STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355053	A. BUILDING _____ B. WING _____	08/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KNIFE RIVER CARE CENTER	118 22ND ST NE BEULAH, ND 58523

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The standard Medicare/Medicaid recertification survey started on 08/16/21 and concluded 08/23/21.	F 000		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(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, staff interview, and review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, the facility failed to complete a significant change in status assessment (SCSA) for 1 of 19 sampled residents (Resident #59) who experienced a significant change in status. 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	F 637	Plan of Correction F-Tag: ___637_____ 1.) What corrective action will be accomplished for those residents affected by the deficient practice?: The corrective action accomplished related to ensuring that the Minimum Data Set (MDS) is accurately completed on residents who experience a significant change in status (SCSA) is that a SCSA MDS was completed for Resident #59. 2.) How will you identify other residents having the potential to be affected by the same deficient practice? The facility recognizes that all residents	9/27/21

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

Electronically Signed | 09/17/2021

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F 637	Continued From page 1 Manual (Version 1.15), dated October 2017, page 2-22 stated, ". . . A 'significant change' is a major 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., [for example] two areas of ADL [Activities of Daily Living] decline or improvement. . . ." Review of Resident #59's medical record occurred on all days of survey. An annual Minimum Data Set (MDS), dated 04/10/21, identified the resident required supervision with bed mobility, transfers, walking in the corridor, and toileting. The medical record identified Resident #59 hospitalized 07/06/21-07/09/21. A quarterly MDS, dated 07/16/21, identified the resident required extensive assistance with bed mobility, transfers, walking in corridor and toileting. The medical record included the following progress note: * "7/20/2021 at 14:07 [2:07 p.m.] . . . Quarterly/5day MDS completed for [Resident #59]. [Resident #59] had a 3 night hospital stay for a urinary tract infection and dehydration. He returned to the facility on 7/9/2021. . . . For the ADL [Activities of Daily Living] look back period [Resident #59] required extensive staff assistance with bed mobility, transfers, dressing, toileting, hygiene and bathing. He required limited staff assistance with ambulation in his	F 637	have the potential to be affected by the same practice. 3.) How the deficiency will be corrected? Include how the facility will correct the existing deficiency. Identify what measures will be put into place and what systemic changes the facility will make to ensure the deficient practice does not recur. Example: Look at the system and determine if a change to the existing system is needed, if a new system is necessary or if a system does not exist and must be developed. Measures put into place to ensure this practice will not reoccur are that the facility MDS Coordinator, MDS IDT Team and Nurse Management Team will receive re-education on information regarding F Tag 637 so that all will have an understanding to what constitutes the requirement of significant change in status for a resident. A new clinical topic with the title, POSSIBLE SIGNIFICANT CHANGES, will be added to the morning clinical report sheet. Emphasis will be put on the need to assure that each resident□s current status is accurately reflected through their MDS assessment and subsequent care plan. 4.) How does the facility plan to monitor its performance to ensure solutions are permanent? What quality assurance process will be developed to ensure the correction is achieved and sustained? Identify the frequency of the monitoring and the staff person by job duty (NOT	

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F 637	Continued From page 2 room. He was able to eat independently after set-up. [Resident #59] had frequent bladder incontinence and was continent of his bowel. . . . Therapy attempted to work with [Resident #59] several times throughout the look back period and [Resident #59] would not work with therapy despite the extra assistance he was needing with his ADL's. He was coded for rejection of care daily as he either refused cares, medications or offers of therapy every day during the look back. We will monitor {resident #59] to see if his ADL performance improves after being back at the facility awhile longer, or if a SCSA will be required. We will continue to monitor and support [Resident #59] through his person centered plan of care. . . ." The record lacked evidence staff completed a SCSA following Resident #59's hospitalization and return on 07/09/21. During an interview on 08/18/21 at 5:00 p.m., an administrative staff member (#1) agreed she failed to follow up on Resident #59's decline in status within 14 days and did not complete a significant change assessment.	F 637	INDIVIDUAL NAME) that will monitor the corrective action? The facility plans to monitor its performance to make sure solutions are sustained by assigning the MDS Coordinator and/or designee to monitor by using random audits that will assure possible significant changes are being discussed in morning clinical meeting and that all resident□s current status is the most accurately reflected. These random audits will be done weekly x 4, monthly x 2, and then for one quarter beginning the week of 9/13/2021. Results will then be reported to the QA team with corrective action implemented, as deemed necessary. 5.) When the deficiency will be corrected. The date of correction must be at least the day after the survey completion (8/23/2021). 9/27/2021	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. 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 (Version	F 641	Plan of Correction F-Tag: ___641_____ 1.) What corrective action will be	9/27/21

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F 641	Continued From page 3 1.17), and staff interview, the facility failed to ensure accurate coding of the Minimum Data Set (MDS) for 2 of 19 sampled residents (Resident #22 and #25). Failure to accurately complete the MDS does not allow each resident's assessment to reflect their current status/needs and may affect the accurate development of a comprehensive care plan and the care provided to the residents. Findings include: SECTION M: SKIN CONDITIONS The Long-Term Care Facility RAI User's Manual, revised October 2019, page M-5 stated, ". . .M0210: Unhealed Pressure Ulcers/Injuries . . . Code 1, yes: if the resident had any pressure ulcer/injury (Stage 1, 2, 3, 4, or unstageable) in the 7-day look-back period. . . ." Review of Resident #25's medical record occurred on all days of survey. A quarterly MDS, dated 05/24/21, showed section M0210 coded 1 indicating a pressure ulcer in the 7-day look back period. A nursing progress note, dated 05/23/21, stated, ". . .Ensure dressing is intact Q [every] shift (Spine Wound) . . . Superficial skin shearing to the third spinous process . . . blanchable, nonbleeding . . ." This is not indicative of a pressure ulcer. During an interview on 08/19/21 at 8:54 a.m., an administrative nurse (#1) confirmed she coded the wound as a pressure ulcer in error on the 05/24/21 quarterly MDS. SECTION N: MEDICATIONS	F 641	accomplished for those residents affected by the deficient practice?: The corrective action accomplished related to ensuring the Minimum Data Set (MDS) accurately reflects the resident□s status is that a modification MDS was completed for Resident # 25 and Resident # 22 in regards to sections M0210 and N0410E. 2.) How will you identify other residents having the potential to be affected by the same deficient practice? The facility recognizes that all residents have the potential to be affected by the same practice. 3.) How the deficiency will be corrected? Include how the facility will correct the existing deficiency. Identify what measures will be put into place and what systemic changes the facility will make to ensure the deficient practice does not recur. Example: Look at the system and determine if a change to the existing system is needed, if a new system is necessary or if a system does not exist and must be developed. Measures put into place to ensure this practice will not reoccur are that facility MDS Coordinator will receive reeducation on information contained within the RAI Manual, specifically in relation to coding of section M and section N through Relias Learning. In regards to section M, the MDS Coordinator will meet once weekly with wound nursing to assure wounds will be appropriately identified for MDS	

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F 641	Continued From page 4 The Long-Term Care Facility RAI User's Manual, revised October 2019, page N-7 stated, ". . .N0410E, Anticoagulant (a blood thinning medication) . . . record the number of days an anticoagulant medication was received by the resident at any time during the 7-day look-back period . . . ." Review of Resident #22's medical record occurred on all days of survey. A quarterly MDS, dated 05/22/21, showed section N0410E coded 0 indicating no use of anticoagulants in the 7-day look-back period. Review of the May medication administration record identified Apixaban (an anticoagulant) 5 mg documented as given two times a day for the entire month of May. During an interview on 08/19/21 at 8:45 a.m., an administrative nurse (#1) confirmed she failed to code 7 days of anticoagulant use on the 05/22/21 quarterly MDS.	F 641	coding. In regards to section N, the MDS Coordinator will print out medication list that corresponds with each resident□s MDS and medications will be double checked for accuracy before the MDS is closed. Emphasis will be put on the need for MDS staff to ensure that section M and section N are accurately completed, in order for all resident□s current status to be most accurately reflected. 4.) How does the facility plan to monitor its performance to ensure solutions are permanent? What quality assurance process will be developed to ensure the correction is achieved and sustained? Identify the frequency of the monitoring and the staff person by job duty (NOT INDIVIDUAL NAME) that will monitor the corrective action? The facility plans to monitor its performance to make sure solutions are sustained by assigning the MDS Coordinator and/or designee to monitor by using random audits that sections M and N accurately reflect the resident'□s status. These random audits will be completed by the MDS Coordinator at a frequency of weekly for no less than 12 weeks. After 12 weeks of monitoring, provided such expectations are consistently met, monitoring will be reduced to monthly. Monthly monitoring will continue for 3 months. If during monitoring/audit process mistakes are found, education will be provided to the respective staff. Results of monitoring will then be reported to the QA team by the	

