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 12/01/2022

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

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F 000	INITIAL COMMENTS The standard Medicare/Medicaid recertification and complaint survey started on 11/28/22 and concluded 12/01/22.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, review of the facility	F 609	1.) What corrective action will be	1/5/23

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

Electronically Signed | 12/26/2022

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F 609	Continued From page 1 policy, and resident and staff interview, the facility failed to report a incident of potential neglect immediately to the State Survey Agency (SSA), for 1 of 1 sampled resident (Resident #32) who experienced injuries. Failure to report the potential neglect and the results of the facility's investigation to the SSA, placed Resident #32 and other residents at risk for possible neglect and/or further injury. Findings include: Review of the facility policy titled "Abuse Prohibition Policy", occurred on 12/01/22. This policy, dated August 2022, stated, ". . . "Neglect" shall mean failure to provide goods and services necessary to avoid physical harm . . . All alleged acts or suspected acts of abuse, neglect . . . shall be immediately and thoroughly investigated and reported . . . in accordance with state law (including to the state survey and certification agency) . . . a report shall be made to the State Survey & Certification Agency State Licensure within five (5) days of the reporting of the alleged incident . . ." During an interview on 11/28/22 at 2:10 p.m., Resident #32 stated, "I was being taken for a bath and my feet were dragging on the ground causing carpet burns to my toes, I did not have my blue boots on or pedals for the wheelchair." Review of the investigation completed by the facility occurred on the morning of 11/30/22, it stated, "10/27/2022 [Nurse's name], UM [unit manager], asked resident, [name of resident], what happened to his right great and right second toe. [Name of resident] reported that	F 609	accomplished for those residents affected by the deficient practice?: The incident involving potential neglect and injury to resident's toe #32 will be reported to the State Survey Agency. 2.) How will you identify other residents having the potential to be affected by the same deficient practice? The facility has determined that all residents have the potential to be affected. Daily Monday through Friday a review of resident progress notes for all days will be completed by the interdisciplinary team. Staff will also utilize a newly developed abuse reporting form on units. 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. The incident involving resident #32 was reported to the State Survey Agency. Reporting forms will be available on the units for staff to be able to report potential abuse. Education provided to all staff on how to complete the form, location of form, where to submit form, and when to complete reporting form. Relias education (conducting abuse investigations course) for administrator, DON, director of social services, director of human resources,	

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F 609	Continued From page 2 injury happened when a CNA's [certified nursing aid] were pushing him to his bath and his toe drug on the ground. [Nurse's name] educated staff to make sure his blue boots are on when on the way to the bath house." During an interview on 12/01/22 at 9:20 a.m., two administrative staff members (#1 and #4) confirmed the facility failed to report resident #32's injury to the SSA. Refer to F689.	F 609	nurse managers, on reporting abuse. A new clinical topic with the title "Any Potential Abuse" added to the morning clinical report sheet. 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 social worker, and/or designee to monitor by conducting a random audit of 6 residents that will assure potential abuse/neglect/exploitation/suspected injury/unknown injury was reported to State Survey Agency. These residents will be assessed and interviewed to ensure that any injuries are identified, properly investigated and reported to the appropriate people. These random audits will be completed weekly for 12 weeks and then monthly for 3 months. If during audit process mistakes are identified, education will be provided to the staff member and potential abuse will be reported to the State Survey Agency. Social worker and/or designee will report audit results to the QA team with corrective action implemented, as deemed necessary. 5.) 1/5/2023	
F 637	Comprehensive Assessment After Signifcant Chg	F 637		1/5/23

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F 637 SS=D	Continued From page 3 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: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 08/23/21 Based on record review, staff interview, and review of the Long-Term Care Facility Assessment Instrument (RAI) 3.0 User's Manual, the facility failed to complete a significant change in status assessment (SCSA) for 1 of 20 sampled residents (Resident #20). Failure to identify the need for and complete a SCSA may limit the facility's ability to accurately assess the resident's status and develop an appropriate care plan. Findings include: The Long-Term Care Facility RAI 3.0 User's Manual (Version 1.15), dated October 2019, 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	F 637	1.) What corrective action will be accomplished for those residents affected by the deficient practice?: The corrective action accomplished for resident #20 affected by the deficient practice who experienced a significant change in status is that a significant change in status assessment (SCSA) MDS was completed and transmitted. 2.) How will you identify other residents having the potential to be affected by the same deficient practice? All residents can potentially be affected by the deficient practice if not being assessed correctly. 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	

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F 637	Continued From page 4 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 mobility, transfers, walking in corridor and toileting." Review of Resident #20's medical record occurred on all days of survey. An annual Minimum Data Set (MDS), dated 04/18/22, identified the resident required limited staff assist with walking in the room, walking in the corridor, locomotion on the unit, and physical behaviors. The next scheduled quarterly MDS, dated 07/18/22, identified Resident #20 required extensive staff assistance with walking in the room, walking in the corridor, locomotion on the unit and physical and verbal behaviors. The record lacked evidence the staff identified and/or completed a SCSA following Resident #20's declines in activities of daily living. During an interview on 12/01/22 at 8:27 a.m., a staff member (#9) confirmed the facility staff failed to complete a significant change in status assessment for Resident #20.	F 637	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 prior MDS assessment to determine if current MDS qualifies for a significant change assessment. -MDS nurse #1 and #2 reviewed the guidelines in the RAI manual 3.0 in chapter 2 "Significant Change in Status Assessment" to determine whether a significant change assessment is deemed necessary. -It was agreed that in morning clinical meetings, MDS IDT and the unit managers will confer to evaluate and compare current MDS to determine if a significant change has occurred to ensure that the alleged practice does not happen again. Reports on residents with potential significant change of status will be included in the 24-hour clinical report. 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? MDS nurses #1 and #2 will randomly audit possible significant changes by randomly selecting a resident from the resident list to assure all residents current status is most accurately reflected. MDS nurses #1 and #2 will randomly audit 6	

