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 08/17/2017

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 and complaint surveys, started on 08/14/17 and completed on 08/17/17, the sample included 4 residents for complete review, 10 residents for focused review, and 3 closed records for review. The sample included 2 additional residents to verify specific concerns during the survey.	F 000		
F 156 SS=C	483.10(d)(3)(g)(1)(4)(5)(13)(16)-(18) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES (d)(3) The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care. §483.10(g) Information and Communication. (1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility. (g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including: (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes - (A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section; (B) A description of the requirements and procedures for establishing eligibility for	F 156		9/21/17

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

Electronically Signed | 09/08/2017

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F 156	Continued From page 1 Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act. (C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and (D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.)	F 156		

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F 156	Continued From page 2 [§483.10(g)(4)(ii) will be implemented beginning November 28, 2017 (Phase 2)] (iii) Information regarding Medicare and Medicaid eligibility and coverage; [§483.10(g)(4)(iii) will be implemented beginning November 28, 2017 (Phase 2)] (iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program; [§483.10(g)(4)(iv) will be implemented beginning November 28, 2017 (Phase 2)] (v) Contact information for the Medicaid Fraud Control Unit; and [§483.10(g)(4)(v) will be implemented beginning November 28, 2017 (Phase 2)] (vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives: (i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office,	F 156		

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F 156	Continued From page 3 adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and (ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community. (g)(13) The facility must display in the facility written information, and provide to residents and applicants for admission, oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. (g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay. (i) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. (ii) The facility must also provide the resident with	F 156		

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F 156	Continued From page 4 the State-developed notice of Medicaid rights and obligations, if any. (iii) Receipt of such information, and any amendments to it, must be acknowledged in writing; (g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in paragraphs (g)(17)(i)(A) and (B) of this section. (g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the	F 156		

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F 156	Continued From page 5 Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: POSTING OF INFORMATION 1. Based on observation and staff interview, the facility failed to post the email addresses of state advocacy groups including the State Ombudsman, State Survey Agency, Protection and Advocacy Network, and Medicaid Fraud/Abuse, on 4 of 4 days of survey (August	F 156	The facility failed to post the email addresses of state advocacy groups including the State Ombudsman, State Survey Agency, Protection and Advocacy Network, and Medicaid Fraud/Abuse. This was corrected on 8-17-17 and correction was given to the surveyor.	

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F 156	Continued From page 6 14-17, 2017). Failure to provide this information has the potential to limit all residents and their families access to these agencies. Findings include: Observation on August 14-17, 2017 showed the names of advocacy groups displayed on a wall near the fellowship room. The facility failed to include/post email contact information for the State Ombudsman, State Survey Agency, Protection and Advocacy Network, and Medicaid Fraud/Abuse. During an interview on the morning of 08/17/17 a social service staff member (#6) confirmed the display lacked the required information. MEDICARE BILLING 2. Based on review of Medicare Part A notices/files and staff interview, the facility failed to provide adequate written notices for 3 of 3 residents (Resident #5, #9, and #15)) reviewed for termination of Medicare coverage. Failure of the facility to provide notices that contained the correct contact information for the Fiscal Intermediary (FI)/Medicare Administrative Contractor (MAC) limits the residents' ability to exercise their rights related to Medicare Part A. Findings include: Review of Medicare billing records occurred on the morning of 08/16/17. The facility provided Resident #5, #9, and #15 with a demand bill form. These forms lacked the correct contact	F 156	The facility has determined that all residents have the potential to be affected as it has the potential to limit all residents and their family'□s access to these agencies. An in-service education program, on 9-11-17 will be conducted by the Social Services Director with all social services staff addressing circumstances regarding required notices for residents upon admission and as needed. This information was posted on the bulletin board outside the Fellowship Hall and will be updated within the admission contract. The Social Service Director will implement the Information and Communication Policy. The updated information along with the policy will be gone over with the Resident Council at their September 20, 2017 meeting. All updated information will be given to all residents and sent to their representative(s) before September 21, 2017. The Social Service Director, or designee, will conduct a random audit of five (5) residents weekly for four (4) consecutive weeks. These residents will be assessed and interviewed to ensure that they have been informed and received all required notices. Findings of this audit will be discussed with the Resident Council. This plan of correction will be monitored	

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F 156	Continued From page 7 information for the intermediary review. During an interview on the morning of 08/16/17, an administrative nurse (#2) stated she was unaware of the address change.	F 156	at the quarterly Quality Assurance meeting until such time consistent substantial compliance has been met. Corrective action completion date: September 21, 2017 Contact information for Fiscal Intermediary (FI) Medicare Administrative Contractor (MAC) was corrected on the Medicare Demand Bill form. The facility has determined that all residents that received Medicare Part A benefits have the potential to be affected. An in-service education program was conducted by the MDS Coordinator and Business Office Manager with the interdisciplinary Medicare team regarding correct contact information for Fiscal Intermediary (FI) Medicare Administrative Contractor (MAC). Business Office Manager, or designee will conduct random audits of Medicare Denial Notices for six (6) months. Business Office Manager, or designee will contact Fiscal Intermediary (FI) Medicare Administrative Contractor (MAC) on a regular basis to ensure facility has correct contact information on Medical Demand Bill forms. This plan of correction will be monitored at the quarterly Quality Assurance	

