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

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 _____	08/11/2011

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 standard Medicare/Medicaid recertification survey started on August 8, 2011 and completed on August 11, 2011, the sample included four (4) residents for complete review, nine (9) residents for focused review, and three (3) closed records for review. The sample included four (4) additional residents to verify specific concerns during the survey.	F 000		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.	F 225	**Plan of Correction F225** Knife River Care Center recognizes the statement, "The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency)." Knife River Care Center also recognizes the statement, "The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent	09/15/11

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

[signature] ADMINISTRATOR 09-01-11

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

[signature] | ADMINISTRATOR | 09-01-11

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F 225	Continued From page 1	F 225		

The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

This REQUIREMENT is not met as evidenced by:
Based on observations, record review, facility policy/procedure, and staff interview, the facility failed to report to the State Agency 1 of 3 alleged incidents of neglect and/or abuse reviewed during the survey (Resident #20). The failure to report, investigate, and take corrective action places residents of the facility at risk for abuse and neglect.

Findings include:

Review of the facility policy titled "Knife River Care Center Abuse Reporting" occurred on 08/11/11. This policy, revised 06/30/11, stated, ". . . Policy Statement All personnel must promptly report any incident or suspected incident of resident abuse, including injuries of unknown source. . . Policy Interpretation and Implementation . . .
7. Facilities must report all allegations of resident mistreatment, neglect, and abuse, including injuries of unknown source and misappropriation of resident property, by a nurse aide or by another individual used by the facility in providing services to a resident to the department [State

further potential abuse while the investigation is in progress."

In the spirit of cooperation the facility has taken the positive action to promote immediate reporting of all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property.

1. The initial report of the allegation was not submitted to the state. However, Knife River Care Center has evidence that the alleged violation affecting resident #20 was investigated, and the determination made that no negative outcome occurred.

2. All residents of Knife River Care Center have the potential to be affected by this practice. The Abuse Prohibition and Abuse Reporting Policies are in place to protect all residents.

3. The Unit Manager and Licensed Social Worker/Social Service Designee will work

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F 225	Continued From page 2 Agency] immediately (as soon as possible, not exceeding 24 hours) . . . followed by the report of the results of their investigation within five working days . . . 10. g. 'Neglect' shall mean failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. This shall include, but not be limited to, when a resident does not receive cares in one or more areas . . . failure to carry out resident services as directed or ordered by the physician . . . failure to give proper attention to residents, or failure to carry out resident services through careless oversight . . . 13. The supervisor who receives the report must complete or assist the reporter to complete a Resident Abuse Report Form . . . A completed copy of the report is provided to the administrator or his/her designee no later than twenty-four (24) hours after the reporting of such incident . . . 18. Any person who had knowledge or reason to believe that a resident has been a victim of mistreatment, abuse, neglect, or any other criminal offense SHALL report, or cause a report to be made of the mistreatment or offense. . . ." - During an interview on the afternoon of 08/09/11, a staff member (#3) stated he/she had reported an incident to the unit manager about "4-5 months ago." This staff member reported finding a resident left on the toilet after the previous staff member had left her/his shift. Review of the facility investigations of alleged abuse and/or neglect occurred at 8:10 a.m. on 08/11/11. During this review, a social services staff member (#5) indicated she did not have information on that alleged incident.	F 225	together on all complaint investigations. The Abuse Prohibition and Abuse Reporting Policies have been updated to clarify the reporting requirements of alleged incidents of neglect and/or abuse. (See Exhibit #F225-1). These policies will be reviewed at the September General Staff meeting on Wednesday, September 28, 2011. Staff will sign and acknowledgement that they were educated on the updated policy. In addition, staff is required to complete annual education on abuse and neglect. Education with all supervisors will be held in September at the regular Department Manager's meeting. 4. A Quality Assurance assessment tool has been devised to randomly monitor the supervisor's knowledge of the Abuse Prohibition Policy and reporting requirements. (See Exhibit F225-2) In addition, a QA will be implemented to measure the	

