STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355058	A. BUILDING _____ B. WING _____	03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAPTIST HEALTH & REHAB	**3400 NEBRASKA DRIVE BISMARCK, ND 58503**

(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 03/04/24 and concluded 03/07/24.	F 000		
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 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)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced	F 604		4/11/24

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

Electronically Signed | 03/27/2024

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F 604	Continued From page 1 by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to assess the use of a wheelchair seatbelt and vest straps as a possible restraint for 1 of 2 sampled residents (Resident #2) observed with a wheelchair seat belt and vest straps . Failure to assess the wheelchair seatbelt and vest straps as possible restraints, monitor their use, and evaluate the need for continued use placed Resident #2 at risk for an unnecessary restraint and injury related to their use. Findings include: Review of the facility policy titled "Physical assistive device assessment" occurred on 03/07/24. This policy, dated 02/27/23, stated, ". . . When appropriate, physical assistive devices will be used for resident safety, assisting with positioning or mobility and/or to help achieve and maintain a resident's highest practicable level of functioning. All assistive devices will be assessed by the interdisciplinary team to assess the risk versus benefit of the device. *Prior to initiation of the device. *A quarterly review of the assessment with the MDS [Minimum Data Set] schedule. *With significant changes in health status. . . . Licensed nurse will conduct the assessment of the assistive device(s), utilizing the designated observation in the EHR [electronic health record]. This assesses whether the physical device properly meets the resident needs and medical symptom that the device is employed to address. . . . This assessment will minimally include . . . if the device will restrict the resident in any way, How the device will assist the resident, Evaluation of the resident ability to safely use the	F 604	1. Assessment will be completed to identify wheelchair seatbelt and vest straps as possible restraint for Resident #2 found to be impacted in survey on 3/8/24 and quarterly thereafter to monitor their use and evaluate the need for continued use. 2. All residents who utilize assistive devices that could possibly restrict movement have the potential to be affected. 3. Facility policies 'Physical assistive device assessment' and 'Restraints: Physical' reviewed by interdisciplinary team on 3/8/24 and determined to be up to date. Facility identified and IDT (including ProRehab) assessed all residents with assistive devices (possible restraint) in use by March 22nd. The facility will review documentation to ensure initial and ongoing assessments (including quarterly) are being completed of assistive devices as possible restraints. Education initially identified to all staff on March 7th. Additional education will be provided to all staff regarding the need for initial and ongoing assessment of any assistive devices that may be considered restraints by March 29th, 2024. ProRehab developed and implemented a tracking process with the interdisciplinary team on March 26, 2024. They will be responsible for the tracking. The initial tracker contained all residents to show that eveyone was properly assessed, but	

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F 604	Continued From page 2 device, potential risks of the device. . . ." Review of Resident #2's medical record occurred on all days of survey. The current care plan failed to address the wheelchair seat belt and vest straps. Observations showed the following: * 03/04/24 at 4:28 p.m.: Resident up in wheelchair. Seat belt and vest straps in place. * 03/07/24 at 9:54 a.m.: Resident up in wheelchair. Seat belt and vest straps in place. The record lacked evidence of an assessment regarding the use of the wheelchair seatbelt and vest straps as possible restraints, monitoring, and evaluation of their continued indications for use. During an interview the morning of 03/07/24, an administrative nurse (#1) confirmed the record lacked an assessment or ongoing evaluation and monitoring of Resident #2's continued use of the wheelchair seat belt and vest straps.	F 604	ongoing the tracker now only contains residents with assistive devices. 4. Quality assurance nurse or designee will complete audits ensuring documentation of assessments are completed for assistive devices (possible restraints) initially and at quarterly intervals. These audits will be completed weekly times 4 weeks, monthly audits x 4 months and present trends and findings to QA&A for further guidance on audit needs. 5. Plan of Correction Date: April 11th, 2024	
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	F 657		4/11/24

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F 657	Continued From page 3 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 staff interview, the facility failed to review and revise the comprehensive care plan to reflect the current status for 3 of 28 sampled residents (Resident #2, #63, and #99). Failure to review and revise the care plan limited staff's ability to communicate needs and ensure continuity of care. Findings include: Review of the facility policy titled "Care plan and baseline care plan" occurred on 03/07/24. This policy, revised 10/14/22, stated, ". . . The resident care plan is constantly changing. It is to be updated routinely in the electronic record to reflect resident's current condition. . . . Care plans are updated with MDS [Minimum Data Set] /Care conference schedule and as needed to assure that they are an accurate reflection of the	F 657	1. For residents #2 and #63 individual care plans were reviewed and updated to reflect current individual assistive seating devices in place on 3/10/24. For resident #99 identified during survey, care plan was reviewed and updated to provide interventions to monitor the dialysis access site at regular intervals on 3/13/24. 2. On March 22nd the facility reviewed all residents residing in the facility with assistive seating devices in place as having the potential to be affected by deficient practice. On March 8th the facility identified all residents receiving dialysis which have the potential to be affected by the same deficient practice. 3. The following policies were reviewed	