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F 641	Continued From page 5	F 641	MDS Coordinator with corrective action implemented, as deemed necessary. 5.) When the deficiency will be corrected. The date of correction must be at least the day after the survey completion (8/23/2021). 9/27/2021	
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review, review of the North Dakota Provider Manual Preadmission Screening and Resident Review (PASARR) and Level of Care Screening Procedures for Long Term Care Services, and staff interview, the facility failed to complete a status change assessment for 1 of 2	F 644	Plan of Correction F-Tag: ____644_____ 1.) What corrective action will be accomplished for those residents affected by the deficient practice?: A new PASARR was completed for	9/27/21

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F 644	Continued From page 6 sampled residents (Resident #26) with a newly diagnosed mental illness. Failure to complete a change in status assessment may result in the delivery of care and services that are inconsistent with the resident's needs. Findings include: The North Dakota PASARR Provider Manual, revised August 2015, page 13, stated, ". . . Change in Status Process . . . Whenever the following events occur, nursing facility staff must contact Ascend to update the Level I screen for determination of whether a first time or updated Level II evaluation must be performed. These situations suggest that a significant change in status has occurred: . . . If an individual with MI, ID, and/or RC (mental illness, intellectual disability, and conditions related to intellectual disability [referred to in regulatory language as related conditions or RC] was not identified at the Level 1 screen process, and condition later emerged to was discovered . . ." Review of Resident #26's medical record occurred on all days of survey and identified an original PASARR completed on 09/18/18. The record showed Resident #26 received a new diagnosis of delusional disorders on 10/27/20, but lacked evidence the facility completed an updated Level I screening/change in status assessment following the new diagnosis. During an interview on 08/18/21 at 4:12 p.m., a social services staff member (#2) confirmed the facility failed to submit another PASARR for Resident #26 following the new diagnosis.	F 644	resident #26, reflecting the missing diagnosis. 2.) How will you identify other residents having the potential to be affected by the same deficient practice? PASARRs will be reviewed for every current resident by the Social Worker to ensure all major mental health diagnosis are appropriately reported. 3.) How the deficiency will be corrected? Include how the facility will correct the existing deficiency. Identify what measures will be put into place and what systemic changes the facility will make to ensure the deficient practice does not recur. Example: Look at the system and determine if a change to the existing system is needed, if a new system is necessary or if a system does not exist and must be developed. Education provided to the facility Social Worker, Nurse Managers, MDS Coordinator, and Health Information Manager on the facility's PASARR policy and practice. Increased communication interventions will be put in place to ensure this deficiency does not reoccur. Staff will work to improve communication regarding mental health diagnosis or change in status. The facility Social Worker, Nurse Managers, and MDS Coordinator will communicate in the facility's morning clinical meeting regarding reports of any new mental health diagnosis and any new changes in status. Health Information Manager will continue to notify Social	

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F 644	Continued From page 7	F 644	Services of changes or additions of mental health to the diagnosis list as they are being entered into the resident's charts to ensure that new diagnosis were not missed. Social Worker will contact respective agency for determination of whether a first time or updated Level II evaluation is needed. 4.) How does the facility plan to monitor its performance to ensure solutions are permanent? What quality assurance process will be developed to ensure the correction is achieved and sustained? Identify the frequency of the monitoring and the staff person by job duty (NOT INDIVIDUAL NAME) that will monitor the corrective action? The facility social worker will review each resident's most recent PASARR in conjunction with their quarterly, annual, and significant change MDS assessment. Review results will be documented in each resident's chart. Social worker will be reporting back to QA IDT team as follow-up to POC. Audits will be conducted of resident chart by the social worker weekly, for no less than 12 weeks to assure Ascend is contacted for the correct level and evaluations are completed. After 12 weeks of audits, provided such audits demonstrate expectations are consistently met, audits may be reduced to monthly. Monthly audits will continue for no less than three months. During audit process, if mistakes present themselves education will be provided to the identified staff on practice	

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F 644	Continued From page 8	F 644	related to reporting mental health diagnosis to KRCC Social Worker. KRCC Social worker, responsible for this improvement, will report out quarterly on this sustained effort to the full QAPI committee. Data and metrics as well as process improvement will be reviewed during designated QAPI meeting time. 5.) When the deficiency will be corrected. The date of correction must be at least the day after the survey completion (8/23/2021). 9/27/2021	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(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: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 09/26/19 Based on record review, review of professional reference, review of facility policy, and staff interview, the facility failed to provide care in accordance with professional standards for 1 of 2 sampled residents (Resident #22) reviewed for insulin use and blood sugar control. Failure to carry out physician's orders and notify the physician of blood sugars greater than 400 mg/dL may result in adverse health effects. Findings include:	F 658	Plan of Correction F-Tag: _____658_____ 1.) What corrective action will be accomplished for those residents affected by the deficient practice?: Education of nursing staff on the importance of following orders for resident #26. Education specifically focusing on KRCC Medication System Procedure provided as well as review of blood sugars by nurse manager for accuracy of nurse reporting. 2.) How will you identify other residents	9/27/21

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F 658	Continued From page 9 Berman, Snyder, and Frandsen's "Kozier & Erb's Fundamentals of Nursing: Concepts, Process, and Practice," 10th ed., Pearson Education, Inc., Massachusetts, page 68, stated, ". . . It is the nurses responsibility to seek clarification of ambiguous or seemingly erroneous orders from the prescriber. . . . If the order is neither ambiguous nor apparently erroneous, the nurse is responsible for carrying it out. . . . " Review of the facility policy titled "Medication System Procedure" occurred on 08/19/21. This policy, reviewed May 2021, stated, ". . . The Charge Nurse is responsible for: . . . Administering all ordered medications to residents at appropriate times and follow through with provider request for notifications/updates as ordered. . . ." Review of Resident #22's medical record occurred on all days of survey. Diagnosis included diabetes mellitus type 2. A physician order, dated 12/03/18, stated, "Accucheck [blood sugar check] four times a day. *Notify PCP [primary care provider] . . . of BS [blood sugar]<70 or >400 [less than 70 or greater than 400]." Review of Resident #22's blood sugars identified the following: * 08/09/21 at 8:00 p.m., 406 mg/dL * 08/16/21 at 8:00 p.m., 403 mg/dL * 07/05/21 at 7:30 a.m., 428 mg/dL * 07/06/21 at 7:30 a.m., 402 mg/dL The medical record lacked documentation the nursing staff notified the physician of the elevated	F 658	having the potential to be affected by the same deficient practice? Physicians are now consistently ordering notification for blood glucose less than 70 mg/dl or greater than 400 mg/dl. Nurses are aware of these order parameters. Review of blood sugars by nurse managers to assure accuracy of notification has been completed. 3.) How the deficiency will be corrected? Include how the facility will correct the existing deficiency. Identify what measures will be put into place and what systemic changes the facility will make to ensure the deficient practice does not recur. Example: Look at the system and determine if a change to the existing system is needed, if a new system is necessary or if a system does not exist and must be developed. Review of blood sugars for any instances of greater than 400 mg/dl or less than 70 mg/dl by nurse manager. Audit tool created and used weekly to identify any staff that require further education. 4.) How does the facility plan to monitor its performance to ensure solutions are permanent? What quality assurance process will be developed to ensure the correction is achieved and sustained? Identify the frequency of the monitoring and the staff person by job duty (NOT INDIVIDUAL NAME) that will monitor the corrective action? Nurse to nurse report twice daily to include report of blood glucose outside of	

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F 658	Continued From page 10 blood sugars as per physician order. During an interview on 08/19/21 at 10:20 a.m., an administrative nurse (#3) confirmed the expectation for nursing staff to call the physician at the time of an out of range blood sugar (>400 or <70). She agreed the medical record lacked documentation of physician notification of the out of range blood sugars.	F 658	defined parameters. Unit managers to use audit tool to review compliance weekly for no less than 12 weeks. After 12 weeks of monitoring, provided such monitoring demonstrates expectations are consistently met, monitoring may be reduced to monthly. Monthly monitoring will continue for no less than three months. If during audit process mistakes are identified, education will be provided to the identified staff member(s). Each unit manager, responsible for this improvement, will report out quarterly on this sustained effort to the full QAPI committee. Data and metrics as well as process improvement will be reviewed during designated QAPI meeting time. 5.) When the deficiency will be corrected. The date of correction must be at least the day after the survey completion (8/23/2021). 9/27/2021	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident interview, and staff interview, the facility failed to provide the necessary services for 2 of 19 sampled residents (Resident #10 and #26) who required staff assistance with Activities of Daily Living (ADL) for bathing and dining. Failure to	F 677	Plan of Correction F-Tag: ____677_____ 1.) What corrective action will be accomplished for those residents affected by the deficient practice?: During care conference with resident #10	9/27/21

