in the freezer labeled "low sodium chicken vegetable soup" dated 02/10/15, an unlabeled sausage patty in a plastic bag, and a	F 364	checked three times per week for 8 weeks, then one time per week thereafter. The results of the monitoring will be reported to the QA committee by the Director of Food Services monthly. The Director of Food Service (or designee) will monitor for storage and dating of frozen foods in the freezer. Monitoring will be conducted weekly for 8 weeks, then one time per week thereafter. The results of the monitoring will be reported to the QA committee by the Director of Food Services monthly.	

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F 364	Continued From page 36 egg and cheese biscuit sandwich labeled "3-3 [03/03/15]." On 09/24/15 at 11:05 a.m., an administrative dietary staff member (#7) stated the milk temperature of 47 degrees was ". . . way too high," and all food items needed to be labeled prior to storing after preparation or service.	F 364		
F 371	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (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, staff interview and policy review, the facility failed to store, prepare, and serve food under sanitary conditions in 4 of 5 kitchenettes (Horizon Towers, Pine View, Wheatland, and Legacy) in the facility. Failure to properly handle food and utensils, sanitize tables, store dishes, and maintain clean kitchenettes may result in food borne illness. Findings include: Review of the facility policy titled "The Safe Food Handler" occurred on 09/24/15. This policy, undated, stated, "How to Use Gloves - If you are	F 371	Correction requested: On page 37 of 43 line 28 should read "Horizon Towers." Please remove "Harmony Towers." A. 1. No Resident's were identified. All Dietary staff members were re-educated on proper glove usage in the dietary department. 2. All Resident's have the potential to be affected. 3. All Dietary staff members were re-educated per memo on September 24, 2015 and on a one on one basis by the Director of Food Service in regards to	10/29/15

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F 371	Continued From page 37 not careful when using gloves, the food you handle can become unsafe. Follow these guidelines. . . . When to Change Gloves - Food handlers must change gloves at all of these times *As soon as they become dirty or torn *Before beginning a different task *After an interruption, such as taking a phone call *After handling raw meat, seafood, or poultry, and before handling ready-to-eat food." Observation of a dietary staff member (#15) serving food in the Horizon Towers Kitchenette occurred on 09/22/15 at 11:50 a.m. The staff member wore gloves throughout the service - plating food, opening the refrigerator, placing food in the microwave, cutting a cucumber in slices, and touching bread for sandwiches. The staff member failed to change her gloves when changing tasks and before handling ready-to-eat food. Observation on 09/23/15 at 10:48 a.m. showed a dietary staff member (#6) wore gloves as she pushed a cart of covered food from the main kitchen to the Pine View kitchenette. The staff member (#6) entered the kitchenette, removed the covers from the steam table and used hot pads to place the pans of food into the steam table. She stored the hot pads in an up-facing stack of plate covers, and continued to prepare for the noon meal. At 11:07 a.m. the staff member (#6) applied fresh gloves, touched her face, and pushed a cart with clean dishes and silverware into the locked unit after pressing the code into the panel on the wall and pushing open the door with her gloved hands. Without changing gloves, she folded cloth napkins, set the tables, touched the drinking surfaces of	F 371	proper glove usage. Copies of proper serving methods were placed in a binder in each neighborhood serving kitchenette. 4. October 29, 2015. 5. The Director of Food Services (or designee) will complete observation of proper glove usage by dietary staff. The monitoring will be conducted by the Director of Food Service (or designee) three times per week for 8 weeks and then 1 time per week thereafter. If concerns are identified, immediate corrective action will be implemented. The results of the monitoring will be reported to the QA committee monthly by the Director of Food Service (or designee). B. 1. No Resident's were identified. The kitchenette on Horizon Towers was cleaned. Gel cold pack was removed from the freezer. Microwave was cleaned. Wall air conditioner was cleaned. 2. All Resident's have the potential to be affected. 3. All Dietary staff members were re-educated on required daily cleaning for kitchenettes. Daily cleaning manual was reviewed with the addition of step by step instruction for each cleaning task. Adjustments were made to both the daily and weekly cleaning schedules. 4. October 29, 2015. 5. The Director of Food Services (or designee) will monitor daily and weekly cleaning schedules weekly for 4 weeks, then monthly there after. If concerns are identified, immediate corrective action will	