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F 156	Continued From page 8	F 156	meeting until such time consistent substantial compliance has been met. Corrective action completion date: September 6, 2017.	
F 157 SS=D	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the	F 157		9/21/17

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F 157	Continued From page 9 physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff, resident, and family interview, the facility failed to promptly notify the physician of a resident's fall with injury for 1 of 4 sampled residents (Resident #11) with a fracture which occurred at the facility. Findings include: Review of the facility policy "NOTIFICATION OF CHANGE" occurred on 08/17/17. The policy, revised 05/19/17, stated, ". . . The facility must inform the resident, consult with the resident's physician . . . when there is a change requiring such notification. . . . Circumstances requiring notification include: 1. Accidents a. resulting in injury. b. potential to require physician intervention. . . ." An interview with Resident #11 and her husband	F 157	The physician was notified of this fall 1 1/2 hours after the event occurred. Resident # 11 was sent to the hospital via ambulance for further evaluation within two hours of documented fall from recliner. The facility has determined that all residents have the potential to be affected. On September 15, 2017, an in-service education program will be conducted by the Director of Nursing Services or designee with all licensed staff addressing circumstances that require notification of the resident□s physician, resident□s representative. Review of the current policy and procedure for falls, which includes assessment of pain and	

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F 157	Continued From page 10 occurred on the afternoon of 08/14/17. During the interview, Resident #11's husband stated the resident had a fall during the night "about two months ago" which resulted in "a chipped vertebrae." The resident stated she could not recall the event, but knew she had fallen from her chair. Her husband stated she wore a cervical collar (neck support) for several weeks after the fall. Resident #11's record, reviewed on all days of survey, identified diagnoses including anxiety disorder, sciatica [low back pain], congestive heart failure, and radiculopathy [disease of a nerve root]. A quarterly Minimum Data Set, dated 06/13/17, identified the resident as cognitively intact and requiring extensive assistance of one staff member with transfers, dressing, toilet use, and personal hygiene. Nursing progress notes identified the following: * 06/01/17 at 1:48 a.m.: "[Resident #11] fell 05.31.17@2330 [11:30 p.m.]. . . . Had c/o [complained of] dizziness and . . . pain down her left side and back. She was unable to keep eyes open. Had an unsteady gait with weakness. . . . she was unable to lift left leg and arm. I called [physician's name] and he stated to send her to the emergency room. 911 was called and EMTs [Emergency Medical Technicians] arrived at 0126 [1:26 a.m.] . . ." An incident report, dated 05/31/17 at 11:30 p.m. identified staff notified the physician of the fall at 1:00 a.m. on 06/01/17. * 06/01/17 at 6:12 a.m.: "ER [Emergency Room] finding: C-3 [neck] bone spur broke off causing pain. Resident back from ER with new orders: . . . Keep cervical collar on at all times. . . ."	F 157	documentation, will be completed at in-service. The Director of Nursing Services, or designee, will conduct a random audit of documentation for five (5) resident falls weekly for four (4) consecutive weeks and monthly for four (4) months . Documentation will be audited to ensure that changes in condition related to a fall have been identified, properly evaluated and communicated to the appropriate people. Findings of this audit will be discussed with the Resident Council. This plan of correction will be monitored at the quarterly Quality Assurance Process Improvement meeting until such time consistent substantial compliance has been met. Corrective action completion date: September 21, 2017.	

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F 157	Continued From page 11 A Computed Tomography (CT) of the cervical spine (neck), dated 06/01/17, identified a fracture of the third cervical vertebrae (neck bone).The record showed Resident #11 wore the cervical collar until 07/18/17. During an interview on the afternoon of 07/15/17, an administrative nurse (#1) provided no information regarding staff's failure to immediately notify the physician of Resident #11's fall with symptoms indicating an injury (pain, dizziness, and inability to 'lift' her left arm and leg).	F 157		
F 203 SS=C	483.15(c)(3)-(6)(8) NOTICE REQUIREMENTS BEFORE TRANSFER/DISCHARGE (c) (3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (b)(5) of this section. (c) (4) Timing of the notice.	F 203		9/21/17

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F 203	Continued From page 12 (i) Except as specified in paragraphs (b)(4)(ii) and (b)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (b)(1)(ii)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (b)(1)(ii)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (b)(1)(ii)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (b)(1)(ii)(A) of this section; or (E) A resident has not resided in the facility for 30 days. (c) (5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is	F 203		

