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 04/10/2018

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 complaint survey was completed on April 9-10, 2018. The sample included five (5) sampled residents and two (2) closed records for focused review.	F 000		
F 563 SS=G	Right to Receive/Deny Visitors CFR(s): 483.10(f)(4)(ii)-(v) §483.10(f)(4) The resident has a right to receive visitors of his or her choosing at the time of his or her choosing, subject to the resident's right to deny visitation when applicable, and in a manner that does not impose on the rights of another resident. (ii) The facility must provide immediate access to a resident by immediate family and other relatives of the resident, subject to the resident's right to deny or withdraw consent at any time; (iii) The facility must provide immediate access to a resident by others who are visiting with the consent of the resident, subject to reasonable clinical and safety restrictions and the resident's right to deny or withdraw consent at any time; (iv) The facility must provide reasonable access to a resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time; and (v) The facility must have written policies and procedures regarding the visitation rights of residents, including those setting forth any clinically necessary or reasonable restriction or limitation or safety restriction or limitation, when such limitations may apply consistent with the requirements of this subpart, that the facility may need to place on such rights and the reasons for the clinical or safety restriction or limitation. This REQUIREMENT is not met as evidenced	F 563		5/15/18

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

Electronically Signed | 04/25/2018

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F 563	Continued From page 1 by: Based on information provided by the complainants, record review, review of facility policy, and staff interview, the facility failed to respect the residents' right to have visitors at the time of their choosing for 1 of 5 sampled residents (Resident #3) and 1 closed record resident (Resident #7). Failure to allow visitation, resulted in psychosocial harm for Resident #7 and his family as they were denied his repeated requests for family visitation. Findings include: Information provided by the first complainant indicated the facility "[didn't] want outsiders in due to the flu," nursing staff refused him/her access to Resident #7 for "five days," knowing Resident #7 was ill, and after being told he requested his/her presence. The complainant indicated he/she offered to don a mask, gloves, gown, etc. and was still denied access to Resident #7. The complainant indicated he/she is "heartbroken" and can't get over the fact "all [Resident #7] wanted was one last visit." Information provided by the second complainant indicated nursing staff refused family members access to Resident #7, knowing he was ill, and after being told he repeatedly requested their presence. The second complainant indicated family members continue to be haunted by the fact Resident #7 expired without family present. Information provided by the third complainant indicated nursing staff turned him away at the door of the facility and refused him/her access to Resident #3. He/she was given no prior notice	F 563	A Quality Assurance Process Improvement (QAPI) group was formed to develop a performance improvement project related to general visitation and restriction levels during flu season or other infectious disease outbreaks. The Visitor restriction level will be posted daily by the main Activities Calendar located outside the fellowship hall and at the entrance of the building. The facility has determined that all residents have the potential to be affected. Revised General Visitation and Restriction Levels Policy. Residents will be educated on the General Visitation and Restriction Levels policy at the Resident Council meeting on April 25th, 2018. This policy will be mailed to the resident's primary contact and a copy given to each resident by May 15th, 2018. Annually, residents and their primary contacts will be given a copy of the General Visitation and Restriction Levels Policy with the flu consent form and Influenza Vaccine Information Statement. Annually, in September, KRCC will publish the General Visitation and Restriction Levels policy in the Beulah Beacon and Hazen Star for community education. KRCC will have the General Visitation and Restrictions Levels both on the KRCC website and Beulah / Hazen community channels year	