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F 637	Continued From page 5	F 637	residents weekly for 12 weeks, monthly for 3 months. Results will be reported to the Quality Assurance team, document the findings and the corrective actions to be taken. 5.) 1/5/2023	
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: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 08/23/21. Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.17.1), and staff interview, the facility failed to ensure accurate coding of the Minimum Data Set (MDS) for 1 of 20 sampled residents (Resident #32). 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: The Long-Term Care Facility RAI User's Manual, revised October 2019, page N-6 stated, ". . . Coding Instructions N0410A-H: Code medications according to the pharmacological classification, not how they are being used. . . . N0410B, Antianxiety: Record the number of days an anxiolytic medication was received by the	F 641	1.) What corrective action will be accomplished for those residents affected by the deficient practice?: The corrective action accomplished for resident #32 affected by the deficient coding is that the MDS was modified to code Section N- Medications to reflect the correct number of days antianxiety was administered. 2.) How will you identify other residents having the potential to be affected by the same deficient practice? All residents can potentially be affected by the deficiency if not assessed correctly. 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	1/5/23

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F 641	Continued From page 6 resident at any time during the 7-day look-back period (or since admission/entry or reentry if less than 7 days)." Review of Resident #32's medical record occurred on all days of survey. A physician order dated 08/19/21 showed an order for "hydroxyzine HCl Tablet (antihistamine) Give 25 mg [milligrams] by mouth at bedtime for Insomnia." Review of the quarterly MDS, dated 10/16/22, identified N0410B coded for the use of an antianxiety medication seven of seven days during the look-back period. During an interview on the morning of 12/01/22, the MDS coordinator (#2) confirmed the facility inaccurately coded hydroxyzine as an antianxiety medication.	F 641	necessary or if a system does not exist and must be developed. MDS nurse #1 and #2 reviewed prescribed medication by category guidelines in the RAI Manual section N - Medications. MDS nurses will double check section N for accuracy before the MDS is completed by reviewing section N. MDS #1 will review MDS #2 section N prior to completion, and MDS #2 will review MDS #1 section N prior to completion. 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? MDS nurse #1 and #2 will randomly complete 6 audits weekly for 12 weeks, monthly for 3 months to ensure MDS assessments Section N- medications are coded correctly. All negative findings will be noted, and modification done for immediate correction. Results will be reported to the Quality Assurance team with corrective action implemented, as deemed necessary. 5.) 1/5/2023	
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-	F 657		1/5/23

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F 657	Continued From page 7 (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: Based on observation, record review, review of facility policy, and resident and staff interview, the facility failed to review and revise comprehensive care plans to reflect the residents' current status for 3 of 20 sampled residents (Resident #20, #57, and #65). Failure to review/revise the care plans to reflect residents' current status limited the staff's ability to communicate needs and ensure continuity of care for each resident. Findings include:	F 657	1.) What corrective action will be accomplished for those residents affected by the deficient practice?: Care plans for resident's #20, #57, and #65 are updated to reflect resident's current status. 2.) How will you identify other residents having the potential to be affected by the same deficient practice? All residents of the facility who have a change in status have the potential to be affected by this practice. Staff will review	

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F 657	Continued From page 8 Review of the facility policy titled "Care Plan Policy" occurred on 12/01/22. This policy, dated February 2022, stated, "Review of care plans . . . on an ongoing basis as the resident's condition changes so that additions or deletions can be made to assure that: a. They reflect the resident's medical and nursing assessment by incorporating identified problem areas. . . ." - Review of Resident #20's medical record occurred on all days of survey and included the diagnosis of Post Traumatic Stress Disorder (PTSD). The care plan stated, ". . . Res [Resident] is able to ambulate independently . . ." Observations showed the following: * 11/29/22 at 4:38 p.m., a certified nursing assistant (CNA) (#8) ambulated Resident #20 with hands on assistance. * 11/30/22 at 8:23 a.m., a CNA (#10) ambulated Resident #20 with hands on assistance. Fall risk assessments dated, 08/29/22 and 10/18/22 stated, " . . . Cannot walk unassisted . . ." Progress notes included the following: * 8/09/22 at 4:45 p.m., stated, " . . . Annual MDS [minimum data set] review completed . . . [Resident #20's name] walks to all destinations with her FWW [front wheeled walker] with staff assist . . ." * 10/18/22 6:28 p.m., stated, " . . . Quarterly MDS review completed. [Resident #20's name] walks to all destinations with her FWW [front wheeled walker] with staff assist . . ." The facility failed to review and revise Resident	F 657	all resident's care plans to identify any other updates or changes needed. 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. A new clinical topic with the title update care plan will be added to the morning clinical report sheet. This sheet is reviewed daily at morning interdisciplinary team huddle. Education provided to nurse managers and social worker on policy care plan revisions upon status change. 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 unit managers, and social service designee and/or other designee to monitor by using random audits that will ensure if a resident experiences a change in status that the care plan is updated to include	