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F 203	Continued From page 13 transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. (c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.	F 203		

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	355053	A. BUILDING _____ B. WING _____	C 08/17/2017

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F 203	Continued From page 14 (c)(8) Notice in advance of facility closure. In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review, and staff interview, the facility failed to notify a representative of the Office of the State of Long-Term Care Ombudsman of a resident transfer or discharge, including destination, the reason for the transfer and the resident's right to appeal the action, for 4 of 4 sampled residents (Resident #4, #9, #10, and #14). Failure to provide a notice of transfer or discharge to the State Ombudsman does not allow the State Ombudsman to act as an advocate for the resident if necessary. Findings include: - Review of Resident #10's medical record occurred on all days of survey and identified the facility transferred the resident to the hospital on 06/08/17. The record lacked evidence the facility provided a copy of the transfer notice to the State Long-Term Care Ombudsman. - Review of Resident #4's medical record occurred on all days of survey and identified the facility transferred the resident to the hospital on 06/11/17. The record lacked evidence the facility provided a copy of the transfer notice to the State	F 203	The transfer form for resident #4, #9, #10, and #14 will be sent to the Office of the State Ombudsman on 9/5/17. The facility has determined that all residents have the potential to be affected. An in-service education program will be conducted on 9/15/17 by the Social Services Director with all social services, ward clerks, and nursing staff on the updated policy and procedure for transfers and discharges and on the new notification forms for hospitalizations, transfers, and therapeutic leave/bed holds. The new forms will be included in the transfer packet the nurse completes for any transfer/discharge/therapeutic leave. The transfer checklist will be updated to reflect these changes. The admission contract will be updated with the new Notice of transfer, discharge, or therapeutic leave/bed hold policy.	

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F 203	Continued From page 15 Long-Term Care Ombudsman. - Review of Resident #9's medical record occurred on all days of survey and identified the facility transferred the resident to the hospital on 07/03/17. The record lacked evidence the facility provided a copy of the transfer notice to the State Long-Term Care Ombudsman. - Review of Resident #14's medical record occurred on all days of survey and identified the facility transferred the resident to the hospital on 07/22/17. The record lacked evidence the facility provided a copy of the transfer notice to the State Long-Term Care Ombudsman. During an interview on 08/16/17 at 5:00 p.m., an administrative staff member (#3) confirmed the facility failed to notify the State Ombudsman of residents discharge or transfer.	F 203	The Notice of transfer of discharge for non-payment will be available in the Business Office. Once completed, a file will also be kept in the Business Office. The Social Service Director, or designee, will conduct a random audit of two (2) residents weekly for four (4) consecutive weeks. This plan will continue to be monitored twice (2) a month for five (5) months and then monthly for the following six (6) months. 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: September 21, 2017	
F 225 SS=D	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or	F 225		9/21/17

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F 225	Continued From page 16 (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities 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. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.	F 225		

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F 225	Continued From page 17 (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey 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 record review, review of facility policy, staff interview, anonymous interviews, and information received from the complainant, the facility failed to report 1 of 1 allegation of abuse (Resident #6) to the State Survey Agency, investigate the allegation, and report the results of the investigation to the State Survey Agency within 5 working days. Failure to investigate circumstances surrounding an incident between staff and Resident #6, placed all residents at risk for abuse and/or neglect, and did not allow the facility to determine causative factors and implement corrective action(s). Findings include: Information provided by the complainant indicated the facility failed to report and/or investigate an allegation of abuse reported to management by a resident and/or staff members. A resident cried as he/she reported to a staff member that another staff member "yelled" at him/her. Review of the facility policy titled "Abuse, Neglect and Exploitation" occurred on 08/17/17. This policy, revised April 2017, stated, ". . . The facility will consider factors indicating possible abuse . . .	F 225	Knife River Care Center does have an Abuse, Neglect, and Exploitation Policy in place. Administrative Staff will be educated on 9-7-17 at our morning stand-up meeting. KRCC does have a Quality Assurance Event form that is filled out when there is a staff to staff event. These forms are reviewed each morning (Monday □-Friday) at the morning stand-up meeting. The facility has determined that all residents have the potential to be affected. An in-service education program will be conducted at the stand-up meeting with supervisors on 9/18/17 about required reporting times for allegations of abuse by the Director of Social Services. The Director of Social Services, or designee, will conduct a random audit of the reported allegations weekly for four (4) consecutive weeks and quarterly thereafter for 1 (one) year to assure all allegations are investigated appropriately	

