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 _____	09/26/2019

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 09/23/19 and concluded on 09/26/19.	F 000		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas;	F 584		10/28/19

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

Electronically Signed | 10/10/2019

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F 584	Continued From page 1 §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations, Resident Council minutes, resident interviews, and staff interviews, the facility failed to maintain a comfortable temperature level in 1 of 3 dining rooms (Golden Grain). Failure to maintain comfortable room temperature levels can result in resident discomfort. Findings include: During an interview on the morning of 09/23/19, Resident C stated, "It's terribly cold in the dining room. I told a nurse, but she just shrugged it off." Review of Resident Council meeting minutes for June, July and August 2019 showed the following: - 06/27/19 - "Residents expressed concerns of how cold the facility is." Resident B stated, "This is our home, we should be able to be comfortable and not always have to wear a jacket or go outside to warm up". - 07/25/19 - "Residents have issues with hallways being cold." Resident C stated, "Dining room is cold". During the initial dining room tour on 09/23/19 at 11:44 a.m., in the Golden Grain dining room,	F 584	1) The corrective action accomplished related to maintaining a comfortable temperature level within the Golden Grain dining room is that maintenance personnel have performed an inspection of this areas heating components, made necessary modifications, and are now ensuring that comfortable dinning room temperature levels exist for all residents. 2) The facility recognizes that all dinning rooms and residents whom eat meals within them have the potential to be affected by the same practice. 3) Measures put into place to ensure this practice will not reoccur are that maintenance personnel will receive reeducation on 10/16/2019 by the Director of Maintenance Services related to ensuring dinning room temperatures are monitored, adjusted accordingly, and then re-checked to assure compliance. The Director of Nursing Services will provide additional education to all staff on 10/17/2019 regarding the need to promptly notify maintenance personnel of	

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F 584	Continued From page 2 Resident A stated, "It's always so cold in here, I've complained to staff, but they don't seem to do anything about it." Resident D also stated, "Yes, its always cold in here when we eat." Observations of air temperatures taken in the Golden Grain dining room showed the following: * 09/24/19 at 10:07 a.m., 70 degrees Fahrenheit (F) * 09/24/19 at 2:20 p.m., 69 degrees F * 09/25/19 at 1:08 p.m., 68 degrees F During an interview on 09/26/19 at 9:31 a.m., a maintenance staff member (#3) stated, "We have had some issues with heat valves getting stuck. I bumped heat up now to 74, it was set at 72, although I noticed yesterday's temp in Golden Grain dining room was only 69 degrees."	F 584	any complaints about uncomfortable room temperature levels. 4) The facility plans to monitor its performance to make sure solutions are sustained by assigning the Director of Maintenance Services and/or designee to monitor by using audits that the dinning rooms temperatures are maintained between 71 and 81 degrees Fahrenheit. These audits will be done weekly indefinitely beginning the week of 10/21/2019. Results will then be reported to the QA team with corrective action implemented as deemed necessary. 5) Corrective action completion date: 10/28/2019	
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: Based on record review, facility policy, resident interview, and staff interview, the facility failed to follow professional standards of practice for 1 of 1 sampled residents (Resident #53) with elevated blood sugars not reported to the provider as ordered. Failure to follow physician's orders regarding notification of elevated blood sugars may result in serious adverse events. Findings include:	F 658	1) Since the window of time has passed to follow physicians orders regarding notification of elevated blood sugar readings for Resident #53, the corrective action is that this resident is now having elevated blood sugar levels reported to the provider as ordered. 2) The facility recognizes that all residents with orders for notification of	10/28/19

