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 07/10/2024

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 An unannounced onsite investigation survey regarding a facility reported incident was completed on July 8, 2024. During the report investigation, the facility was found non-compliant with regulatory requirements. Based on the results of the investigation survey, an extended survey was conducted on July 10, 2024.	F 000		
F 689 SS=K	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to ensure an environment free of accident hazards for 1 of 1 sampled resident (Resident #5) who experienced a burn related to hot coffee. Failure to ensure appropriate coffee/water temperatures resulted in Resident #5 sustaining burns and placed all residents at risk for serious burns/injuries. During the on-site facility reported incident (FRI) investigation, the team consulted with the State Survey Agency (SSA) and determined an Immediate Jeopardy (IJ) situation existed on 07/03/24. A nursing progress note, dated 07/03/24 at 1:03 p.m., stated, ". . . Resident fell	F 689	What corrective action will be accomplished for those residents affected by the deficient practice: Resident #5 was evaluated by therapy, given mugs with lids, hot liquids served to resident #5 (and all residents) must be less than 140 degrees Fahrenheit, dietary care plan was updated, and meal ticket was updated for Resident #5. All staff were educated regarding resident #5's mugs with lids and that all residents need hot liquids less than 140 degrees Fahrenheit. How will you identify other residents	7/31/24

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

Electronically Signed | 08/01/2024

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F 689	Continued From page 1 asleep at the table and spill [sic] hot coffee on her lap. Taken back to her room, pants removed. Large area of redness to bilateral thighs (top and inner) with blistering noted." The IJ resulted from temperature readings obtained from the coffee/hot water machine, a lack of temperature monitoring by staff, and an injury to a resident. This finding placed residents in immediate danger due to hot temperatures and potential for serious burns. *07/08/24 at 5:58 p.m. the survey team notified the administrator of the IJ situation, provided the IJ template, and requested a plan for removal of the IJ. *07/09/24 at 8:30 a.m. the survey team reviewed and accepted the facility's removal plan for the IJ. The removal plan contained the following: *Education sent to all staff members who worked on 07/08/24. A mass notice sent to all staff on 07/08/24 informing them they will be provided education before the start of their next shifts. *Education included training staff members on the correct procedure for taking temperatures of hot liquids and ensuring the beverages are less than 140 degrees Fahrenheit (F) prior to serving them to residents. *Education identified staff are not to serve hot beverages to resident that temped higher than 140 degrees Fahrenheit (F) and to hold the beverage until the temperature is less than 140 degrees (F) before serving the beverage to a resident. *07/10/24, the survey team verified the	F 689	having the potential to be affected by the same deficient practice? The facility recognizes that all residents have the potential to be affected by hot liquids. How the deficiency will be corrected? Include how the facility will correct the existing deficiency. Identify what measures will be put into place and what systemic changes the facility will make to ensure the deficient practice does not recur. Example: Look at the system and determine if a change to the existing system is needed, if a new system is necessary or if a system does not exist and must be developed. Hot liquid temperatures are monitored daily to ensure residents receive hot liquids less than 140 degrees Fahrenheit. Ongoing monitoring will be completed on each unit by the dietary servers at each meal service. Coffee Shop temperatures will be monitored by the main cooks. All staff were educated on ensuring hot liquids are below 140 degrees Fahrenheit when served to residents. The policy titled Hot Liquid Safety Policy was adopted. All staff were educated regarding the Hot Liquid Safety policy. In addition, the assessment titled Hot Liquid Safety Evaluation was adopted for all new admissions to be assessed for increased risk of exposure to hot liquids. Managers educated on Hot Liquid Safety Evaluation with new admissions. The assessment will be completed by the COTA and/or designee. In addition, the facility has	

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F 689	Continued From page 2 implementation of the removal plan as of 07/08/24 and the IJ removal. The deficient practice remained at a "G" scope and severity following the removal of the immediate jeopardy. Findings include: Review of Resident #5's medical record occurred on 07/08/24. Nursing progress notes included the following: - 07/03/24 at 1:03 p.m. ". . . Resident fell asleep at the table and spill [sic] hot coffee on her lap. Taken back to her room, pants removed. Large area of redness to bilateral thighs (top and inner) with blistering noted. Assisted to bed and placed in a gown. Call placed to [physician's name] office. Awaiting return call. [Family's name] notified." - 07/03/24 at 3:15 p.m. ". . . IDT [interdisciplinary team] met and reviewed incident regarding resident spilling her coffee. Resident to have covered mugs for all hot liquids." - 07/04/24 at 7:47 a.m. ". . . L) [left] thigh has 5 large fluid filled blister [sic]. R) [right] has 1 fluid filled blister. cleansed with gentle soap and water. Applied bacitracin [antibiotic ointment]. Telfa to cover with kerlix [a gauze strip] to hold dressing in place." Resident #5's care plan identified a focus initiated on 01/17/23, which stated, "Resident is at risk for injury related to hot liquids. She has spilled tea on her hand, arm and thighs in the past . . . Remind staff to assure that resident has a coffee mug with a cover. RESIDENT DOES REMOVE COVERS FROM MUGS . . ." During an interview on 07/08/24 at 1:18 p.m., an	F 689	worked with its hot liquid vendor to ensure that all machines that dispense hot liquids are below 140 degrees Fahrenheit. The facility created temperature logs that will be completed on each unit (completed by server) and the coffee shop (completed by main cooks). Temp logs will be reviewed/maintained by the dietary manager. How does the facility plan to monitor its performance to ensure solutions are permanent? What quality assurance process will be developed to ensure the correction is achieved and sustained? Identify the frequency of the monitoring and the staff person by job duty (NOT INDIVIDUAL NAME) that will monitor the corrective action? The facility plans to monitor its performance to make sure solutions are sustained by assigning Unit Managers and the Dietary Manager to each complete one audit per week for a total of four audits per week. The audit consists of an assessment of a resident's care plan and meal ticket for adaptive equipment, assessment during a meal service to verify adaptive equipment is utilized (if applicable), ask staff if they are aware of adaptive equipment for resident (if applicable), and taking the temperature of a hot liquid to verify it is less than 140 degrees Fahrenheit. Four audits will be completed weekly for 9 weeks and then will be sustained by completing four audits per month thereafter. Audits will be monitored by the QAPI Nurse. Results of	

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F 689	Continued From page 3 administrative nurse (#2) identified the mug lids were not on the meal ticket or the dietary care plan at the time Resident #5 spilled her coffee in the dining room. Staff interviews conducted by the facility while investigating Resident #5's coffee spill failed to identify a lid on the coffee cup or that during the meal the resident removed the lid. During an interview on 07/08/24 at 3:45 p.m., an administrative staff member (#1) confirmed the tray provided to Resident #5 at the noon meal on 07/03/24 lacked a lid on the hot beverage. Temperatures obtained by the dietary staff member (#3) with the surveyor on the afternoon of 07/08/24 showed the following: * Harvest Lane kitchenette: Coffee 170 degrees F * Whispering Winds kitchenette: Coffee 164 degrees F, hot water 186.9 degrees F * Shady Lane kitchenette: Coffee 161 degrees F, hot water 178.5 degrees F * Coffee/cappuccino machine: Coffee 171.1 degrees F, and cappuccino 155.7 degrees F During interviews on the afternoon of 07/08/24 with staff members from administration (#1 and #2) and dietary (#3, #4, and #5), all confirmed the facility failed to monitor the temperature of hot beverages before, on the day of, or since Resident #5 experienced burns from hot coffee.	F 689	these audits will be reported to the QAPI committee. When the deficiency will be corrected? 7/31/2024	