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

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355053	A. BUILDING _____ B. WING _____	C 02/26/2015

RECEIVED
APR 27 2015
Division of Health Facilities

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KNIFE RIVER CARE CENTER	118 22ND ST NE BEULAH, ND 58523

(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 complaint survey started on 02/25/15 and completed on 02/26/15, the sample included nine (9) residents for complete review.	F 000		
F 246 SS=E	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE STANDARD SURVEY COMPLETED ON 06/05/14. Based on observation, record review, review of facility policy, resident interview, and staff interview, the facility failed to provide reasonable accommodations of individual needs regarding call light response times for 9 of 9 sampled residents (Resident #1, #2, #3, #4, #5, #6, #7, #8, and #9) with call light response times greater than 30 minutes. Failure to answer call lights in a timely manner may result in falls, avoidable incontinence, increased behaviors, and a decreased quality of life. Findings include: Review of the facility policy titled "CALL LIGHT, USE OF" occurred on 02/26/15. This policy,	F 246	**Plan of Correction F246** 1. All Staff educated on the importance of answering call lights in a timely manner to decrease falls, incontinence, behaviors, and to increase quality of life. Appropriate call badge assignment review done to determine need for portable call system in addition to standard call system for all residents in the facility. The system programmed to monitor/trigger resident based on individual need for safety tracking throughout the building. 2. All residents are potentially at risk. 3. The Director of Nursing Services provided in-service education for all facility staff addressing policies and	03/31/15

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

Brett Erdman | ADMINISTRATOR | 03/19/2015

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

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F 246	Continued From page 1 revised 2012, stated, ". . . Procedure: 1. All nursing personnel must be aware of call lights at all times. 2. Answer ALL call lights promptly whether or not you are assigned to the resident. . . ." - Observation on 02/25/15 at 1:50 p.m. showed Resident #2's call light illuminated outside her door. At 2:35 p.m., an unidentified certified nursing assistant (CNA) entered the resident's room with an afternoon snack and turned the call light off. Review of Resident #2's medical record occurred on all days of survey. Diagnoses included chronic obstructive pulmonary disease. The quarterly Minimum Data Set (MDS), dated 02/05/15, identified the resident as cognitively intact. During an interview on 02/25/15 at 1:50 p.m., Resident #2, identified by the facility as interviewable, stated she often waits over 30 minutes for a staff member to answer her call light. On 01/27/15, a friend of hers called the front desk to have someone come to her room because she had trouble breathing. (Refer to F328). Resident #2 stated earlier in January a resident (Resident #7) down the hall fell in the middle of the night and hollered for help. No one came so Resident #2 pushed her call light and it still took a long time for someone to answer the call light and come to help him (Resident #7). Review of Resident #2's call light response time report, dated January 01 through February 25, 2015, showed at the time of Resident #7's fall, Resident #2 had her call light on for 31 minutes. Further review of the report identified the following:	F 246	procedure, regulations and facility expectations of staff regarding answering call lights in a timely manner on 3/31/15. All staff educated on the call system, how it works, appropriate utilization of call badges, and immediate reporting to IT department with any call light/call badge issues. 4. Extensive all staff education on call light usage and the importance of answering them in a timely manner will be completed by IT department. Director of Nursing or designee will do random checks daily x 1 week, weekly x 1 month, monthly x3, quarterly x1 year. This plan of correction will be monitored at QAPI meetings until such time consistent substantial compliance has been met. Corrective action completion date: March 31, 2015.	

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*On 19 occasions, Resident #2 waited 30 to 60 minutes
*On 11 occasions, Resident #2 waited more than 60 minutes

- Review of Resident #3's medical record occurred on all days of survey. The annual MDS, dated 12/30/14, identified severely impaired cognition.

Review of Resident #3's call light response time report, dated January 01 through February 24, 2015 identified the following:
*On five occasions, Resident #3 waited 30 to 60 minutes
*On five occasions, Resident #3 waited more than 60 minutes

- Review of Resident #7's medical record occurred on all days of survey. The annual MDS, dated 11/20/14, identified moderately impaired cognition.

Review of Resident #7's call light response time report, dated December 01, 2014 through February 24, 2015 identified the following:
*On six occasions, Resident #7 waited 30 to 60 minutes
*On nine occasions, Resident #7 waited more than 60 minutes

- Review of Resident #8's medical record occurred on all days of survey. Diagnoses included dementia and a fractured femur (hospitalized from 01/27/15 to 02/09/15). The quarterly MDS, dated 02/16/15, identified moderately impaired cognition.