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F 657	Continued From page 9 #20's care plan to update increased assistance with ambulation. A quarterly MDS, dated, 10/18/22, identified a diagnosis of PTSD. The facility failed to address Resident #20's diagnosis of PTSD on the care plan and lacked specific interventions to avoid triggers for the resident's PTSD. During an interview on 12/01/22 at 8:19 a.m., an administrative nurse (#1) confirmed the facility failed to update Resident #20's care plan regarding ambulation and included a diagnosis PTSD. - Review of Resident #57's medical record occurred on all days of survey. The current care plan, stated, ". . . The resident has an ADL [activities of daily living] self-care performance deficit r/t [related to] Limited Mobility. . . LOCOMOTION: Resident uses a power w/c [wheelchair] for locomotion in facility and requires set-up assistance. . ." A "Therapy Daily Encounter" note dated 10/28/22 stated ". . . Res. [resident] has had incidents with power wc since this am reported by nsg. [nursing] staff . . . it was decided due to several incidents with power wc the Res. is not able to use it at this time. . . ." Last power wheelchair assessment was completed on 07/19/2022. During an interview on 12/01/2022 at 09:20 a.m., an administrative staff member (#1) agreed staff failed to update the care plan to the current locomotion needs.	F 657	new or modified intervention. These random audits will be completed on 6 residents weekly for 12 weeks and then monthly for 3 months. If during audit process mistakes are identified education will be provided to the staff member. Each unit manager and social service designee will report audit results to the QA team with corrective action implemented, as deemed necessary. 5.) 1/5/2023	

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F 657	Continued From page 10 - Review of Resident #65's medical record occurred on all days. The care plan stated, " . . . The resident has an ADL self-care performance deficit r/t dementia . . ." The quarterly MDS, dated 11/07/22, indicated the resident required extensive assist with toileting. The facility failed to address Resident #65's toileting needs on the care plan. During an interview on 12/01/22 at 8:19 a.m., an administrative nurse (#1) verified the facility failed to address toileting for Resident #65's care plan.	F 657		
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 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, and resident interview, the facility failed to ensure staff provided appropriate interventions to prevent new ulcers from developing for 1 of 4 sampled residents (Residents #32) with	F 686	1.) What corrective action will be accomplished for those residents affected by the deficient practice?: Education provided to nursing staff that resident #32 is to have pressure relieving	1/5/23

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

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F 686	Continued From page 11 physician orders for pressure ulcer treatment/prevention. Failure to implement ordered interventions has the potential for the development of new pressure ulcers that can result in pain and/or infection for residents. Findings include: During an observation and interview on 11/28/22 at 2:10 p.m., and 11/30/22 at 4:11 p.m., it was observed that Resident #32 did not have on pressure relieving boots and Resident #32 stated, "no one has offered to put on my boots" Review of Resident #32's medical record occurred on all days of survey. The Physician orders stated: * Dated 12/05/18, "Resident to wear foam boots daily unless resident refuses." * Dated 06/15/22, "Ensure Blue Boots (to relieve pressure) are on @ (at) ALL times - even when in W/C (wheelchair)" * Dated 07/21/22, "L) (left) heel: Aquaphor (gauze dressing) to heel. Wear blue boots at ALL TIMES." The care plan, revised on 04/28/21, stated, "The resident has paraplegia, limited mobility and needs assistance with his Activities of Daily Living. . .The resident will remain free of complications related to immobility, including contractures, thrombus (blood clot) formation, skin-breakdown. . . . Heel flotation boots to be on at all times while in bed." Observations completed on 11/28/22, 11/29/22, and 11/30/22 showed facility staff failed to apply Resident #32's pressure relieving boots.	F 686	boots on at all times unless resident refuses and to chart refusal. 2.) How will you identify other residents having the potential to be affected by the same deficient practice? Identification of other residents that utilize pressure relieving boots. Chart review completed by unit managers. Education provided to nursing staff in regard to pressure injury prevention and management. 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 nursing staff on "Pressure Injury Prevention and Management Policy" and importance of following interventions to prevent pressure injuries. Education also provided if a resident refuses pressure relieving device to chart in POC as resident refused. 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	

