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 _____	09/06/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The standard Medicare/Medicaid recertification survey started on 09/04/18 and concluded on 09/6/18.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview the facility failed to provide assistance and/or accommodations to meet the resident's needs for 1 of 1 sampled resident (Resident #76) observed during meals. Failure to provide assistance to residents during dining has the potential for weight loss and a risk for dehydration. Findings include: Observations on 09/04/18 at 11:33 a.m. showed Resident #76 seated in her wheelchair at the table in the dining room leaning to the left with her body braced on the left armrest as she struggled to drink from a glass. While leaning to the left, she struggled to bring the glass to her mouth, but was unable to tip the glass to drink. Observation at 11:44 a.m. showed the glass of juice had fallen to the floor. A staff member came over to the resident's table, picked up the glass, and attempted to help the resident sit up in her	F 558	1)The corrective action accomplished related to providing assistance and/or accommodations to meet needs during meals is that Resident #76 is now being provided with the necessary level of assistance during mealtimes. Resident #76 was screened for appropriate positioning while at the dining room table by Physical therapy on 09/06/2018 with modifications made to ensure optimal positioning and also is currently being observed by Occupational therapy to ensure both the appropriate level of assistance is being provided and to assess for any potential adaptive equipment needs. 2) The facility recognizes that all residents who require assistance during mealtimes have the potential to be affected by the same practice.	10/10/18

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

Electronically Signed | 09/24/2018

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F 558	Continued From page 1 wheelchair. At 11:48 a.m. an unidentified certified nurse assistant (CNA) sat down to help the resident eat, but failed to provide another glass of juice for the resident. Observation on 09/04/18 at 5:18 p.m. showed Resident #76 seated at the table in her wheelchair attempting to drink milk from a glass. As she struggled with the glass, it dropped to the floor. She then reached with her fingers for the fruit in the bowl and tried to eat the mandarin oranges, then dumped the bowl onto her plate of food. During this time staff failed to offer assistance to the resident. At 5:42 p.m. while reviewing Resident #76's meal intakes, a CNA (#12) reported the resident also dropped her glass of water on the floor. Review of Resident #76's medical record occurred on all days of survey. A quarterly Minimum Data Set (MDS), dated 08/14/18, identified impaired cognition and limited assistance of one person for eating. Review of the current care plan stated, ". . . Potential for alteration in nutritional status . . . Set up meals and assist as needed . . ." During an interview on the afternoon of 09/05/18, an administrative nurse (#1) confirmed the staff should have helped Resident #76 with her drinks.	F 558	3) Measures put into place to ensure this practice will not reoccur are that facility staff will receive reeducation on 10/03/2018 related to appropriate positioning at the dining room table via the facility policy titled, Repositioning The Resident While In Wheelchair, by the Director of Nursing Services. Emphasis will be put on the need to intervene and offer assistance during mealtimes to residents if accommodations are needed. 4) The facility plans to monitor its performance to make sure solutions are sustained by assigning the Director of Rehabilitation and/or designee to monitor by using random audits that facility staff is providing the necessary level of assistance to residents who require assistance during mealtimes. These random audits will be done weekly x 4, monthly x 2, and then for one quarter beginning the week of 10/08/2018. Results will then be reported to the QA team with corrective action implemented as deemed necessary. Corrective action completion date: 10/10/2018	
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.	F 578		10/10/18

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F 578	Continued From page 2 §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the	F 578	1) The corrective action accomplished	