Review of Resident #8's call light response time

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report, dated January 01 through February 24, 2015 identified the following:
*On five occasions, Resident #8 waited 30 to 60 minutes
*On two occasions, Resident #8 waited more than 60 minutes

- Review of Resident #1's medical record occurred on all days of survey. The quarterly MDS, dated 12/04/14, identified the resident as cognitively intact.

During an interview on 02/26/15 at 4:20 p.m., Resident #1 stated, "Sometimes it takes staff an hour or more to answer the call light. Staff did mention a few time that there were problems with the call lights not working at different times in the last few months."

Review of Resident #1's call light response time report, dated January 01 through February 25, 2015, identified the following:
*On 13 occasions Resident #1 waited 30 to 60 minutes
*On 8 occasions Resident #1 waited over 60 minutes

- Review of Resident #4's medical record occurred on all days of survey. The quarterly MDS, dated 12/13/14, identified the resident as cognitively intact and required limited assistance of one for transfers, walking, and toileting.

Nursing notes, dated 02/25/15, stated, "Weekly Summary . . . Amb [ambulate] with walker with gaitbelt and assist of one when waits for staff in room."

During an interview on 02/26/15 at 4:40 p.m.

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Resident #4 stated, "They don't answer call lights. I just go to the bathroom myself. Luckily I haven't fallen lately. I did fall about four months ago . . . I don't remember the details. I am suppose to have help when I am up in case I would fall. Sometimes the call light doesn't work properly. I haven't used it much lately, because I just do it myself."

Review of Resident #4's call light response time report, dated January 01 through February 25, 2015, identified the following:
*On 34 occasions Resident #4 waited 30 to 60 minutes
*On 17 occasions Resident #4 waited over 60 minutes

- Review of Resident #5's medical record occurred on February 25-26, 2015. Diagnoses included Alzheimer's Disease and dementia. The quarterly MDS, dated 01/02/15, identified severely impaired cognition, required supervision for transfers and walking in room, and extensive assistance for toileting.

Review of Resident #5's call light response time report, dated January 01 through February 25, 2015, identified the following:
*On 26 occasions Resident #5 waited 30 to 60 minutes
*On 29 occasions Resident #5 waited over 60 minutes

- Review of Resident #6's medical record occurred on all days of survey. During an interview on 02/25/15 at 4:50 p.m. Resident #6, identified by the facility as interviewable, stated she had problems with her call light a few weeks ago and staff replaced her call button and now it

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F 246	Continued From page 5 works. Review of Resident #6's call light response time report, dated January 01 through February 25, 2015, identified the following: *On 8 occasions Resident #6 waited 30 to 60 minutes *On 5 occasions Resident #6 waited over 60 minutes - Review of Resident #9's medical record occurred on all days of survey. Review of the call light response time report, dated January 01 through February 25, 2015, identified the following: *On 34 occasions Resident #9 waited 30 to 60 minutes *On 23 occasions Resident #9 waited over 60 minutes During an interview on 02/26/15 at 8:50 a.m. a nurse manager (#1) could not explain call light response times greater than one hour except staff failed to answer them.	F 246		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.	F 328	**Plan of Correction F328** 1. On 1/28/15, at 12:37 a.m. on being called to resident #2 room, who then complained of feeling as though she was not getting any oxygen, the night nurse found the humidifier bottle was not screwed on straight to the oxygen concentrator. She reattached the	03/31/15