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F 677	Continued From page 11 provide assistance with bathing as scheduled may result in poor personal hygiene and decreased self-esteem. Failure to provide assistance with dining may result in weight loss. Findings include: - Review of Resident #10's medical record occurred on all days of survey. The current care plan stated, "The resident has an ADL self-care performance deficit . . . BATHING/SHOWERING: The resident requires staff assistance of one for bathing and/or showering. . . ." Review of the bathing record showed Resident #10 is scheduled to receive a bath on Monday's. During an interview on 08/16/21 at 11:45 a.m., Resident #10 stated he/she had not received a bath in over two weeks. The resident stated, "I never know when my bath is supposed to be. This morning they came in and woke me up for a bath and I wasn't prepared so I said no, not now". Review of the bathing records for Resident #10 from 07/22/21 to 08/18/21 showed the resident received one bath, (08/05/21) during the four week period. During an interview on 08/18/21 at 5:53 p.m., a nurse manager (#3) confirmed the documentation showed Resident #10 had received one bath during the four week period, and stated staff are expected to document the refusal and offer the bath again at a later time and/or day. -Review of Resident #26's medical record	F 677	and family, resident agreed to weekly baths. Resident #10 does not feel the need for more than a few baths per month. Nursing staff educated on Monday baths with the directive to offer again on Thursday if resident refuses on Monday. Resident and family member are in favor/agreeance of this plan. Nursing staff will clearly document completion or refusal of service so that all staff are able to identify need to offer again. Resident #26 has been reviewed by dietician and a protein additive has been started in Resident #26 Pepsi to help with nutrition. Resident #26 has also been changed to an assist of 1 with meals. Resident #26 intake is being monitored by dietary and nursing staff. 2.) Resident is now being relocated to dining room for lunch and supper and has assistance with 100% of those meals. Resident continues to feed herself but does allow encouragement and is receptive to a few substitutions. MDS review of bathing as well as nurse manager review of bathing and refusal will be used to identify potential need in the future. Weight review as well as observation at meal times is currently being used to determine the need for further assistance with meals. Staff educated on providing nutritional dietary substitutions as well. 3.) How the deficiency will be corrected? Include how the facility will correct the existing deficiency. Identify what	

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F 677	Continued From page 12 occurred on all days of survey. The current care plan stated, "Potential for Alteration in Nutritional Status d/t [due to] dx [diagnosis]. dementia, Hx [history]. UTI [urinary tract infection]. Hx. Low Albumin. Weight loss. Hx. Has Refused oral nutritional supplements. Skin breakdown. . . . Resident can feed herself but is needing more help with eating a PFA [Paid Feeding Assistant] can assist with eating. . . ." Current physician's orders, dated, 06/16/21, stated, "Assist/encourage eating at all meals." Observation during the noon meal on 08/18/21 showed staff failed to assist or encourage Resident #26. Review of Resident #26's documented meal assistance from July 20- August 17, 2021, showed staff provided physical assistance 10 of 87 meals. During an interview on 08/19/21 at 1:19 p.m., an administrative nurse (#3) confirmed staff failed to assist/encourage Resident #26 to eat on a consistent basis.	F 677	measures will be put into place and what systemic changes the facility will make to ensure the deficient practice does not recur. Example: Look at the system and determine if a change to the existing system is needed, if a new system is necessary or if a system does not exist and must be developed. Review of charting practice and use of N/A versus accept or refuse. Also education of staff around the importance of bathing. Tub seat cushions ordered in hopes of making bathing more enjoyable. Lastly, following a patient center approach, encouragement is provided to residents to try new tubs. Protein liquid with acceptable taste to mix with Pepsi as resident will frequently accept Pepsi. Protein used in addition to multiple drinks to aid in wound healing. Weekly weight review with identification of at risk residents based on KRCC Weight policy. Education around KRCC weights policy completed with nursing staff. 4.) How does the facility plan to monitor its performance to ensure solutions are permanent? What quality assurance process will be developed to ensure the correction is achieved and sustained? Identify the frequency of the monitoring and the staff person by job duty (NOT INDIVIDUAL NAME) that will monitor the corrective action? Each unit manager monitoring bathing acceptance and working directly with resident and family for their respective units. Bath acceptance and charting also	

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F 677	Continued From page 13	F 677	monitored quarterly by MDS. Weekly weight audit by night shift charge nurse in Shady Lane. Also weight review by unit managers on Mondays. Lastly, weight review with MDS by dietician quarterly. Facility unit managers will conduct weekly audits of resident charts for no less than 12 weeks. After 12 weeks, provided all requirements are consistently met, frequency of audits will be reduced to monthly for 3 months. If during audits mistakes are identified education will be provided to the respective staff members. Unit managers, responsible for this improvement, will report out quarterly on this sustained effort to the full QAPI committee. Data and metrics as well as process improvement will be reviewed during designated QAPI meeting time. 5.) When the deficiency will be corrected. The date of correction must be at least the day after the survey completion (8/23/2021). 9/27/2021	
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives	F 686		9/27/21

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F 686	Continued From page 14 necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of professional reference, resident interview, and staff interview, the facility failed to provide the necessary care and services to prevent the development of pressure ulcers, for 1 of 6 sampled residents (Resident #53) with pressure ulcers. Failure to properly position medical device equipment, resulted in Resident #53 developing a facility acquired pressure ulcer and may result in the development of new ulcers. Findings include: "National Pressure Ulcer Advisory Panel, European Pressure Ulcer Advisory Panel and Pan Pacific Pressure Injury Alliance, Prevention and Treatment of Pressure Ulcers: Quick Reference Guide," Emily Haesler (Ed.), Cambridge Media, Osborne Park, Western Australia, 2014, Page 24 stated, ". . . Avoid positioning the individual directly onto medical devices, such as tubes, drainage systems or other foreign objects. . . ." During an interview on 08/17/21 at 10:08 a.m., Resident #53 stated "I have a sore on my leg from my catheter tubing." Observation on 08/17/21 at 10:43 a.m., showed a staff nurse (#6) performed a dressing change to Resident #53's upper left calf. The wound measured approximately 5 inches x 1.5 inches,	F 686	Plan of Correction F-Tag: _____686_____ 1.) What corrective action will be accomplished for those residents affected by the deficient practice?: Positioning education has been completed with all nursing staff for proper catheter placement with resident #53. Special emphasis provided on catheter tubing placement. 2.) How will you identify other residents having the potential to be affected by the same deficient practice? Visual observation of residents by nursing staff after completion of positioning training. Identification of residents at risk for pressure ulcers on MDS review. Daily discussion, by interdisciplinary team, of skin integrity risk for identified residents. QAPI team focusing on skin integrity. This team reports out quarterly to the large interdisciplinary team. 3.) How the deficiency will be corrected? Include how the facility will correct the existing deficiency. Identify what measures will be put into place and what systemic changes the facility will make to ensure the deficient practice does not recur. Example: Look at the system and determine if a change to the existing	

