STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355053	A. BUILDING _____ B. WING _____	C 11/26/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced onsite investigation survey regarding a facility reported incident was completed on November 26, 2024. During the survey some of the issues identified were found non-compliant with the regulatory requirements.	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on review of the facility reported incident and investigation documents, record review, and review of facility policy, the facility failed to ensure residents remained free from abuse for 1 of 1 sampled resident (Resident #2) who experienced physical abuse. Failure to ensure an environment free from abuse placed Resident #2 and all other residents residing in the memory care unit at risk for abuse, fear, anxiety, and/or psychosocial harm. This citation is considered past non-compliance based on review of the corrective action the facility implemented	F 600	Past noncompliance: no plan of correction required.	

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

Electronically Signed | 12/05/2024

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F 600	Continued From page 1 following the incident. Findings include: The surveyor determined a deficient practice existed on 11/12/24. The facility implemented and completed corrective action on 11/12/24. Review of the facility policy titled "ABUSE PROHIBITION POLICY" occurred on 11/26/24. This policy, dated 09/05/24, stated, ". . . Residents must not be subject to abuse by anyone, including, but not limited to, . . . other residents . . . Abuse shall be defined as follows . . . 'Abuse' shall mean the willful infliction of injury . . . resulting in physical harm or pain or mental anguish . . . 'Physical abuse' shall include hitting, slapping, pinching, and kicking. . . ." Review of the facility reported incident information identified on 11/12/24 at 2:00 p.m. two staff nurses (#1 and #2) heard moaning outside an office. The nurses found Resident #2 lying on the floor on his back outside the office and observed Resident #1 seated in a wheelchair kicking Resident #2 in the lower leg. One of the nurses immediately removed Resident #1 to ensure Resident #2's safety. Review of Resident #1's medical record occurred on 11/26/24. A quarterly Minimum Data Set (MDS), dated 10/22/24, identified severely impaired cognition. The care plan stated, ". . . has a behavior problem r/t [related to] childhood trauma. . . . LOCOMOTION . . . ambulates via wheelchair per self-and/or staff assistance, depending on his day . . . becomes aggressive towards other residents . . . is/has a potential to	F 600		

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F 600	Continued From page 2 become agitated r/t dementia . . . has a behavior problem (physical and verbal symptoms) r/t dementia . . ." Resident #1's progress notes stated the following: * 11/12/24 at 3:49 p.m., ". . . At 1400 [2:00 p.m.] I found resident in wheelchair kicking another resident who was on the floor. Staff interjected. Family and provider updated. . . ." * 11/12/24 at 5:29 p.m., ". . . Resident placed on 15 minute checks 24/7 [around the clock] for duration of investigation. Staff were educated on 15 minute checks and redirection as needed. . . ." * 11/15/24 at 10:37 a.m., ". . . Called [Power of Attorneys name] and offered a room change to a different unit and she stated no that WW [Whispering Winds memory care unit] is now his home. . . ." - Review of Resident #2's medical record occurred on 11/26/24. A quarterly MDS, dated 11/03/24, identified severely impaired cognition. The care plan stated, ". . . ambulates independently without any assistive device . . . is a wanderer r/t Disoriented to place, impaired safety awareness, Resident wanders aimlessly . . . is/has potential to be verbally aggressive r/t Dementia and hostility . . . has potential to be physically and verbally aggressive r/t dementia. . . . has a communication problem r/t cognitive deficits. Has dx of early onset Alzheimer's disease and dementia. Is sometimes understood and usually understands . . ." Resident #2's progress notes stated the following: * 11/12/24 at 3:36 p.m., ". . . At 1400 I heard	F 600		

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F 600	Continued From page 3 resident moaning so myself and another nurse went to see why he was moaning, he was on the floor on his back and another resident was in a wheelchair beside him kicking him. Resident kicking was removed, myself and other staff assessed resident and got him upright, no injuries noted, resident denies discomfort at this time, . . . Family and provider updated. . . ." Based on the following information, non-compliance at F600 is considered past non-compliance. The facility implemented corrective actions as follows: * The interdisciplinary team met to problem solve and implement changes and interventions for resident care and safety. * Notified providers of the incident. * Notified resident representatives of the incident and actions implemented. * Education provided to all staff on the Whispering Winds unit on action plan and behavioral interventions that work best for Residents #1 and #2.	F 600		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident.	F 657		12/31/24

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F 657	Continued From page 4 (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: Based on record review, the facility failed to review and revise care plans to reflect residents' current status for 1 of 2 sampled residents (Resident #1). Failure to update Resident #1's care plan limited staffs ability to communicate needs and ensure continuity of care. Findings include: Review of Resident #1's medical record occurred on 11/26/24. The nursing progress notes stated the following: * 03/19/24 at 2:37 p.m., ". . . Resident struck another resident. Resident kicking unit doors stating he is going to hell, resident told staff he was going to hang himself. . . ." * 03/25/24 at 10:26 p.m., ". . . Resident had behaviors tonight, mentioned about committing suicide . . ." * 04/06/24 at 3:32 p.m., ". . . CNA [certified nurse aid] reported . . . res [resident] sitting in his	F 657	1. What corrective action will be accomplished for those residents affected by the deficient practice: a. The deficient practice was corrected by updating resident #1's care plan for suicide ideation. Education provided to Social Service Designee on implementing suicidal ideation care plans with interventions for resident #1. Staff on WW educated about interventions for resident #1 as well as informing charge nurse and SSD when a resident is expressing suicidal thoughts/actions. 2. How will you identify other residents having the potential to be affected by the same deficient practice? a. All current facility residents were reviewed for suicidal ideation care plans, care plans were added as necessary/appropriate. 3. How the deficiency will be corrected?	

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F 657	Continued From page 5 wheelchair . . . began talking about his bandages on his hands to the CNA, he became increasingly verbally agitated and then stated, '. . . I'm just gonna commit suicide!' . . ." Resident #1's care plan failed to include history of suicidal ideation.	F 657	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. a. The deficient practice was corrected by educating the Social Service Designee and all personnel. Education to the SSD consisted of ensuring that when a resident is expressing suicidal thoughts/actions that a suicide ideation care plan is put in place with person centered interventions that best help/fit the resident. All personnel were educated to ensure a call is placed to the SSD when a resident is expressing suicidal thoughts/actions. Performance improvement plan is in place with a corresponding focus QAPI regarding care plans. 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? a. The facility plans to monitor its performance to make sure solutions are sustained by assigning Social Services or its Designee by using random audits for	

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F 657	Continued From page 6	F 657	suicide ideation care plans. These audits will be conducted at a frequency of 3 audits per week for 3 months than 6 per month for 3 months. For a total of 6 months of audits. Audits will be monitored by Social Services or its Designee and results reported to the QAPI committee. 5. When the deficiency will be corrected. a. 12/31/2024	