STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355100	A. BUILDING _____ B. WING _____	C 12/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - DEVILS LAKE	302 7TH AVE NE DEVILS LAKE, ND 58301

(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 and complaint survey started on December 12, 2016, and completed on December 15, 2016, the sample included two (2) residents for complete review, nine (9) residents for focused review, and one (1) closed records for review. The sample included three (3) additional residents to verify specific concerns during the survey.	F 000		
F 241 SS=D	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide care in a manner that maintained, enhanced, and respected each resident's dignity and individuality for 1 of 2 sampled residents (Resident #4) and 1 supplemental resident (Resident #13) who required assistance with meals. Failure to feed residents in a dignified manner does not promote their dignity or enhance their quality of life. Findings include: Observation of the morning meal on 12/14/16 at 8:30 a.m. showed the following: * Resident #4 seated in a wheelchair and a certified nursing assistant (CNA) (#9) assisted with the meal. Yogurt dripped from the resident's	F 241	1. Resident #4 is assisted with meals in a dignified manor. Staff are using cloth napkins to clean excess food from face. Care plan interventions for cloth napkins to wipe excess food updated 01/04/2017. Resident #13 is assisted by staff who sit along side resident during meals. Any excess food is being wiped off with cloth napkin. 2. The facility has identified all residents who require assistance with meals as having the potential to be affected. 3. Clothing protectors will be replaced with cloth napkins. In-service education	1/30/17

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

Electronically Signed | 01/05/2017

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F 241	Continued From page 1 mouth, down her chin, and onto her clothing protector. The CNA (#9) wiped the resident's face with the clothing protector. * Resident #13 seated in a wheelchair and a CNA (#12) fed her. The CNA sat behind the resident and reached around her to feed. Food dripped from the resident's mouth and covered her chin. The CNA (#12) scrapped the excess food from the Resident #13's face and re-fed the food or placed it back in the meal cup. During an interview on 12/15/16 at 11:45 a.m., two administrative staff members (#2 and #14) agreed the CNAs (#9 and #12) failed to feed/assist Resident #4 and #13 in a dignified manner.	F 241	was completed 12/30/2016 on resident dignity and resident assisted dining for all staff members who assist residents with eating. 4. An audit of assisted dining needs will be completed by restorative nurse or designee weekly X4, monthly X2 and quarterly X3. An audit summary report will be reviewed by the Quality Assurance Committee for monitoring and further recommendations to ensure compliance. 5. Compliance will occur on or before 01/30/2017	
F 279 SS=E	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the	F 279		1/30/17

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F 279	Continued From page 2 comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.	F 279		

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F 279	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, resident interview, and staff interview, the facility failed to develop and/or review and revise the residents' comprehensive plan of care to address specific problems identified for 4 of 11 sampled residents (Resident #3, #5, #10, and #11). Failure to develop a comprehensive care plan limits the staff's ability to assist the resident to attain or maintain their highest practicable physical, mental and psychosocial well being, to ensure continuity of care, and resident safety. Findings include: Review of the facility policy titled, "Care Plan" occurred on 12/15/16. This policy, revised 2016, stated, " . . . Purpose: To develop a comprehensive care plan using an interdisciplinary team approach. Policy: Residents will receive and be provided the necessary care and services to attain or maintain the highest practicable well-being in accordance with the comprehensive assessment. Each resident will have an individualized, person-centered, comprehensive plan of care that will include measurable goals and timetables directed toward achieving and maintaining the resident's optimal medical nursing, physical, functional, spiritual, emotional, psychosocial and educational needs. - Review of Resident #3's medical record occurred on days of survey. Diagnoses included unspecific pain, insomnia, disorder of the kidney and ureter, and history of urinary tract infections	F 279	1. Resident #3s care plan was updated 12/15/16 to reflect current use of a hearing aid. On 12/20/2016 care plan was updated to reflect use of Xanax for dx of insomnia, per physician dx and orders. Care plan was updated on 12/23/2016 to discontinue PT/OT services and replace with restorative therapy. End of therapy MDS completed 12/26/2016. On 01/04/2017 care plan was updated with interventions to monitor for signs and symptoms of UTI. 1. Resident #10 care plan was updated on 12/16/2016 to include information regarding smoking and use of self release safety belt. An assessment for the use of self release safety belt was completed on 01/05/17. 1.Resident #5 care plan was updated to include smoking and keeping smoking materials at secured location 12/16/16. 1. Resident #11 is no longer at the facility. 2. All residents who smoke or use a safety belt in wheel chair have the potential to be affected. 3. Process will include, admission nurses will complete 24 hour care plan, the MDS Coordinator will complete portions of care plan related to triggers from MDS and the Interdisciplinary care plan team will address any additional information that is	

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F 279	Continued From page 4 (UTI). Physicians orders included hearing aid to be placed in a.m., occupational (OT) and physical therapy (PT) to treat and evaluate. Medications included Tylenol 500 milligrams (mg) four times a day for pain, Xanax (antianxiety medication) 0.25 mg half tablet at bedtime related to insomnia. Nursing progress notes stated the following: 11/04/16 1:17 p.m. Admit note: " . . . Skilled services to be provided: . . . UTI . . . skilled therapy for strengthening. 11/18/16 4:41 p.m. "Res. [resident] will be started tonight on oral a/b [antibiotic] for UTI. . . " 11/21/16 11:45 a.m. Admission MDS (Minimum Data Set): Resident currently working with PT/OT. Resident receives Xanax .25 for insomnia . . . Tylenol 500 mg Q6hr [every six hours] for pain relief. . . .Hearing aid in place to aid hearing abilities. Resident #3's current care plan failed to identify the following problems: * Diagnosis of insomnia and use of Xanax * History of UTI and UTI on 11/18/16 * Pain and pain medication used * PT/OT services * Hearing aid used - Review of Resident #10's medical record occurred on December 14-15, 2016. Random observations during the survey showed Resident #10 utilizing a seat belt in his wheelchair. During an interview on 12/14/16 at 4:30 p.m. Resident #10 stated he used the seat belt whenever he was in his wheelchair and he could	F 279	current to residents care. Education will be provided on 01/06/17 on this process. 4. An audit to monitor this process has been developed and will be completed by the MDS Coordinator or designee weekly X4, monthly X2 and quarterly X3. An audit summary report will be provided to Quality Assurance Committee for further recommendations and monitoring to ensure compliance. 5. Compliance will occur on or before 01/30/17	

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F 279	Continued From page 5	F 279		

release it himself. The resident stated he started to smoke cigarettes about a month ago.