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F 225	Continued From page 3 Later in the morning of 08/11/11 the social services staff member (#5) presented a form titled, "Notice of Counseling/Discipline." This form, dated 04/20/11, stated, ". . . On 4/6 about 2:45pm, [staff name] used the standing lift and placed resident [Resident #20] on the toilet in her room. She did not report this to anyone. Shortly after 3:30 a CNA was looking for the standing lift and found it hooked up to the resident sitting on the toilet in the bathroom. The resident was sleeping and awoke when the CNA entered the bathroom. The resident commented that she was glad to see her because she had 'been on the toilet for almost an hour'. . . The second concern is that the resident was left on the toilet for a considerable amount of time placing her at high risk for skin breakdown. . . There wasn't any skin breakdown noted, however, the risk was there. . . ." Review of a report submitted by the Unit Manager, undated, also stated, ". . . On 4/7 when I came to work there was a written communication under my door . . . She [the CNA making the report] also, said that the resident wasn't hooked up to O2 [oxygen], which is continuous, so she had been without it for the same period of time. (Incidentally, the tubing is long enough on her oxygen to reach the bathroom.). . ." Record review identified the facility addressed the incident as a disciplinary action rather than an allegation of neglect. Review of Resident #20's closed medical record occurred on 08/11/11. The most recent care plan	F 225	compliance of standards in alleged abuse/neglect investigations. (See exhibit # 225-3)	

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F 225	Continued From page 4 indicated a problem of "weakness and hx [history] of falls. Has a (L) leg prosthesis with an approach of "transfers [with] standing lift & [and] 1-2 assist. . . Potential for impaired skin integrity due to hx of pressure ulcer. Hx of open area to coccyx area . . ." Review of Resident #20's IDP notes included the following: *04/03/11 "Orders for O2 [oxygen] 1-4 L [liters] to keep sats [saturations] above 90% . . . O2 sats 96% on 4LNC [liters per nasal canula]" *04/04/11 "O2 sat's [arrow down] O2 [arrow up] 3L N/C. . ." *04/05/11 "Weekly summary . . . O2 cont 3L N/C to keep O2 sats [arrow up] . . ." Physician's orders dated 04/06/11 listed "Oxygen 1-4 L/NC". During an interview on the morning of 08/11/11, the social services staff member (#5), agreed that the alleged incident "should have been reported." Failure to report and investigate allegations of resident abuse or neglect to the State survey and certification agency places all facility residents at risk of abuse and neglect.	F 225		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident 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	F 274	**Plan of Correction F 274** In the spirit of cooperation, Knife River Care Center has taken a positive action to conduct a comprehensive assessment of a resident within 14 days after the facility determines that there has been a significant change in the resident's physical or mental condition.	09/15/11

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F 274	Continued From page 5 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, and staff interview, the facility failed to complete a comprehensive assessment of residents within 14 days when a significant change occurred in the resident's condition for 1 of 1 sampled resident (Resident #10) who experienced a significant change (decline) in behaviors, functional status, and bladder/bowel status; and for 1 of 1 sampled resident (Resident #3) who experienced a significant change (improvement) in functional and bladder/bowel status. Findings include: - Review of Resident #10's medical record occurred on all days of survey and identified diagnoses included Alzheimer's disease, osteoarthritis, and depression. A quarterly MDS dated 02/25/11, identified Resident #10 as independent with the following Activities of Daily Living (ADL's): bed mobility, transfer, locomotion on and off the unit, and toilet use with set up assist only. This MDS also identified the resident as continent of bowel and bladder and no indicators of behaviors. A quarterly MDS, dated 05/27/11, indicated	F 274	1. In reviewing the record for Resident #10 and the record for Resident #3, the MDS was completed in a timely manner, and no negative outcome occurred as a result of an MDS being coded incorrectly. A significant change in status assessment for Resident #10 has been scheduled with ARD of 09/18/11 and will be completed on 09/14/11. 2. Knife River Care Center will take positive action to identify and evaluate any resident to determine if a significant change in status has occurred. The Unit Managers, Social Services, Risk Manager, Therapy Services and Resident Care Coordinators will continue to attend weekly Quality Assurance Incident review meetings. During this interdisciplinary meeting, there will be a review of residents who have recently had illnesses including hospitalizations, falls, or any change in condition. A	