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F 686	Continued From page 15 with a pink wound bed. Review of Resident #53's medical record occurred all days of survey. Diagnoses included paraplegia and neuromuscular dysfunction of the bladder. A quarterly Minimum Data Set dated 06/23/21 identified an indwelling catheter and a very high risk for developing pressure ulcers with no current pressure ulcers. The care plan stated ". . . The resident has potential for pressure ulcer development or risk for impaired skin integrity r/t [related to] Hx [history] of pressure ulcers, immobility, and non-compliance with recommendations. . . . The resident needs assistance to turn/reposition at frequent intervals, more often as needed or requested. Will often refuse, chart any refusals. . . ." A Physician Communication Fax Form dated 08/10/21 stated, ". . .Resident has a 2.25 inch x1 in. [inches] open area to posterior L [left] calf, it appears as though this may have been a blistered [sic], the area is now open with the 'blistered skin' sloughing. There is a 0.05 cm red border surrounding the open bed wound [sic]. Area cleansed with sterile with sterile wipe and a Mepilex 4X4 applied to cover open area. Please advise for tx [treatment]. . . ." Provider documentation, dated 08/12/21, stated, ". . . Cleanse posterior L [left] calf wound with NS [normal saline], pat dry, Medihoney to wound bed only, skin prep outer peri wound before applying 5X5 Mepilex. DX [diagnosis]: Stage 3 pressure injury *Ensure catheter tubing is NOT under his limbs or trunk* . . . ." A nursing note dated 08/13/21 at 10:23a.m.,	F 686	system is needed, if a new system is necessary or if a system does not exist and must be developed. Nursing education around the risk for pressure ulcers has been completed. Continuing education for skin integrity of residents is being identified by newly formed skin integrity QAPI group. 4.) How does the facility plan to monitor its performance to ensure solutions are permanent? What quality assurance process will be developed to ensure the correction is achieved and sustained? Identify the frequency of the monitoring and the staff person by job duty (NOT INDIVIDUAL NAME) that will monitor the corrective action? Monitoring of skin integrity issues via pressure ulcer metric on CASPER report. Monthly monitoring during skin integrity QAPI and quarterly monitoring with large QAPI group. Weekly monitoring during wound rounds and documentation as well as monthly rounds by visiting wound care specialist. Wounds nurse will conduct weekly documented visual audits for no less than 12 weeks to assure proper placement of medical device equipment. After 12 weeks of monitoring, provided such monitoring demonstrates expectations are consistently met, monitoring may be reduced to monthly. Monthly monitoring will continue for no less than three months. If during audit process mistakes are identified, education will be provided to the respective staff members. Wound nurse, responsible for	

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F 686	Continued From page 16 stated, "First time observation of stage 3 pressure injury to left upper posterior calf. Measurements are 5.0 [inches] x 1.8 [inches]. Wound bed contains 90% thin slough and 10% pink wound bed. Peri-wound is pink dry and intact. No s/sx [signs or symptoms] of infection. No odor appreciated and no drainage. . . ." Review of turning and repositioning documentation from 08/05/21-08/18/21 showed 13 instances of refusals out of 142 attempts or completions of turning and repositioning. During an interview on 08/19/21 at 10:20 a.m., an administrative nurse (#3) agreed the staff failed to position the resident off the catheter tubing resulting in a facility acquired stage 3 pressure ulcer.	F 686	this improvement, will report out quarterly on this sustained effort to the full QAPI committee. Data and metrics as well as process improvement will be reviewed during designated QAPI meeting time. 5.) When the deficiency will be corrected. The date of correction must be at least the day after the survey completion (8/23/2021). 9/27/2021	
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;	F 692		9/27/21

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F 692	Continued From page 17 §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, record review, review of professional reference, and staff interview, the facility failed to ensure acceptable parameters of nutritional status for 1 of 4 residents sampled for weight loss (Resident #26). Failure to implement existing nutritional and feeding interventions and inadequately monitor weights resulted in continued severe weight loss, contributed to new pressure ulcers/injuries, and delay in healing of current pressure ulcers/injuries. Findings include: Review of Resident #26's medical record occurred on all days of survey. Diagnoses included pressure ulcers and dementia. The current care plan stated, "Potential for Alteration in Nutritional Status d/t [due to] dx [diagnosis]. dementia, Hx [history]. UTI [urinary tract infection]. Hx. Low Albumin. Weight loss. Hx. Has Refused oral nutritional supplements. Skin breakdown . . . Encourage food/fluid intake at meals and throughout day . . . Encourage protein intake (meat, cheese, eggs, milk, yogurt, peanut butter) as resident will accept. Resident can feed herself but is needing more help with eating a PFA [Paid Feeding Assistant] can assist with eating . . ." Current physician's orders, dated, 06/16/21 stated, ". . . Assist/encourage eating at all meals.	F 692	Plan of Correction F-Tag: ____692_____ 1.) What corrective action will be accomplished for those residents affected by the deficient practice?: Resident #26 is now eating all meals in the dining room with direct supervision by nursing staff. Hoyer scale has been replaced to facilitate accurate weekly weights. 2.) How will you identify other residents having the potential to be affected by the same deficient practice? Weekly weight review by nursing staff as well as review by dietician to identify at risk individuals. MDS review of residents. Meal substitution education for nursing staff to help identify the need for substitution of a menu items to meet the specific needs of residents by following a patient centered and nutritional approach. 3.) How the deficiency will be corrected? Include how the facility will correct the existing deficiency. Identify what measures will be put into place and what systemic changes the facility will make to ensure the deficient practice does not recur. Example: Look at the system and determine if a change to the existing system is needed, if a new system is	

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F 692	Continued From page 18 . . ." Observation of Resident #26 during the noon meal on 08/18/21 showed: * 11:42 a.m. The Resident received meal tray containing ground meat loaf with gravy, cooked broccoli, Au gratin potatoes, a pumpkin bar, and a container of yogurt. In addition, the Resident received an egg cut in half, served in a bowl, and placed to the right above the plate and beverage glasses. The Resident attempted to eat the egg but was unable to reach it. * 11:53 a.m. The Resident attempted to eat broccoli and ground meat loaf but struggled to keep the items on the fork. A Medication Aide (MA) passed medications to Resident #26 while she attempted to get food on a fork. The MA failed to assist or encourage Resident #26. * 11:58 a.m. The Resident continued to reach for the egg but obtained just small pieces of the yolk on the fork. * 12:01 p.m. The Resident attempted to place ground meat and potatoes onto the fork but was unsuccessful. Resident #26 attempted to reach an egg in the bowl above the plate but failed. * 12:07 p.m. The Resident attempted to place potatoes onto the fork, failed, and set down the fork. * 12:13 p.m. The Resident stabbed at a pumpkin bar with a fork but failed. * 12:15 p.m. The Resident attempted to eat yogurt with a fork. * 12:18 p.m. An unidentified Certified Nursing Assistant (CNA) asked Resident #26 if she was "okay", the resident did not respond. The CNA failed to assist the resident with meal and left the table. * 12:19 p. m. The Resident attempted to eat	F 692	necessary or if a system does not exist and must be developed. Review of weekly weights by nursing staff as well as dietician review of weights. Education to nursing and dietary staff for charting of meal intake as well as the need to offer nutritional substitutions. 4.) How does the facility plan to monitor its performance to ensure solutions are permanent? What quality assurance process will be developed to ensure the correction is achieved and sustained? Identify the frequency of the monitoring and the staff person by job duty (NOT INDIVIDUAL NAME) that will monitor the corrective action? Daily use of dietary check in sheets for trays as well as observation of meals. Weight review of each resident weekly by staff nurse and unit manager. Dietician reviews weights weekly as well and as part of MDS. MDS nurse to review weights as part of the quarterly MDS assessment. Unit managers are conducting weekly documented visual audits for no less than 12 weeks to assure appropriate assistance is being provided at meal time in relation to orders and care plan. After 12 weeks of weekly audits, provided such monitoring meets expectations consistently, audits will be reduced to monthly. Monthly audits will continue for no less than three months. If during audit process mistakes are identified, education will be provided to the respective staff members involved. Unit managers, responsible for this	

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F 692	Continued From page 19 potatoes and the fork fell out of her hand. * 12:20 p.m. The Resident dragged the bowl containing an egg with her fork closer to herself and failed to get more than small pieces of egg yolk onto her fork. * 12:25 p.m. An unidentified CNA walked by Resident #26's table and failed to encourage her to eat or offer assistance. * 12: 26 p.m. A second unidentified CNA asked Resident #26 if she wanted more water, failed to encourage her to eat or offer a substitute, and assisted the Resident out of the dining room. During the noon meal three staff interacted with Resident #26 but failed to assist or encourage the resident. The resident struggled for 44 minutes to eat the meal. The resident had difficulty getting the food on the fork, reaching the items on the tray, and getting the food to her mouth. During these observations staff failed to provide assistance the resident needed per the care plan and physician's orders. At the end of the meal the resident had only consumed the egg volk, water, and a hot beverage. Review of Resident #26's documented meal assistance from July 20-August 17, 2021, showed staff provided physical assistance 10 of 87 meals in the last 29 days. Review of the facility policy titled "KRCC [Knife River Care Center] Weight Monitoring Policy" occurred on 08/19/21. This policy, revised 05/01/21, stated, ". . . Residents with weight loss - monitor weight weekly or as ordered by PCP [Primary Care Provider] . . ." Resident #26's weights included the following:	F 692	improvement, will report out quarterly on this sustained effort to the full QAPI committee. Data and metrics as well as process improvement will be reviewed during designated QAPI meeting time. 5.) When the deficiency will be corrected. The date of correction must be at least the day after the survey completion (8/23/2021). 9/27/2021	