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F 563	Continued From page 2 that the facility was on lock-down. Review of the facility policy titled "Policy for Visitor Restrictions" occurred on 04/10/18. This policy, revised 10/01/17, stated, ". . . In the most extreme situations, no visitation will be allowed. . . . In less severe situations, visitors will be asked to use good judgement in deciding whether or not to visit. If they are experiencing cold or flu symptoms . . . they are asked NOT to visit until symptoms have subsided. There may be postings of specific criteria that must be followed when visiting (especially during the influenza season), i.e.: wear a mask, use hand sanitizer upon entry and when leaving, visit only in resident rooms, etc.) . . ." - Review of Resident #7's medical record occurred on both days of survey and identified diagnoses including major depressive disorder. The care plan identified, ". . . I have a life long history of depression. . . . Support the facilitate privacy for my family and friend visitors . . . Allow me opportunities to make choices regarding my schedule. . . ." The nursing progress notes identified the following: * 02/13/18 at 7:50 p.m., ". . . There are inflammatory changes around the bladder. . . . This is nonspecific and may represent infalmmation [sic] or infection. . . ." * 02/14/18 at 12:02 a.m., ". . . [Physician's name] then stated that resident most likely has a bladder infection due to his white blood cell count and to start him on Cipro [antibiotic]" . . . At 8:20 a.m., "Summoned to room at [6:45 a.m.] Respirations ceased, no BP [blood pressure], no	F 563	round with the current visitation level. KRCC will post the current visitation level at the entrance of the building and by the main activity calendar so all visitors know the current level. The Social Service Director and/or the Infection Preventionist will monitor this through the "Right to receive/deny visitors and Inform of visitation rights/equal visitation privileges" QA starting April 25th, 2018 weekly for four (4) weeks, twice monthly for five (5) months, then monthly for six (6) months. General Staff meeting will take place on May 8th, 2018 for education on Resident Rights and the General Visitation and Restriction Levels policy. Annual training on General Visitation and Restriction Levels policy and Resident Rights will be completed. This plan of correction will be monitored at the quarterly Quality Assurance meeting until such time consistent substantial compliance has been met. Corrective action completion date: May 15th, 2018.	

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F 563	Continued From page 3 HR [heart rate]. . . ." The progress notes failed to reflect Resident #7 had repeatedly requested family visitation, that family members had contacted administrative staff in an effort to arrange visitation, that the facility continued to deny them access to Resident #7, or the rational behind their decision. During an interview 04/09/18 at 5:00 p.m., an administrative nurse (#5) stated, "The medical director said 'I don't want any visitors.' [The facility failed to provide documentation confirming this statement.] The flu was all over in the community. The IDT team got together and decided on locking the door." She confirmed "no flu in the building" at the time of the lock-down. The administrative nurse (#5) reported the facility "was on lock-down for four days total, and was opened on [Resident's 7's] death date. [Resident #7] didn't feel good, he went to the clinic, [and his] doctor sent him back. He ate supper in the dining room. [Facility staff] just found him gone in the morning."	F 563		
F 564 SS=E	Inform Visitation Rghts/Equal Visitation Prvl CFR(s): 483.10(f)(4)(vi)(A)-(D) §483.10(f)(4)(vi) A facility must meet the following requirements: (A) Inform each resident (or resident representative, where appropriate) of his or her visitation rights and related facility policy and procedures, including any clinical or safety restriction or limitation on such rights, consistent with the requirements of this subpart, the reasons for the restriction or limitation, and to whom the restrictions apply, when he or she is informed of his or her other rights under this section. (B) Inform each resident of the right, subject to	F 564		5/15/18