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F 686	Continued From page 12 Review of Resident #32's November Treatment Administration Record (TAR) staff signed that pressure relieving boots were applied daily. During an interview on 12/01/22 at 9:20 a.m., with administrative staff members (#1 and #4) confirmed staff failed to apply pressure relieving boots as ordered and failed to document any refusals from the resident.	F 686	corrective action? The facility plans to monitor its performance to make sure solutions are sustained by assigning the nurse managers, and/or designee to monitor by conducting a random audit of 6 residents that will assure interventions to prevent pressure injuries were followed. These random audits will be completed weekly for 12 weeks and then monthly for 3 months. If during audit process mistakes are identified, education will be provided to the staff member. Unit Managers and/or designee will report audit results to the QA team with corrective action implemented, as deemed necessary. 5.) 1/5/2023	
F 689 SS=D	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: 1. Based on information provided by the complainant, observation, record review, review of facility policy, and staff and resident interviews, the facility failed to provide appropriate supervision and devices to prevent an accident for 1 of 1 resident (Resident #32) who received an injury when transported by staff to the bathing area. Failure to ensure staff utilized bilateral foam	F 689	1.) What corrective action will be accomplished for those residents affected by the deficient practice?: Education provided to activities, therapy, and nursing staff that resident #20 needs a gait belt for transfers. Education provided to nursing staff that resident #32 will wear protective boots on the way to	1/5/23

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F 689	Continued From page 13 boots and/or wheelchair foot pedals caused an injury to Resident #32's toes. Findings include: Information provided by the complainant indicated the resident was not in his chair properly and staff let his feet drag on the floor which caused open wounds. Review of the facility policy titled "Incidents and Accidents" occurred on 12/01/22. This policy, revised October 2022, stated, "Accident refers to any unexpected or unintentional incident, which results or may result in injury or illness to a resident. . . .The following incidents/accidents require to be reported . . .Observed accidents/incidents . . . resident injuries due to staff handling. . ." Review of Resident #32's medical record occurred on all days of survey. Resident #32 has medical diagnosis of diabetes, diabetic neuropathy, paraplegia, and history of pressure ulcers. Current Physician orders stated, "Cleanse R) [right] big toe, and second right toe with NS [normal saline] then cover with bandaid every day and prn [as needed]. Monitor for any s/s [signs or symptoms] of infection." Observation on the morning of 11/28/22 showed, black scabs to Resident's #32's right big toe and right second toe. During an interview on 11/28/22 at 2:10 p.m., Resident #32 stated, "I was being taken for a bath and my feet were dragging on the ground causing carpet burns to my toes, I did not have	F 689	the bath house. 2.) How will you identify other residents having the potential to be affected by the same deficient practice? Review of resident's needing a gait belt with transfers. Review of resident's that are transported to bath house in bathing chair. 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 activities, therapy, and nursing staff on gait belt policy and also education provided to nursing staff on incidents and accidents policy. Education provided that gait belt and footrest are used to prevent injury to the residents. Audit tools created and used 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? The facility plans to monitor its	

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F 689	Continued From page 14 my blue boots on or pedals for the wheelchair." During an interview on 12/01/22 at 9:20 a.m., administrative staff members (#1 and #4) stated, staff failed to properly transport the resident with blue boots on and/or pedals on the wheelchair causing injury to toes. 2. Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide adequate supervision and assistive devices necessary to prevent accidents for 1 of 3 sampled residents (Resident #20) observed during a gait belt transfer. Failure to utilize the gait belt during transfers placed Resident #20 at risk of an accident and/or injury. Findings include: Review of the facility policy titled "AMBULATING/TRANSFERRING A RESIDENT WITH A GAIT BELT" occurred on 12/01/22. This policy, revised February 2022, stated, "Purpose: To ensure staff will use gait belts when assisting with ambulation/transfers for residents who are care planned as unsafe to ambulate/transfer independently. . . ." Review of Resident #20's medical record occurred on all days of survey and included a diagnosis of Alzheimer's disease. A quarterly Minimum Data Set (MDS), dated 10/18/22, identified the resident required limited assist with ambulation and extensive assist with transfers. Review of fall risk assessments dated, 08/29/22 and 10/18/22 identified, " . . . Cannot walk unassisted . . ."	F 689	performance to make sure solutions are sustained by assigning the unit managers, therapy, and/or other designee to monitor by using random audits that will ensure if a gait belt is being utilized during transfers and footrest utilized during transportation to the bath house. These random audits will be completed on 6 residents weekly for 12 weeks and then monthly for 3 months. If during audit process mistakes are identified education will be provided to the staff member. Each unit manager and therapy will report audit results to the QA team with corrective action implemented, as deemed necessary. 5.) 1/5/2023	

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F 689	Continued From page 15 Observations of staff assistance with Resident #20 showed the following: * 11/29/22 at 4:38 p.m., showed a certified nursing assistant (CNA) (#8) transferred Resident #20 from the recliner using the resident's walker. The CNA lifted under Resident #20's left arm to stand. The resident unable to stand, the CNA again lifted under the resident's left arm and the resident stood. The CNA held onto the back of the resident's pants while the resident ambulated to the bathroom. After the resident finished toileting the CNA again lifted the resident under the left arm to assist to a standing position. The bag on the resident's walker contained a gait belt. * 11/30/22 at 8:23 a.m., showed a CNA (#10) assisted Resident #20 from a dining chair to a standing position. The CNA attempted to use a gait belt and the resident refused. The CNA lifted under the resident's left arm three times until the resident was able to stand up. The CNAs (#8 and #10) failed to use the gait belt when transferring Resident #20. During an interview on 12/01/22 at 8:19 a.m., an administrative nurse (#1) stated staff are expected to use the gait belt during all assisted transfers and should not lift under the resident's arms or pull on their pants even if the resident refuses to use the gait belt.	F 689		
F 761 SS=D	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	F 761		1/5/23