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F 578	Continued From page 3 facility failed to ensure the medical record accurately reflected each resident's code level for 2 of 18 sampled residents (Resident #59 and #40). Failure to ensure the residents' medical records accurately reflected their wishes limited emergency personnel from knowing the residents' desires in the event of a medical emergency. Findings include: - Review of Resident #59's medical record occurred on all days of survey. The front cover of the paper medical record identified No CPR (cardio pulmonary resuscitation). This was inconsistent with the "Code and Resuscitate Status Code Form," dated 07/24/18 and signed by Resident #59 which stated, "Full Code." Review of the current physician's orders identified Resident #59's code status as "Full Code." - Review of Resident #40's medical record occurred on all days of the survey. The front cover of the paper medical record identified NO CPR. This was inconsistent with the "Code and Resuscitative Status Code Form" dated 04/23/18 and signed by Resident #40's power of attorney (POA) which stated, "Full Code." A "Resuscitation Form" dated 07/7/16 and signed by the residents POA stated, Do Not Resuscitate (DNR). Review of the current physician's orders identified Resident #40's code status as "DNR". During an interview on 09/06/18 at 10:40 a.m., an administrative nurse (#1) stated he expected staff to look for the residents code status in the electronic medical record (EMR).	F 578	related to ensuring the medical record accurately reflects a residents wishes is that Residents #40 and #59 now have a singular Code and Resuscitative Status Form in place. Code status stickers will be removed from the front cover of Residents #40 and #59 paper medical record, as well as from those of all other resident paper medical records. 2) The facility recognizes that all residents with advanced directives have the potential to be affected by the same practice. 3) Measures put into place to ensure this practice will not reoccur are that facility staff will receive reeducation on the facility policy titled, Advanced Directives, on 10/03/2018 by the Director of Nursing Services. Emphasis will be put on the need for staff to reference the Code and Resuscitative Status Form in the resident□s paper medical record in the event of a medial emergency. A facility initiated Performance Improvement Project (PIP) had been previously implemented on 02/09/2018 in relation to Advanced Directives and will remain active to ensure continued compliance. 4) The facility plans to monitor its performance to make sure solutions are sustained by assigning the QA Coordinator and/or designee to monitor by using random audits that resident medical records accurately reflect their current code status. These random audits	

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F 578	Continued From page 4 During an interview on 09/06/18 at 11:38 a.m., a nurse (#2) stated she would look at the front cover of the paper medical chart.	F 578	will be done weekly x 4, monthly x 2, and then for one quarter beginning the week of 10/08/2018. Results will then be reported to the QA team with corrective action implemented as deemed necessary. Corrective action completion date: 10/10/2018	
F 625 SS=E	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which	F 625		10/10/18

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F 625	Continued From page 5 specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to provide a bed-hold notice upon transfer to the hospital for 4 of 7 sampled residents (Resident #23, #64, #74 and #385) and 1 closed record resident (Resident #85). Failure to provide the facility's bed-hold policy does not allow residents or their legal representatives to make informed choices regarding their readmission rights. Findings include: - Review of Resident #23's medical record occurred on all days of survey and identified the facility transferred the resident to the hospital on 06/13/18. The medical record lacked evidence the facility staff provided Resident #23 and/or their family member/legal representative written notice of the bed-hold policy upon transfer to the hospital. - Review of Resident #64's medical record occurred on all days of survey and identified the facility transferred the resident to the hospital on 05/04/18. The medical record lacked evidence the facility staff provided Resident #64 and/or their family member/legal representative written notice of the bed-hold policy upon transfer to the hospital. - Review of Resident #74's medical record occurred on all days of survey and identified the facility transferred the resident to the hospital on 05/22/18, 07/10/18, and 08/23/18. The medical	F 625	1) Since the window of time has passed to provide a bed-hold notice upon transfer to the hospital for Residents #23, #64, #74, #85, and #385, the corrective action is that all residents are now receiving a bed-hold notice upon transfer to the hospital per regulatory requirements. 2) The facility recognizes that all residents who get transferred to the hospital have the potential to be affected by the same practice. 3) Measures put into place to ensure this practice will not reoccur are that facility staff will receive reeducation on the facility policy titled, Notice of a Transfer, Discharge or Therapeutic Leave/Bed Hold, on 10/03/2018 by the Director of Nursing Services and the Director of Social Services. Emphasis will be put on the need for staff to offer residents a bed-hold notice upon transfer to an acute care hospital. The Transfer to ER/Hospital Checklist has also been updated to reflect the need for completion of a bed-hold notice, including instructions for its distribution. 4) The facility plans to monitor its performance to make sure solutions are sustained by assigning the Director of Social Services and/or designee to monitor by using random audits that	