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F 564	Continued From page 4 his or her consent, to receive the visitors whom he or she designates, including, but not limited to, a spouse (including a same-sex spouse), a domestic partner (including a same-sex domestic partner), another family member, or a friend, and his or her right to withdraw or deny such consent at any time. (C) Not restrict, limit, or otherwise deny visitation privileges on the basis of race, color, national origin, religion, sex, gender identity, sexual orientation, or disability. (D) Ensure that all visitors enjoy full and equal visitation privileges consistent with resident preferences. This REQUIREMENT is not met as evidenced by: Based on information provided by the complainants and record review, the facility failed to inform each resident or representative of his/her visitation rights, including safety restrictions/limitations on such rights, for 1 of 5 sampled residents (Resident #3) and 1 closed record resident (Resident #7). Failure to communicate limitations placed on visitation, the safety reasons for the limitations, and the specific individuals the restrictions applied to, resulted in a violation of the residents and/or representatives rights. Findings include: Information provided by the first complainant indicated the facility "[didn't] want outsiders in due to the flu," nursing staff refused him/her access to Resident #7 for "five days," knowing Resident #7 was ill, and after being told he requested his/her presence. The complainant indicated he/she offered to don a mask, gloves,	F 564	A Quality Assurance Process Improvement (QAPI) group was formed to develop a performance improvement project related to general visitation and restriction levels during flu season or other infectious disease outbreaks. The Visitor restriction level will be posted daily by the main Activities Calendar located outside the fellowship hall and at the entrance of the building. The facility has determined that all residents have the potential to be affected. Revised General Visitation and Restriction Levels Policy. Residents will be educated on the General Visitation and Restriction Levels policy at the Resident Council meeting on April 25th, 2018. This policy will be	

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F 564	Continued From page 5 gown, etc. and was still denied access to Resident #7." Information provided by the third complainant indicated nursing staff turned him away at the door of the facility and refused him/her access to Resident #3. He/she was given no prior notice that the facility was on lock-down. The facility failed to provide the residents or representatives advance notification of the facility-wide lock-down. See F563.	F 564	mailed to the resident's primary contact and a copy given to each resident by May 15th, 2018. Annually, residents and their primary contacts will be given a copy of the General Visitation and Restriction Levels Policy with the flu consent form and Influenza Vaccine Information Statement. Annually, in September, KRCC will publish the General Visitation and Restriction Levels policy in the Beulah Beacon and Hazen Star for community education. KRCC will have the General Visitation and Restrictions Levels both on the KRCC website and Beulah / Hazen community channels year round with the current visitation level. KRCC will post the current visitation level at the entrance of the building and by the main activity calendar so all visitors know the current level. The Social Service Director and/or the Infection Preventionist will monitor this through the "Right to receive/deny visitors and Inform of visitation rights/equal visitation privileges" QA starting April 25th, 2018 weekly for four (4) weeks, twice monthly for five (5) months, then monthly for six (6) months. General Staff meeting will take place on May 8th, 2018 for education on Resident Rights and the General Visitation and Restriction Levels policy. Annual training on General Visitation and Restriction Levels policy and Resident Rights will be completed.	

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F 564	Continued From page 6	F 564	This plan of correction will be monitored at the quarterly Quality Assurance meeting until such time consistent substantial compliance has been met. Corrective action completion date: May 15th, 2018.	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced	F 657		5/15/18

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F 657	Continued From page 7 by: Based on information provided by the complainant, record review, review of facility policy, and staff interview, the facility failed to review/revise the comprehensive care plan for 1 of 5 sampled residents (Resident #3). Failure to review/revise Resident #3's care plan limited communication between staff regarding her care needs and did not ensure continuity of care. Findings include: Information provided by the complainant indicated nursing staff failed to prevent Resident #3 from falling and/or protect her from injury. Review of the facility policy titled "Care Plan Policy" occurred on 04/10/18. This policy, revised 11/22/17, stated, ". . . Review of care plans . . . is expected to occur . . . on an ongoing basis as the resident's condition changes so that additions or deletions can be made to assure that . . . They reflect . . . . identified problem areas . . . are oriented toward preventing declines in functioning . . . attempt to manage risk factors . . . Care plans shall consist of . . . the following . . . Problems - any area of difficulty or concern that prevents the resident from reaching his/her fullest potential . . . Interventions - the specific action(s) that the staff will take to assist the resident in meeting/achieving the goals(s) . . ." Review of Resident #3's medical record occurred on both days of survey and identified diagnoses including dementia, severely impaired cognitive skills, history of urinary tract infections, and history of falls with fractures. The record identified Resident #3 fell on 07/27/17, 08/12/17,	F 657	Resident #3's Care Plan was revised on 4/12/2018. The facility has determined that all residents have the potential to be affected. The citation was in relation to fall interventions, specifically for resident #3. All residents care plans will be updated with any fall interventions that were put into place or attempted with each fall the resident has. The resident care plan books will be brought to weekly Interdisciplinary Department Team (IDT) fall/event meetings to ensure all interventions/approaches have been appropriately reflected in the care plan. A psychotropic medication care plan was added to reflected resident #3's use of anti-psychotic medications. Any resident taking any psychotropic medication has had an individual care plan implemented to reflect their use of the medication. To follow up with psychotropic medications, the care plans will be updated regularly after each visit with Doctor (Dr.) on psych rounds for any changes and any resident who does not see psychiatry, who is followed by their regular Dr., will be updated after the Primary Care Physician (PCP) rounds. In regards to adjusting the care plan to reflect specific times of the day of the date that staff should check and change	

