STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355066	A. BUILDING _____ B. WING _____	01/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WISHEK LIVING CENTER	400 S 4TH ST WISHEK, ND 58495

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F 000	INITIAL COMMENTS The standard Medicare/Medicaid recertification survey started on 01/02/19 and concluded 01/04/19.	F 000		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview, and review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, the facility failed to complete a significant change in status assessment (SCSA) for 1 of 14 sampled residents (Resident #10). Failure to determine the need for and complete a SCSA in response to a resident's decline limited the facility's ability to accurately assess the resident's status, and identify and implement appropriate care approaches. Findings include: The Long- Term Care Facility RAI User's Manual (Version 1.5), dated October 2017, page 2-22	F 637	F637 1.) Resident #10□s medical record has been updated to include a change of status assessment and is currently being completed by MDS staff. 2.) All residents have the potential to be affected by this deficient practice. 3.) The IDT will be educated on the definition of significant change and the federal requirements for submission on 1/17/19. MDS Coordinator will review the information in the RAI 3.0 User□s Manual regarding significant changes. 4.) MDS Coordinator/Designee implemented a quality monitoring system starting 1/21/19 to review each resident's	1/24/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/17/2019

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F 637	Continued From page 1 stated, " . . . A 'significant change' is a major decline or improvement in a resident's status that: 1. Will not normally resolve itself without staff intervention . . . 2. Impacts more than one area of the resident's health status; and 3. Requires interdisciplinary review and/or revision of the care plan . . ." and page 2-25 stated, "A SCSA is appropriate if there are either two areas of decline or two areas of improvement. . . . This may include two changes within a particular domain (e.g., [for example] two areas of ADL [Activities of Daily Living] decline or improvement. . . ." Review of Resident #10's medical record occurred on all days of the survey. An Annual Minimum Data Set (MDS), dated 07/08/18, identified the resident as required extensive assist with transfers and toileting, and limited assist with eating. A quarterly MDS, dated 10/07/18, identified the resident as dependent with transfers and toileting, and extensive assist with eating. The current care plan stated, ". . . check and change, total assist of two. . . . Total lift for all transfers. . . . Eating: supervision to extensive at times. . . . May need more assist with soups and supper meal. . . ." Review of Resident #10's medical record identified the following progress note: * 10-9-18- "CNA [certified nurse aide] documentation reviewed for MDS. Resident is dependent on staff for transfers via the total lift and is also dependent on staff for toileting cares as resident is check and change. Care plan reviewed. . . ." During the survey the following observations of	F 637	MDS assessment to assure the significant change guidelines and/or documentation is being followed. A QA study will be initiated to monitor 100% of February MDS, 75% of March MDS, 50% of April MDS and then 25% of May MDS. Any irregularities will be reported to the DON for further review and if needed will be referred to IDT for change of status assessment. 5.) 1/24/19	

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F 637	Continued From page 2 Resident #10 occured: * 01/02/19 at 12:13 p.m. in wheelchair in the dining room with a plate of food in front of her that she was not attempting to eat. * 01/02/19 at 12:20 p.m. an unidentified CNA feeding the resident at this time. * 01/03/19 at 08:39 a.m. two CNAs (#5 and #6) checked and changed the resident and assisted resident from the bed to the wheelchair using the total hoyer lift. * 01/03/19 at 02:54 p.m. two CNAs (#3 and #4) checked and changed the resident and assisted the resident from the bed to the wheelchair using the total hoyer lift. During an interview on 01/04/19 at 9:04 a.m. an administrative nurse, (#7) stated "We [the facility] follow the RAI manual regarding completing significant change assessments and we would complete when there is two or more areas of change with ADLs." During an interview on the late morning of 01/04/19 an administrative nurse (#7) confirmed that Resident #10 required total assistance with toileting and transfers and required extensive assist with eating at times.	F 637		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality.	F 658		1/21/19

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F 658	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of professional reference, and staff interview, the facility failed to follow professional standards of practice regarding medication administration for 1 of 7 residents (Resident #102) observed during medication pass. Failure to directly observe residents taking their medications may result in missed doses and/or adverse reactions. Findings include: Saxton and Clark's "Geriatric Medication Handbook," 7th edition, American Society of Consultant Pharmacists, pages 148-149, stated, ". . . Steps of Medication Administration . . . Patient observed while taking medications . . ." Review of Resident #102's medical record occurred on all days of survey. A self-administration of medication assessment, dated 12/10/18, stated, ". . . Staff will administer at this time d/t [due to] being new admission. . . ." Current physician's orders stated, "No self administration of meds [medications]." Observation of the noon medication pass on 01/02/19 identified a staff member (#1) prepared two medications for Resident #102 and left them with the resident, who was seated at the dining room table. The staff member did not observe the resident taking the medications and stated, "He's a self administration." During the noon medication pass on 01/03/19, a staff member (#1) prepared two medications for Resident #102 and left them with the resident at	F 658	F658 1.) Resident #102□s clinical information was update in the eMAR to reflect that he is able to self-administer. 2.) All residents have the potential to be affected by this deficient practice. 3.) The nurses and medication assistants will be in-serviced on the protocol for self-administration of medications on 1/21/19. 4.) QA nurse will observe a medication pass of 3 residents weekly x4, monthly x2 and quarterly x3 to ensure compliance with self-administration of medications. Irregularities will be reported to the DON for further education. QA monitoring will begin 1/21/19. 5.) 1/21/19	