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F 625	Continued From page 6 record lacked evidence the facility staff provided Resident #74 and/or their family member/legal representative written notice of the bed-hold policy upon transfer to the hospital. - Review of Resident #85's medical record occurred on all days of survey and identified the facility transferred the resident to the hospital on 01/11/18. The medical record lacked evidence the facility provided Resident #85 and/or their family member/legal representative written notice of the the bed-hold policy upon transfer to the hospital. - Review of Resident #385's medical record occurred on all days of survey and identified the facility transferred the resident to the hospital on 08/13/18. The medical record lacked evidence the facility staff provided Resident #385 and/or their family member/legal representative written notice of the bed-hold policy upon transfer to the hospital. During an interview on the afternoon of 09/06/18, a social services member (#5) confirmed the facility failed to provide the bed-hold notices.	F 625	residents who are transferred to the hospital receive a bed-hold notice. These random audits will be done weekly x 4, monthly x 3, and then for one quarter beginning the week of 10/08/2018. Results will then be reported to the QA team with corrective action implemented as deemed necessary. Corrective action completion date: 10/10/2018	
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 observation, record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.5), and staff interview, the facility failed	F 641	1) The corrective action accomplished related to ensuring the Minimum Data Set (MDS) accurately reflects the resident□s status is that a modification MDS was	10/10/18

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F 641	Continued From page 7 to ensure the Minimum Data Set (MDS) accurately reflected the resident's status for 1 of 18 sampled residents (Resident #63). Failure to accurately complete Section J (Health Conditions) of the MDS does not allow a resident's assessment to reflect their current status and may affect development of a comprehensive care plan and the care provided to the resident. Findings include: The Long-Term Care Facility RAI User's Manual, revised October 2017, page J30-33 stated,". . . J1800 . . . Code 1, Yes: if the resident has fallen since the last assessment. Continue to Number of Falls Since Admission/Entry or Reentry or Prior Assessment item (J1900), whichever is more recent. . . ." Review of Resident #63's medical record occurred on all days of survey. The quarterly MDS dated 08/04/18, showed staff failed to code Section J1800 correctly, therefore Section J1900 C was not coded. During an interview on 09/06/18 at 10:00 a.m. an administrative nurse (#1) confirmed staff coded the quarterly MDS, dated 08/04/18, Section J1800 and J1900 incorrectly.	F 641	completed for Resident #63 in regards to sections J1800 and J1900 on 09/12/2018. 2) The facility recognizes that all residents have the potential to be affected by the same practice. 3) Measures put into place to ensure this practice will not reoccur are that facility MDS staff will receive reeducation on information contained within the RAI Manual, specifically in relation to section J□s coding, on 10/04/2018 by the Director of Nursing Services. Emphasis will be put on the need for MDS staff to ensure that section J is accurately completed, in order for all resident□s current status to be most accurately reflected. 4) The facility plans to monitor its performance to make sure solutions are sustained by assigning the Assistant Director of Nursing and/or designee to monitor by using random audits that section J accurately reflects the resident□s status. These random audits will be done weekly x 4, monthly x 2, and then for one quarter beginning the week of 10/08/2018. Results will then be reported to the QA team with corrective action implemented as deemed necessary. Corrective action completion date: 10/10/2018	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)	F 657		10/10/18

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F 657	Continued From page 8 §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE STANDARD SURVEY CONDUCTED ON 08/17/2017 Based on observation, record review, review of facility policy, and staff interview, the facility failed to review and revise the comprehensive care plan to reflect the resident's current status for 1 of	F 657	1) The corrective action accomplished related to ensuring the review and revision of the comprehensive care plan is that modifications have been made to the care plan for Resident #385. The modification of Resident #385'□s care plan was completed on 09/21/2018 to identify a Foley catheter as a new focus	