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F 692	Continued From page 20 * 02/18/2021 at 9:14 a.m. 135.2 lbs. (pounds) * 03/14/2021 at 10:48 a.m. 130.0 lbs. * 03/18/2021 at 11:16 a.m. 131.2 lbs. * 04/15/2021 at 11:15 a.m. 124.4 lbs. (5.9% decrease in 30 days represents a severe weight loss) * 04/22/2021 at 11:01 a.m. 123.2 lbs. * 04/28/2021 at 5:59 p.m. 123.1 lbs. * 05/4/2021 at 10:47 a.m. 126.2 lbs. * 05/13/2021 at 11:12 a.m. 126.6 lbs. (12% decrease in 90 days represents a severe weight loss) * 06/9/2021 at 3:04 p.m. 126.6 Lbs. * 06/16/2021 at 3:56 p.m. 126.6 Lbs. * 07/8/2021 at 1:05 p.m. 118.8 Lbs. (6.2% decrease in 30 days represents a severe weight loss) * 08/17/2021 at 5:22 p.m. 111.4 Lbs. (6.2% decrease in 30 days represents a severe weight loss and 17.6% decrease in 180 days represents a severe weight loss) Staff failed to weigh Resident #26 weekly from 02/18/21 to 03/14/21, from 03/18/21 to 04/15/21, from 05/13/21 to 06/09/21, from 06/16/21 to 07/08/21, and from 07/08/21 to 08/17/21. During an interview on 08/18/21 at 3:25 p.m., a licensed nutrition professional (#10) stated she expected the nursing department to weigh Resident #26 weekly and expected staff to sit with Resident #26 to supervise/assist/encourage during meals. During an interview on the afternoon of 08/19/21 an administrative nurse (#3) stated she expected weights to be obtained weekly. Kozier & Erb's "Fundamentals of Nursing:	F 692		

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	355053	A. BUILDING _____ B. WING _____	08/23/2021

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F 692	Continued From page 21	F 692		

Concepts, Process, and Practice," 11th ed., Pearson Education, Inc., New Jersey, page 904, stated, "To reduce the likelihood of pressure injury . . . the nurse employs a variety of preventive measures to maintain the skin integrity . . . the nurse optimizes nutrition and hydration . . . Because an inadequate intake of calories, protein, vitamins, and iron is believed to a risk factor for pressure injury development . . . Monitor weight regularly to help assess nutritional status. . . ."

Review of Resident #26's Minimum Data Set (MDS) assessments showed:
* 03/08/21 significant change MDS section M0210 specified 0 indicative of no pressure ulcers/injuries
* 05/24/21 quarterly MDS section M0210 specified 1 indicative of a pressure ulcer/injury

Review of Resident #26's nursing progress notes showed:
* 03/24/21 "STAGE 3 PRESSURE INJURY TO RIGHT COCCY-GEAL [sic] AREA. MEASURING 2.2 X 0.9. THERE IS 25% PINK WOUND BED AND 75% YELLOW SLOUGH . . ."
* 07/23/21 "DTI [Deep Tissue Injury] PRESSURE AREA TO LEFT GREAT TOE. MEASURES 0.8 X 0.8. IT HAS A NON-BLANCHE-ABLE DARK PURPLE CENTER. IT IS NOT OPEN. HAS NO S/SX [signs and symptoms] OF INFECTION . . ."
* 07/23/21 "DTI PRESSURE AREA TO LEFT HEEL. MEASURES 1.0 X 1.0. IT HAS A NON-BLANCHEABLE PURPLE CENTER. IT IS NOT OPEN . . ."

The facility failed to provide assistance with meals as needed, failed to offer substitutions

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F 692	Continued From page 22 when Resident #26 did not consume food originally ordered, and failed to consistently monitor weight, resulting in Resident #26 experiencing continued significant weight loss, contributed to the development of further tissue injury, and delayed healing of a current Stage 3 pressure injury.	F 692		
F 726 SS=E	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents'	F 726		9/27/21

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F 726	Continued From page 23 needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to complete a performance evaluation and competency skills evaluation for 1 of 3 certified nurse assistants (CNAs) (Staff A) at least once every 12 months. Failure to monitor the skills/techniques of the CNA, may result in physical or psychological harm to the residents through improper care. Findings include: Review of the CNA (Staff A's) individual employee record identified the following: * Hire date 04/29/19. * No yearly evaluation completed since hire date. * Competency verification last completed 04/29/19. During an interview on 08/19/21 at 10:26 a.m., an administrative nurse (#3) stated the facility does not perform CNA competencies and evaluations yearly and verified the facility failed to complete an evaluation and competency testing for Staff A since her hire date.	F 726	Plan of Correction F-Tag: _____F726_____ 1.) What corrective action will be accomplished for those residents affected by the deficient practice?: Knife River Care Center implemented a performance management program for all staff. This performance management program looks at staff performance, attendance over the past 12 months, established strengths/opportunities for growth and goals for the future. We also have formed a partnership with UKG HR software to streamline the performance review process for the future. The performance management program along with our facility assessment are used to developed the necessary skills that nursing staff are educated/trained on annually. 2.) How will you identify other residents having the potential to be affected by the same deficient practice? Knife River Care Center has worked in coordination with our managers throughout the facility to assure all employees performance and skills training are properly assessed so we can provide the highest quality of care through implementation of a performance management system which leads to our skills training and development with staff.	

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F 726	Continued From page 24	F 726	3.) How the deficiency will be corrected? Include how the facility will correct the existing deficiency. Identify what measures will be put into place and what systemic changes the facility will make to ensure the deficient practice does not recur. Example: Look at the system and determine if a change to the existing system is needed, if a new system is necessary or if a system does not exist and must be developed. F726 was corrected through the proper implementation of a performance management program, and use of a facility assessment to develop correct skills to educate and train our nursing staff. All managers in the facility were educated on the process during the performance management interviews with employees. 4.) How does the facility plan to monitor its performance to ensure solutions are permanent? What quality assurance process will be developed to ensure the correction is achieved and sustained? Identify the frequency of the monitoring and the staff person by job duty (NOT INDIVIDUAL NAME) that will monitor the corrective action? The facility will ensure the solutions are permanent through a double check methodology. Each department manager is responsible to complete and submit their performance management slips to the Director of Human Resources. The Director of Human Resources will mark off employees to assure we get all staff. In	

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F 726	Continued From page 25	F 726	the future, each departmental manager, lead by the Director of Human Resources, knows that performance review time comes around each March, which is tracked in our HR software, personal calendars, and annual tasks. The performance management program will be audited weekly for no less than 16 weeks. After 16 weeks of monitoring, provided such monitoring demonstrated expectations are consistently met, monitoring may be reduced to monthly for 6 months. If mistakes are identified during audits, education will be provided to the respective staff member(s). After performance reviews are completed, the Director of HR, and staff educator will develop a skills training/education program based on our performance reviews and our facility assessment. The facility assessment will be reviewed by our QAPI committee annually and as needed. The Dir. of HR, responsible for this improvement, will report out quarterly on this sustained effort to the full QAPI committee. Data and metrics as well as process improvement will be reviewed during designated QAPI meeting time. 5.) When the deficiency will be corrected. The date of correction must be at least the day after the survey completion (8/23/2021). 9/27/2021	
F 732 SS=B	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information.	F 732		9/27/21

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F 732	Continued From page 26 §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the	F 732	Plan of Correction	

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F 732	Continued From page 27 facility failed to ensure posting of accurate and complete staffing information for 3 of 4 days of survey (August 17-19, 2021). Failure to post accurate staffing data does not allow residents and visitors to be aware of the number of licensed and unlicensed staff on duty each shift. Findings include: Observation of the daily staffing report occurred on all days of survey. The report failed to identify all the categories of licensed and unlicensed nursing staff directly responsible for resident care per shift on August 17-19, 2021. During an interview on 08/19/19 at 10:13 a.m., an administrative nurse (#3) reported she expected the posting of staff daily.	F 732	F-Tag: ___732_____ 1.) What corrective action will be accomplished for those residents affected by the deficient practice?: Posting of schedule added to shift duties for night nurse on Shady Lane. Verbal education of that task given to night shift nurses on that unit. Daily staffing has been completed consistently since that education was completed. 2.) How will you identify other residents having the potential to be affected by the same deficient practice? All residents had potential to be effected by this deficiency. 3.) How the deficiency will be corrected? Include how the facility will correct the existing deficiency. Identify what measures will be put into place and what systemic changes the facility will make to ensure the deficient practice does not recur. Example: Look at the system and determine if a change to the existing system is needed, if a new system is necessary or if a system does not exist and must be developed. Education of night shift nurses on Shady Lane to complete the daily staffing sheet has occurred. The task of completing the daily staffing sheet has been added to the task checklist given to new nurses called "tour of duty". The reception staff responsible for collecting the daily staffing sheet M-F is the second check for this process. If they do not have a daily staffing sheet to collect they will notify	