Resident #10's current care plan failed to identify the resident's smoking habits, use of a seat belt in his wheelchair and the medical record lacked an assessment for the use of a seat belt.

During an interview on 12/15/16 at 9:00 a.m. a nurse manager (#2) confirmed staff failed to identify the above areas on Resident #3 and #10's comprehensive care plans.

- Review of Resident #5's medical record occurred on all days of survey. The Tobacco Use Assessment, dated 11/15/16, stated, " . . . currently uses (smoking) tobacco . . ." The progress notes dated 11/15/16, stated, ". . . went out for two smoke breaks during the night shift . . ."

An observation of Resident #5's room on 12/15/16 at 8:00 a.m. showed Resident #5 kept a tin can in his pocket containing cigarettes and a lighter.

During an interview on 12/15/16 at 8:50 a.m., a licensed nurse (#7) stated Resident #5 currently smokes.

Resident #5's current care plan failed to identify smoking.

During an interview on the morning of 12/15/16, an administrative nurse (#2) confirmed staff should care plan for Resident #5's smoking.

- Review of Resident #11's medical record

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F 279	Continued From page 6 occurred on December 14-15, 2016. Diagnoses included nicotine dependence, cigarettes. The Tobacco Use Assessment, dated 11/01/16, stated, ". . . currently uses (smoking) tobacco . . ." During an interview on 12/15/16 at 9:30 a.m., a licensed nurse (#8) confirmed Resident #11 currently smokes. Resident #11's current care plan failed to identify smoking. During an interview on the morning of 12/15/16, an administrative nurse (#2) confirmed staff should care plan for Resident #11's smoking.	F 279		
F 280 SS=E	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care.	F 280		1/30/17

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F 280	Continued From page 7 (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident.	F 280		

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F 280	Continued From page 8 (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED 01/21/16 Based on observation, record review, review of facility policy, and staff interview, the facility failed to review and revise the comprehensive care plan to reflect the residents' current status for 4 of 11 sampled residents (Resident #1, #2, #4, and #9). Failure to revise the care plans limited staff's ability to communicate care needs and ensure continuity of care for each resident. Findings include: Review of the facility policy titled "Care Plan" occurred on 12/15/16. This policy, revised November 2016, stated, " . . . Purpose: . . . Each resident will have an individualized, person-centered, comprehensive plan of care	F 280	1. Resident #2's care plan has been updated to reflect resident's use of weighted blanket, as well as resolving the use of geri-sleeves and heel booties 12/16/16. Resident #1s care plan has been updated on 01/04/2017 to reflect no straws per physician order. Resident #4s care plan was updated on 01/04/2017 regarding toileting interventions and care plan was updated 12/28/2016 regarding total lift for transfers. Resident #9 care plan was updated 12/19/2016 to include interventions for	

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F 280	Continued From page 9 that will include measurable goals and timetables directed toward achieving and maintaining the resident's optimal medical nursing, physical, functional, spiritual, emotional, psychosocial and educational needs. . . . A qualified team of persons will review care plans at least quarterly. Care plans also will be reviewed, evaluated and updated when there is a significant change in the resident's condition. This plan of care will be modified to reflect the care currently required/provided for the resident." - Review of Resident #1's medical record occurred on all days of survey. Physician's orders, dated 09/12/16, stated, "Regular diet, Regular fluid consistency, Small portions and no straws . . ." Resident #1's care plan stated, "Focus: I have nutritional problem or potential problem R/T [related to] poor food intake E/B [evidenced by] weight loss . . . Eating: No Straws (initiated 05/06/15) . . ." Observation on 12/12/16 at approximately 2:00 p.m. showed Resident #1 in her room visiting with a family member. A travel mug of water with a straw was located on the bedside table. Observation on 12/13/16 at 8:40 a.m. showed a nurse (#2) assisted Resident #1 with cares. After completion of cares, the nurse offered water from the travel mug's straw. Observation on 12/14/16 at 8:30 a.m. and 2:50 p.m. showed a travel mug of water with a straw on Resident #1's night stand. During an interview on 12/14/16 at 2:50 p.m., a family member of Resident #1 stated she drinks	F 280	supervision while smoking outside. 2. All residents of the facility have the potential to be affected by this practice. 3. Process change, the PCC communication tab will be used for any new or updated information regarding residents or care plan updates. Interdisciplinary team will ensure updated resident care is indicated as necessary on the care plan. Education was provided to nursing staff and interdisciplinary care plan team on 01/04/17. 4. An audit to monitor this process has been developed and will be completed by Social Services or designee for each weekly scheduled residents care plan, weekly X4, monthly X2 and quarterly X3. An audit summary report will be provided to Quality Assurance Committee for further recommendations and monitoring to ensure compliance. 5. Compliance will occur on or before 01/30/2017	

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F 280	Continued From page 10	F 280		

from a straw all the time.

During an interview on the morning of 12/15/16, an administrative nurse (#2) stated staff had recently upgraded Resident #1's diet, and she believed the resident could have a straw.

The facility failed to revise Resident #1's care plan related to straw use.

- Review of Resident #4's medical record occurred on all days of survey. The quarterly Minimum Data Set (MDS), dated 11/28/16, identified extensive assistance required for transfers and toilet use and continent of bowel. Resident #4's care plan stated, ". . . Toilet Use: Resident requires assist of 1 with transfers . . . Transfer: Resident requires assist of 2 with the total lift for all transfers . . ."

Observation on 12/12/16 at 4:45 p.m. showed two certified nursing assistants (CNAs) (#4 and #5) and a nurse (#6) in Resident #4's room. The resident stated, "I have to go to the bathroom so badly." The CNA (#4) removed the resident's soiled brief and provided personal cares. The two CNAs and the nurse then utilized a hoyer (full body mechanical lift) and transferred her to the toilet. The resident did not void on the toilet.

Observation on 12/13/16 at 9:05 a.m. showed two CNAs (#1 and #5) utilized a hoyer and transferred Resident #4 to the toilet where she voided.

Observation on 12/13/16 at 3:40 p.m. showed two CNAs (#10 and #11) checked Resident #4's brief (dry) then utilized a hoyer and transferred

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F 280	Continued From page 11	F 280		

her from the bed to the wheelchair. The CNA (#10) stated Resident #4 had been a sit-to-stand transfer but changed to a full body lift about 3 weeks ago. Facility staff now check and change her brief rather than take her to the toilet.