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F 371	Continued From page 38 glasses, and eating surfaces of the silverware. She picked up a few pieces of clean silverware in her hand, scratched her face with the silverware still in her hand, and then placed the silverware on resident tables. Observation at on 09/23/15 11:42 a.m. showed a dietary staff member (#8) in the Wheatland kitchenette wore gloves as she plated food and placed it in the serving window for staff to serve to the residents. The staff member (#8) used her gloved hands to open the refrigerator and remove drinks for residents, then used those gloves to open a bag of bread, removed two slices and placed them in the toaster. Observation of a dietary staff member (#16) serving food in the Legacy Kitchenette occurred on 09/23/15 at 11:45 a.m. The staff member wore gloves throughout the service - plating food, opening drawers, opening the refrigerator, and buttering bread. The staff member failed to change her gloves before handling ready-to-eat food. On 09/23/15 at 11:53 a.m. in the Pine View kitchenette, a dietary staff member (#6) wore gloves and plated food and placed it in the serving window. The staff member adjusted her glasses with gloved hands, scooped food onto a plate, then picked up a slice of buttered bread with her gloved hands. The staff member failed to change her gloves before handling ready-to-eat food. Observation of the Harmony Towers kitchenette, on 09/24/15 at 8:00 a.m., showed the upright refrigerator/freezer with food spills and food	F 371	be implemented. The results of this monitoring will be reported to the QA committee monthly by the Director of Food Services (or designee). C. 1. No Resident's were identified. All Dietary staff members were re-educate on the process for utilizing the detergent/sanitizer solution and allow solution to air dry. 2. All Residents have the potential to be affected. 3. All Dietary staff members were re-educated on the process of utilizing the detergent/sanitizer and allow solution to air dry. This re-education occurred on September 24, 2015 via memo and on a one on one basis with Director of Food Service (or designee). 4. October 29, 2015. 5. The Director of Food Service (or designee) will complete observation of dietary staff cleaning tables and allowing solution to air dry three times per week. If concerns are identified, immediate corrective action will be implemented. The results of the monitoring will be reported to the QA committee by the Director of Food Services monthly.	

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F 371	Continued From page 39 debris in both compartments and gel cold packs (for resident pain relief) in the freezer compartment next to ice cream containers. Observation showed numerous dried-on food debris on all surfaces inside the microwave, dust and debris on the wall air conditioner, and numerous liquid spills, food debris, and dirt on the kitchen floor. On 09/24/15 at 8:40 a.m. observation showed a dietary staff member (#6) pushed a cart out of the Pine View nursing unit filled with dirty dishes and cleaning supplies. The staff member stated they used a detergent/sanitizer solution to wipe down the tables, then sprayed the table with sanitizer and immediately wiped it off with a towel. On 09/24/15 at 11:05 a.m., an administrative dietary staff member (#7) stated she expected: staff to clean kitchenettes weekly, staff to not touch ready-to-eat food with bare hands or soiled gloves, staff to remove gloves, wash their hands, and apply new ones if they touched their faces. The staff member (#7) stated she expected staff to clean the tables with a soap solution, then spray the tables with sanitizer and let it air dry in order to effectively sanitize.	F 371		
F 425	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.	F 425		10/29/15

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F 425	Continued From page 40 A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure the removal of expired medications in 1 of 5 units (Horizon) utilizing treatment carts. Failure to dispose of medication by the recommended time frame has the potential to affect the potency and efficacy of the medication. Findings include: Observation on 09/23/15 at 3:00 p.m. of the Horizon unit treatment cart located on the unit's third floor identified: * Four tubes of Mupirocen 2% ointment with expiration dates of October 2014, December 2014, January 2015, and June 2015 * One tube of anti-itch 2% ointment expired January 2015 * One tube of hydrocortisone cream expired March 2015 * One tube of triple antibiotic ointment expired	F 425	1. No Residents were identified. The four tubes of mupirocen 2% ointment, one tube of anti-itch 2% ointment, one tube of hydrocortisone cream, and one tube of triple antibiotic ointment were removed from the treatment cart. All medication and treatment carts were checked and no other expired medications were identified. 2. All Residents have the potential to be affected. 3. Nightly chore list was updated to include checking of expired medications one day per month. Nursing staff were re-educated on October 14th & 15th, 2015 and will be on October 27th & 28th, 2015 to check medication and treatment carts monthly for expired medications. 4. October 29, 2015. 5. The Infection Control Nurse (or designee) will monitor for expired medications weekly for 8 weeks, then monthly for 10 months. If concerns are	

