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 02/26/2025

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 The standard Medicare/Medicaid recertification survey started on 02/24/25 and concluded 02/26/25.	F 000		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas;	F 584		4/2/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/18/2025

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 584	Continued From page 1 §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility cleaning logs, and family and staff interview, the facility failed to ensure a safe, clean, comfortable, and homelike environment for 2 of 11 sampled residents (Resident #32 and #65) who required a wheelchair. Failure to maintain a safe, clean, and sanitary environment may lead to injury from unsafe equipment, does not provide a homelike living area for residents, and fails to promote quality of life. Findings include: - Observation on 02/24/25 at 9:57 a.m. showed Resident #32's wheelchair in disrepair, with the vinyl of the armrest pads cracked, missing pieces, and flaking. During an interview on 02/26/25 at 11:28 a.m., a staff member (#4) confirmed the armrest pads need replacement. - During an interview on 02/24/25 at 4:50 p.m., a family member (#1) of Resident #65 stated staff do not clean his Broda chair (special type of wheelchair) or his room, noting tissues and a lollipop stick on the floor. The family member pointed to dried feces on the frame of the Broda	F 584	What corrective action will be accomplished for those residents affected by the deficient practice: Resident #65 wheelchair was cleaned and education provided to nursing staff that resident #65 wheelchair is to be cleaned weekly and documented. Resident #32 wheelchair armrest pad was replaced. Education provided to Shady Lane staff to report repair issues with equipment through our facility WorkxHub platform. Education provided to therapy staff to be doing quarterly rounds on all resident equipment to ensure in good condition (clean and free from disrepair issues). How will you identify other residents having the potential to be affected by the same deficient practice? Identification of other residents that utilize wheelchairs and/or walkers analyzed for cleanliness and in good condition was completed. Education provided to nursing staff in regard to wheelchairs and walkers need to be cleaned weekly and on the "Safe Resident Handling/Transfers" policy. Education provided to all staff to	

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F 584	Continued From page 2 chair. Observation showed a dried brown substance with the odor of feces on the metal frame and on the middle crossbars beneath the seat. Observation on 02/25/25 at 3:24 p.m. showed Resident #65's Broda chair contained food debris in the area between the seat and chair sides, in the pocket-like area at the top of the leg rests, and on the arm rests. The dried feces remained on the frame. A certified nurse aide (CNA) (#5) agreed the chair needed cleaning and took it to the shower to clean it. Review of the facility's "Nite [sic] Shift Wheelchair/Walker & Cane Cleaning Schedule" occurred on 02/25/25. The schedules for December 2024 - February 2025 showed Resident #65's Broda chair scheduled for weekly cleaning every Saturday night and showed staff failed to sign off on this task for seven of the 12 scheduled weeks. During an interview on 02/25/25 at 3:38 p.m., an administrative nurse (#1) stated she expected staff to clean the wheelchairs on the night shift weekly as scheduled.	F 584	report repair issues with equipment through our facility WorkxHub platform. Education provided to therapy staff to be doing quarterly rounds on all resident equipment to ensure in good condition (clean and free from disrepair issues). 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. Education provided to nursing staff on “Safe Resident Handling/Transfers” policy and education to nursing staff that wheelchairs and walkers need to be cleaned weekly and charted when completed. Cleaning schedule added in tasks in PCC for CNAs to document on. Education provided to all staff to report repair issues with equipment through our facility WorkxHub platform. Education provided to therapy staff to be doing quarterly rounds on all resident equipment to ensure in good condition (clean and free from disrepair issues). 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?	

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F 584	Continued From page 3	F 584	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 therapy, and/or designee to monitor by conducting a random audit of 6 residents that will assure wheelchairs and walkers are clean and free from disrepair (cracked armrests, missing pieces, flaking, etc.). These random audits will be completed for 6 residents weekly for 12 weeks and then 6 residents monthly for 3 months. Sustained monitoring will be done quarterly by therapy staff doing quarterly rounds on all resident equipment to ensure the equipment is in good condition (clean and free from disrepair issues). If during the audit process mistakes are identified, education will be provided to the staff member. Therapy staff and/or designee will report audit results to the QA team with corrective action implemented, as deemed necessary. When the deficiency will be corrected. The date of correction must be at least the day after the survey completion (2/27/25). Or a maximum of 35 days after the date of the exit conference, so this would be 4/2/2025 before the end of day. 4/2/2025	
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents.	F 689		4/2/25

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F 689	Continued From page 4 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, review of manufacturer's instructions, and staff interview, the facility failed to provide adequate assistance for 1 of 4 sampled residents (Resident #40) observed during a ceiling lift transfer. Failure to ensure proper use of the ceiling lift, including use of the sling/straps, placed the resident at risk for a fall and injury. Findings include: Review of the manufacturer's instructions for the Maxi Sky 2 (ceiling lift) stated, ". . . Method 1-Cross-through, legs closed with crossing straps . . ." Review of Resident #40's medical record occurred on all days of survey. The current care plan stated, ". . . The resident has limited physical mobility r/t [related to] contractures, weakness . . . requires a ceiling track for transfers . . ." Observation on 02/24/25 at 10:28 a.m. showed a certified nurse aid (CNA) (#3) transferred Resident #40 from the wheelchair to the bed. The CNA attached the leg strap loops of the sling to the spreader bar and failed to use the cross-through method.	F 689	What corrective action will be accomplished for those residents affected by the deficient practice: Education that resident #40 for ceiling lift transfer is to have the cross-through method used with the leg sling straps. How will you identify other residents having the potential to be affected by the same deficient practice? Identification of other residents that utilize ceiling lift transfers. Education provided to nursing staff in regard to ceiling lift transfers that cross-through method is to be used with the leg sling straps and education on the “Safe Resident Handling/Transfers” policy. 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.	

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F 689	Continued From page 5 During an interview on 02/26/25 at 9:34 a.m., a nursing supervisor (#4) confirmed staff should use the cross-through method with the sling straps, especially with Resident #40 due to his muscle weakness.	F 689	Education provided to nursing staff on "Safe Resident Handling/Transfers" policy and education that for ceiling lift transfers the cross-through method is to be used with the leg sling straps. 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 the nurse managers and/or designee to monitor by conducting a random audit of 3 residents that will assure ceiling lift transfer is done with the cross-through method for the leg sling straps. These random audits will be completed for 3 residents weekly for 12 weeks and then 3 residents monthly for 3 months. If during the audit process mistakes are identified, education will be provided to the staff member. Unit Managers and/or designee will report audit results to the QA team with corrective action implemented, as deemed necessary. When the deficiency will be corrected. The date of correction must be at least the day after the survey completion (2/27/25). Or a maximum of 35 days after the date of the exit conference, so this	

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F 689	Continued From page 6	F 689	would be 4/2/2025 before the end of day. 4/2/2025	