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F 732	Continued From page 28	F 732	leadership. 4.) How does the facility plan to monitor its performance to ensure solutions are permanent? What quality assurance process will be developed to ensure the correction is achieved and sustained? Identify the frequency of the monitoring and the staff person by job duty (NOT INDIVIDUAL NAME) that will monitor the corrective action? If daily staffing sheet is absent or has not been updated, reception staff will notify the reception supervisor or director of nursing. The scheduler at KRRC will be conducting weekly documented visual audits to assure proper completion of staffing sheets has occurred for no less than 12 weeks. After 12 weeks of audits, provided that such monitoring demonstrates expectations are consistently met, audits will be reduced to monthly for no less than three months. If during the audit process mistakes are identified, education will be provided to the respective staff member(s). KRCC Scheduler, responsible for this improvement, will report out quarterly on this sustained effort to the full QAPI committee. Data and metrics as well as process improvement will be reviewed during designated QAPI meeting time. 5.) When the deficiency will be corrected. The date of correction must be at least the day after the survey completion (8/23/2021). So 35 days would be 9/27/2021.	

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F 732	Continued From page 29	F 732	9/27/2021	
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in	F 758		9/27/21

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F 758	Continued From page 30 §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to monitor and assess the continued need for psychotropic medications for 3 of 5 sampled residents (Resident #38, #42, and #45) reviewed for unnecessary medications. Failure to monitor residents for tardive dyskinesia (abnormal involuntary movements) may result in the residents receiving unnecessary antipsychotic medications and experiencing adverse reactions. Findings include: Upon request, the facility failed to provide a policy regarding monitoring residents for adverse reactions while on antipsychotic medication. - Review of Resident #42's medical record occurred on all days of survey. The current care plan stated, ". . . The resident uses psychotropic medications r/t diagnoses of anxiety disorder and major depressive disorder. . . . The resident will be/remain free of psychotropic drug related complications, including movement disorder, . . .	F 758	Plan of Correction F-Tag: _____758_____ 1.) What corrective action will be accomplished for those residents affected by the deficient practice?: AIMS assessment has been completed for resident #45, #38 and #42. Review of other resident has been completed as well. 2.) How will you identify other residents having the potential to be affected by the same deficient practice? Residents receiving anti-psychotics have been reviewed by nursing as well as consulting pharmacist for compliance. 3.) How the deficiency will be corrected? Include how the facility will correct the existing deficiency. Identify what measures will be put into place and what systemic changes the facility will make to ensure the deficient practice does not recur. Example: Look at the system and	

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F 758	Continued From page 31 Monitor/document/report PRN any adverse reactions of PSYCHOTROPIC medications: unsteady gait, tardive dyskinesia, (shuffling gait, rigid muscles, shaking), . . ." Resident #42's current physician's orders included the antipsychotic Olanzapine, started 06/10/21. The consultant pharmacist's Drug Regimen Review, dated 06/15/21, regarding the medication order for Olanzapine stated, "Recommended monitoring is recommended when antipsychotics are used. Such recommended monitoring includes: AIMS [Abnormal Involuntary Movement Scale]/DISCUS [Dyskinesia Identification System: Condensed User Scale] assessments." The resident's physician and the director of nursing signed acknowledgment of the recommendation on 07/28/21. Review of Resident #42's record showed staff failed to complete an AIMS or DISCUS assessment. During an interview on 08/19/21 at 11:20 a.m., an administrative nurse (#3) reported staff should complete an AIMS assessment quarterly and with any change in condition. At 11:55 a.m., the nurse (#3) verified the facility failed to complete an AIMS assessment before Resident #42 started on Olanzapine or after the pharmacist's recommendation. - Review of Resident #38's medical record occurred on all days of survey. The current care plan stated, ". . . The resident uses psychotropic	F 758	determine if a change to the existing system is needed, if a new system is necessary or if a system does not exist and must be developed. KRCC has adopted an interdisciplinary team approach to this issue. Consulting pharmacist will now provide guidance to complete AIMs with monthly med review. Nurse managers have added new medications and new diagnosis to their daily report sheet. This report sheet is verbally shared at huddle daily M-F. Nurse managers are now completing AIM□s assessments as residents need them. 4.) How does the facility plan to monitor its performance to ensure solutions are permanent? What quality assurance process will be developed to ensure the correction is achieved and sustained? Identify the frequency of the monitoring and the staff person by job duty (NOT INDIVIDUAL NAME) that will monitor the corrective action? Interdisciplinary team to meet daily M-F to review. MDS Coordinator will review for compliance quarterly. MDS Coordinator is responsible to conduct audits weekly for no less than 12 weeks. After 12 weeks, provided expectations are consistently met, audits may be reduced to monthly. Monthly audits will continue for no less than 3 months. Audits consist of looking over residents who had psychotropic medication changes to verify appropriate AIMs assessment was completed. If audits find mistakes, education will be	

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F 758	Continued From page 32 medications r/t [related to] diagnoses of anxiety disorder and major depressive disorder. . . . The resident will be/remain free of psychotropic drug related complications, including movement disorder, . . . Monitor/document/report PRN [as needed] any adverse reactions of PSYCHOTROPIC medications: unsteady gait, tardive dyskinesia, EPS [extrapyramidal symptoms] (shuffling gait, rigid muscles, shaking), . . ." Resident #38's current physician's orders included the antipyschotic Olanzapine, started 03/26/21. Review of Resident #38's record showed staff completed an AIMS assessment on 12/14/20. Staff failed to complete any additional AIMS assessments. - Review of Resident #45's medical record occurred on all days of survey. The current care plan stated, "The resident uses psychotropic medications r/t Disease process of personal history of other mental and behavioral disorders, and major depressive disorder . . . The resident will be/remain free of psychotropic drug related complications, including movement disorder, . . . Monitor/document/report PRN any adverse reactions of PSYCHOTROPIC medications: unsteady gait, tardive dyskinesia, EPS (shuffling gait, rigid muscles, shaking), . . ." Resident #45's current physician's orders included the antipyschotic Seroquel, started 01/24/18. Review of Resident #45's record showed staff	F 758	provided to the respective staff member(s). MDS Coordinator, responsible for this improvement, will report out quarterly on this sustained effort to the full QAPI committee. Data and metrics as well as process improvement will be reviewed during designated QAPI meeting time. 5.) When the deficiency will be corrected. The date of correction must be at least the day after the survey completion (8/23/2021). 9/27/2021	

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F 758	Continued From page 33 completed an AIMS assessment quarterly through 03/25/21. Staff failed to complete an AIMS assessment since March 2021.	F 758		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to ensure accurate labeling and storage of medications for 2 of 3 residents (Resident #4 and #58) and 1 of 2 medication refrigerators (Shady	F 761	Plan of Correction F-Tag: ____761_____ 1.) What corrective action will be accomplished for those residents affected by the deficient practice?:	9/27/21