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F 657	Continued From page 9 18 sampled residents (Resident #385). Failure to review/revise the care plan to reflect each resident's current status limited the staff's ability to communicate needs and ensure continuity of care for the resident. Findings Include: Review of the policy titled "Care Plan Policy" occurred on 09/06/18. The policy dated 09/11/15, stated, "The team [Interdisciplinary care plan assessment team] shall meet as necessary to review each resident's care plan . . . On an ongoing basis as the resident's condition changes so that additions or deletions can be made to assure that . . . They reflect the resident's medical and nursing assessment by incorporating identified problems areas . . . Attempt to manage risk factors . . . Reflect standards of current professional practice . . . Identify the professional services that are responsible for each element of care . . . Have treatment objectives with measurable outcomes . . ." Observation on all days of survey showed Resident #385 had a Foley catheter in place. Review of Resident #385's medical record occurred on all days of survey. A nursing note, dated 08/31/18, stated, "While hospitalized . . . Resident had Foley catheter placed 8/27/18 d/t [due to] urinary retention that is still in place." Resident #385's current care plan failed to identify the catheter and interventions related to its use. During an interview on 09/06/18 at 12:32 p.m., an	F 657	area. 2) The facility recognizes that all residents who return from the hospital have the potential to be affected by the same practice. 3) Measures put into place to ensure this practice will not reoccur are that facility staff will receive reeducation on the facility policy titled, Care Plan, on 10/03/2018 by the Director of Nursing Services. Emphasis will be put on the need for staff to ensure care plans are reviewed on an ongoing basis as the resident□s condition changes, including following readmission from a hospital stay. 4) The facility plans to monitor its performance to make sure solutions are sustained by assigning the QA Coordinator and/or designee to monitor by using random audits that residents who return from the hospital have their care plans updated to accurately reflect their current status in a timely manner. These random audits will be done weekly x 4, monthly x 4, and then for one quarter beginning the week of 10/08/2018. Results will then be reported to the QA team with corrective action implemented as deemed necessary. Corrective action completion date: 10/10/2018	

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F 657	Continued From page 10 administrative nurse (#9) stated she expected the nursing staff to update a resident's care plan after hospitalization.	F 657		
F 658 SS=E	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: Based on record review, review of facility policy, and staff interview, the facility failed to provide the necessary care and services for 4 of 7 sampled residents (Resident #30, #38, #71, and #83) with a history or risk of weight loss. Failure to identify the accuracy of weights in a reasonable time may delay needed treatment for weight loss or gain and not allow residents to maintain a sufficient nutritional status. Findings include: Review of the facility policy titled "Obtaining a Weight" occurred on 09/06/18. This policy, dated August 2017, stated, ". . . The resident's weight should be obtained upon admission and at regular intervals as needed. . . . If possible, the same staff person should be responsible for obtaining weights on each neighborhood. This assures consistency in procedure. . . . Compare weight to previous weight obtained. If variance of 5 pounds or more is noted, reweigh resident to verify weight and tell the charge nurse. . . ." - Review of Resident #71's medical record	F 658	1) Since the window of time has passed to identify the accuracy of previous weights for Residents #30, #38 #71, and #83, the corrective action is that these residents are now having their weights obtained in accordance with the facilities policy. 2) The facility recognizes that all residents who are weighed have the potential to be affected by the same practice. 3) Measures put into place to ensure this practice will not reoccur are that facility staff will receive reeducation on the facility policy titled, Obtaining a Weight, on 10/03/2018 by the Director of Nursing Services. Emphasis will be put on the need for staff to notify the charge nurse if a variance of 5 pounds or more is noted and also to obtain a timely reweigh if indicated. The daily bathing sheet will be updated and a new column added to allow for documentation of resident□s prior weight, thus allowing for enhanced	10/10/18

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	355053	A. BUILDING _____ B. WING _____	09/06/2018

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

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F 658	Continued From page 11 occurred on all days of survey. Review of Resident #71's weights showed the following: * 08/13/18 - 135 pounds (lbs.) * 08/14/18 - 127 lbs. (loss 8 lbs.) * 08/16/18 - 129.8 lbs. * 08/24/18 - 135 lbs. (gain 6 lbs.) * 08/27/18 - 128 lbs. (loss 7 lbs.) * 08/28/18 - 131 lbs. Review of Resident #71's dietary progress notes showed the following: * 08/15/18 3:58 p.m. - ". . . wt. [weight] 127# [pounds] 8-4-18 (question accuracy) *135# 8-13-18 . . . Requested reweigh . . ." * 08/22/18 12:41 p.m. - ". . . nursing reported weight from today to be 133# . . ." The facility staff failed to reweigh and report to charge nurse when obtaining questionable weights. - Review of Resident #83's medical record occurred on all days of survey. Review of Resident #83's weights showed the following: * 07/31/18 - 170 lbs. * 08/07/18 - 170 lbs. * 08/14/18 - 170 lbs. * 08/21/18 - 191 lbs. (seven days later and a gain of 21 lbs.) Review of Resident #83's progress notes stated the following: *08/18/18 2:14 p.m., ". . . Current wt. 170 lbs as of 8/14/18. . . ." *08/22/18 12:09 p.m., "Nutrition Asmt [assessment] . . . No significant weight change indicated . . . "	F 658	monitoring and easier identification of weight discrepancies from the prior weight. 4) The facility plans to monitor its performance to make sure solutions are sustained by assigning the QA Coordinator and/or designee to monitor by using random audits that residents weights are accurate and timely reweigh occurs if warranted. These random audits will be done weekly x 4, monthly x 3, and then for one quarter beginning the week of 10/08/2018. Results will then be reported to the QA team with corrective action implemented as deemed necessary. Corrective action completion date: 10/10/2018	