Observation on 12/14/16 at 9:55 a.m. showed two CNAs (#12 and #13) changed Resident #4's incontinent brief. The CNA (#12) stated if the resident asks to go to the bathroom, staff give her a bedpan.

During an interview on the morning of 12/15/16, an administrative nurse (#2) agreed Resident #4's care plan failed to reflect her current needs.

The facility failed to revise Resident #4's care plan to reflect her current transfer and toilet needs.

- Review of Resident #9's medical record occurred on December 14-15, 2016. Diagnoses included dementia. The admission MDS, dated 10/09/16, identified severe cognitive impairment and a fall prior to admission to the facility.

The current care plan stated, "Focus: I use tobacco products E/B use of cigarettes . . . I am independent wit tobacco use and my cigarettes are locked up on the nurse's cart. . . ."

Review of a progress note, dated 11/20/16, identified Resident #9 fell in the courtyard and hit her head.

During an interview on 12/15/16 at 10:10 a.m., an administrative nurse (#2) stated since Resident #9's fall, facility staff go outside with her when

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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 280	Continued From page 12 she smokes. The facility failed to revise Resident #9's care plan to reflect the need for supervision while outside smoking. - Review of Resident #2's medical record occurred on all days of survey. Diagnoses included dementia. Physician's orders included resident to wear blue heel booties when in bed. Resident #2's care plan stated, " I exhibit behavior symptoms R/T dementia, anxiety . . . Minimize potential of behavior problems by modifying environmental factors and daily routine of placing Geri-sleeves [arm protectors] on me. . . . [Resident name] has potential for impairment to skin R/T decreased mobility . . . May use protective booties on when in bed. . . ." Observation during survey showed Resident #2 did not have Geri sleeves in place. Observation on 12/13/16 at 1:30 p.m. showed Resident #2 on her back in bed without the heel booties in place. A weighted blanket covered the resident. During an interview on 12/14/16 at 2:45 p.m. a nursing supervisor (#2) stated Resident #2 no longer uses geri sleeves or heel booties and confirmed staff failed to care plan Resident #2's weighted blanket.	F 280		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility	F 309		1/30/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355100	A. BUILDING _____ B. WING _____	C 12/15/2016

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F 309	Continued From page 13 residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: 1. Based on record review, review of professional literature, and staff interview, the facility failed to provide medication in a timely manner for 1 of 4 sampled residents (Resident #6) who experienced a UTI (urinary tract infection). Failure to administer medication in a timely manner to treat a UTI may have caused Resident #6 to experience discomfort and/or affected their mental and physical well-being. Findings include: Kozier & Erb's "Fundamentals of Nursing: Concepts, Process, and Practice," 9th ed.,	F 309	Part 1 1. Resident #6 had no adverse affects from delay in treatment. Medications are being administered per physician orders in a timely manner. 2. All residents at risk for UTIs have the potential to be affected by this practice. 3. When licensed nurse receives a report in which action needs to be taken, interventions will be implemented immediately. On 01/04/2017 licensed nursing staff were educated on obtaining	

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F 309	Continued From page 14 Pearson Education Inc., New Jersey, page 818, states, ". . . Laboratory examination of specimens such as urine . . . provides important adjunct information for diagnosing health care problems and also provides a measure of the responses to therapy. . . . Report abnormal laboratory findings to the health care provider in a timely manner consistent with the severity of the abnormal results. . . ." Review of Resident #6's medical record occurred on all days of survey. Review of Resident #6's current care plan stated, " . . . has bladder incontinence . . . Monitor for s/s (signs and symptoms) UTI . . . urinary frequency . . . altered mental status, change in behaviors . . ." Review of Resident #6's interdisciplinary notes identified the following: * 04/21/16: Note to doctor, stated, "hollering for help consistently, requesting the bathroom, and voiding small amounts" * 04/29/16: UTI susceptibility diagnosis results received by the facility. * 04/30/16: Progress notes, stated, "Culture antibiotics back, no order (for antibiotic) from MD (Medical Doctor)" * 05/03/16: MAR (Medication Administration Record) showed received first dose of Macrodantin (antibiotic). The facility failed to initiate an antibiotic from April 29-May 3, 2016 (five days) after they received the culture results. During an interview on 12/14/16 at 4:55 p.m., a nurse manager (#2) confirmed there was a delay in Resident #6's treatment and would expect staff	F 309	a physicians order timely after a positive culture is received and implement necessary interventions. 4.An audit to monitor this process has been developed and will be completed by the Quality Assurance Coordinator/RN or designee weekly X4, monthly X2 and quarterly X3. An audit summary report will be provided to Quality Assurance Committee for further recommendations and monitoring to ensure compliance. Part 2 1. Resident #1 care plan has been revised for no milk of magnesia due to kidney failure 01/03/17. Resident will receive fruit bomb on day two of no bowel movement. Bowel/abdomen assessment was completed on 01/04/2017 Resident #4 received a physicians order on 01/04/17 for Miralax. Fruit bomb will be administered on day two of no BM and a bowel assessment was completed on 01/04/2017 2. The facility has identified all residents and residents with kidney failure have the potential to be affected by this practice. 3. Residents who are in the parameters of the bowel protocol for no BM for two or more days, and residents who have kidney failure will be reviewed in the interdisciplinary team clinical morning stand up.	

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F 309	Continued From page 15 to initiate an antibiotic. CONSTIPATION 2. Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide the necessary care and services to manage constipation for 2 of 10 sampled residents (Resident #1 and #4) with a diagnosis of constipation. Failure to implement interventions to manage constipation in a timely manner and administer the less invasive intervention may have resulted in these residents receiving unnecessary suppositories. Findings include: Review of the facility policy titled "Bowel Protocol" occurred on 12/13/16. This undated policy stated: "1. On day 2 of no bowel movement give 1 tablespoon of fruit bomb (found in each nurses station fridge upstairs). 2. On day 3 of no bowel movement give Milk of Magnesia [MOM] 2400 mg[milligrams]/10 ml [milliliters] po [by mouth] (ensure MD [medical doctor] order). Assess abdomen and listen for bowel sounds. Document findings. If abnormal findings contact MD immediately (abnormal findings would be no bowel sounds, painful abdomen, hardened abdomen, no flatulence) 3. On day 4 of no bowel movement give Bisacodyl Suppository - give 10 mg or 1 supp [suppository] per rectum (ensure MD order). Again assess abdomen and listen for bowel sounds. Document findings . . . 4. In afternoon of day 4 if resident has still not had bowel movement give Fleets enema . . ."	F 309	On 01/04/2017 education was provided to licensed nursing regarding facilities bowel protocol including policy and procedure for bowel assessments as well as no orders for milk of magnesia for residents with kidney failure. 4. An audit to monitor this process has been developed and will be completed by the DNS or designee weekly X4, monthly X2 and quarterly X3. A summary report will be provided to Quality Assurance Committee for further recommendations and monitoring to ensure compliance. 5. Compliance will occur on or before 01/30/17	