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F 657	Continued From page 8 08/20/17, 08/22/17, 08/23/17 (resulting in bilateral pubic ramous fractures), 03/03/18, 03/08/18, and 03/17/18. The Minimum Data Set (MDS), dated 04/10/18, identified Resident #3 as totally dependent on staff for transfers, locomotion on/off the unit, and toileting cares. The Physical Therapy progress notes, dated August 10-December 13, 2018, identified staff had attempted the following interventions in an attempt to improve Resident #3's overall safety: cueing/redirection, a lap belt and Velcro belt (both of which Resident #3 was unable to release independently), an ultra hemi height chair, wedge cushion, weighted blanket (which Resident #3's family refused), a Rock-n-Go chair (reclining wheelchair), and an ultra hemi height chair with tilt-n-space option. In addition, they consulted a positioning specialist. The current care plan identified, "Problem . . . I am at risk for a fall related injury [secondary]to my dementia. I have no safety awareness and may be impulsive. . . . Approaches . . . My room area will remain free of clutter, Adequate glare free lighting will be provided, Staff will remind me and reinforce safety awareness, My IDT [interdisciplinary team] will provide my family and I teaching to include safety measures to reduce fall risk and what to do if a fall occurs, Remind [me]/assure [my] brakes are locked on bed, chair, etc before transferring, Remind me to use my adaptive device properly . . . I am to wear grippy socks at all times when not wearing shoes. . . ." Based on the results of the positioning assessments, the facility failed to individualize Resident #3's care plan to reflect the interventions staff had attempted to improve her	F 657	resident #3, the care plan will be updated per KRCC policy with the words, "I have a check and change routine at regular intervals including upon rising, between meals, after naps, before bed, every 2-3 hours once in bed for the night, as well as PRN. All resident's care plans with total incontinence and on a check and change routine will be updated per KRCC protocol. Care plan Policy has been updated. An educational in-service will be given to IDT members on April 30th, 2018, updating each member of the above actions put into place. The MDS coordinator or designee will assure the care plans are updated with each MDS assessment. The MDS Coordinator will conduct random audits of five (5) resident's care plans per week to assure accuracy in the cited sections of the MDS for four (4) consecutive weeks. The audits will continue monthly for six (6) months after the initial four (4) weeks In-service training for IDT members regarding care plan timing and revision will be completed by the MDS Coordinator no later than May 15th, 2018. This plan of correction will be monitored at quarterly Quality Assurance Process Improvement meetings until such time	