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F 225	Continued From page 18 including but not limited to . . . Psychological abuse of resident . . . When suspicion of abuse . . . or reports of abuse . . . occur, an investigation is immediately warranted. Once the resident is cared for and initial reporting has occurred, an investigation should be conducted. . . . Obtain witness statements . . . All statements should be signed and dated by the person making the statement . . . Document the entire investigation chronologically . . . Examples of ways to protect a resident from harm during an investigation of abuse, neglect and exploitation may include, but are not limited to: . . . Reassignment of staff duties . . . Respond to the needs of the resident and protect them from further incident . . . Notify the Director of Nursing, Director of Social Services, and/or Administrator . . . Notify the attending physician, resident's family/legal representative and Medical Director . . . Obtain witness statements . . . Suspend the accused employee pending completion of the investigation. Remove the employee from resident care areas immediately . . . Document actions taken in steps above in the medical record . . . the facility must: . . . Ensure all alleged violation involving abuse . . . are reported immediately, but not later than 2 hours after the allegation is made if the events that the cause the allegation involve abuse . . . to the administrator of the facility and to other officials (including the State Survey Agency and adult protected services where state law provides for jurisdiction in long-term care facilities) in accordance with State laws. . . . Have evidence that all alleged violations are thoroughly investigated . . . Report the results of all investigations to the administrator or his or her designated representative and . . . to the State	F 225	and reported to the State Survey and Certification Agency in a timely manner. This plan of correction will be monitored by the Director of Social Services/designee, Director of Nursing/designee, and Administrator. Corrective action completion date: September 21, 2017	

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F 225	Continued From page 19 Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. The Director of Social Services or his/her designee should follow up with government agencies, during business hours, to confirm the report was received, and to report the results of the investigation when final, as required by state agencies. . . ." Review of Resident #6's medical record occurred on all days of survey. The record identified the resident as cognitively intact and required extensive assist of two or more persons for bed mobility, transfers, dressing, toileting, and personal hygiene. The current care plan stated, ". . . am a very private person . . . prefer to eat in my room for all meals . . . Offer me TLC [tender loving care] and support. . . ." An anonymous interview on the morning of 08/17/17 identified the following: * On 06/10/17 at approximately 5:00 p.m., two certified nursing assistants (CNA) (#7 and #8) toileted Resident #6 * Resident #6 requested to return to bed after toileting and just before dinner to transfer into his/her wheelchair to eat * In front of the resident, one CNA (#8) loudly stated to the other CNA (#7), "That's stupid" regarding the resident's request to transfer back to bed, and then in less than thirty minutes transfer into his/her wheelchair for dinner * The resident, upset by this conversation, stated, "Don't worry about it! I won't eat tonight!" * A nurse overheard the conversation from the hallway, removed one CNA (#8) from the room, spoke to the tearful resident regarding the	F 225		

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F 225	Continued From page 20 incident, and the next day reported the incident to management/social services During an interview on 08/16/17 at 2:30 p.m. and 08/17/17 at 9:45 a.m., three administrative staff members (#1, #5, and #6) confirmed knowledge of the above incident and verified failure to: * Document the exact date and time of the incident * Document the reporting of the CNA's actions to the travel agency * Complete an incident report and follow-up with an investigation	F 225		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE (b)(2)(ii) 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 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 record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, and staff interview, the facility failed to complete a significant change in status assessment (SCSA) for 1 of 4 sampled residents (Resident #4) who experienced a significant change in status.	F 274	A Significant change in status (SCSA) was completed on resident #4 by the Multidisciplinary MDS Staff to accurately reflect the decline that occurred in the resident's physical condition after the resident suffered a hip fracture in late June. This assessment was submitted to	9/21/17

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F 274	Continued From page 21 Failure to determine the need for and complete a SCSA in response to a resident's decline limited the facility's ability to accurately assess the resident's status, and identity and implement appropriate care approaches. Findings include: The Long-Term Care Facility RAI 3.0 User's Manual (Version 1.14), dated October 2016, page 2-22 stated, ". . . A 'significant change' is a decline or improvement in a resident's status that: 1. Will not normally resolve itself without staff intervention . . . 2. Impacts more than one area of the resident's health status; and 3. Requires interdisciplinary review and/or revision of the care plan. . . ." and page 2-25 stated, "A SCSA is appropriate if there are either two or more areas of decline or two or more areas of improvement. This may include two changes within a particular domain (e.g., [such as] two areas of ADL [Activities of Daily Living] decline or improvement. . . ." - Review of Resident #4's medical record occurred on all days of survey. An annual Minimum Data Set (MDS), dated 03/17/17, identified the resident required supervision with transfers, walking in the room and corridor, locomotion on and off the unit, eating, and toilet use; and limited assistance with dressing and personal hygiene. The record indicated Resident #4 had a fall resulting in a fractured right hip on 06/11/17. A quarterly MDS, dated 06/21/17, identified the resident required extensive assistance of one person with bed mobility, transfers, locomotion on and off the unit, dressing, toilet use, and personal hygiene; and	F 274	CMS and the State of ND on 9/5/2017. The facility has determined that all residents have the potential to be affected. At weekly Medicare/Events meetings, the Interdisciplinary team (IDT)including Nurse Managers, Social Service staff and Therapy staff will discuss any residents with declines or improvements that could possibly meet the criteria for a SCSA. The MDS Coordinator will hold an in-service training related to the F274 tag to all IDT members including: Multidisciplinary MDS staff, Nurse Managers, Social Services staff and Therapy managers on September 15, 2017. The training will include education on the criteria/guidelines for a SCSA as they are interpreted in the F274 survey regulations and the Resident Assessment Instrument (RAI) manual recommendations. The MDS Coordinator (in coordination with the MDS multidisciplinary staff and IDT) will complete audits for determination in whether or not a resident fits the criteria for a SCSA. Audits will be completed during the Medicare/Events weekly meetings to record residents identified by the IDT who meet criteria for a SCSA. Determination audits will be completed weekly for one (1) month and then	