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F 425	Continued From page 41 August 2009 During an interview on 09/24/15 at 9:00 a.m., an administrative staff member (#1) indicated the night nurses' responsibility included checking and removing expired medications.	F 425	identified, immediate corrective actions will be implemented. The Infection Control Nurse (or designee) will report results of monitoring monthly for 12 months at the QA committee.	
F 431	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 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	F 431		10/29/15

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F 431	Continued From page 42 quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to properly store and label medications for 1 of 7 medication refrigerators (Legacy unit), 2 of 7 medication rooms (Harmony and Wheatland units), and 4 of 7 medication carts (Harmony, Legacy, Wheatland, and Horizon). Failure to store and label medications correctly may effect the efficacy of medications, and may result in unauthorized access to medications. Findings include: Review of the facility policy titled "Security of Medication Cart" occurred on 09/24/15. This policy, dated July 2014, stated, ". . . Medication carts must be securely locked at all times when out of the nurse's view. . . . When the medication cart is not being used, it must be locked . . ." Review of the facility policy titled "Medication Administration" occurred on 09/24/15. This policy, dated May 2013, stated, ". . . Labeling of medications . . . should have resident name . . . and expiration date . . ." Unlocked Medication Cart - Observation on 09/22/15 at 4:03 p.m. showed an unattended and unlocked medication cart in the hallway of the Wheatland unit. Observation showed no licensed nurse or medication aide	F 431	A. 1. No Residents were identified. The Licensed Nurse involved was re-educated to lock medication cart when cart is not in direct view. 2. All Residents have the potential to be affected. 3. All Licensed Nursing staff were re-educated on locking of the medication cart when the cart is not in direct view of staff. This education was provided on October 14th & 15th, 2015 and will be on October 27th & 28th, 2015. 4. October 29, 2015. 5. The Assistant Director of Nursing Services (or designee) will monitor locking of medication carts daily for four weeks, then weekly for one month, then monthly for ten monthly. If concerns are identified, immediate corrective actions will be implemented. Results of the monitoring will be reported to the QA committe by the Assistant Director of Nursing Services (or designee) monthly for 12 months. B. 1. No Residents were identified. The identified hydrocodone medication cards were placed under double lock in the medication cart. 2. All Residents have the potential to be affected.	

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F 431	Continued From page 43 within view of the cart, and several residents walked by the medication cart. A licensed nurse (#3) entered the hallway from a resident's room after twenty minutes and locked the medication cart. During an interview on 09/23/15 at 5:30 p.m., an administrative staff member (#1) and an administrative nurse (#2) stated medication carts should be locked at all times and should be within view of the nurse or medication aide. Double Locked Narcotics - Observation on 09/23/15 at 2:20 p.m. showed the Horizon unit's third floor medication cart contained approximately four separate blister pacs of hydrocodone/APAP (Vicodin/narcotic pain med) tablets among the single locked medications. Failure to ensure Schedule II narcotics are double locked may increase the potential for drug diversion. During an interview on 09/24/15 at 9:00 a.m., an administrative staff member (#1) stated staff are to keep all Schedule II narcotics double locked in medication carts. Unlocked Medication Cabinets/Refrigerators - Observation on 09/23/15 at 5:14 p.m. showed an unlocked medication room on Harmony unit with the stock medication cupboards unlocked. During a staff interview on 09/23/15 at 5:20 p.m., a nurse (#3) stated the medication rooms are unlocked and the cupboards with medications are to be locked. - Observation on 09/23/15 at 5:20 p.m. of the	F 431	3. All medication carts were checked to assure hydrocodone was double locked. All Licensed Nursing staff were re-educated of requirement of medication cards that contained schedule II narcotics including hydrocodone are to be double locked in the medication carts. This education was completed on October 14th & 15th, 2015 and will be on October 27th & 28th, 2015. A laminated list of medications required to be double locked will be placed on the medication carts. 4. October 29, 2015. 5. The Assistant Director of Nursing Services (or designee) will monitor double locking of schedule II narcotics including hydrocodone in medication carts weekly for 4 weeks, then monthly for three months, then quarterly for three quarters. If concerns are identified, immediate corrective actions will be implemented. The results of this monitoring will be reported to the QA committee by the Assistant Director of Nursing Services monthly for four months, then quarterly for three quarters. C. 1. No residents were identified. New auto passage locks were placed on Wheatland and Harmony neighborhood medication rooms. Wheatland and Harmony neighborhood Licensed Staff were re-educated to lock medication refrigerator and medication storage cupboards. 2. All Residents have the potential to be affected. 3. New auto passage locks were placed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355070	A. BUILDING _____ B. WING _____	09/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHEL LUTHERAN NURSING & REHABILITATION CENTER	1515 2ND AVE WEST WILLISTON, ND 58801