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F 328	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on record review, professional reference review, resident interview, and staff interview, the facility failed to provide the necessary care and services for 1 of 4 sampled residents (Resident #2) on continuous oxygen. Failure to provide oxygen as ordered to maintain appropriate oxygen levels and failure to ensure oxygen equipment functions properly caused Resident #2 to experience decreased oxygen levels, anxiety, and has the potential for other residents to experience complications related to low oxygen saturation levels. Findings include: Berman, A.T., and Snyder, S. (2012). "Kozier & Erb's Fundamentals of Nursing: Concepts, Process, and Practice," (9th ed). *Page 1397 stated, "OXYGEN THERAPY . . . Like any medication, oxygen is not completely harmless to the client. Clients can receive an inadequate amount or an excessive amount of oxygen and both can lead to a decline in the client's condition. An inadequate amount of oxygen (hypoxia) will lead to cell death, and if left untreated can ultimately lead to death. . . ." *Page 1401 stated, "Administering Oxygen by Cannula, . . . Administering Oxygen by Cannula . . . 4. Set up the oxygen equipment and the humidifier . . . *Attach the prescribed oxygen tubing and delivery device to the humidifier. 5. Turn on the oxygen at the prescribed rate and ensure proper functioning. *Check that the oxygen is flowing freely through the tubing. . . . You should feel the oxygen at the outlets of the	F 328	bottle and resident received adequate supply of oxygen. 2. The Facility has determined that all residents with humidified oxygen concentrators have the potential to be affected. 3. An in-service education program will be conducted on 3/19/15 by the Director of Nursing Services with nurses and certified medication aides and again on 3/25/15 with all facility staff alerting all staff to the significance and necessity of oxygen equipment in adequate working condition to provide appropriate oxygen per physician order. 4. The Director of Nursing Services and the nursing management team have reviewed each resident with oxygen to ensure equipment is connected properly and in working condition.	

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F 328	Continued From page 7 cannula . . ." Review of Resident #2's medical record occurred on February 25-26, 2015. Diagnoses included chronic obstructive pulmonary disease (COPD), anxiety, and chronic pain. Physician's orders included oxygen at 3 liters per nasal cannula (L/NC) with exertion and 2 L/NC at rest. The quarterly Minimum Data Set (MDS), dated 02/05/15, identified the resident as cognitively intact. Resident #2's progress notes stated the following: *01/27/15: - "[6:00 p.m.] summoned to room resident is complaining of chest pain with radiation down her left arm. Skin warm and dry. BP [blood pressure] 92/62, P [pulse] 98, R [respirations] 20 O2 sat [oxygen saturation] 88%. Dr. [name] notified order Nitro SL [nitroglycerin sublingual] 0.4 mg [milligrams] po [by mouth] q [every] 5 min [minutes] x 3 [three times] . . . " - "[6:05 p.m.] Nirto [sic] 0.4 mg SL . . ." - "[6:10 p.m.] Chest pain has subsided 'some'. Resident is adamant that she does not want to go to the ER [emergency room]. Given Nitro 0.4 mg SL BP 90/62, P 101, R 20, O2 sat." (the nurse failed to document the O2 sat) - "[6:20 p.m.] States her pain is about a 5-6 on the 0-10 pain scale. . . ." *01/28/15 at 12:04 a.m. (late documentation): - "At [7:02 p.m.] I went into residents room to check on her to see how she was feeling. . . . O2 sats 86% and her pain was still about a 6 in her chest radiating down her arm. . . ." - "[8:00 p.m.]- went into residents room to check on her. BP 103/59, O2 83%. He pain level was the same and in the same areas. . . . " - "[9:00 p.m.]: Neb [nebulizer] treatment given per	F 328	The Director of Nursing Services (DON), or designee, will complete random equipment audits for four (4) consecutive weeks to ensure that all oxygen equipment is properly connected and in working condition. Audited records will be reviewed by the QAPI Committee until such time consistent substantial compliance has been achieved as determined by the committee. Findings of this audit will be discussed with the Resident Council. Corrective action completion date: March 31, 2015.	

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MAR [medication administration record] . . . O2 79-81%. No change in pain . . . Nasal cannula changed to oxygen mask to see if that would help. We will continue to monitor resident throughout the night and to keep her as comfortable as we can."
*01/28/15 at 12:37 a.m. - "Asked to come to residents room. When got there, she was asking to get cleaned up and in pajamas. She also stated that she took the mask off and put her nasal cannula back on because the mask was uncomfortable. I checked her sats and they were still down at 81%. She stated it didn't feel like she was getting the oxygen at all. I checked the tubing to see if it had been connected right and I could not feel oxygen coming out of it. I changed the concentrator and I could still not feeling [sic] any oxygen come out. I then checked the container of water to see if that was the problem. The cap was screwed on crooked and so I rescrewed it on the correct way and instantly could feel the air come out of the cannula. Checked residents sats and right away they were up to 90%. So throughout the day, she was probably not getting much or if any oxygen out of her cannula."

During an interview on 02/25/15 at 1:50 p.m. regarding the above incident, Resident #2 stated she had trouble breathing the night of January 27 and 28. She called a friend and he told her to turn on her call light. She told him she had and no one answered it yet. Resident #2 stated the friend said he would call the front desk for her and ask someone to come to her room.