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F 274	Continued From page 22 did not walk in the room or corridor. The record lacked evidence why staff failed to complete a SCSA for Resident #4 following the hip fracture. During an interview, on 08/16/17 at 3:00 p.m., an MDS nurse (#2) confirmed the record lacked a reason why staff did not complete a SCSA for Resident #4.	F 274	monthly for six (6) months. Corrective action completion date: 9/21/2017.	
F 278 SS=E	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material	F 278		9/21/17

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F 278	Continued From page 23 and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual (Version 1.14), and staff interview, the facility failed to ensure accurate coding of Minimum Data Sets (MDSs) for 6 of 14 sampled residents (Resident #2, #6, #7, #8, #9, and #10). Failure to accurately complete Section J (health conditions) (Resident #2, #6, #7, #8, #9, and #10) and Section M (skin conditions) (Resident #2) of the MDS does not allow each resident's assessment to reflect their current status/needs, and has the potential to affect the accurate development of a comprehensive care plan and the care provided to the residents. Findings include: SECTION J: HEALTH CONDITIONS The Long-Term Care Facility RAI User's Manual, revised October 2016, Chapter 3, pages J3, J23, and J24 stated, ". . . Coding instructions for J0100C, Received Non-medication Intervention for Pain *Code 0, no: if the medical record does not contain documentation that a non-medication pain intervention was received. *Code 1, yes: if the medical record contains documentation that a non-medication pain intervention was scheduled as part of the care plan and it is documented that	F 278	MDS corrections were completed on the residents from the sample group that were inaccurate as indicated by the state survey team. MDS corrections were completed on Resident #2 (sections J and M), Resident #6 (section J), Resident #7 (section J), Resident #8 (section J), Resident #9 (section J), and Resident #10 (section J). Modified MDS's were submitted to the State of ND and CMS on 9/6/2017. The facility has determined that all residents have the potential to be affected. An education in-service will be conducted by the MDS Coordinator and will include the MDS interdisciplinary staff and Interdisciplinary Team (IDT)on September 15,2017. Education on the "Accuracy of the Assessment" per F278 guidelines will be offered in order for us to continue to provide assessments that accurately represent the resident's status. Education will be offered on Section J0100, Section J1400, and Section M1200H as per the Resident Assessment Instrument(RAI) Manual guidelines. Emphasis will be given on referring to the	

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F 278	Continued From page 24 the intervention was actually received and assessed for efficacy. . . . J1400: Prognosis . . . Steps of Assessment 1. review the medical record for documentation by the physician that the resident's conditions or chronic disease may result in a life expectancy of less than 6 months, or that they have a terminal illness. 2. If the physician states that the resident's life expectancy may be less than 6 months, request that he or she document this in the medical record. Do not code until there is documentation in the medical record. 3. Review the medical record to determine whether the resident is receiving hospice services. Coding Instructions *Code 0, no: if the medical record does not contain physician documentation that the resident is terminally ill and the resident is not receiving hospice services. *Code 1, yes: if the medical record includes physician documentation: 1) that the resident is terminally ill; or 2) the resident is receiving hospice services. . . ." - Review of Resident #2's medical record occurred on all days of survey. The admission MDS, dated 01/04/17, was incorrectly coded at J0100C (nonmed [non-medication] pain management) due to receiving skilled physical therapy (PT) and occupational therapy (OT). - Review of Resident #6's medical record occurred on all days of survey. The admission MDS, dated 05/26/17, was incorrectly coded at J0100C (nonmed pain management) due to receiving skilled PT, restorative therapy (RT), and OT. - Review of Resident #7's medical record	F 278	RAI manual when coding. The MDS Coordinator will make corrections to the inaccurate coding of the MDS's on all other residents that were affected by the same practice that resulted in the F278 tag. Modifications will be made to the residents most current MDS. The MDS Coordinator will conduct a random audit of five (5) residents MDS's per week to assure accuracy in the cited sections of the MDS for four (4) consecutive weeks. After the first month, audits will be twice (2) a month for five (5) months and then monthly for six (6) months. These residents and their medical records will be assessed to ensure that the resident is able to be coded properly. Modifications to the most current MDS's of all the residents that were affected by the deficient practice will be submitted and the action completed by 9/21/2017. This plan of correction will be monitored at the quarterly QAPI meeting until such time consistent substantial compliance has been met. Corrective action completion date: 9/21/2017	

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F 278	Continued From page 25	F 278		

occurred on all days of survey. A quarterly MDS, dated 05/25/17, failed to code Resident #7 as terminally ill at J1400.