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F 657	Continued From page 4 resident and their care needs. . . ." - Review of Resident #2's medical record occurred on all days of survey. The current care plan stated, "Impaired physical mobility: potential for falls r/t [related to] impaired mobility . . . W/C [wheelchair] for locomotion. . . ." Observations on 03/04/24 at 4:28 p.m. and 03/07/24 at 9:54 a.m. showed Resident #2 in a wheelchair with seat belt and vest straps in place. Resident #2's current care plan lacked the interventions of the wheelchair seat belt and vest straps. - Review of Resident #63's medical record occurred on all days of survey. The current care plan stated,". . . Impaired physical mobility: potential for falls r/t impaired mobility . . . W/C for locomotion. . . ." An occupational therapy evaluation, completed 12/06/23, stated, ". . . Clinical Impressions/Findings: Residents custom seating equipment arrived this date. Pelvic belt to be fabricated and installed by seating specialist. . . ." Observations on 03/05/24 at 10:14 a.m. and 03/06/24 at 10:45 a.m. showed Resident #63 in a wheelchair with seat belt, vest straps, and foot straps in place. Resident #63's current care plan lacked the interventions of the wheelchair seat belt, vest straps, and foot straps.	F 657	by an interdisciplinary team on 3/8/24 and determined to be up to date including'Dialysis', 'Physical assistive device assessment', 'Care plan and Baseline Care plan', and 'Restraints: Physical'. Education initially identified to all staff on March 7th. Additional education provided to all staff regarding the need for initial and ongoing review of all resident care plans to accurately reflect each resident□s needs regarding assistive devices and assessing dialysis access sites by March 29th, 2024. All residents currently residing in the facility were reviewed for presence of assistive seating devices and were updated to ensure accuracy of care plans on March 26th, 2024. All residents residing in the facility that receive dialysis were reviewed and updated to ensure interventions were care planned to determine ongoing assessment of dialysis access site on March 26th, 2024. 4. Quality nurse or designee will complete audits ensuring care plans are up to date for residents identified who receive dialysis services and use assistive seating devices. Audits will be completed weekly times 4 weeks, monthly audits x 4 months and present trends and findings to QA&A for further guidance on audit needs. 5. Plan of Correction Date: April 11th, 2024	

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F 657	Continued From page 5 During an interview the morning of 03/07/24, an administrative nurse (#1) confirmed the care plans for Resident #2 and Resident #63 failed to include the assistive devices to be used when the residents were in their wheelchairs. Review of the facility policy titled "Dialysis" occurred on 03/05/24. This policy, dated 11/06/23, stated, ". . . Residents who require dialysis will receive this service consistent with professional standards of practice . . . The coordinated, person-centered care plan will include . . . Adverse responses/complications to dialysis and treatment of these complications included how to manage concerns with the vascular access device [fistula] . . ." - Review of Resident #99's medical record occurred on all days of survey. Resident #99's current care plan stated, ". . . Dialysis . . . Type of dialysis access: Left upper arm Arteriovenous fistula . . ." Resident #99's care plan lacked the interventions to monitor the fistula for adverse responses/complications and how to manage concerns with the fistula.	F 657		
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 observation, record review, review of facility policy, review of professional reference, and staff interview, the facility failed to follow	F 658	1. For resident #135 the medication administration record was amended to reflect medication refusal on 3/5/24. MA	4/11/24

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F 658	Continued From page 6 professional standards of nursing practice for 1 of 1 supplemental resident (Resident #135) observed during medication administration. Failure of staff to ensure residents swallowed medications, reported behaviors during medication administration, and re-administered unswallowed or refused medications may lead to adverse health conditions. Findings include: Review of the facility policy titled "Medication administration" occurred on 03/07/24. This policy, revised 07/18/19, stated, ". . . Medications will be administered by licensed nurses or trained medication aides . . . under the supervision of a licensed nurse. . . ." Review of "Kozier & Erb's Fundamentals of Nursing: Concepts, Process, and Practice," 11th ed., Pearson Education, Inc., Massachusetts, page 837, stated, ". . . Administering Medications Safely . . . Some older people may be confused by the prescription of several medications and may passively accept their medications from nurses but not swallow them, spitting out tablets or capsules after the nurse leaves the room. For this reason, the nurse is advised to stay with clients until they have swallowed the medications. . . ." page 840, stated, ". . . Medication Administration. . . . Stay with the client until all medications have been swallowed. Rationale: The nurse must see the client swallow the medication before the drug administration can be recorded. The nurse may need to check the client 's mouth to ensure that the medication was swallowed and not hidden inside the cheek. . . . If medication was refused or omitted, record	F 658	#4 received verbal education on 3/5/24 regarding the process for amending administration record, re-administering medication and notification of nurse for medications refused. 2. Residents residing in the facility that have the potential to be affected by the same deficient practice include all residents whom the identified staff member, MA #4, administers medications to. 3. For MA #4 education was provided immediately regarding corrective action for medication identified as not administered on 3/5/2024. 'Medication Administration' and 'Medication Incident' Policies reviewed for accuracy by interdisciplinary team on 3/8/24 and determined to be up to date. The same policies were provided to and reviewed with the staff member MA #4 related to the observation which entailed failure to observe a resident swallow medications on March 19th, 2024. A performance improvement plan was identified and put in place with staff member MA #4 related to this observed deficient practice on 3/19/24 with expectation of initiation of plan by 3/22/24. A comprehensive medication administration observation was completed with staff member MA #4 on March 22nd by quality nurse designee to establish current ability to administer medications at a professional level. 4. Quality nurse or designee will complete	