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F 658	Continued From page 12 *08/25/18 2:11 p.m., ". . . Current wt. 191 lbs as of 8/21/18. . . ." The record failed to identify staff re-weighed Resident #83 after the 21 lbs. weight gain on 08/21/18. -Review of Resident #38's medical record occurred on all days of survey. Review of Resident #38's weights showed the following: *06/08/18 - 267 lbs. *07/27/18 - 267 lbs. *08/03/18 - 196 lbs. (loss 71 lbs) *08/24/18 - 272 lbs. *08/31/18 - 184 lbs. (loss 88 lbs) Review of Resident #38's progress notes stated the following: "Noted discrepency in resident's most recent weight being #184 on 08/31/18 . . . did ask CNA to reweigh resident . . . " The record failed to identify staff reweighed Resident #38 after the 71 lb. weight loss on 08/03/18 or significant weight changes on 08/24/18 and 08/31/18. - Review of Resident #30's medical record occurred on all days of survey. Review of Resident #30's weights showed the following: * 06/05/18 - 210 lbs. * 06/19/18 - 170 lbs. (loss 40 lbs) The record showed staff failed to reweigh Resident #30 until 14 days later. Facility staff failed to reweigh and report to charge nurse when obtaining questionable weights. During an interview on 09/06/18 at approximately	F 658		

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F 658	Continued From page 13 12:20 p.m., a dietary supervisor (#6) stated the nursing staff is in charge of re-weights for the residents with a 5 pound loss/gain differential. During an interview on the afternoon of 09/06/18 an administrative nurse (#1) stated when the staff weigh residents and find a weight difference greater than 5 pounds, they are to follow the facility policy.	F 658		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of information received from the facility, professional reference and resident interview, the facility failed to ensure residents remained free from accident hazards for 1 of 1 sampled resident (Resident #22) who experienced chemical burns during his shower. Failure of the facility to provide a safe environment for its residents while showering resulted in avoidable chemical burns requiring medical treatment and resulted in Resident #22 being denied the opportunity to shower independently. Findings include: Review of the medical record for Resident #22	F 689	1) The corrective action accomplished related to the assurance of a safe environment for showering is that Resident #22 had a Saint Louis University Mental Status (SLUMS) and Allen Cognitive Level Screen (ACLS) completed by Occupational therapy on 09/20/2018, which revealed mild neurocognitive disorder, and therefore further supports that Resident #22 continues to require supervision when showering to ensure his overall safety. 2) The facility recognizes that all residents who shower independently have the potential to be affected by the same	10/10/18