- Review of Resident #8's medical record occurred on all days of survey. The quarterly MDS, dated 06/24/17, was incorrectly coded at J0100C (nonmed pain management) due to receiving skilled PT and OT.

- Review of Resident #9's medical record occurred on all days of survey. The quarterly MDS, dated 07/17/17 and annual MDS, dated 06/27/17, were incorrectly coded at J0100C (nonmed pain management) due to receiving skilled PT.

- Review of Resident #10's medical record occurred on all days of survey. The quarterly MDS, dated 06/27/17, was incorrectly coded at J0100C (nonmed pain management) due to receiving skilled OT.

SECTION M: SKIN CONDITIONS

The Long-Term Care Facility RAI User's Manual, revised October 2016, Chapter 3 pages M-37 and M-40 stated, "SECTION M: SKIN CONDITIONS . . . M1200: Skin and Ulcer Treatments . . . Coding Instructions: Check all that apply in the last 7 days. . . . M1200H Application of Ointments/Medications Other than to Feet . . . This category may include ointments or medications used to treat a skin condition . . . Ointments/medications may include topical creams, powders, and liquid sealants used to treat or prevent skin conditions. . . ."

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F 278	Continued From page 26 - Review of Resident #2's medical record occurred on all days of survey. The January 01-13, 2017 Medication Administration Record (MAR) identified staff applied Topical Ammonium Lactate 12% every day for 2 weeks to Resident #2's feet. An admission MDS, dated 01/04/17, identified staff coded M1200H for "Applications of ointment/medications other than to feet." During an interview on the morning of 08/16/17, a nurse manager (#2) confirmed M1200H should not have been coded.	F 278		
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care.	F 280		9/21/17

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F 280	Continued From page 27 (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (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).	F 280		

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F 280	Continued From page 28 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 by: THIS IS A REPEAT DEFICIENCY FROM THE STANDARD SURVEY COMPLETED ON 07/14/16. Based on record review, review of facility policy, and staff interview, the facility failed to review and revise the comprehensive care plan to reflect the residents' status for 3 of 14 sampled residents (Resident #2, #9 and #12). Failure to review and revise the care plan limited staff's ability to communicate care needs and ensure continuity of care for each resident. Findings include: Review of the facility policy titled "Care Plans" occurred on 08/17/17. This policy, revised January 2017, stated, ". . . 5. The team shall meet as necessary to review each resident's care plan but no less than once every three months. Review of care plans by individual members is expected to occur at the time of the quarterly	F 280	Resident #2 Care Plan was revised on 8-14-17. Resident #9 Care Plan was revised on 9-6-17. Resident #2 Menu card was revised on 8-16-17. The facility has determined that all residents have the potential to be affected. All orders, care plans, and menus will be checked for accuracy and updated as appropriate. The care plan process for diet texture changes were reviewed on 9-5-17 with Licensed Registered Dietician (LRD), Certified Dietary Manager (CDM), Physical Therapy (PT) and Certified Occupational Therapy Assistant (COTA) in attendance. COTA/OT will make changes to care plans when diet texture changes are made for residents per the COTA/OT recommendations. CDM will be notified of diet texture change via Diet	

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F 280	Continued From page 29 care conference and on an ongoing basis as the resident's condition changes . . ." - Review of Resident #2's medical record occurred on all days of survey and identified diagnoses including Parkinson's disease. The current care plan identified the resident on, ". . . Nectar Thick Liquids - due to difficulty with chewing or swallowing. I will be provided thickened liquids as ordered. . . ." The meal cards from August 10-15, 2017 also identified nectar thick liquids. Physician's orders, dated 08/10/17, identified the resident may have thin liquids. Staff failed to update the care plan to reflect the current physician's order. - Review of Resident #9's medical record occurred on all days of survey. The current care plan stated, ". . . I will be provided thickened liquids as ordered. . . ." Physician orders, dated 09/19/16, identified regular diet with high protein. The care plan shows inconsistency with the doctor (Dr.) orders the care plan specified thickened liquids. - Review of the facility "Incontinence Policy" occurred on 08/17/17. The policy, revised 01/11/17, stated, ". . . The Care Plan will reflect each individual resident's urinary incontinence management care needs. . . ." - Review of Resident #12's medical record occurred on August 17-18, 2017 and identified diagnoses including dementia with behavior disturbance and left tibia fracture. An admission Minimum Data Set (MDS), dated 06/07/17, identified the resident with severe cognitive impairment and required total assistance with	F 280	Order Communication form. CDM will make diet texture change in menu program and new menus will be run off and distributed to the neighborhood kitchens. The COTA, LRD, or designee, will conduct a random audit for accuracy of care planning to ensure care plans reflect the resident current status/needs. Audits of five (5) residents will be completed weekly for four (4) weeks and monthly for six (6) months. Audit records will be reviewed at the quarterly QAPI committee meetings until such time consistent substantial compliance has been achieved as determined by the committee. Corrective action completion date: 9/21/2017 Resident #12□s Care Plan was revised on 8/25/17. The facility has determined that all residents have the potential to be affected. All care plans were checked for accuracy and updated as appropriate. The care plan will be adjusted to reflect the resident□s current incontinence management care needs. The MDS Coordinator or designee will assure the care plans are updated with each MDS	

