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	355033	A. BUILDING _____ B. WING _____	07/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CATHERINES LIVING CENTER	1307 N 7TH ST WAHPETON, ND 58075

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F 000	INITIAL COMMENTS The standard Medicare/Medicaid recertification survey started on 07/09/18 and concluded on 07/12/18.	F 000		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review, review of the North Dakota Provider Manual for Preadmission Screening and Resident Review (PASARR) and Level of Care Screening Procedures For Long Term Care Services, and staff interview, the facility failed to complete a status change assessment for 2 of 2 sampled residents (Resident #8 and #44) with a newly diagnosed mental illness. Failure to complete a change in status assessment may result in the delivery of	F 644	F 644 1. Residents #8 had the status change assessment completed and was referred for Level II PASARR, which was completed onsite on July 21, 2018. Resident #44 had the status change assessment (PASARR) completed on 7/13/2018. 2. Licensed Social Worker (LSW) will review all resident charts for evidence of	8/15/18

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

Electronically Signed | 07/25/2018

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F 644	Continued From page 1 care and services that are inconsistent with residents' needs. Findings include: The North Dakota PASARR Provider Manual page 13 states, ". . . Change in Status Process . . . Whenever the following events occur, nursing facility staff must contact Ascend to update the Level I screen for determination of whether a first time or updated Level II evaluation must be performed. These situations suggest that a significant change in status has occurred: . . . If an individual with MI, ID, and/or RC (mental illness, intellectual disability, and conditions related to intellectual disability [referred to in regulatory language as related conditions or RC]) was not identified at the Level I screen process, and that condition later emerged or was discovered. . . ." - Review of Resident #44's medical record occurred on all days of survey. The record showed an initial PASARR completed on 09/26/11 and identified no mental illness. The screening, dated 09/26/11, stated the Level I screen conducted for the individual determined there was no evidence to suggest presence or known conditions of mental illness, mental retardation, or a condition related to mental retardation. Resident #44's medical record identified the following current diagnoses: psychotic disorder with hallucination due to known physiological condition (dated 06/30/14), dementia with behavioral disturbance (dated 09/09/14), and major depressive disorder (dated 09/30/12). The	F 644	and identify any missing PASARR□s. Will contact Ascend and request copies of any missing PASARR and will identify ones that need a status change assessment completed. Will run the ICD -10 Diagnosis Report to identify all residents that have a newly evident or possible serious mental disorder, intellectual disability, or a related condition for Level II resident review upon significant change in status assessment. 3. Licensed Social Workers (LSW) will be educated by a consultant on the coordination of PASARR and assessments required by incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident□s assessment, care planning and transitions of care. The policies and procedures were reviewed with Licensed Social Workers on July 23, 2018. LSW will review each resident□s diagnosis changes at quarterly IDT care planning meeting to assure all newly diagnosed screening/change in status assessment were completed. 4. Audits will be reviewed initially by LSW to ensure all residents have a PASARR completed, in chart, Level II completed, if needed and in residents chart. Results from the audit will be completed initially by LSW, then quarterly for one year. Results from the audits will be reported at the Quality Assurance Committee. The Administrator will follow up on further education/training on an as needed basis.	

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F 644	Continued From page 2 record lacked evidence of an updated Level I screening/change in status assessment since the additional diagnoses. - Review of Resident #8's medical record occurred on July 10-12, 2018 and identified staff completed a Level I screening for Resident #8 on 04/10/13. The record identified a new diagnosis, dated 07/25/13, of "unspecified psychosis." The record lacked evidence staff performed an updated Level I change in status assessment following this new diagnosis. An interview with a Licensed Social Worker (LSW) (#3) occurred on 07/12/18 at 8:40 a.m. regarding PASARR assessments for Resident #8 and #44. The LSW (#3) confirmed staff did not perform the updated Level I assessments for Resident #8 and #44 at the time of the new diagnoses.	F 644	5. August 15, 2018	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(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. (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).	F 657		8/15/18

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F 657	Continued From page 3 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: Based on observation, record review, and staff interview, the facility failed to review and revise the comprehensive care plan for 2 of 12 sampled residents (Resident #8 and #23). Failure to review and revise the care plan limits the ability of staff to communicate care needs and ensure continuity of care for each resident. Findings include: - Review of Resident #23's medical record occurred on all days of survey. A quarterly MDS, dated 05/23/18, identified rejection of cares occurred 4 to 6 days. Review of the Behavior Chart for the month of July 2018 indicated the staff was to monitor for anxiety and restlessness behaviors. The current care plan stated, ". . . Behavioral symptoms . . . She has declined both physically and cognitively and requires total care for her needs and she has difficulty making her needs known . . . Resident often carries doll for comfort and anxiety . . . offer reassurance, redirect and	F 657	F657 1. The care plans were updated to give our staff the ability to communicate care needs and ensure continuity of care for each resident. The care plan and behavior sheets for resident #23 were revised with appropriate behavior interventions including updates to the Problem/Approach on 7/23/2018. The care plan for Resident #8 was updated to reflect appropriate behavior interventions and removed the discontinued prn Ativan including updates to Problem and Approaches on 7/20/2018. 2. The Licensed Social Worker (LSW) will review and revise care plans for all residents that display behavior symptoms, and include measurable objectives and interventions to meet the residents medical and nursing needs related to behavior and as applies per resident. The Behavior Sheets will be updated to match the care plan behavior and interventions.	