(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 431	Continued From page 44 Wheatland unit showed an unlocked medication room with an unlocked cabinet containing stock medications. - Observation on 09/23/15 at 5:25 p.m. of Wheatland unit's medication room identified an unlocked medication refrigerator containing the following medications: * Bisa evac rectal suppositories * Latanoprost eye drops * Ofloxacin eye drops * Lantus insulin * Novolog insulin * Levemir insulin * Rebif syringes (interferon for multiple sclerosis) * Preperation H suppositories During an interview on 09/23/15 at 5:30 p.m. an administrative staff member (#1) and an administrative nurse (#2) stated the cabinets which contain medications and the medication refrigerators should be locked at all times. No Expiration Date - Observation on 09/24/15 at 8:45 a.m. of the Legacy unit's medication cart identified eighty-three blister pacs containing medication from the pharmacy with no expiration dates on the label or packaging. - Observation on 09/24/15 at 9:05 a.m. of the Harmony unit's medication cart identified thirty-nine blister pacs containing medication from the pharmacy with no expiration dates on the label or packaging. During an interview on 09/24/15 at 11:45 a.m. an administrative staff member (#1) stated the labels	F 431	on Harmony, Wheatland, and Legacy neighborhood medication rooms. All Licensed Nursing staff were re-educated on the new auto passage locks installed (Wheatland, Harmony, Legacy Neighborhoods) and locking of medication cupboards and refrigerators in the medication rooms on October 14th & 15th, 2015 and will be on October 27th & 28th, 2015. 4. October 29th, 2015. 5. The Assistant Director of Nursing Services (or designee) will monitor medication rooms, medication cupboards, and medication refrigerator to assure locked. The monitoring will be conducted weekly for four weeks, monthly for three months, quarterly for three quarters. If concerns are identified, immediate corrective actions will be implemented. The results of the monitoring will be reported to the QA committee by the Assistant Director of Nursing Services monthly for 4 months, then quarterly for three quarters. D. 1. No Residents were identified. On September 25, 2015 the Administrator notified pharmacy involved of medication cards received did not have the expiration date. 2. All Residents have the potential to be affected. 3. On September 25, 2015 fax received from pharmacy involved that education had been provided to the pharamcy staff of requirement for presence of expiration date on carded medications. All Licensed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355070	A. BUILDING _____ B. WING _____	09/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHEL LUTHERAN NURSING & REHABILITATION CENTER	1515 2ND AVE WEST WILLISTON, ND 58801

(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 431	Continued From page 45 from pharmacy should display an expiration date on the label.	F 431	Nursing staff were re-educated to check for the expiration date on carded medications on October 14th & 15th, 2015 and will be on October 27th & 28th, 2015. 4. October 29, 2015. 5. The Charge Nurse (or designee) will check for expiration date on carded medications when checking in ordered medication. If when Charge Nurse is checking the medications in and expiration date is absent medication card will be returned to pharmacy to have expiration date identified. Monitoring tool will be turned into the Nurse Manager on weekly basis. Monitoring will be completed weekly for 8 weeks, then monthly for 10 months. The results of the monitoring will be reported to the QA committe by the Director of Nursing Services (or designee) monthly for 12 months.	