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F 280	Continued From page 30 toilet use and personal hygiene; and always incontinent of bladder. Review of Resident #12's care plan, dated 06/19/17, identified "I am always incontinent of urine related to my end stage dementia." Staff failed to update the care plan to reflect the resident's current urinary incontinence management.	F 280	assessment. The Quality Management Nurse, or designee, will conduct a random audit of five (5) residents that will be completed weekly for four (4) weeks and monthly for six (6) months. Audit records will be reviewed at the quarterly QAPI committee meetings until such time consistent substantial compliance has been achieved as determined by the committee. Corrective action completion date: 9/21/2017	
F 281 SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, review of manufacturer's guidelines, and staff interview, the facility failed to provide medications according to professional standards of practice for 1 of 1 supplemental resident (Resident #19) observed receiving an injection of Victoza (diabetic medication). Failure to appropriately utilize a Victoza injection pen has the potential for residents to receive inaccurate doses of medications and/or effect the efficacy of the medication.	F 281	Resident #19 received Victoza injection without manufacturer□s directions followed. On 8/18/17 1:1 education was provided to this nurse. Proper injection of medication was passed through report on 8/17/17 from nurse to nurse verbal report. All residents who use Victoza had details added to their Electronic Health record medication Administration orders.	9/21/17

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F 281	Continued From page 31 Findings include: Review of the manufacturer's guidelines for Victoza occurred on 08/17/17. The guidelines stated, " . . . How should I use Victoza? . . . You may give an injection of Victoza and insulin in the same body area (such as your stomach area), but not right next to each other. . . . Routine Use: . . . Step H. . . . keep the dose button pressed down and make sure that you keep the needle under the skin for a full count of 6 seconds to make sure the full dose is injected. Keep your thumb on the injection button until you remove the needle from the skin. . . ." Observation during medication pass on 08/15/17 at 8:15 a.m. showed a nurse (#14) administered Lantus insulin and Victoza to Resident #19. The nurse injected the medications less than two inches apart into the left abdomen. The nurse depressed the button to inject the Victoza medication and immediately withdrew the needle. The nurse failed to keep the button depressed with the needle under the resident's skin for 6 seconds. During an interview on 08/17/17 at 11:35 a.m., a nurse manager (#15) stated she expected staff to leave the needle under the skin for 6 seconds and to administer the medications in different areas of the abdomen, not close together.	F 281	The facility has determined that all residents with this specific order have the potential to be affected. An in-service education on manufacturer□s directions on administering Victoza will be conducted by the Director of Nursing Services or designee on September 15, 2017. The Director of Nursing Services, or designee, will conduct random audits of Victoza administration of one nurse weekly for four (4) weeks, then one nurse monthly for four (4) months to ensure compliance with facility guidelines. 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: September 21, 2017.	
F 363 SS=E	483.60(c)(1)-(7) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED (c) Menus and nutritional adequacy. Menus must-	F 363		9/21/17

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F 363	Continued From page 32 (c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; (c)(2) Be prepared in advance; (c)(3) Be followed; (c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; (c)(5) Be updated periodically; (c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and (c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 07/14/16. Based on observation, review of facility menus, review of facility policy, and staff interview, the facility failed to meet the nutritional needs of residents by serving incorrect portion sizes in 3 of 3 dining rooms (Whispering Winds, Shady Lane, and Harvest Lane). Failure to follow recommended portion sizes as outlined in the facility's menus may result in weight changes and/or inadequate nutritional intake for all residents.	F 363	Portion sizes of all foods on the facility menus have been re-evaluated by the Registered Dietitian and the Dietary Manager to assure accuracy and adequacy of planned meals. Foods are being served using proper serving and scoop sizes for the accurate delivery of portion sizes to all residents. The facility has determined that all residents have the potential to be affected. On September 5, 2017 the Dietary	