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F 274	Continued From page 6 Resident #10 needed extensive assist of one person for the following ADL's: bed mobility, transfer, locomotion off the unit, and toilet use. This MDS identified frequent urinary incontinence, occasionally bowel incontinent, and rejection of care occurred one to three days during the assessment period. Observations of care provided during August 8-9, 2011, showed Resident #10 continued to require extensive assistance of one person for transfer from the bed to the toilet, personal hygiene, and locomotion in a wheelchair. The record lacked evidence the staff considered completing a significant Change in Status Assessment (SCSA) for the resident's decline in the following: bed mobility, transfer ability, locomotion, toilet use, and bowel/ bladder continence. Failure to complete a comprehensive assessment in response to Resident #10's physical and mental decline placed the resident at risk for continued decline and the lack of appropriate interventions to restore or maintain physical and mental function. - Review of Resident #3's medical record occurred on all days of survey. Resident #3's diagnoses included congestive heart failure, insulin dependent diabetes mellitus, chronic obstructive pulmonary disease, osteoarthrosis, and atrial fibrillation. Resident #3's admission MDS, dated 11/23/10, identified the resident required extensive assistance of one person for bed mobility,	F 274	Resident Care Coordinator, along with C.N.A staff, Unit Managers, Therapy and the Risk Manager will continue to review residents for improvement or declines in transfers at the monthly Safe Lift committee meeting. In addition to these routinely scheduled meetings charge nurses will continue to evaluate and report any changes in resident condition as needed. 3. Monitoring for significant change in health conditions will be accomplished by Interdisciplinary participation in Care conferences, Quality Assurance Incident review meetings and Safe Lift meetings. Any resident who returns from the hospital will have the medical record reviewed for determination of further evaluation. A determination serviced on reporting change in condition to the charge nurse on September 7, 2011 during the C.N.A meeting. On October 6, 2011, Nurses will be in-serviced	

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F 274	Continued From page 7 transfer, locomotion on/off the unit, dressing, toilet use, and personal hygiene; limited assistance of one person with ambulation in the room; and frequently incontinent of urine. The quarterly MDS, dated 02/15/11, identified Resident #3 required limited assistance of one person for bed mobility, dressing, toilet use, and personal hygiene; supervision with ambulation in the room/corridor and locomotion on/off the unit; independent with transfers; and continent of urine. Resident #3's record lacked evidence facility staff considered completing a comprehensive assessment when the resident exhibited improvement in functional and bowel/bladder status. The quarterly MDS, dated 05/14/11, identified the resident as independent with bed mobility, transfers, ambulation in the room/corridor, locomotion on the unit, eating, and toilet use. Observations made the morning of 08/09/11 showed Resident #3 independent with bed mobility, transfers, and ambulation in the room/corridor; and continent of urine. Facility staff failed to recognize Resident #3's improvement and complete a significant change MDS.	F 274	of significant change in condition will be assessed, and scheduled for Significant change in status assessment when criteria met. In addition, C.N.A staff will be in- on significant change in status assessments and reporting a decline or improvement in health to the Unit Manager or Resident Care Coordinators. A memo containing significant change in status assessment criteria will be posted in the neighborhood communication areas for staff to review, and this memo will be reviewed at the General Staff Meeting on 8-31-11, as well as on 9-7-11 at the C.N.A meeting and October 6, 2011 Nurses meeting will be a follow up to General Staff meeting held on August 31, 2011. (See Exhibit 274 # 1)	
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section.	F 311		

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F 311	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy and procedure, record review, and staff interview, the facility failed to provide residents with restorative therapy services as ordered and required to maintain or improve strength and endurance for 2 of 4 sampled residents (Resident #5 and #12) on a walk-to-dine restorative therapy program. Failure to consistently implement the residents' walk-to-dine restorative therapy program did not allow the residents to achieve and maintain their highest practicable level of physical, mental, and psychosocial well-being. Findings include: Review of the facility policy/procedure titled "Restorative Nursing - Bed Mobility and/or Walking Training" occurred on 08/11/11. This policy, dated 04/09/10, stated, "POLICY: 1. Restorative nursing staff will provide bed mobility and/or walking training as determined by the therapist to maintain the ability to reposition in bed, ability to ambulate, encourage independence, and influence positive self image. 2. Restorative nursing staff will provide bed mobility and/or walking training as determined by the therapist to help promote independence with toileting and increase strength. PROCEDURE: . . . 4. Gather any assistive devices such as a walker or a cane and bring them to the resident. 5. Encourage and assist the resident in performing as much as possible independently . .	F 311	4. A quality assurance assessment tool has been developed to review resident records to determine if a change in status has occurred where a significant change MDS would have been warranted. (See Exhibit F274-#2.) 5. The QA tool will be completed by nursing staff in September 2011 and quarterly thereafter. Results of the QA will be reviewed at the quarterly Quality Assurance meeting tentatively scheduled for November 2011 and quarterly thereafter as needed.	