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F 689	Continued From page 14 occurred on all days of survey. Resident #22's diagnoses included a diagnosis that placed him at risk for an increased risk to infections and anxiety. A quarterly Minimum Data Set (MDS), dated 03/20/18 identified the resident as being independent with bathing, and having a Brief Interview for Mental Status (BIMS) score of 13 indicating the resident is cognitively intact, receiving antianxiety medication daily, and no behaviors. The annual MDS, dated 06/19/18, identified the resident to have a BIMS of 15 which indicates the resident is cognitively intact,and identified the resident no longer independent with bathing and required one person physical assist with bathing. Resident #22's current care plan stated, ". . . Problem Onset: 06/22/16 . . . Bathing: Independent . . . [updated] 05/30/18 Supervision with bathing/showers. . . ." During an interview on 09/04/18 at 10:26 a.m., Resident #22 stated, "Monday, Wednesday, Friday are my shower days. Awhile ago they set the shower up the wrong way and the sanitizer was on and I had burns under my arms and where the chemical went. I got cream. The yellow is the sanitizer. Now its labeled so that does not happen again, I went to the Emergency Department when I had my chemical burns plus I had some in my eyes." Review of information received from the facility, dated 05/30/18, stated, ". . . I was walking by the Res. [resident's] room and asked how the shower went. He said good but it burned. I asked how like the water was hot. He said no like there was chemical in the water. I then asked which handle	F 689	practice. 3) Measures put into place to ensure this practice will not reoccur are that any resident being deemed safe to shower independently will not utilize the bathing suites, but rather be placed in a room with a private shower. Facility staff will receive reeducation on the facility policy titled, Tub Room Inspections and Safety, on 10/03/2018 by the Director of Nursing Services. Additional education will be provided to all staff on the facility policy titled, Chemical Storage, by the Director of Nursing Services on 10/03/2018. 4) The facility plans to monitor its performance to make sure solutions are sustained by assigning the Director of Environmental Services and/or designee to monitor by using audits that the ARJO shower panel hoses and sprayer nozzles are appropriately labeled. An additional audit will be performed to ensure that only residents who require supervision with bathing are utilizing the facilities bathing suites. These audits will be done weekly x 8 and then continue at monthly intervals indefinitely in accordance with the manufacturer□s guidelines. Results will then be reported to the QA team with corrective action implemented as deemed necessary. Corrective action completion date: 10/10/2018	

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F 689	Continued From page 15	F 689		

he used. He stated the gray one. That's when the bath aide at the end of the hall said they are turned around/backwards in that bathroom . . . The gray handle was attached to the chemical and the yellow handle was attached to the water . . . Interview with certified nurse assistant [CNA] bath aide on 05-31-18 . . . A CNA indicated the shower nozzle (gray) was broken over a month ago as the handle was dropped and needed to be replaced. She recalls this being replaced with a yellow nozzle as there was not a gray one in-house as it needed to be ordered. A CNA stated this particular shower had been worked on approximately three times in the last month. . . ."

Nursing progress notes identified the following:

- 05/29/18 11:33 p.m., "Weekly Summary: Resident remains alert and oriented in all spheres . . . Remains independent of all cares and transfers. . . ."
- 05/30/18 10:12 a.m., ". . . He has taken a shower . . . no skin problems noted. . . ."
- 05/30/18 11:27 a.m., "Resident taking shower on Elm, Did not know the hoses were switched and used the chemical sanitizer to bathe in. After getting dressed resident informed staff, he was showered for 20 mins and eyes rinsed for 20 mins. Called [the physician] and he gave verbal order to send to the emergency room [ER] for Observation and treatment. Sent at 1125. . . ."
- 05/30/18 12:57 p.m., "Writer observed residents skin at approximately 1130 this am after he had showered and used sanitizer as soap . . . Writer observed [Resident #22] to have a splotchy area of redness around his neck/collarbone area, areas of redness to both armpits and redness to groin and buttock area . . . [Resident #22] stated

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F 689	Continued From page 16 that the areas were [burning a little] . . . Since [Resident #22's] arrival at facility, he has been independent with his showering with only set-up if needed . . . At this time, we will update his careplan to reflect that he have supervision with his showers from this point forward. . . ." - 05/30/18 2:42 p.m., "Res [sic] returned from [name of medical center] Dx [diagnosis] Chemical burns: Apply Silvadene cream to burning areas on anterior scrotum and armpits BID [twice daily] x 5 days. . . ." - 05/31/18 8:58 a.m., "Resident states his scrotum hurts and rates 6/10 when he walks. . . ." - 05/31/18 4:17 p.m., "Scrotum is is [sic] bright red. Silvadene cream applied per order . . . Armpits and neck remain slightly reddened. . . ." - 06/04/18 12:27 p.m., "Burned areas to armpits and scrotum/groin are lightly reddened . . . Complains of some discomfort but states it is minimal. Re-education on showering with someone available to observe and assist if necessary along with chemical education. . . ." - 06/09/18 6:24 a.m., " . . . Chemical burns have resolved. . . ." - 06/13/18 6:31 a.m., ". . . underscrotum [sic] & under arms have slight brownish discoloration from previous chemical burns. . . ." - 06/20/18 12:26 p.m., ". . . very slight yellowish brown discoloration in bilateral arm pits. . . ." Observation on the afternoon of 09/06/18 of the Shady Lane Elm shower showed a wall mounted unit containing three handles. Above the handle on the left the word "Sanitizer" was written on the unit in black marker, above the handle in the middle the words "Hot Cold" were written on the unit in black marker and above the handle on the right the words "Reg [regular] water" were written	F 689		