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- Review of Resident #1's medical record occurred on all days of survey. Diagnoses included pain and constipation. Medications included hydrocodone/acetaminophen (may cause constipation) 5/325 mg one tablet twice daily, Senokot S (a laxative and stool softener) one tablet daily, and Bisacodyl Suppository (a laxative) as needed (PRN).

Resident #1's quarterly Minimum Data Set (MDS), dated 11/13/16, identified moderate cognitive impairment and continent of bowel. The current care plan stated, "Focus: The resident has potential for constipation R/T [related to] decreased mobility and poor fluid intake. Medications: Bisacodyl suppository, Senokot, Citrucel, MOM, Miralax . . . Goal: The resident will pass soft, formed stool every 3 days . . . Interventions: Increase fluid intake. Fiber juice daily . . ."

Review of Resident #1's bowel movement records and medication administration records (MARs), dated October 01 - December 14, 2016, identified the following:
* October:
No bowel movement (BM) from the 1st through the 7th (7 days)
No BM from the 14th through the 18th (5 days)
No BM from the 23rd through the 27th (5 days)
The facility staff offered a bisacodyl suppository on the 1st, 6th, and the 30th and Resident #1 refused them all.
* November:
No BM from the 2nd through the 5th (4 days)
No BM on the 9th and 10th (2 days)
No BM from the 16th through the 18th (3 days)

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No BM from the 20th through the 23rd (4 days)
The facility staff administered bisacodyl suppositories on the 3rd (effective), 10th (ineffective), 19th (effective), 28th (effective), and the 30th (resident refused).
* December:
No BM from the 2nd through the 4th (3 days)
No BM from the 7th through the 10th (4 days)
The facility staff administered a bisacodyl suppository on the 1st and the 11th, both effective.

During an interview on 12/15/16 at 8:05 a.m., an administrative nurse (#2) stated Resident #1 has a diagnosis of kidney failure and MOM is contraindicated. The facility failed to identify the resident cannot receive MOM on the care plan.

The facility failed to follow their bowel policy and administer fruit bomb on day 2 of no BM and document a bowel/abdomen assessment.

- Review of Resident #4's medical record occurred on all days of survey. Diagnoses included constipation and pain. Medications included hydrocodone/acetaminophen 5/325 mg one tablet three times a day, Senokot S one tablet twice a day, and bisacodyl suppository PRN.

Resident #4's quarterly MDS, dated 11/28/16, identified severe cognitive impairment and continent of bowel. The current care plan stated, Focus: The resident has constipation R/T decrease movement . . . Goal: The resident will pass soft, formed stool at the preferred frequency of every 3 days . . . Interventions: Increase fiber and fluid intake to provide more bulk in diet. I

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F 309	Continued From page 18 receive fiber juice daily . . ." Observation on 12/13/16 at 8:10 a.m. showed Resident #4 received four ounces of fiber juice. Review of Resident #4's bowel records and MARs, dated October 01 - December 14, 2016, identified the following: * October: No BM on the 14th through the 18th (5 days) No BM from the 20th through the 22nd (3 days) No BM from the 27th through the 29th (3 days) The facility staff administered a bisacodyl suppository on the 19th and the 30th, both effective. * November: No BM on the 4th through the 9th (7 days) No BM on the 22nd through the 24th (3 days) No BM on the 26th through the 28th (3 days) The facility staff administered a bisacodyl suppository on the 3rd (ineffective) and the 10th (effective). * December: No BM on 8th through the 11th (4 days) The facility staff administered a bisacodyl suppository on the 5th (even though the resident had a BM on the 3rd) and on the 12th, both effective. During an interview on the morning of 12/15/16, the nurse (#3) stated she administers fruit bomb on day two without a BM but does not document the administration in the resident's record. The facility failed to follow their bowel policy and administer fruit bomb on day 2 of no BM, MOM on day 3 of no BM, and document a bowel/abdomen assessment.	F 309		

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F 323 SS=E	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of policies/procedures, review of professional literature, and staff interview, the facility failed to provide an environment free from accidents and/or hazards as possible for 4 of 4 sampled residents (Resident #5, #9, #10, and #11) who smoke. Failure to complete a smoking assessment (Resident #10), reassess residents when a change in status has occurred (Resident	F 323	1. On 12/15/2016 smoking receptacle located one foot from receding wall, east of main door and under the eave has been removed permanently. On 12/15/2016 resident #5, #9 #10 and #11 were informed by DNS for safety reasons no residents will be allowed to keep smoking materials in their	1/30/17

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F 323	Continued From page 20 #9), provide a safe and accessible smoking area, and ensure smoking receptacles are away from entrances placed these residents and all residents, staff members, and visitors at risk of accidents and/or injuries. Findings include: Review of the facility policy titled "Smoke-Free Locations" occurred on 12/15/16. This policy, revised March 2016, stated, ". . . Such [outdoor smoking] areas shall be away from the main entrance of the location or as state, county or local laws allow. . . . The location must ensure precautions are taken for the resident's/clients individual safety, as well as the safety of others in the location. Smoking by residents/clients when oxygen is in use is prohibited. . . . Upon admission, all residents/clients who smoke or use tobacco products will be assessed using the Tobacco Use Assessment. Assessments also will be administered if a resident/client has a change in cognitive ability, judgment, manual dexterity and/or mobility. Care plans are updated as needed. . . ." The National Fire Protection Association (NFPA) "Medical Oxygen Safety" NFPA Public Education Division, Quincy, MA, (2016), stated, ". . . There is no safe way to smoke in the home when oxygen is in use. . . . Keep oxygen cylinders at least five feet from a heat source, open flames . . . Smoking materials is the leading heat source resulting in medical oxygen related fires, injuries, and deaths. . . ." - Observations on December 13-15, 2016 showed a cigarette receptacle located less than	F 323	possession, but they will be secured in nurses cart. On 12/15-16/2016 Social Worker completed an updated tobacco use assessment on resident #5, #9 and #10. Care plans were updated. Resident #11 - at time of survey was on smoking cessation and is no longer in facility. On 12/15/2016 DNS informed resident #10 of the facilities designated smoking area. On 12/15/2016 sidewalk to designated smoking area was made free of snow and ice by facility maintenance staff. 2. All residents have the potential to be affected. 3. Smoking items are kept in a secure location. On 12/30/2016 in-service education was provided to nursing staff and maintenance staff regarding new smoking process and environment safety. 4. An audit will be completed by Social Service Director or designee weekly X4, monthly X2 and quarterly X3. An audit summary report will be provided to the Quality Assurance Committee for further recommendations and monitoring to ensure compliance. 5. Compliance will occur on or before	