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F 657	Continued From page 9 overall safety, the process staff utilized to evaluate the effectiveness of the interventions, and the adjustments they made to the interventions to make them more effective in addressing her risk of falls. The care plan also included many interventions that were inappropriate given her current cognitive status, placement on the dementia unit, and total dependence on staff. The current care plan also identified, ". . . Problem Onset: Toileting: asst [assist] x 2 [staff members] CHECK AND CHANGE . . ." The facility failed to individualize Resident #3's care plan to reflect specific times of the day staff should check and change her. The April 2018 physician's orders identified Resident #3 received both Risperdal [an anti-psychotic medication] and Ativan [an anti-anxiety medication]. Resident #3's care plan failed address her use of anti-psychotics/anti-anxiety medications and/or the risk factors associated with their use. During an interview 04/10/18 at 11:58 p.m., a managerial nurse (#4) acknowledged Resident #3's current care plan failed to address interventions staff had attempted to improve her overall safety, the process staff utilized to evaluate the effectiveness of the interventions, the adjustments made to the interventions to make them more effective, the specific times of the day staff should check and change her, and her use of Risperdal and Ativan.	F 657	that substantial compliance has been met. Corrective action completion date: May 15th, 2018.	
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3)	F 690		5/15/18

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F 690	Continued From page 10 §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on information provided by the complainant, observation, record review, review	F 690	All Certified Nursing Assistants (CNAs) will be trained at the in-service on May	

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KNIFE RIVER CARE CENTER	118 22ND ST NE BEULAH, ND 58523

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F 690	Continued From page 11 of facility policy, and staff interview, the facility failed to ensure staff provided incontinence cares in accordance with the facility's policy for 1 of 5 sampled residents (Resident # 3) requiring toileting assistance. Failure to check-and-change the resident per facility policy may result in skin breakdown. Findings include: Information provided by the complainant indicated nursing staff failed to toilet Resident #3 for approximately five hours during one of his/her visits. Review of the facility policy titled "Toileting Protocol" occurred on 04/10/18. This policy, revised 09/08/17, stated, ". . . If the resident is always incontinent . . . a 'check and change' strategy will be used. . . . The resident's care plan will state 'I have a check and change routine at regular intervals as needed' . . . Regular intervals is described as, but not limited to 'upon rising, between meals, after naps, before bed, and as requested' . . ." Review of Resident #3's medical record occurred on both days of survey and identified diagnoses including dementia, history of urinary tract infection, falling, and fractures. The Minimum Data Set (MDS), dated 04/10/18, identified total dependence on staff for toileting cares. The current care plan identified, ". . . Problem Onset: Toileting: asst [assist] x 2 [staff members] CHECK AND CHANGE . . ." Observation on 04/09/18 at 1:45 p.m. showed	F 690	7th, 2018 on the facility's Practice Guideline for Knife River Care Center's Incontinence Policy. The facility has determined that all residents that have been identified as incontinent according to Section H of the MDS have the potential to be affected. All CNAs will be in-serviced on the facility's Incontinence Policy and Practice Guidelines. An in-service to review the Incontinence Policy and Toileting Protocol will be provided to CNAs on May 7, 2018 meeting and will be provided to nurses on May 11, 2018. During the QA process, the findings will be reviewed with the CNAs involved with the care of the random sample of residents after monitoring is completed. Corrective action will be provided as needed. The Director of Nursing Services (DNS) or designee will monitor a sample of five (5) residents. The residents will be monitored weekly for four (4) weeks, and then twice a month for one (1) month, then monthly for ten (10) months to assure the Incontinence Policy is followed by the Certified Nursing Assistants (CNAs)involved with the care of the random sample of residents after monitoring is completed. This plan of correction will be monitored at quarterly Quality Assurance Process Improvement meetings until such time that substantial compliance has been	

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 04/10/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 690	Continued From page 12 two certified nursing assistants (CNAs) (#1 and #2) transferred Resident #3 onto her bed utilizing a ceiling lift before providing her toileting (check-and-change) cares. Facility staff failed to notify the surveyor of additional toileting cares provided during the afternoon of 04/09/18 and the morning of 04/10/18. Review of Resident #3's "Individualized Toileting" record, dated March 10-April 10, 2018, identified a range of 1.5 hours-to-17 hours between toileting cares.	F 690	met. Corrective action completion date: May 15th, 2018.	