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F 689	Continued From page 17 on the unit in black marker. Attached to the unit were two identical hand held shower heads, one connected to a yellow hose and the other connected to a white hose. Based on an interview with administrative staff during the observation, the unit was marked with the words after the incident occurred. Review of the Material Safety Data Sheet (MSDS) for the chemical that is used to sanitize the facility shower, dated 01/15/13, stated, " . . . PRODUCT NAME: ARJO-ALL PURPOSE DISINFECTANT CLEANER GENERIC NAME: Disinfectant . . . Hazardous Decomposition Products: . . . may product toxic fumes . . . Eyes: Eye contact causes painful damage and corneal irritation. Skin: Contact can cause redness, burns, pain and blistering. Inhalation [of mist]: Can cause nose, throat and respiratory tract irritation, coughing and headaches. EFFECTS OF CHRONIC EXPOSURE: . . . material will be corrosive to the skin and eyes upon direct or prolonged contact. Solvent vapors or mists or product can produce irritation of mucous membranes. . . ." The facility failed to address how and why the incident occurred and implement effective interventions to the shower station to prevent future chemical burns, increasing the potential for another incident. Furthermore, the facility's solution resulted in Resident #22 being denied the opportunity to continue to shower independently, as no evidence was provided that indicated he could not do so, if the facility implemented effective shower safety measures.	F 689		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812		10/10/18

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F 812	Continued From page 18 §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, review of the Food and Drug Administration (FDA) Food Code 2013, and staff interview, the facility failed to store, prepare, and serve food under sanitary conditions in 2 of 4 kitchens (Main kitchen and Shady Lane kitchenette). Failure to ensure the cleanliness of food preparation and storage areas has the potential to result in foodborne illness to residents, staff, and visitors. Findings include: The FDA Food Code 2013, page 139, stated, ". . . Nonfood-contact surface of equipment shall be kept free of an accumulation of dust, dirt, food	F 812	1) The corrective action accomplished related to ensuring that food is stored, prepared, and served under sanitary conditions is that the fans in the walk-in cooler were cleaned on 09/06/2018 by the Director of Food and Nutrition. The kitchenette dishwashers were also immediately put out of service via lockout-tag out on 09/06/2018 by facility staff. In addition, all water cups were collected and rewashed in the facilities main dishwasher, which was at the appropriate temperature to ensure adequate sanitization.	

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F 812	Continued From page 19 residue and other debris." A tour of the kitchen occurred on 09/04/18 at 9:44 a.m. and on 09/06/18 at 08:54 a.m. Observation during both tours showed dusty fans in the walk-in cooler blowing dust particles across the top of the coolers ceiling. During an interview on 09/06/18 at 08:54 a.m., the dietary supervisor (#13) identified maintenance cleans the fans in the walk-in cooler on a quarterly basis, and as needed by work request. During an interview on the morning of 09/06/18, an administrative maintenance staff member (#10) stated the fans are cleaned quarterly and as needed by request of the dietary staff. He last cleaned the fans in March 2018. Failure to ensure food storage is free from dust/debris increased the risk for contamination and may affect all residents who consume food prepared in the kitchen. The FDA Food Code 2013, pages 145-146, stated, ". . . Sanitization of equipment and utensils . . . Hot water mechanical operations . . . achieving utensil surface temperature of 71 degrees Celsius [C] (160 degrees Fahrenheit [F]) as measured by an irreversible registering temperature indicator. . . ." Observation on the morning of 09/06/18 showed a dishwasher in each kitchenette. Two unidentified certified nursing assistants (CNAs) (#1 and #2) stated the CNAs and the Restorative Therapy (RT) staff utilize the dishwasher for	F 812	2) The facility recognizes that all residents have the potential to be affected by the same practice. 3) Measures put into place to ensure this practice will not reoccur are that dietary staff will receive reeducation on the Food and Drug Administration (FDA) Food Code on 10/03/2018 by the Director of Food and Nutrition. Emphasis will be put on the need to ensure all equipment is free for an accumulation of dust particles. Furthermore, facility staff will also be educated on the facilities new procedure for sanitization of water cups via the main dishwasher on 10/03/2018 by the Director of Nursing Services and the Director of Food and Nutrition. All kitchenette dishwashers have been disabled and will remain out of service. 4) The facility plans to monitor its performance to make sure solutions are sustained by assigning the Director of Food and Nutrition and/or designee to monitor by using audits that the fans in the walk-in cooler are free from dust particles. An additional audit will be performed to ensure that the facilities main dishwasher remains at the appropriate temperature to ensure adequate sanitization of water cups. These audits will be done weekly x 4, monthly x 2, and then for one quarter beginning the week of 10/08/2018. Results will then be reported to the QA team with corrective action implemented as deemed necessary.	