Review of the call light response time reports, dated 01/27/15, identified facility staff answered Resident #2's call light at 10:25 p.m., 42 minutes after she had turned it on.

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F 328	Continued From page 9 During an interview on the afternoon of 02/26/15, an administrative nurse (#2) stated Resident #2 oxygen saturation usually measures in the upper 80's to low 90's.	F 328		
F 463 SS=F	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE STANDARD SURVEY COMPLETED ON 06/05/14. Based on facility policy review, review of facility work orders, resident interview, and staff interview, the facility failed to provide a functional call light system which allows residents to call for assistance when needed on 3 of 3 units. Failure to provide a functional call system may result in unmet resident needs. Findings include: Review of the facility policy titled "CALL LIGHT, USE OF" occurred on 02/25/15. This policy, revised in 2012, stated, ". . . Procedure: . . . 8. Check all call lights daily and report any defective call lights to the charge nurse immediately. 9. Report defective call lights, with exact location. . . . 11. In the event that the alert system does not receive alerts, this will be communicated to staff.	F 463	**Plan of Correction F463** 1. Facility had/has a working call system. 2. The Facility has determined that all residents have the potential to be affected by the call system. 3. An in-service education program on importance of immediate reporting of any call system issue to IT was done with C N A s on 3/12/15 and will be conducted by the IT department with nurses and CMAs on 3/19/15 and with all staff on March 25, 2015. Review of Intelligent Insights computer access for computer stations, re-education on importance of calling IT with any system problem related to the call system, what to do when	03/31/15

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F 463	Continued From page 10 Hourly room checks will be started. Staff will be in line of sight for when residents do put on call lights. This will remain in effect until system is functioning properly." Review of the resident council meeting notes, dated November 2014 through February 25, 2015, identified the following: * 01/14/15 - "Call light system does not work. 'Sometimes the lights go off, sometimes they don't', 'the lights don't go off around here.' 'Lights are not getting answered.' Statements received from a group of residents. Several options are being looked into to upgrade this call light system. If your light is not being answered please come see a social worker." * 02/11/15 - "Call light system: Bid has been received on a more efficient and effective call light system. There will have to be some changes made to the call lights system we have now in place." Review of the facility's work orders from October 2014 through February 25, 2015, showed work orders related to 31 residents' badges and/or call lights not functioning correctly. - During an interview on 02/26/15 at 4:20 p.m., Resident #1, identified by the facility as interviewable, stated, "Sometimes it takes staff an hour or more to answer the call light. Staff did mention a few time that there were problems with the call lights not working at different times in the last few months." - During an interview on 02/26/15 at 4:40 p.m. Resident #4, identified by the facility as interviewable, stated, "They don't answer call lights. I just go to the bathroom myself. Luckily I	F 463	call system is not functioning properly, discussion of culture change- -all staff are responsible to answer lights. Detailed education will be conducted monthly with New Employee Orientation. Procedure has been revised to include Badge Checks. Facility has ordered Remote Stations for each resident room which will enhance our present Nurse Call system. The new remote stations are being installed as quickly as we can. 4. The IT department, or designee , will conduct a random audit of call lights and working status weekly x4, monthly x3, and quarterly x1 year. This plan of correction will be monitored at the monthly QAPI meeting until such time consistent substantial compliance has been met. Corrective action completion date: March 31, 2015.	

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haven't fallen lately. I did fall about four months ago . . . I don't remember the details. I am suppose to have help when I am up in case I would fall. Sometimes the call light doesn't work properly. I haven't used it much lately, because I just do it myself."

Review of the facility's work orders, dated 11/17/14 and 02/05/15, identified Resident #4's personal badge and bathroom call light failed to "turn hall light on or alert pagers."

- During an interview on 02/25/15 at 4:50 p.m. Resident #6, identified by the facility as interviewable, stated after staff replaced her call button a few weeks ago, she has had no problems when using the call button for staff assistance.

Review of the facility's work orders, dated 10/13/14, identified Resident #6's "badge lite [light] not turning on outside of room . . . bulb replaced" and then on 10/14/14, "badge not working . . . Badge replaced."

During an interview on the afternoon of 02/26/15, two administrative staff members (#1 and #4) stated they are aware of the issues related to the call light system.