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F 761	Continued From page 16 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, facility policy review, and staff interview, the facility failed to ensure the safe and secure storage of drugs and biologicals in 1 of 4 medication carts observed. Failure to lock the medication cart may result in unauthorized access to medications. Findings include: Review of the facility policy titled "Medications System Procedure" occurred on 12/01/22. This policy, revised July 2022, stated, ". . . J. Keeping med (medication) cart locked at all times unless dispensing medication . . ."	F 761	1.) What corrective action will be accomplished for those residents affected by the deficient practice?: Education provided to nurses and CMAs on the facility's policy, medication system procedure. 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	

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F 761	Continued From page 17 - Observation on 11/29/22 from 11:06 a.m. to 11:15 a.m., showed the certified medication aid (CMA) (#5) stepping into a resident room and leaving the medication cart (Shady Lane) unlocked. Further observation showed unidentified staff members and residents walking by the unlocked and unattended medication cart. During an interview on 12/01/22 at 9:20 a.m., with administrative staff members (#1 and #4) confirmed that staff failed to lock the unattended medication cart.	F 761	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 nurses and CMAs on the facility's policy, medication system procedure. Audit tool created and used 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? The facility plans to monitor its performance to make sure solutions are sustained by assigning the unit managers and/or designee to complete random audits according to frequency that will assure medication cart is locked when not dispensing medications. There will be 6 random audits completed weekly for 12 weeks and then monthly for 3 months. If during audit process mistakes are identified, education will be provided to the staff member. Each unit manager will report audit results to the QA team with corrective action implemented, as deemed necessary.	

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F 761	Continued From page 18	F 761	5.) 1/5/2023	
F 880 SS=K	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 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;	F 880		12/31/22

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F 880	Continued From page 19 (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 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: 1. Based on observation, review of facility policy, and staff interview, the facility failed to ensure staff followed infection control practices for 1 of 3 sampled residents (Resident #71) on transmission based precautions related to	F 880	1.) What corrective action will be accomplished for those residents affected by the deficient practice?: "The facility will immediately implement an appropriate infection prevention and	

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F 880	Continued From page 20 positive COVID-19 status. Failure to provide and properly utilize personal protective equipment (PPE) for residents on transmission based precautions has the potential to spread the COVID-19 virus to other residents, personnel, and visitors. During the on-site survey, the team determined a potential Immediate Jeopardy (IJ) situation existed on 11/28/22 at 4:30 p.m. The IJ potential resulted from observations of improper use of PPE and lack of staff knowledge/education regarding infection control practices and procedures. These findings placed residents in immediate danger due to the potential spread of the COVID-19 virus. * 11/28/22 at 2:25 p.m.-The survey team contacted the management staff at the State Survey Agency (SSA) to report the findings and to discuss a potential IJ situation. * 11/28/22 at 4:30 p.m.- The survey team notified the facility's administrator, director of nursing (DON), of the IJ and requested they develop a plan for removal of the immediate jeopardy.The team provided the facility with the IJ template. * 11/28/22 at 4:55 p.m.- The SSA notified the regional office of the immediate jeopardy situation. * 11/29/22 at 8:25 a.m.- The facility provided a written removal plan (via verbal and e-mail) for the IJ. * 11/29/22 at 9:22 a.m.- The survey team reviewed and accepted the facility's written plan. * 11/29/22 at 10:00 a.m.- The survey team conducted staff observations and interviews. The survey team identified discrepancies in facility staff infection control practices and requested the	F 880	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 consistent system for ensuring a system for: (1) Ensuring staff entering and exiting a room on precautions donned, doffed, disposed of personal protective equipment (PPE), in accordance with CDC guidelines. (2) Ensuring staff have adequate knowledge of hygienic cleaning practices and the facility's cleaning/disinfecting product(s) in order to utilize them correctly for disinfection and cleaning purposes. (3) Ensuring staff hand hygiene or handwashing when donning PPE, moving between tasks, residents, and after touching potentially contaminated surfaces, in accordance with CDC guidelines. The DON, staff development coordinator (SDC), IP or designee, in conjunction with applicable IDT members, will: (1) Educate staff on selecting, donning, doffing and disposing of PPE when entering a room on precaution isolation/quarantine procedures. To verify each of this/these staff understands the procedure, then each will perform a successful return demonstration of selecting, donning, doffing and disposing	