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F 323	Continued From page 21	F 323	01/30/2017	

one foot from the receding wall, east of the main door, and under the eave.

- Observation on 12/15/16 at 5:15 p.m. showed Resident #10 outside the main entrance smoking.

- Observations on December 13-15, 2016 showed the sidewalk leading to a cigarette receptacle in the courtyard covered with snow and ice. The facility has designated this ssmoking area for residents.

- Review of Resident #5's medical record occurred on all days of survey. Diagnosis included a personal history of traumatic brain injury. The Tobacco Use Assessment, dated 11/15/16, stated, ". . . currently uses (smoking) tobacco . . . Cognitive loss (Modified independence) . . . Uses tobacco products 1-2 times per day . . . Can always light their own cigarette . . ." The admission Minimum Data Set (MDS), dated 11/21/16, identified severely impaired cognition.

An observation of Resident #5's room on the morning of 12/15/16 showed Resident #5 kept a tin can in his pocket containing cigarettes and a lighter. Resident #5's roommate uses oxygen. Observation showed an oxygen tank and an oxygen concentrator in the room. A sign outside Resident #5's room stated, "no smoking oxygen in use".

During an interview on 12/15/16 at 8:35 a.m., a staff nurse (#7) confirmed Resident #5 keeps his own lighter and cigarettes in his room and smokes in the enclosed court yard.

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F 323	Continued From page 22 During an interview on 12/15/16 at 9:50 a.m., an administrative nurse (#2) confirmed Resident #5 has impaired cognition, access to smoking materials, and potential to use his lighter. Refer to F- 279 - Review of Resident #11's medical record occurred on December 14-15, 2016. Diagnoses included nicotine dependence on cigarettes. The tobacco use assessment, dated 11/01/16, stated, ". . . currently uses (smoking) tobacco . . . at times needs assistance getting in and out of the court yard for smoking. . . ." During an interview on 12/15/16 at 8:30 a.m., a staff nurse (#8) confirmed resident currently smoked in the enclosed courtyard. Refer to F- 279 - Review of Resident #10's medical record occurred on December 14-15, 2016. During an interview on 12/14/16 at 4:30 p.m. Resident #10 stated he started to smoke cigarettes about a month ago and he kept his cigarettes and lighter in his shirt pocket. During an interview on 12/15/16 at 9:25 a.m. a nurse manager (#8) stated Resident #10 started smoking about a month ago and the facility failed to complete a smoking assessment. Refer to F- 279 - Review of Resident #9's medical record	F 323		

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F 323	Continued From page 23 occurred on December 14-15, 2016 and identified an admission date of 10/03/16. On the day of admission, the staff member (#17) completed the resident's "Tobacco Use Assessment." The assessment stated, ". . . Resident does not have a diagnosis of cognitive impairment currently . . ." The current care plan stated, ". . . I am independent with tobacco use and my cigarettes are locked up on the nurse's cart. Date Initiated: 10/13/16 . . ."(Refer to F-280) Resident #9's progress note, dated 11/20/16, stated, "writer informed MD [medical doctor] resident report of falling in courtyard and hitting head . . ." During an interview on 12/15/16 at 10:10 a.m., an administrative nurse (#2) stated Resident #9 now has a diagnosis of Alzheimer's disease and, since Resident #9's fall on 11/20/16, facility staff go outside with her when she smokes. The facility failed to complete a new "Tobacco Use Assessment" when Resident #9's cognition changed she fell in the courtyard.	F 323		
F 325 SS=D	483.25(g)(1)(3) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE (g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- (1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable	F 325		1/30/17

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F 325	Continued From page 24 body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; (3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to adequately assess the nutritional status, needs, and risk factors, and implement appropriate interventions to restore/maintain adequate nutritional status for 1 of 3 sampled residents (Resident #2) who experienced significant weight loss. Failure to meet residents' nutritional needs through diet, supplements, or other interventions may have contributed to the resident experiencing significant weight loss. Findings include: Review of the facility policy titled, "Weight and Height" occurred on 12/15/16. This policy, revised September 2015, stated, ". . . 8. The licensed nurse should notify the DDS [Director of Dietary Services] within 24 hours regarding any significant weight change. Significant weight change is defined as five percent in 30 days, 7.5 percent in 90 days and 10 percent in 180 days. . . ." Review of Resident #2's medical record occurred on all days of survey. Diagnoses included dementia and nutritional deficiency. The annual Minimum Data Set, dated 02/23/16, identified	F 325	1. Resident #2s weight is stable, care plan has been updated to reflect current status. Weight is being monitored for any changes. 2. All residents have the potential to be affected. 3. All residents are weighed weekly. Director of Dietary Service will bring roster of all residents current weights to interdisciplinary team meeting on a weekly basis for review. Residents who experience a change in weight will be assessed by dietary and nursing for proper interventions. On 01/04/2017 in-service-education was provided to nursing staff. Education was provided to Dietary Manager on 01/05/2017. On 01/04/2017 in-service-education was provided to nursing staff regarding taking, recording and reporting weights and notifying Dietary manager. On 01/04/2017 education was provided to nursing staff regarding compliance of weight loss interventions.	