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F 311	Continued From page 9 23. Document time spent with resident and self-performance/assistance needed on the CNA [certified nursing assistant]/RNA [restorative nursing assistant] documentation sheets." - Review of Resident #5's medical record occurred on all days of survey. Diagnoses included degenerative joint disease, depression, anxiety, and a left hip fracture occurring from a fall on 04/27/11. The quarterly Minimum Data Set (MDS), dated 05/23/11, identified the resident required limited assistance of one staff member for transfers and locomotion on the unit and supervision for walking in her room and in the corridor. The MDS identified the resident had a functional limitation in range of motion on one side of her lower extremities and participated in a restorative nursing program for walking on three days during the assessment period. Review of Resident #5's therapy progress notes showed an order, dated 06/22/11, which stated, "Start walk-to-dine program. Assist of [one] [and] use of FWW [front wheeled walker] to and from dining room for each meal, sit in dining room chair." Observation of the supper meal on 08/08/11, the breakfast meal on 08/09/11, and the lunch meal on 08/09/11 showed Resident #5 sitting in her wheelchair at the dining room table. Staff failed to ambulate the resident to and from the meals. Resident #5's CNA ADL [activities of daily living] Flowsheets from June 22, 2011 to August 11, 2011 showed staff assisted the resident to meals using the "walk-to-dine" program on 65 of 148 possible opportunities.	F 311	**Plan of Correction F 311** It is Knife River Care Center's Practice to provide the necessary care and services to attain or maintain, the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. In the spirit of cooperation, the facility has taken a positive action to promote the physical, mental and psychosocial well-being of our residents. 1. Residents #5 and #12, who are not actively participating in their walk-to-dine program will be referred to therapy services for re-evaluation and if needed, modifications will be made to the current plan of care, and treatment plan changes will be adjusted or modified as needed. (Exhibit F-311 #1)	09/15/11

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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 311	Continued From page 10 - Review of Resident #12's medical record occurred on August 10-11, 2011. Diagnoses included history of a left hip fracture, history of venous thrombosis, arthritis, osteoporosis, and edema. The annual MDS, dated 05/25/11, identified the resident required extensive assistance of one staff member for transfers and locomotion on the unit and limited assistance of one staff member when walking in her room and in the corridor. The MDS showed the resident participated in a restorative nursing program for walking on four days during the assessment period. Review of Resident #12's therapy progress notes showed an order, dated 01/12/11, which stated, "Start walk-to-dine program to and from all meals [with] FWW and assist of [one]." Observation on 08/10/11 at 5:00 p.m. showed Resident #12 sitting in her wheelchair at the dining room table. Staff failed to ambulate the resident to the meal. Review of Resident #12's CNA ADL [activities of daily living] Flowsheets from June 01, 2011 to August 11, 2011 showed staff assisted the resident to meals using the "walk-to-dine" program on 134 of 216 possible opportunities. During an interview on 08/11/11 at 10:00 a.m., two administrative nurses (#1 and #6) stated they recognized there were problems with the facility's walk-to-dine program.	F 311	2. All residents currently on the walk-to-dine program who are not actively participating in the Walk to Dine program will be referred to therapy services for re-evaluation and modification to the current plan of care if needed. (Exhibit F-311 #2). Restorative Therapy staff hold monthly meetings consisting of R.T/C.N.A staff, RN Supervisor and Therapy Services. Those resident(s) in the Walk to Dine Program will be evaluated on a regular basis at these meetings and modifications will be made as needed. (Exhibit F-311 #3) 3. The Walk to Dine program will be reviewed at the General Staff meeting on August 31, 2011 and at the regular C.N.A meeting on September 7, 2011. Included will be education on documenting time spent with a	

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