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F 657	Continued From page 4 reorientate [sic] as needed, offer food/fluid, offer toileting, provide calm environment, validate resident concerns and respond to concerns appropriately, assess for pain, and monitor tremors and related medications . . ." Observation on the morning of 07/10/18 showed the resident calling/yelling out wanting to get ready for the day. Throughout morning cares, Resident #23 showed agitation and would occasionally kick her legs at staff. Review of Resident #23's progress notes from 04/05/18 to 07/07/18 indicated 14 incidents of combative with cares (hitting, kicking, pinching, and scratching), yelling out, and rejection of medication. The care plan failed to address Resident #23's above behaviors and lacked specific interventions for staff to manage those behaviors. - Review of Resident #8's medical record occurred on all days of survey. The resident's current care plan stated, "Resident displays increased anxiety . . . restlessness, hollering out for help, increased confusion and disorientation at times . . ." Approaches to the problem included: "attempt non pharmalogical [sic] interventions . . . Document interventions prior to use of prn [as needed] Ativan. . . ." The record identified the physician discontinued the prn Ativan on 10/13/17. An interview with a Licensed Social Worker (LSW) (#3) occurred on 07/12/18 at 8:40 a.m. The LSW stated she was unaware of the	F 657	3. The Care Plan policy and procedures will be reviewed by the Administrator, Director of Nursing and Licensed Social Workers. All staff responsible for completing the behavior plan of care were educated on July 12, 2018 to ensure the care plans have current behavior interventions to meet the medical and nursing needs of every resident. These interventions will include appropriate interactions with residents to minimize resident behaviors. Revisions to all residents plan of care will be communicated to the C.N.A. group sheets and behavior sheets. 4. Audits will be completed initially by the Licensed Social Worker to ensure all residents that have a behavior care plan include interventions to meet the residents medical and nursing needs relating to behaviors as applies per resident. Care Plan/Behavior Audits will be completed monthly for one quarter, then quarterly for one year. Results of monitoring will be reported to the Quality Assurance Committee quarterly. The Administrator and/or Director of Nursing will follow up on further education on an as needed basis. 5. August 15, 2018	

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F 657	Continued From page 5 behaviors displayed by Resident #23 or that the physician had discontinued Resident #8's prn Ativan. The LSW (#3) confirmed staff should have updated the residents' care plans regarding the behaviors and the medication change.	F 657		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of professional reference, and facility policy review, the facility failed to provide care and services in a manner to maintain the highest practicable well-being for 1 of 1 sampled resident (Resident #24) observed leaning markedly to the left while eating. Failure to provide assistance and properly position Resident #24's upper body, placed the resident at risk for falls/safety, discomfort, and aspiration. Findings include: Nancy B. Swigert, "The Source for Dysphagia: Third Edition", LinguiSystems Inc, 2007, page 125, identified ". . . During the oral intake of . . . foods and/or liquids, it is optimal for a patient to be seated at a 90 degree angle, whether in bed or chair . . . prior to and during feeding . . . the 90	F 684	F 684 1. The facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the person-centered care plan and the residents□ choices. Resident #24 was evaluated by Occupational Therapist on July 16, 2018 and was assigned to their treatment for proper chair positioning. The care plan and C.N.A. group sheets were updated to cue resident on sitting straight and in an upright position while in a chair. 2. The nursing department in conjunction with the Occupational Therapy department will do random time weekly observation audits in the dining room to identify residents needing alignment and repositioning in chairs to sit	8/15/18

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F 684	Continued From page 6 degree position allows the patient to control material in the oral cavity with a minimal impact of gravity." Review of the facility policy titled, "Repositioning" occurred on 07/11/18. This policy, dated 2013, stated, " . . . Components to evaluate when a resident is in a chair: a. Does the resident need intervention to maintain postural alignment? b. Is the resident's weight distribution even? c. Does the resident need devices to maintain sitting balance? . . . Assist the resident to change his or her position in the chair. . . Place resident in a comfortable position in accordance with the resident's individualized care plan." Observation of Resident #24 during 3 of 3 meals (supper on 07/09/18, lunch on 07/10/18, and breakfast on 07/11/18) in the dining room, showed the resident sitting and leaning to her extreme left over the arm of the dining room chair. Staff failed to assist the resident with positioning to prevent falls and/or aspiration. Review of Resident #24's medical record occurred on July 9-12, 2018. Diagnoses included Alzheimer's disease, dementia, history of falls with fractures, and muscle weakness. A physical therapy note, dated 06/21/18, for Resident #24 stated, " increased left lateral trunk side bend with impaired upright posture and decreased stability." Review of Resident #24's current care plan identified staff failed to address Resident #24's positioning during meals to reduce the potential for falls or aspiration.	F 684	properly upright in chair. The care plans of the identified residents requiring necessary repositioning and proper alignment in a chair will be updated. All residents will be properly positioned prior to providing food or liquids to prevent the potential for aspiration and discomfort. 3. The Director of Nursing and/or Therapist will educate all staff on the policy and procedure on Repositioning: A. Does the resident need intervention to maintain postural alignment? B. Is the resident□s weight distribution even? C. Does the resident need devices to maintain sitting balance? D. Assist the resident to change his or her position in the chair. Place resident in a comfortable position in accordance with the resident□s individualized care plan. 4. The observation audits will be completed weekly for one month and reviewed by the Director of Nursing. The results will be compiled monthly and trended quarterly for the Quality Assurance Committee. These results will be reported to the Quality Assurance Committee quarterly for one year. The Administrator will follow up on further training on an as needed basis. 5. August 15, 2018	

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