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F 325	Continued From page 25 short and long term memory loss and extensive assistance of one person for eating. The current care plan stated, " . . . [Resident name] has potential for nutritional problem R/T [related to] Dementia E/B [evidenced by] poor intake of meals resulting in unplanned weight loss. . . . Provide [Resident name] with calm, quiet setting at meal times with adequate eating time. Small portions. . . . Offer me a High Calorie Shake at afternoon snack. I get fortified milk for all meals, greek yogurt at breakfast and Ensure pudding at noon meal. . . ." Review of Resident #2's weight record identified the following: 03/08/16 - 146.5 lbs. 03/14/16 - 146.1 lbs. 03/21/16 - 146.5 lbs. 03/29/16 - 136.8 lbs. (6.6 % weight loss in 8 days) (re-weigh requested) 03/31/16 - 137.2 lbs. (6.3 % weight loss) 04/05/16 - 137.5 lbs. 05/02/16 - 139.1 lbs. (5% weight loss in 34 days) 05/31/16 - 133.2 lbs. 06/07/16 - 133.5 lbs. (8.8 % weight loss 90 days) Dietary progress notes stated the following: * 03/29/16 - 2:51 p.m. "Weight 136.8# [pounds] Question accuracy of this weight was 146.5# (3/21/16). Meal intakes averaged 45% over the past week which is typical for res [resident]. Will follow weights." * 04/05/16 - 1:30 p.m. "Weight 136.6 (3/29/16), 137.2 (3/31/16). Meal intakes over the past week averaged 51% which is fairly typical for res. Will continue to monitor weights." * 04/12/16 - 3:04 p.m. "Weight 138# (4/11/16) BMI [body mass index] 25.2. Meal intakes	F 325	4.An audit tool has been developed to ensure resident weights are being monitored and interventions are being provided. Audits will be completed by Director of Dietary Services or designee weekly X4, Monthly X2 and quarterly X3. An audit summary report will be provided to the Quality Assurance Committee for compliance. 5. Compliance will occur on or before 01/30/17	

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F 325	Continued From page 26 averaged 57% over the past week. Will continue to monitor weights." * 06/07/16 1:28 p.m. "Weight 133.2# (5/31/16) Meal intakes over past week averaged 53%. Res. is currently receiving A/B [antibiotic] tx [treatment] for UTI [urinary tract infection] which is likely the cause of weight decrease. Will offer fortified milk with meals and Ensure pudding at noon meal for additional calories. Will continue to monitor." * 07/12/16 2:24 p.m. "Weight 132.2# . . . Suggest also high calorie shake (4 oz [ounce] Mighty Shake mixed with 1/2 cup ice cream) for PM snack daily. Will continue to monitor." Observation on 12/13/16 during the P.M. shift showed Resident #2 did not receive a high calorie shake. The nutritional documentation showed Resident #2 received a shake at 4:42 p.m. During an interview on the afternoon of 12/14/16 a certified nursing assistant (#4) stated she mistakenly documented the intake of the high calorie shake. During an interview on 12/14/16 at 5:00 p.m. with two nurse managers (#8 and #16), and a dietary manager (#15), the nurse manager (#8) confirmed staff failed to address Resident #2's severe weight loss at the end of March 2016.	F 325		
F 329 SS=D	483.45(d) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS (d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug	F 329		1/30/17

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F 329	Continued From page 27 therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to ensure a medication regimen free from unnecessary medications for 1 of 1 sampled resident (Resident #1) received a scheduled medication for fever. Failure to discontinue acetaminophen when the fever subsided resulted in Resident #1 receiving unnecessary medication for approximately eight months. Findings include: Review of the facility policy titled "Unnecessary Medications" occurred on 12/15/16. This policy, dated 2012, stated: "PURPOSE: To eliminate unnecessary use of medications. POLICY: Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: a. In excessive dose (including duplicate therapy) or	F 329	1. On 12/15/2016 resident #1s Physician was notified of unnecessary medication acetaminophen 325 mg TID for fever and medication was discontinued. 2. The facility has identified all residents of the facility have the potential to be affected by this practice. 3.The Health information Manager will run a report twice a week to review all new medication orders for any unnecessary medication regimens. On 01/04/2017 in-service-education was provided to licensed nurses and Health information Manager regarding process change. 4. An audit tool has been developed and will be completed by Quality Assurance Coordinator/RN or designee weekly X4, monthly X2 and quarterly X3. An audit summary report to be reviewed and	

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F 329	Continued From page 28 b. For excessive duration or . . . d. Without adequate indications for its use or . . . f. Any combination of the reasons above . . ." Review of Resident #1's medical record occurred on all days of survey. Diagnoses included osteoarthritis. Physician's orders included hydrocodone/acetaminophen 5/325 milligrams (mg) twice a day for pain (initiated 04/23/16) and acetaminophen 325 mg three times a day for fever (initiated 04/03/16). During an interview on 12/15/16 at 8:05 a.m., an administrative nurse (#2) stated the physician ordered acetaminophen in April when Resident #1 experienced a fever. The facility failed to obtain an order to discontinue the medication when the resident's fever subsided.	F 329	monitored by the Quality Assurance Committee to ensure compliance. 5. Compliance will occur on or before 01/30/17	
F 332 SS=D	483.45(f)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE (f) Medication Errors. The facility must ensure that its- (1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to ensure a medication error rate of less than five percent for 2 of 7 supplemental residents (Resident #14 and #15) observed during medication pass. Two errors occurred during staff administration of twenty five medications, resulting in an eight percent error rate. Failure to ensure medication are administered correctly may result in adverse side effects.	F 332	1. Resident #15 and #14 are now receiving correct medication dosages. On 12/13/2016 DNS and certified medication assistant removed and replaced Calcium 600 mg plus vitamin D 200 IU with Calcium 600 mg plus vitamin D 400 IU to reflect resident #15 current medication order. On 12/13/2016 DNS educated licensed nurse #3 on how to correctly measure Geri Mucil using disposable	1/30/17