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F 880	Continued From page 21 facility administrator, DON and IP [infection preventionist] develop additional measures for removal of the immediate jeopardy. * 11/29/22 at 10:30 a.m.- The facility provided a revised written plan for the removal for the IJ. * 11/29/22 at 1:30 p.m.- The survey team reviewed and accepted the facility's revised written plan of correction for the IJ. * 11/29/22 at 1:50 p.m.- The survey team notified the facility administration and removed and reduced the IJ from a scope and severity of K to a scope and severity of E. * 11/29/22 at 1:50 p.m.- The SSA notified the CMS [Center for Medicare and Medicaid Services] location of the removal of the immediate jeopardy. Findings include: Review of the facility policy titled "Infection Prevention and Control Program" occurred on 12/01/22. this policy, revised August 2022, stated, ". . . Transmission-based precautions [TBP] and Isolation Precautions refer to the actions (precautions) implemented . . . that are based upon the means of transmission (airborne, contact, and droplet) in order to prevent or control infections . . . facility staff will apply TBP to residents who are known or suspected to be infected with certain infectious agents requiring additional controls to prevent transmission . . . " Review of the facility policy titled, " . . . Personal Protective Equipment (PPE) Guidance" occurred on 12/01/22. This policy, revised November 2022, stated, " . . . PPE when caring for known/suspected COVID-19 residents . . . a N95 mask, eye protection, gloves, and gown must be worn at all times with every resident interaction . .	F 880	of PPE for providing cares in a droplet precaution room. (2) Educate staff on hygienic cleaning technique to prevent cross contamination when cleaning resident rooms on correct dwell times and cleaning product use to achieve desired disinfection in resident rooms. To verify this/these staff understands the training, the staff will complete a return demonstration of cleaning a room in a hygienic manner using proper dwell times to achieve disinfection. (3) Educate staff on correctly completing hand hygiene after changing tasks, moving between residents, changing gloves, and touching potentially contaminated surfaces. To verify this/these staff understands hand hygiene and handwashing, this/these staff will perform a successful return demonstration of identifying the need and correct procedure for performing hand hygiene and handwashing. (4) Staff educated on the process of cleaning up body fluid spills, involving proper cleaning products to use, location of cleaning products, contact time, and return demonstration of how to properly clean up spills. (5) Staff educated on the proper steps of completing perineal care in accordance with Hartman's Perineal Care. Education involves video, hand-out, and return demonstration. 2.) How will you identify other residents having the potential to be affected by the same deficient practice?	

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F 880	Continued From page 22 . donning and doffing should be done in accordance with current Center for Disease Control [CDC] and Center for Medicare and Medicaid Services [CMS] and the North Dakota Department of Health [NDDOH] guidance, procedure . . ." Review of Resident #71's medical record occurred on 11/28/22. Diagnoses included COVID19 positive on 11/22/22. The current care plan identified Resident #71 on airborne and contact precautions related to COVID 19 infection . . . Resident infection will be resolved without complications . . . Keep resident room door closed if possible to maintain resident's safety . . . Resident to quarantine in room . . . Staff to wear N95 mask when in room . . . Staff will donn and doff PPE appropriately when entering resident's room . . ." Observation on 11/28/22 at 11:40 a.m. showed signage stating ". . . Droplet precautions . . . Stop . . . everyone must clean their hands with sanitizer before entering and when leaving the room . . . make sure their eyes, nose and mouth are fully covered before room entry . . . remove face protection before room exit . . . Donning PPE full Garb: Gown, N95 respirator, face shield, gloves, bouffant . . . Doffing PPE full garb: Gown and gloves, bouffant, face shield, N95 respirator . . ." Observation on 11/28/22 at 11:25 a.m. showed a certified nurse aide (CNA) (#5) entered Resident #71's room wearing a surgical mask and failed to donn a N95 mask, gown, face shield or gloves or perform hand hygiene. The CNA (#5) exited the room with the same surgical mask, was not	F 880	The IP and DON, in conjunction with the applicable 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. In conjunction with IP/DON and IDT as necessary meet, analyze, and developed education/training plan to assure proper cleaning of bodily fluid spills, and perineal care is being provided to all residents. 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. "On or before 12/31/2022 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 select, don and utilize the necessary PPE for precautions isolation/quarantine room access, in accordance with CDC guidelines. b. Failure to ensure cleaning was completed in a hygienic manner with	

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F 880	Continued From page 23 wearing other PPE, failed to perform hand hygiene, and carried a meal tray with dishes (no paper products) down the hall to the kitchen. During an interview on 11/28/22 at 11:40 a.m., a CNA (#5) stated she failed to donn and doff the proper PPE (N95 mask, faceshield or goggles, gown, gloves) or hand sanitize when entering and exiting a COVID19 positive resident room. During an interview on 11/28/22 at 4:30 p.m., an administrative nurse (#1) stated she expected all staff to donn/doff appropriate PPE and perform hand hygiene when entering and exiting a COVID19 positive resident room. THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 08/23/21. 2. Based on observation, record review, review of facility policy, and staff interview, the facility failed to follow standards of infection control for 3 of 9 sampled residents (Residents #20, #32, and #50) observed during cares. Failure to follow infection control standards has the potential for transmission of communicable diseases and infections to residents, staff, and visitors. Findings include: SANITATION Review of the facility policy/procedure titled "Knife River Care Center Standard Precautions" occurred on 12/01/22. This policy, dated September 2022, stated, ". . . Body fluids considered potentially infectious include: . . . All body fluids, secretions, and excretions except sweat . . . 9. Clean up spills of blood or other	F 880	appropriate dwell times to achieve disinfection in accordance with CDC guidelines and cleaning product manufacturer instructions. c. Failure to complete handwashing or 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, SDC, IP or suitable designee will ensure the following: a. Educate all staff who perform the daily COVID-19 staff and visitor screenings on all changes and updates to the facility screening policy and procedures. b. Educate all staff whose normal duties include entering resident rooms on the correct procedure for selecting, donning, using and doffing PPE when entering an isolation/quarantine precaution room. This education will include the CDC's lesson on personal protective equipment developed for nursing home staff available at https://youtu.be/YYTATw9yav4. c. Educate all staff whose job duties include cleaning tasks on hygienic cleaning procedures including effective contact or dwell times for disinfectants used in the housekeeping/cleaning process. This education will include the CDC's lesson on cleaning available at https://youtu.be/t7OH8ORr5Ig. d. All staff will receive education on keeping hands clean between tasks,	