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F 658	Continued From page 4 the dining room table. During an interview on 01/04/19 at 10:21 a.m., a supervisory nurse (#2) confirmed Resident #102 may not self administer and staff should observe him taking his medications.	F 658		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident interview, and staff interview, the facility failed to provide respiratory care consistent with physician's orders for 1 of 4 (Resident #37) sampled residents receiving continuous oxygen . Failure to ensure oxygen is administered as ordered may complicate a resident's respiratory status. Findings include: Observation on all days of survey showed Resident #37 receiving oxygen from a portable tank via nasal cannula (NC) at 3 liters per minute (LPM). Review of Resident #37's medical record occurred all days of survey. The current	F 695	F695 1.) Resident #37□s portable oxygen tank was turned to the correct setting (4L) upon notification of incorrect practice (1-4 -19). 2.) All residents on oxygen therapy have the potential to be affected by this deficient practice. 3.) CNA staff will be in-serviced to leave the oxygen dose set in place at all times and refer to the nurse to check the setting if the machine has been turned off or switching machines for any reason. Nurse/CMA staff will be in-serviced to check the oxygen settings on both oxygen concentrators and portable tanks each shift to ensure correct dose and document on eTAR that oxygen was	1/21/19

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F 695	Continued From page 5 physician's orders included an order for continuous oxygen at 4 LPM via NC. Her current care plan stated, ". . . Medications as ordered by provider. . . ." The treatment administration record (TAR) included continuous oxygen at 4 LPM via NC. During an interview on 01/03/19 at 3:19 p.m., Resident #37 stated staff switched her from her oxygen concentrator to her portable oxygen and adjusted the flow rate. During an interview on 01/04/19 at 9:40 a.m., an administrative nurse (#2) confirmed the oxygen failed to match the physician's orders. She stated she expected staff to follow the physician's orders but failed to provide a policy referencing oxygen therapy.	F 695	checked. In-service for CNAs was completed 1/15/19 and will be completed with nurses and medication assistants on 1/21/19. 4.) QA will monitor all oxygen tanks weekly x4, monthly x2 and quarterly x3. Irregularities will be reported to the DON for further education. QA monitoring will begin 1/21/19. 5.) 1/21/19	
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist	F 756		2/7/19

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F 756	Continued From page 6 during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to provide rationale from the physician indicating the gradual dose reduction (GDR) recommended by the consulting pharmacist was contraindicated for 1 of 5 residents (Resident #26) reviewed for unnecessary medication. Failure of the physician to provide rationale of the contraindication may lead to the prolonged and unnecessary use of medications potentially resulting in adverse consequences. Findings include: - Review of Resident #26's medical record	F 756	F756 1.) Medical director/attending physician reviewed resident # 26□s medical record and agrees with the rationale provided by the NP of why the GDR of ability was contraindicated and he signed off on such. 2.) All residents have the potential to be affected by this deficient practice. 3.) Pharmacy will continue to complete their pharmacy reviews as currently being done. When a provider (such NP or PA) addresses any of the pharmacy□s recommendations that were referred to them the provider will review and dictate	

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F 756	Continued From page 7 occurred all days of survey. Physician's orders included Abilify (antipsychotic medication) 5 milligrams daily written on 09/27/17 for major depressive disorder. A consultant pharmacist's Departmental Note, dated 08/27/18, stated, "Annual GDR for Abilify due in September. . . ." A Progress Note from a nurse practitioner (NP), dated 09/12/18, rejected the recommendation and stated, "As long as she is not showing any signs of side effects, we are going to continue the Abilify at this dose indefinitely. . . ." The record lacked evidence the resident's physician provided rationale and/or confirmed the NP's rationale of why a GDR of Abilify was contraindicated. During an interview with an administrative nurse (#2) on 01/04/19 at 8:54 a.m., she confirmed the attending physician failed to sign off on the rationale rejecting a recommendation for a GDR.	F 756	the change to be made, or provide rationale as to why no changes were made. The resident coordinators will give a list to the ward clerk of the provider□s reviews that were addressed. Upon receiving completed dictations, the ward clerk will give to the attending physician for further review. The physician will either confirm the provider□s decision or make a change and provide rationale. 4.) QA will monitor all pharmacy review recommendations to ensure they are reviewed and signed by a physician monthly x12. QR monitoring will begin in February. All irregularities will be reported to the DON and education will be provided as necessary. 5.) 2/7/19	