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F 332	Continued From page 29 Findings include: Review of the facility policy titled "MEDICATION ERRORS" occurred on 12/15/16. This policy, dated May 2016, stated, ". . . The location (Good Samaritan Society, Devils Lake) will ensure that it is free of medication error rates of five percent or greater . . . Medication errors consist of the following . . . Wrong Dose/Amount . . . Medication Error . . . The observed preparation or administration of medications or biologicals which is not in accordance with the prescriber's order . . ." - Observation of medication pass occurred on 12/13/16 at 5:25 p.m. A certified medication aide (CMA) (#1) dispensed several medications for Resident #15. Resident #15's physician's orders included Calcium 600 mg (milligram) plus vitamin D 400 IU (international units) one tablet by mouth a day. The CMA (#1) administered Calcium 600 mg plus vitamin D 200 IU. During an interview on 12/13/16 at 5:35 p.m., a nurse manager (#2) confirmed the CMA administered the wrong dose of medication. - Observation of medication pass occurred on 12/13/16 at 9:40 a.m. A licensed nurse (#3) dispensed several medications for Resident #14. The licensed nurse obtained two heaping teaspoons of Geri Mucil (fiber laxative) and mixed the powder in water. Resident #14's physician order stated give 2 grams by mouth one time a day for constipation. Each rounded tablespoon contains two grams. The facility failed to ensure a failure rate on	F 332	measuring cups for resident #14. On 01/06/2017 a medication error report was completed for resident #15 and resident #14. Families and primary Physicians were notified of medication errors. 2. The facility has identified all residents of the facility have the potential to be affected. 3. Process change; Over the counter medication bottles will be labeled once they are opened. On 01/04/2017 in-service-education was provided to licensed nurses and certified medication assistants regarding proper medication administration practices and labeling of over the counter medications. 4. An audit tool will be developed that will monitor resident medication passes to ensure compliance of medication administration. Audit will be completed by DNS or designee weekly X 4, monthly X 2 and quarterly X 3. An audit summary report will be reviewed and monitored by the Quality Assurance Committee monthly to ensure compliance. 5. Compliance will occur on or before 01/30/17	

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F 332	Continued From page 30 medication pass of less then five percent. During an interview on 12/14/16 at 10:15 a.m., a nurse manager (#2) stated she expected staff to measure the Geri Mucil powder in a plastic medication cup and confirmed the license nurse administered the wrong dose of medication.	F 332		
F 333 SS=D	483.45(f)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS (f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy and procedure, and staff interview, the facility failed to ensure 1 of 1 sampled residents (Resident #3) remained free of significant medication errors. Failure to administer the correct dosage of medication may result in a negative outcome. Findings include: Review of the facility policy titled "MEDICATION ERRORS" occurred on 12/15/16. This policy, dated May 2016, stated, ". . . The location (Good Samaritan Society, Devils Lake) will ensure that it is free of . . . significant medication errors . . . Medication errors consist of the following . . . Wrong Dose/Amount . . . Significant Medication Error: One which causes the resident discomfort or jeopardizes the resident's health and safety. . . . Wrong Dose/Amount: When the resident receives an amount of medication that is greater than or less than the amount ordered by the prescriber. . . ."	F 333	1. Resident #3 was assessed and no adverse consequences were noted. Resident #3 is now receiving correct dosages of medications ordered by physician. On 01/06/2017 a medication error report was completed. Resident #3s primary Physician and family were notified of the medication error. 2. The facility has identified all newly admitted residents have the potential to be affected by this practice. 3. Two admission nurses will review and sign off on residents admission orders. All admit nurses were educated on 01/05/17 on this procedure. 4. An audit tool has been developed to ensure all new admission orders have been signed by two admission nurses and that all medications are correctly	1/30/17

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F 333	Continued From page 31 Review of Resident #3's medical record occurred on all days of survey. Diagnoses included hypertension, atrial fibrillation and glaucoma. Resident #3's admission orders dated 11/04/16 stated the following: * Digoxin (for rapid heart rate) 0.125 milligrams (mg) take 1/2 tablet by mouth daily * Metoprolol (for high blood pressure) 50 mg take 1.5 tablets by mouth daily * Brimonidine-timolol (glaucoma eye drops) one drop in the left eye every 12 hours. Review of the November 2016 Medication Administration Record identified Resident #3 received the following medications from 11/04/16 until 11/22/16: * Digoxin .125 mg daily - (twice the ordered dose) * Metoprolol 50 mg daily - (order was for 75 mg daily) * Brimonidine-timolol one drop in both eyes every 12 hours Resident #3's nursing progress notes stated the following: * 11/15/16 3:20 p.m. "residents [sic] daughter approached writer and stated that resident was receiving Metoprolol 75 mg daily at home as [sic] 1/2 of Digoxin 0.125 daily. Current orders read Metoprolol 50mg daily and Digoxin 0.125mg daily. Writer send a fax as well as current b/p's [blood pressures] and pulse to MD [Medical Doctor] to see if he would like to make changes." * 11/15/16 11:09 p.m. "Continue current medication dose per Dr. [name]." The facility failed to give a half tab of the Digoxin and Metoprolol 75 mg as ordered on admission.	F 333	administered. The audits will be completed by HIM or designee weekly X4, monthly X2, and quarterly X3. An audit summary report will be provided to Quality Assurance Committee for monitoring and recommendations to ensure compliance. 5. Compliance will occur on or before 01/30/17	

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F 333	Continued From page 32 During an interview on 12/14/16 at 2:45 p.m., an administrative nurse (#2) confirmed Resident #3 received the wrong dosage of medications.	F 333		
F 431 SS=D	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) 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. (a) Procedures. 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. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary	F 431		1/30/17

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F 431	Continued From page 33 instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals. (1) 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. (2) 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 quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, policy review, and staff interview, the facility failed to store controlled narcotic medications in a secure manner for 1 of 3 medication carts (North cart) observed during medication pass. Failure to store narcotic medications in a double locked system may allow unauthorized access to these medications. Findings include: Review of the facility policy titled "Controlled Substances" occurred on 12/15/16. This policy, revised May 2016, stated, ". . . Purpose: To provide safe storage for all controlled substances. Policy: . . . The access system used to lock Schedule II medications and other medications subject to abuse cannot be the	F 431	1. Resident #14 had no adverse affects by this practice. Nurse #3 was immediately educated by DNS to follow double lock procedure for narcotics. 2. The facility has identified all residents have the potential to be affected. 3.Process change; all narcotic boxes will have a label for double lock system requirement. Education was provided on 01/04/2017 to all license nurses and certified medication assistance on the proper storage of narcotics. 4. An audit tool was developed to monitor required storage of narcotics. Audit will be	

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F 431	Continued From page 34 same access system used to obtain the non scheduled medications." Observation of medication pass on 12/13/16 at 9:40 a.m. showed a licensed nurse (#3) dispensed Oxycodone 5/325 milligrams for Resident #14. The nurse obtained the medication from an unlocked narcotic box located within the medication cart. After obtaining the medication the nurse did not lock the narcotic box. The nurse reopened the unlocked narcotic box to retrieve the medication card and replaced the medication card without locking the narcotic box. During an interview at this time, the licensed nurse (#3) confirmed staff should lock the narcotic box.	F 431	completed by DNS or designee weekly X 4, monthly X 2 and quarterly X 3. An audit summary report will be provided to the Quality Assurance Committee for further recommendations to ensure compliance. 5. Compliance will occur on or before 01/30/17	
F 441 SS=E	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to:	F 441		1/30/17