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F 880	Continued From page 24 infectious material in the following manner . . . b. disinfect the surface with a tuberculocide/germicide supplied by the facility . . ." Observation on 11/28/22 at 4:16 p.m. showed a certified nurse assistant (CNA) (#7) donned gloves and emptied a urinary catheter bag for Resident #32, in the process of emptying the bag, the CNA (#7) spilled urine on the floor. The CNA (#7) wiped up the urine with a paper towel after finishing emptying the bag, completed hand hygiene and left the room without disinfecting the floor. Record review of facility Infection Log dated October 2022 occurred on 11/29/22. This log shows Resident #32 having a urinary infection and was on contact precautions. During an interview on the afternoon of 12/01/22, an administrative nurse (#1) confirmed the floor should have been disinfected according to facility policy. PERINEAL CARE Review of the facility policy titled "Perineal Care" occurred on 12/01/22. This policy, dated January 2022, stated, ". . . It is the practice of this facility to provide perineal care to all incontinent residents . . . to . . . prevent infection . . . front to back . . ." Review of Resident #20's medical record occurred on all days of survey. The care plan stated, ". . .The resident has an ADL [activities of daily living] self-care deficit . . . Requires	F 880	contacts with potentially contaminated surfaces and between residents. This education will include the CDC's lesson on clean hands available at https://youtu.be/xmYMUly7qiE. (3) The facility leadership will contact the North Dakota Quality Improvement Organization (QIO), to inquire about the assistance and services available from the QIO in improving infection prevention and control within the facility through quality assurance process improvement (QAPI) methods. (4) Education, training, and return demonstration provided to Nursing, Maintenance, Housekeeping, Therapy, and Activity staff in regards to proper clean up of spills of bodily fluid. (5) Education, training, and return demonstration provided to Nursing, maintenance, therapy, activity staff in regards proper perineal steps/procedure according to Hartman's perineal care. 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 approaches to ensure infection control and prevention are effective will include: Weekly for no less than 12 weeks, the DON, IP, SDC or a designee will conduct on-going monitoring to ensure, via	

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F 880	Continued From page 25 extensive assist from 1 staff to assist resident with routine toileting . . . provide peri cares . . ." During an observation on 11/29/22 at 4:38 p.m., a CNA (#8) assisted Resident #20 to the bathroom. The resident was incontinent of urine and while performing perineal cares the CNA wiped, the resident's perineum from the back to the front, right groin, back to front again and left groin. The CNA failed to provide proper perineal cares to prevent risk of infection. During an interview on 12/01/22 at 8:09 a.m., an administrative staff nurse (#1) stated she expected staff to use proper infection control practices when providing perineal cares. HAND HYGIENE Review of the facility policy/procedure titled "Knife River Care Center Employee Handwashing Procedure" occurred on 12/01/22. This policy, dated 6/22/22, stated, ". . . Wash Hands (at a minimum) . . . Before and after each resident contact . . . After contact with any body fluids, After handling any contaminated items (linens, soiled briefs, garbage, etc.) . . ." Observation on 11/30/22 at 11:00 a.m. showed a CNA (#3) donned gloves and provided perineal care for Resident #50. The CNA (#3) cleansed the rectal area of stool, removed her gloves, donned clean gloves, applied a brief, and removed her gloves. Without performing hand hygiene, the CNA (#3) positioned the resident's pillows, blankets, call light and applied heel booties.	F 880	observation, the approaches to correct deficient practice related to infection control and prevention are consistently implemented and effective. Infection preventionist will complete 2 PPE audits, 2 hand hygiene audits. Housekeeping supervisor will complete 3 audits of room cleaning. Such monitoring will include: (1) Observations of all staff types to ensure correct selection, donning, use and doffing of PPE when entering and exiting precaution isolation/quarantine rooms. (2) Observations of housekeeping and other staff engaged in cleaning activities to ensure cleaning and disinfection is completed in a hygienic manner and cleaning products are used in accordance with manufacturer instructions to achieve disinfection. (3) Observations of all staff types to ensure performance of proper handwashing and 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	

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F 880	Continued From page 26 During an interview on the afternoon of 12/01/22, an administrative nurse (#1) stated she expected staff to remove gloves and perform hand hygiene after perineal care before continuing other resident cares.	F 880	the quality assurance process improvement (QAPI) committee as part of QAPI activities. Monitoring will not be discontinued until the facility completes three consecutive rounds of monthly monitoring that demonstrate sustained compliance as approved by the QAPI committee and medical director. (4) Housekeeping supervisor and/or designee will complete audits in regards to cleaning up bodily fluids 3 audits per week for no less than 12 weeks, and monthly for no less than 3 months. If issues are identified in audits, education provided to staff on the spot and results will be reported to QAPI committee. (5) Infection Preventionist, unit manager and/or designee will complete audits in regards to proper perineal care 2 audits per week for no less than 12 weeks, and monthly for no less than 3 months. If issues are identified in audits, education provided to staff on the spot and results will be reported to QAPI committee. 5.) 12/31/2022	
F 888 SS=D	COVID-19 Vaccination of Facility Staff CFR(s): 483.80(i)(1)-(3)(i)-(x) §483.80(i) COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration	F 888		1/5/23