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F 812	Continued From page 20 washing residents' water cups. A CNA (#1) stated the water lids are placed in the bottom rack and the water cups are placed in the top rack of the dishwasher. The CNA (#2) demonstrated the placement of dishwasher detergent into the appropriate compartment, then stated, "We just hit the start button." A hotplate thermometer, placed in the Shady Lane dishwasher on 09/06/18 at 12:22 p.m., showed a maximum temperature of 126.7 degrees Fahrenheit. The CNAs (#1 and #2) stated the staff do not track/log the temperatures of the dishwashers in the kitchenettes. Failure to ensure utensil surface temperatures reach 160 degrees Fahrenheit resulted in inadequate sanitization and may result in foodborne illness.	F 812	Corrective action completion date: 10/10/2018	
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 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	F 880		10/10/18

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F 880	Continued From page 21 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 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	F 880		

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 _____	09/06/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 22 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 and staff interview, the facility failed to ensure staff followed standard infection control practices for 1 supplemental resident (Resident #36) observed during catheter cares. Failure to follow standard infection control practices may result in the spread of infections within the facility. Findings include: Observation on 9/05/18 at 8:05 a.m. showed the certified nursing assistant (CNA) (#4) drained the catheter bag into a bedside urinal and then emptied the urinal into the toilet. The CNA (#4) rinsed the urinal with water obtained from Resident #36's bathroom sink faucet and emptied the urinal into the toilet. The CNA (#4) failed to sanitize the sink after rinsing the urinal. Observation on 9/05/18 at 3:45 p.m. showed the CNA (#3) drained the catheter bag into a bedside urinal and then emptied the urinal into the toilet. The CNA (#3) rinsed the urinal with water obtained from Resident #36's bathroom sink faucet and emptied the urinal into the toilet. The	F 880	1) The corrective action accomplished related to ensuring standard infection control practices for Resident #36 is that direct care staff is currently utilizing a plastic cup when obtaining the water needed for rinsing of the bedside urinal or graduate cylinder. A bedpan washer diverter will be installed in order to allow for easier rinsing of Resident #36's bedside urinal or graduated cylinder by date certain. 2) The facility recognizes that all residents who have Foley catheters have the potential to be affected by the same practice. 3) Measures put into place to ensure this practice will not reoccur are that facility staff will receive reeducation on the facility procedure titled, Catheter Care, on 10/03/2018 by the Director of Nursing Services. Emphasis will be put on the proper infection control practices to follow when cleaning either a bedside urinal or	

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F 880	Continued From page 23 CNA (#3) failed to sanitize the sink after rinsing the urinal. During an interview on 09/06/18 at 2:26 p.m., an administrative nurse (#1) stated staff should use an additional cylinder to obtain water from the sink to rinse the urinal and should not rinse the urinal in the sink.	F 880	graduated cylinder, which is via the bedpan washer diverter. In its absence, staff will be informed to use plastic cups when obtaining the water needed for rinsing of these devices. The Director of Environmental Services will also install bedpan washer diverters in the rooms of residents who have a current Foley catheter. 4) The facility plans to monitor its performance to make sure solutions are sustained by assigning the QA Coordinator and/or designee to monitor by using random audits that facility staff is following appropriate infection control standards when cleaning bedside urinals or graduated cylinders. These random audits will be done weekly x 4, monthly x 2, and then for one quarter beginning the week of 10/08/2018. Results will then be reported to the QA team with corrective action implemented as deemed necessary. Corrective action completion date: 10/10/2018	