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F 441	Continued From page 35 (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the	F 441		

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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 441	Continued From page 36 spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: PERINEAL CARE 1. Based on observation, review of facility policy, and staff interview, the facility failed to follow infection control practices for 2 of 6 sampled residents (Resident #2 and #4) observed during perineal cares. Failure to follow infection control practices of hand hygiene during perineal cares has the potential to spread infection within the facility. Findings include: Review of the facility policy titled "Hand Hygiene and Handwashing" occurred on 12/15/16. This policy, revised March 2016, stated, " . . . 5. . . . use an alcohol-based hand rub for routinely cleaning hands. . . . After having direct contact with another person's skin, After having contact with body fluids, . . . After removing gloves . . ." - Observation on 12/12/16 at 4:45 p.m. showed Resident #4 laying on her bed while a certified nursing assistant (CNA) (#4), donned gloves and provided personal cares after an incontinent bowel movement. Without removing gloves and performing hand hygiene, the CNA (#4) assisted another CNA (#5) and a nurse (#6) with the resident's clean brief, pants, and placement of a sling (full body lift) under the resident. The CNA (#4) then removed the soiled gloves and	F 441	1. (part 1) Resident #2 and #4 are being assisted with perineal cares by staff that follow required hand hygiene and infection control practices. 1. (part 2) Resident #14 was not negatively affected by this practice. DNS made aware of this practice and immediately education nurse #3 on infection control practices. All multi-use cups were removed from thickeners and beneprotein on medication carts and in kitchen. 2.The facility has identified that all residents of the facility have the potential to be affected this practice. 3.(part 1)On 01/04/17 in-service/education was provided to nursing staff on proper process of hand hygiene during cares. 3.(part 2) process change; dietary will use disposable cups for thickener. Nurse medication carts are now storing multi-use cups in plastic baggie and use disposable cups for thickener, which are stored outside of container. On 01/04/17 Licensed nurses and	

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	355100	A. BUILDING _____ B. WING _____	C 12/15/2016

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F 441	Continued From page 37 performed hand hygiene. - Observation on 12/13/16 at 9:12 p.m. showed a CNA (#9) assisted Resident #2 onto the toilet using a sit to stand lift. Before sitting the resident onto the toilet seat, the CNA (#9) obtained a perineal wipe and cleansed the toilet seat. Without changing gloves or performing hand hygiene, the CNA (#9) pulled the resident's pants and brief down, and using the remote on the lift, lowered Resident #2 onto the toilet. When asked, the CNA (#9) stated the toilet seat had BM (bowel movement) on it from Resident #2's roommate. The CNA (#9) failed to remove her gloves and perform hand hygiene after cleaning BM from the toilet seat. - Observation on 12/13/16 at 4:10 p.m. showed a CNA (#4) used a sit-to-stand lift to assist Resident #2 onto the toilet. After the resident voided, the CNA (#4) donned gloves and provided perineal care. Without removing gloves or performing hand hygiene, the CNA (#4) assisted the resident into the wheelchair, removed the sling from behind the resident, removed the foot strap from the lift, attached and adjusted the leg rests on the wheelchair, removed her gloves, and performed hand hygiene. The CNA (#4) failed to remove her gloves and perform hand hygiene after perineal care, before performing other tasks. During an interview on 12/15/16 at 11:20 a.m., a nurse manager (#2) stated she expects staff to remove gloves and perform hand hygiene after perineal care. MEDICATION PASS	F 441	certified medication assistants were educated on proper storage of multi-used scoops and infection control practice while handling and administering medications. 4. An audit will be developed to monitor the process for proper hand hygiene during resident cares. Audit will be completed by MDS Coordinator/RN or Designee 3X a week for 4 weeks, 1X a week for 4 weeks, Monthly X2 and quarterly X2. Another audit will be developed to monitor proper administration and storage of supplies for medication and supplement administration. Audit will be completed by DNS or Designee weekly X4, monthly X2 and quarterly X3. Audit summary reports will be provided to the Quality Assurance Committee for further recommendations and monitoring to ensure compliance. 5. Compliance will occur on or before 01/30/17	

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F 441	Continued From page 38 2. Based on observation, and review of facility policy, the facility failed to follow infection control practices during 1 of 1 day of observation of medication pass (12/13/16). Failure to follow infection control practices during medication pass and by storing a multi-use cup in thickener and beneprotein on the medication carts and in the kitchen has the potential to spread infection. Findings include: - Observation on 12/13/16 at 9:40 a.m. showed a licensed nurse (#3) prepared Resident #14's medications. The nurse punched out an Oxycodone tablet into her bare hand from a medication blister pack, used a ballpoint pen to punch a hole into other medication blister pack to remove pills for the resident; and poured three baby aspirin pills into the lid of the bottle, held one back with her bare finger, and poured the other two into the resident's medication cup. The nurse (#3) failed to follow infection control practice by using an unsanitary ball point pen, and touching medication with bare hands. - Observation on 12/13/16 at 11:35 a.m. showed the nurse (#3) prepared Resident #13's medications. The nurse, with bare hands, obtained a two ounce medication cup from inside a container of thickener to thicken the resident's nutritional supplement; used a ballpoint pen to punch a hole into a medication blister pack to remove a pill for the resident; and poured three Gas Relief pills into the lid of the bottle, held two back with her bare finger, and poured the the other one into the resident's medication cup. The nurse (#3) failed to follow infection control	F 441		

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F 441	Continued From page 39 practices by storing a multi-use cup in the container of thickener, using an unsanitary ball point pen, and touching medication with bare hands. - Observation during the dietary tour on 12/14/16 at 3:10 p.m. showed a multi-use cup in a container of thickener. A dietary manager (#15) removed the multi-use cup. - An observation of the North, West #1, and West #2 nursing units medication cart on the afternoon of 12/14/16 identified a scoop in each of the units beneprotein container. During an interview on 12/14/16 at 3:20 p.m. a managerial nurse (#2) confirmed staff should not store scoops in the beneprotein powder containers.	F 441		