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F 888	Continued From page 27 of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine. §483.80(i)(1) Regardless of clinical responsibility or resident contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its residents: (i) Facility employees; (ii) Licensed practitioners; (iii) Students, trainees, and volunteers; and (iv) Individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangement. §483.80(i)(2) The policies and procedures of this section do not apply to the following facility staff: (i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section; and (ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section. §483.80(i)(3) The policies and procedures must include, at a minimum, the following components: (i) A process for ensuring all staff specified in paragraph (i)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have	F 888		

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F 888	Continued From page 28 received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its residents; (iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19; (iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (i)(1) of this section; (v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC; (vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law; (vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements; (viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains:	F 888		

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F 888	Continued From page 29 (A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and (B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications; (ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and (x) Contingency plans for staff who are not fully vaccinated for COVID-19. Effective 60 Days After Publication: §483.80(i)(3)(ii) A process for ensuring that all staff specified in paragraph (i)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations; This REQUIREMENT is not met as evidenced by: Based on record review, facility policy review, review of professional reference, and staff interview, the facility failed to ensure staff	F 888	1.) What corrective action will be accomplished for those residents affected by the deficient practice?:	

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F 888	Continued From page 30 completed the primary COVID19 vaccination series for 2 of 2 staff member (Staff A and B) reviewed who were partially vaccinated. Failure to ensure staff completed all recommended doses of the vaccination series for a multi-dose COVID19 vaccine placed residents and staff at risk for COVID19 infection. Findings include: Review of the facility policy titled "Covid19 Vaccination" occurred on 12/01/22. This policy, dated 12/20/21, stated, ". . . staff documentation related to the COVID19 vaccine includes at a minimum: the offering of the COVID19 vaccine or information on obtaining the COVID19 vaccine; and the COVID19 vaccine status of staff and related information as indicated by the National Health Care Safety Network (NHSN) . . . effective March 15, 2022, all Knife River Care Center (KRCC) employees are required to be fully vaccinated against the coronavirus unless exemption has been granted . . . Review of the Centers for Disease Control and Prevention (CDC) guidelines for Pfizer COVID19 Vaccine found at www.cdc.gov/coronavirus.vic.gov.au stated, ". . . Pfizer-BioTech COVID-19 Vaccine . . . Number of shots: 2 doses in primary series, second dose given 3 weeks (or 21 days) after first dose . . . may be given up to 42 days (6 weeks) after first dose . . ." Review of staff COVID19 vacination records showed Staff A and Staff B received the first dose of Pfizer COVID19 vaccine on 08/15/22. The records lacked a date for Staff A and Staff	F 888	Education provided to the Director of Human Resources and the Infection Preventionist in regards to COVID-19 vaccine mandate policy. The director of human resources will have a discussion during new hire paperwork to assure KRCC is 100% vaccinated, and fix staff members A & B to assure KRCC is at 100% vaccinated. 2.) How will you identify other residents having the potential to be affected by the same deficient practice? The director of Human Resources will assess KRCC's vaccine matrix to assure we achieve the 100% vaccination rate as a facility. If issues are found, the director of human resources will work in conjunction with the infection preventionist to assure a 100% vaccination rate. 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. The Director of Human Resources has added the COVID-19 vaccine mandate policy review/completion to new hire checklist. Upon review of the COVID-19 vaccine mandate policy with the new hire they will bring to infection preventionist for COVID-19 vaccine administration or	

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F 888	Continued From page 31 B's second dose of Pfizer COVID-19. During an interview in the afternoon on 12/01/22, an infection control nurse (#6) confirmed Staff A and B did not complete the second dose of Pfizer COVID19 vaccine and were not fully vaccinated. The facility failed to ensure all staff are fully vaccinated for COVID19.	F 888	share with the employee the medical/religious exemption forms. The Infection Preventionist will put a reminder on the calendar on the days of when the respective staff member would qualify based on manufacturer guidelines of proper vaccine administration. Infection Preventionist will notify the Director of Human Resources of Covid-19 vaccination administration, to update the COVID-19 vaccine matrix. The Director of Human Resources will place reminders in calendar/planner to follow-up with staff member for receipt of exemption forms. 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 Director of Human Resources will complete one audit weekly for 12 weeks and one audit monthly for 3 months. The audits involve randomly selecting one KRCC staff member and one agency staff member from the COVID-19 vaccine matrix to assure compliance with KRCC COVID-19 vaccine mandate policy/procedure. If an audit shows an issue, Director of Human Resources and Infection Preventionist will work together with the employee to immediately get back into compliance with the KRCC COVID-19 Vaccine Mandate Policy. A report will be given to the large group	

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F 888	Continued From page 32	F 888	QAPI committee quarterly. 5.) 1/5/2023	