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F 363	Continued From page 33 Findings include: Review of the facility policy titled "Portion Control Menu Planner" occurred on 08/16/17. This policy, undated, identified, ". . . Green scoop is 2 2/3 ounces or 1/3 cup; Gray scoop is 4 ounces or 1/2 cup . . ." - Observation of tray line occurred in the Whispering Winds dining room on 08/15/17 during the noon meal. Observation showed the following inconsistencies between portion sizes listed on the facility's menus and the actual amount served to residents: * Beef tips in gravy served with a 30 milliliter (one ounce) ladle. The menu identified 2/3 cup (5 ounces). * Ground beef with a green scoop (1/3 cup). The menu identified 2/3 cup. - Observation of tray line occurred in the Shady Lane dining room on 08/15/17 during the noon meal. Observation showed the following inconsistencies between portion sizes listed on the facility's menu and the actual amount served to residents: * Buttered noodles served with a green scoop (1/3 cup) for a bland diet. The menu identified 1/2 cup for the bland diet. * Ground beef with a gray scoop (1/2 cup) for regular portions. The menu identified the regular portion as 2/3 cup. Ground beef with a gravy ladle (one ounce) for small portions. The menu identified 2/3 cup (5 ounces). * Pureed meat with a green scoop (1/3 cup). The menu identified 1/2 cup. * Served the vegetable with tongs. The menu identified 1/2 cup.	F 363	Manager or designee in-serviced the dietary staff on the facility guidelines for portion sizes. All server staff performed return demonstration at an in-service on September 5, 2017. The Dietary Manager or designee will conduct (4) food preparation and service audits weekly for four (4) weeks and monthly for six (6) months to ensure compliance. Audit results will be reviewed quarterly by the Risk Management/Quality Assurance 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: September 21, 2017	

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F 363	Continued From page 34 - Observation of tray line occurred in the Harvest Lane dining room on 08/15/17 during the noon meal. Observation showed the following inconsistencies between portion sizes listed on the facility's menu and the actual amount served to residents: * Buttered noodles served with a green scoop (1/3 cup) for a bland diet. The menu identified 1/2 cup for the bland diet. * Ground beef served with a green scoop (1/3 cup). The menu identified 2/3 cup. * Pureed meat served with a green scoop (1/3 cup). The menu identified 1/2 cup. During an interview on 08/17/17 at 10:55 a.m., a dietary supervisory (#4) confirmed staff failed to use the correct scoop sizes.	F 363		
F 371 SS=D	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.	F 371		9/21/17

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F 371	Continued From page 35 (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to serve food under sanitary conditions in 1 of 3 kitchenettes (Shady Lane). Failure to ensure staff washed hands after picking up food service garbage from the floor had the potential to result in a food borne illness. Findings include: - Observation on 08/15/17 during the lunch meal on Shady Lane showed a dietary staff member (#9) wore the same gloves throughout the time of observation and performed the following tasks: * Served food. * Left the serving area to obtain a set of tongs from a drawer. * Returning to the serving area the dietary staff member (#9) picked up food service garbage from the floor. * Served food including obtaining buttered bread with her gloved hands. * Dished beef tips in gravy by holding a corner of the plastic lining in the serving pan with her gloved hand, then letting the plastic fall back into the food after scooping food from the container. This happened two times. * Served buttered bread with her gloved hands moving the food between her two hands.	F 371	Staff members involved were not promptly in-serviced on proper sanitary techniques for service on the tray line during this noted event as no facility management were present at the time of the observation by surveyor. The facility has determined that all residents who consume food by mouth have the potential to be affected. On September 5, 2017 all dietary staff were in-serviced on the facility□'s policies and practice guidelines for maintaining a sanitary tray line and on appropriate hand washing/glove use when retrieving service garbage items from the floor. In-service training included observation of each employee performing the procedure. A Validation Checklist was completed for each dietary employee to determine if the employee was performing the procedure correctly. Findings were reviewed with each employee. Corrective action was provided as needed. The Dietary Manager or designee will complete random validation reports of	

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

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F 371	Continued From page 36 The dietary staff member (#9) failed to remove her gloves, wash her hands, and donn clean gloves after picking up food service garbage from the kitchen floor. During an interview on 08/17/17 at 10:55 a.m., a dietary supervisory (#4) identified the staff member would be expected to wash her hands after picking up food service garbage from the floor.	F 371	dietary staff performing procedures to ensure staff performance is in accordance with the facility policy weekly for four (4) weeks, monthly for six (6) months. Findings of this audit will be discussed with the Resident Council. 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: September 21, 2017.	
F9999	FINAL OBSERVATIONS Based on observation, record review, review of facility policy, and resident, family, and staff interviews, the complaint regarding resident care was not substantiated and the complaint regarding abuse was substantiated. Refer to F225.	F9999		