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F 761	Continued From page 34 Lane) observed during medication pass and medication storage review. Failure to correctly label, store, and dispose of medications may increase the risk of residents receiving an inaccurate dose of medication and/or reduced medication efficacy. Findings include: MEDICATION LABELING Review of the facility policy titled "Medication System Procedure" occurred on 08/19/21. This policy, reviewed May 2021, stated, ". . . All medications must be checked on the medication record and compared to the medication card for accuracy before given . . . are labeled with the resident name, RX [prescription] number, name of medication, dosage, lot number, and expiration date . . ." - Observation on 08/17/21 at 5:34 p.m. showed the label on Resident #58's insulin box identified Novolog insulin 5 units twice a day and 8 units at HS [bedtime]. Review of Resident #58's physician orders showed an order for Novolog 5 units twice a day in addition to sliding scale and Novolog 8 units in the evening. During an interview on 08/17/21 at 5:40 p.m., a staff nurse (#5) stated the pharmacist or pharmacy technicians bring and apply new labels needed for medications if there is an order change. The staff nurse agreed the label did not match the physician order.	F 761	Updated labeling of insulin vials has been completed for resident #4, and #58. Tracking of refrigerator temp has been performed daily and has been within normal limits. All effected medications were used or discarded in compliance with manufactures recommendation. 2.) How will you identify other residents having the potential to be affected by the same deficient practice? Residents receiving insulin have been reviewed and any discrepancies between the vial and chart have been resolved. Pharmacies have been instructed to put sig on the vial label going forward. Insulins are now part of the med check in process for accuracy. Refrigerator temperatures are now recorded at the start of the CMA shift for accurate documentation. Nursing reviews these temperatures after recorded. 3.) How the deficiency will be corrected? Include how the facility will correct the existing deficiency. Identify what measures will be put into place and what systemic changes the facility will make to ensure the deficient practice does not recur. Example: Look at the system and determine if a change to the existing system is needed, if a new system is necessary or if a system does not exist and must be developed. Insulins are now part of the monthly medication check in for accuracy. Pharmacies have been asked to label vials with complete sig. Refrigerator	

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F 761	Continued From page 35 - Observation on 08/18/21 at 8:35 a.m. showed the label on Resident #4's insulin box identified Novolog insulin 2 units once daily, 3 units twice daily. The staff nurse (#6) administered 2 units subcutaneously into the left arm. Review of Resident #4's physician orders showed an order dated 12/30/20 that stated, "Novolog solution inject 2 unit subcutaneously in the morning and inject 3 unit subcutaneously one time a day and 2 unit subcutaneously in the afternoon". During an interview on 08/18/21 at 10:00 a.m., the staff nurse (#6) stated the resident's order was for "Novolog 2 units in the morning and at supper and 3 units at lunch." The staff nurse agreed the label did not match the current physician order. MEDICATION STORAGE A tour of the Shady Lane medication room occurred on 08/18/21 at 2:00 p.m. with a medication assistant (MA) (#7). The medication refrigerator contained a thermometer that displayed a temperature reading of 49 degrees F (Fahrenheit), and confirmed by the MA (#7). The refrigerator contained the following medications: * Humalog (injectable insulin) * Novolog (injectable insulin) * Levemir (injectable insulin) * Lantus (injectable insulin) * Basaglar (injectable insulin) * Perforomist (inhaled medication to treat Chronic Obstructive Pulmonary Disease) * Copaxone (multiple sclerosis injectable medication)	F 761	temperatures are recorded at the beginning of the CMA shift. Those temperatures are reviewed by nursing after recording. 4.) How does the facility plan to monitor its performance to ensure solutions are permanent? What quality assurance process will be developed to ensure the correction is achieved and sustained? Identify the frequency of the monitoring and the staff person by job duty (NOT INDIVIDUAL NAME) that will monitor the corrective action? Monthly review of insulin is done during medication check-in to ensure accuracy. Staff nurses are educated on the need for sig to be part of the labeling of each vial of insulin. Refrigerator temps are monitored daily by the CMA and nursing staff. Monthly temp monitoring sheets are reviewed by the Unit manager. Unit managers will be conducting weekly documented audits of labels and fridge storage temperatures for no less than 16 weeks. After 16 weeks of audits, provided such audits demonstrate expectations are consistently met, audits may be reduced to monthly. Monthly audits will continue for no less than six months. During the audit process if mistakes present themselves, education will be provided to the respective staff member(s). Unit managers, responsible for this improvement, will report out quarterly on this sustained effort to the full QAPI committee. Data and metrics as well as process improvement will be reviewed	

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F 761	Continued From page 36 * Shingrix (vaccine that prevents shingles virus) * Lantoprost (eye drop) A review of the manufacturer instructions for all the above medications stated the medications are to be stored in the refrigerator at 36-46 degrees F. A second check of the Shady Lane medication room refrigerator on 08/18/21 at 3:30 p.m. with an administrative nurse (#8) showed the thermometer with a temperature reading of 49 degrees F, and confirmed by the administrative nurse (#8). The Refrigerator Temperatures tracking sheet for Shady Lane identified temperature expectations to be 45 degrees F or below. Review of the Refrigerator Temperatures tracking sheet for 08/01/21-08/18/21 showed refrigerator temperatures recorded 9 of 18 days with the last date being 08/15/21. An administrative nurse (#3) agreed the medication room refrigerator temperature failed to meet manufacturers guidelines for the stored medications.	F 761	during designated QAPI meeting time. 5.) When the deficiency will be corrected. The date of correction must be at least the day after the survey completion (8/23/2021). 9/27/2021	
F 806 SS=E	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced	F 806		9/27/21

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F 806	Continued From page 37 by: Based on observation and staff interview, the facility failed to offer an alternative menu item of similar nutritive value for 4 of 19 residents sampled (Resident #8, #26, #35, and #47). Failure to offer substitutes may result in inadequate nutrition, new or worsening pressure ulcers, and weight loss. Findings include: Observation of the noon meal on 08/18/21 showed Resident #8 refused most of the main entree, and staff failed to offer a substitute. Observation of the noon meal on 08/18/21 showed Resident #26 refused the main entrée, starch, vegetable, and ate a few bites of the dessert/supplemental protein sources. Staff failed to offer a substitute. Observation of the noon meal on 08/18/21 showed Resident #35 ate a few bites of the main entrée, a few bites of the vegetable, and staff failed to offer a substitute. Observation of the noon meal on 08/18/21 showed Resident #47 refused the main entrée, drank liquids, and ate a few bites of the vegetable/dessert. Staff failed to offer a substitute. During an interview on the afternoon of 08/19/21, an administrative nurse (#3) stated she expected staff to offer an alternate option when a resident is not eating what they originally ordered.	F 806	Plan of Correction F-Tag: ____806_____ 1.) What corrective action will be accomplished for those residents affected by the deficient practice?: Staff have been educated on the need to provide dietary substitutions for resident #8, #26, #35, #47. 2.) How will you identify other residents having the potential to be affected by the same deficient practice? Nursing staff is trained to identify residents that are not consuming their meals and offer a substitution. Dietary staff are using a check list when collecting trays after meals to ensure that residents have consumed their meals. In the event that a resident does not consume a meal this is reported to nursing to offer a nutritional substitutions. 3.) How the deficiency will be corrected? Include how the facility will correct the existing deficiency. Identify what measures will be put into place and what systemic changes the facility will make to ensure the deficient practice does not recur. Example: Look at the system and determine if a change to the existing system is needed, if a new system is necessary or if a system does not exist and must be developed. Nursing staff is trained to identify residents that are not consuming their meals and offer a nutritional substitution. Dietary staff are using a check list when	

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F 806	Continued From page 38	F 806	collecting trays after meals to ensure that residents have consumed their meals. In the event that a resident does not consume a meal a nutritional substitution will be offered. KRCC staff, responsible for this improvement, will report out quarterly on this sustained effort to the full QAPI committee. 4.) How does the facility plan to monitor its performance to ensure solutions are permanent? What quality assurance process will be developed to ensure the correction is achieved and sustained? Identify the frequency of the monitoring and the staff person by job duty (NOT INDIVIDUAL NAME) that will monitor the corrective action? Facility will monitor intake through daily observation of checklist. Facility will also monitor intake through quarterly review by dietician. Information from reviews are shared with families during care conferences. KRCC Certified Dietary Manager, will conduct weekly audits to assure intake checklist are being completed by staff for no less than 16 weeks. After 16 weeks, provided such requirements are consistently sustained, monitoring may be reduced to monthly. Monitoring will continue monthly for 6 months. KRCC certified Dietary Manager will also conduct weekly documented visual audits to assure alternatives are offered, monitoring will be completed for no less than 16 weeks. After 16 weeks, provided such requirements are consistently sustained, monitoring may be	

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F 806	Continued From page 39	F 806	reduced to monthly. Monitoring will continue monthly for 6 months. During the audit process if mistakes present themselves education will be provided to the respective staff member(s). Data and metrics as well as process improvement will be reviewed and reported to IDT QAPI Committee by the certified dietary manager. 5.) When the deficiency will be corrected. The date of correction must be at least the day after the survey completion (8/23/2021). 9/27/2021	
F 811 SS=D	Feeding Asst/Training/Supervision/Resident CFR(s): 483.60(h)(1)-(3) §483.60(h) Paid feeding assistants- §483.60(h)(1) State approved training course. A facility may use a paid feeding assistant, as defined in § 488.301 of this chapter, if- (i) The feeding assistant has successfully completed a State-approved training course that meets the requirements of §483.160 before feeding residents; and (ii) The use of feeding assistants is consistent with State law. §483.60(h)(2) Supervision. (i) A feeding assistant must work under the supervision of a registered nurse (RN) or licensed practical nurse (LPN). (ii) In an emergency, a feeding assistant must call a supervisory nurse for help. §483.60(h)(3) Resident selection criteria. (i) A facility must ensure that a feeding assistant	F 811		9/27/21