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F 658	Continued From page 3 Review of facility policy titled, "Notification of Change", occurred on 09/26/19. This policy, revised 05/19/17, stated, "The purpose of this policy is to assure the resident, physician and /or family member or legal representative is promptly informed when there is a change requiring notification. . . . Circumstances requiring notification include . . . Circumstances that require a need to alter treatment. . . . " Review of Resident #53's medical record occurred on all days of survey. Current diagnoses included Type 2 Diabetes Mellitus. Current physician's orders identified, "Accucheck QID [4 times a day] (Call provider if glucose greater than 400 or less than 60)". Order dated 08/24/19. Medications included Novolog 20 units (short acting insulin) with meals, Detemir 50 mg (long acting insulin) every AM (morning), Levemir 45 units (long acting insulin) at HS (bedtime), and sliding scale. During an interview on 09/24/19 at 9:10 a.m., Resident #53 stated her blood sugars have been running high. Review of Resident #53's blood sugars from September 1-26, 2019 identified the following elevated blood sugars and provider not notified. * 09/04/19 at 9:12 p.m.: blood sugar 408.0 milligrams per deciliter (mg/dl). * 09/10/19 at 8:34 p.m.: blood sugar 464.0 mg/dl. * 09/12/19 at 10:20 a.m.: blood sugar 418.0 mg/dl. During an interview on 09/26/19 at 10:02 a.m., a supervisory nursing staff member (#1) confirmed	F 658	elevated blood sugar readings 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, Notification of Change, on 10/17/2019 by the Director of Nursing Services. Emphasis will be put on the need for staff to notify providers regarding blood sugar readings outside of identified parameters and document accordingly. Residents with specific parameters for notification will be identified and have those orders entered separately into Point Click Care, in order to allow for enhanced monitoring and easier identification of individualized parameters. 4) The facility plans to monitor its performance to make sure solutions are sustained by assigning the Director of Quality Assurance and/or designee to monitor by using random audits that elevated blood sugars are reported to providers as ordered. These random audits will be done weekly x 8, monthly x 2, and then for one quarter beginning the week of 10/21/2019. Results will then be reported to the QA team with corrective action implemented as deemed necessary. 5) Corrective action completion date: 10/28/2019	

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F 658	Continued From page 4 the facility failed to notify the provider of the elevated blood sugars.	F 658		
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, review of facility policy, and staff interview the facility failed to assist with activities of daily living (ADL's) for 1 of 10 sampled residents (Resident #31) who required staff assistance for grooming and personal cares. Failure to provide assistance to residents who cannot perform the task independently may result in decreased self-esteem and poor grooming and hygiene. Findings include: Review of facility policy titled "Perineal Care" occurred on 09/26/19. This policy, reviewed/revised on 09/26/19, stated, " . . . Perineal care, including the external genitalia . . . should be performed with morning and bedtime cares for incontinent residents. . . . FEMALE PERINEAL CARE: . . . Separate the labia with one hand and cleanse with the other using gentle downward strokes from front to back of the perineum. . . . This method is used to prevent intestinal organisms from contaminating the urethra. . . ." Review of Resident #31's medical record occurred on all days of survey. Diagnosis	F 677	1) The corrective action accomplished related to providing assistance to residents who cannot perform tasks independently, is that Resident #31 is now receiving the necessary assistance with her activities of daily living. 2) The facility recognizes that all residents whom require staff assistance for grooming and personal cares have the potential to be affected by the same practice. 3) Measures put into place to ensure this practice will not reoccur is that facility staff will receive reeducation on the facility policy titled, Perineal Care, on 10/17/2019 by the Director of Nursing Services. Emphasis will be put on the need for staff to ensure that resident requests are honored and assistance provided with performing perineal cares per indiviualized plan of care. 4) The facility plans to monitor is performance to make sure solutions are sustained by assigning the Director of	10/28/19

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F 677	Continued From page 5 included dementia, Parkinson's disease and scoliosis. The care plan stated, " . . . The resident has an ADL self-care performance deficit r/t [related to] Confusion, Dementia, Musculoskeletal impairment. . . . PERSONAL HYGIENE: The resident requires staff assist of 1 for personal hygiene task. . . . The resident has mixed bladder incontinence . . . INCONTINENT: Check PRN [as needed] as required for incontinence. Wash, rinse and dry perineum. . . . BRIEF USE: The resident uses disposable incontinence products. . . ." Observation on 09/24/19 at 7:58 a.m., showed a certified nursing assistant (CNA) (#2) assisted Resident #31 with morning cares in the bathroom. The CNA removed the residents incontinent product that was soiled with urine and then had the resident stand up off the toilet. The CNA then washed Resident #31's bottom and put on a new incontinent product. While the CNA was washing Resident #31's bottom the resident stated, "I need this washed up here, it smells", and the resident put her hands by her perineum. The CNA did not acknowledge the residents request and did not perform perineal cares for the resident. During an interview on 09/26/19 at 8:55 a.m., an administrative nurse (#1) stated he would expect staff to perform perineal cares according to facility policy.	F 677	Quality Assurance and/or designee to monitor by using random audits that perineal cares are performed per facility policy and in accordance with resident requests. These random audits will be done weekly x 8, monthly x 2, and then for one quarter beginning the week of 10/21/2019. Results will then be reported to the QA team with corrective action implemented as deemed necessary. 5) Corrective action completion date: 10/28/2019	