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F 811	Continued From page 40 provides dining assistance only for residents who have no complicated feeding problems. (ii) Complicated feeding problems include, but are not limited to, difficulty swallowing, recurrent lung aspirations, and tube or parenteral/IV feedings. (iii) The facility must base resident selection on the interdisciplinary team's assessment and the resident's latest assessment and plan of care. Appropriateness for this program should be reflected in the comprehensive care plan. This REQUIREMENT is not met as evidenced by: Based on review of the facility Paid Feeding Assistant (PFA) program documentation, review of the Licensing Rules for Nursing Facilities in North Dakota, and staff interview, the facility failed to complete an annual competency evaluation as consistent with State law for 1 of 1 PFA's (#4). Failure to complete an annual competency evaluation does not allow the facility to ensure PFA's continue to demonstrate appropriate feeding techniques, assistance with feeding and hydration, safety practices, infection control practices, and/or honoring of resident rights. Findings include: Review of the Licensing Rules for Nursing Facilities in North Dakota, revised June 2004, occurred on 08/19/21. The rules identified, ". . . The nursing facility must ensure that the ongoing competency of paid feeding assistants is evaluated and documented at least annually. . ." Review of the PFA program documentation occurred on the morning of 08/19/21.	F 811	Plan of Correction F-Tag: ___811_____ 1.) What corrective action will be accomplished for those residents affected by the deficient practice?: Annual competency to be completed with paid feeding assistant. 2.) How will you identify other residents having the potential to be affected by the same deficient practice? Facility only employs one paid feeding assistant. PFA list is updated as changes occur with residents. All residents that PFA interacts with have been identified as having no harm. 3.) How the deficiency will be corrected? Include how the facility will correct the existing deficiency. Identify what measures will be put into place and what systemic changes the facility will make to ensure the deficient practice does not recur. Example: Look at the system and determine if a change to the existing	

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F 811	Continued From page 41 Documentation showed a competency evaluation for the PFA (#4) last occurred on 07/31/19. During an interview on 08/19/21 at 1:30 p.m., an administrate nurse (#3) confirmed the facility failed to complete an annual competency evaluation for the PFA (#4).	F 811	system is needed, if a new system is necessary or if a system does not exist and must be developed. Annual competency for PFA has been updated and completed for 2021. KRCC paid feeding assistant policy has also been updated to include the need for annual competency. 4.) How does the facility plan to monitor its performance to ensure solutions are permanent? What quality assurance process will be developed to ensure the correction is achieved and sustained? Identify the frequency of the monitoring and the staff person by job duty (NOT INDIVIDUAL NAME) that will monitor the corrective action? Annual competency for PFA added to yearly criteria for education as well as HR. KRCC staff, responsible for this improvement, will report out quarterly on this sustained effort to the full QAPI committee. Data and metrics as well as process improvement will be reviewed during designated QAPI meeting time. 5.) When the deficiency will be corrected. The date of correction must be at least the day after the survey completion (8/23/2021). 9/27/2021	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program	F 880		9/27/21

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F 880	Continued From page 42 designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism	F 880		

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F 880	Continued From page 43 involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to follow infection control standards for 2 of 16 sampled residents (Resident #36 and #45) observed during toileting. Failure to follow infection control practices for hand hygiene and glove use related to perineal cares has the potential to spread infection within the facility. Findings include: Review of the facility policy titled "Employee	F 880	1. Corrective Action The facility will immediately implement an appropriate infection prevention and intervention plan consistent with the requirements of ¿483.80 for the affected resident(s)/neighborhood(s) identified in the deficiency. The infection preventionist (IP), director of nursing (DON), in conjunction with applicable interdisciplinary team (IDT) members, shall identify and implement a	

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F 880	Continued From page 44 Handwashing Procedure" occurred on 08/19/21. This policy, dated 05/01/21, stated, ". . . When to Wash Hands (at a minimum) . . . After contact with any body fluids * After handling any contaminated items (linens, soiled briefs, garbage, etc.) . . ." - Review of Resident #36's medical record occurred on all days of survey. The current care plan stated, ". . . The resident has an ADL [activities of daily living] self-performance deficit . . . TOILET USE: The resident requires extensive assist of one staff." Observation on 08/17/21 at 9:11 a.m. showed a certified nurse aide (CNA) (#9) donned gloves and transferred Resident #36 off the toilet after the resident had a bowel movement (BM). The CNA wiped the resident's buttocks soiled with BM, completed perineal cares, applied a skin protectant ointment to the resident's buttocks, removed her gloves, assisted the resident to the sink to wash his/her hands, transferred the resident to the recliner, removed the gait belt, hung the gait belt on the door, pulled the bedside tray table closer to the resident and then sanitized her hands. During an interview on 08/19/21 at 10:09 a.m., an administrative nurse (#3) agreed the CNA should have removed the gloves and performed hand hygiene after completing perineal cares and before doing other tasks. - Review of Resident #45's medical record occurred on all days of survey. The current care plan stated, ". . . The resident is totally dependent on 1 staff for toilet use. Resident is able to use	F 880	consistent system for ensuring a system for: (1) Ensuring staff perform hand hygiene or handwashing after removing gloves, after performing perineal care and after leaving a residents room, in accordance with CDC guidelines. 2. Identification of Others The IP and DON, in conjunction with the applicable the interdisciplinary team (IDT) members, will review current COVID-19 nursing facility guidelines from CDC and CMS. The IP, DON and applicable IDT members will evaluate the facility's compliance with the guidelines. The facility will develop action plans to address any newly identified non-compliance. 3. System Changes On or before 09/23/2021 the facility shall complete the following actions: (1) DON, IP and applicable IDT members will conduct root-cause analysis to identify and address the reasons for non-compliance related to: a. Failure to complete hand hygiene in accordance with CDC guidelines. Information about root cause analysis can be found at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/GuidanceforRCA.pdf (2) The DON, IP or suitable designee will ensure the following: a. All staff will receive education keeping hands clean between tasks, contacts with	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355053	A. BUILDING _____ B. WING _____	08/23/2021

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F 880	Continued From page 45 the toilet via Standing lift and one staff. And requires assistance from staff with incontinent cares and changing incontinent products." Observation on 08/16/21 at 4:54 p.m. showed a certified nurse aide (CNA) (#9) donned gloves and transferred Resident #45 with a mechanical stand lift to the toilet to void. The CNA checked the resident's brief, completed perineal cares, adjusted Resident #45's clothing, transferred the resident to a wheelchair, placed foot pedals on the wheelchair, and handed Resident #45 a cup of water to drink and a doll to hold. The CNA (#9) then removed her gloves and performed hand hygiene. The CNA (#9) failed to remove her gloves and complete hand hygiene after performing perineal cares. During an interview on 08/19/21 at 8:10 a.m., an administrative nurse (#3) agreed the CNA should have removed the gloves and performed hand hygiene after completing perineal cares and before doing other tasks.	F 880	potentially contaminated surfaces and between residents. This education will include the CDC's lesson on clean hands available at https://youtu.be/xmYMUly7qiE. 4. Monitoring Weekly for no less than 12 weeks, the DON, IP, or a designee will conduct on-going monitoring to ensure, via observation, the approaches to correct deficient practice related to infection control and prevention are consistently implemented and effective. Such monitoring will include: (1) Observations of certified nursing staff to ensure performance of proper hand hygiene, when indicated, in the course of their routine duties. Observations will be made across all shifts and neighborhoods/units. Observations of noncompliance with the above will result in ad hoc education for the involved staff. Such education will be documented on monitoring forms. After twelve weeks of monitoring, provided that such monitoring demonstrates expectations are consistently met, monitoring may be reduced to monthly. Monthly monitoring will continue for no less than three months. All monitoring will be reported to the quality assurance process improvement (QAPI) committee as part of QAPI activities. Monitoring will not be discontinued until the facility completes	

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F 880	Continued From page 46	F 880	three consecutive rounds of monthly monitoring that demonstrate sustained compliance as approved by the QAPI committee and medical director. 5. Correction Date 09/27/2021	