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F 658	Continued From page 7 this fact on the appropriate record; document the reason, when possible, and the nurse's actions according to agency policy. . ." Review of Resident #135's medical record occurred on 03/05/24. Diagnoses included Alzheimer's disease. Observations identified the following: * 03/05/24 at 8:18 a.m. showed a medication aide (MA) (#4) administered medications from a cup to Resident #135. After the MA walked away, before ensuring the resident had swallowed the medication, Resident #135 removed a pill from her mouth and placed it on top of her water cup lid.. * 03/05/24 at 8:25 a.m. showed the MA (#4) observed the pill on top of Resident #135's water cup lid, picked the pill up and placed it in the garbage. The MA did not re-administer the medication. Review of the electronic medical administration record (EMAR), dated 03/05/24 from 7:00 a.m. to 10:00 a.m. identified the following medications signed off by the MA (#4). ASA chewable 81 milligrams (mg) Eliquis 2.5 mg (blood thinner) Fludrocortisone 0.1 mg (steroid) Memantine 5 mg (treat Alzheimer's) Risperdal 2 mg (antipsychotic) Tylenol 325 mg 2 tablets During an interview on 03/05/24 at 5:38 p.m., the staff nurse (#7) confirmed the MA (#4) failed to notify her of any medication concerns with Resident #135.	F 658	observations of staff member MA #4 ensuring medications are administered as ordered and documented in real time following medication administration and medication incident policy weekly times 4 weeks, monthly audits x 4 months and present trends and findings to QA&A for further guidance on audit needs. 5. Plan of Correction Date: April 11th, 2024	

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F 658	Continued From page 8 During an interview on 03/05/24 at 5:39 p.m., the MA (#4) initially denied Resident #135 spitting out a medication with the morning medication pass. After the surveyor informed the MA of the observation, the MA (#4) stated she administered the medication later. On 03/05/24 at 5:41 p.m., an administrative nurse (#1) verified the incident had not been reported to the unit nurse, and the medical record showed no documentation of the incident. During an interview on 03/06/24 at 2:12 p.m., an administrative nurse (#1) confirmed staff had not re-administered any medication to Resident #135 during the previous morning's medication pass.	F 658		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and family interview, the facility failed to provide an ongoing program of meaningful activities designed to meet the interests and physical, mental, and psychosocial well-being for 1 of 5 sampled residents (Resident	F 679	1. For resident #60, her care plan was reviewed and was updated. Additional preferences were identified in the care plan including holding and interacting with the baby doll, as well as staff offering a sensory blanket or pillow for tactical	4/11/24

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F 679	Continued From page 9 #60) dependent on staff for activities. Failure to provide meaningful activities for residents limited Resident #60's ability to reach her highest practicable level of physical, mental, and psychosocial well-being. Findings include: During an interview on 03/05/24 at 10:50 a.m., a family member (A) stated, "[Resident #60] sits out by the nurses' station. They [residents] are always sitting in the lounge. They are lined up and not stimulated. Not one aide will be sitting there, engaging them. I can go up any time of the day, but there is no one interacting with them." Review of the facility policy titled "One to One Therapeutic Activity Programs" occurred on 03/07/24. This policy, revised 05/01/22, stated, ". . . One to One Activity programs will be provided per assessed needs for sensory stimulation . . . alternative individual program choices . . . One to One Activity Programs may include but are not limited to . . . Music Therapy . . . Sensory visits with a theme . . . Pet Therapy Visits, Reading Out Loud, Spiritual programs . . . Physical Movement . . . Social or emotional support visits . . . Grooming such as manicures . . . Favorite snacks or taste activities . . . Outdoor walks or exposure . . ." Review of Resident #60's medical record occurred on all days of survey. The admission Minimum Data Set (MDS), dated 04/19/23, identified animals, books, music, the outdoors, and religious services were very important to Resident #60. The current care plan stated, ". . . [Resident #60] typically enjoys activities such as	F 679	stimulation. 2. To identify which residents have the potential to be affected by the deficient practice, all residents were screened using their BIMS Summary Score (C0500) from the most recent MDS that had the BIMS completed, to determine what their cognitive level was. Any resident that was assessed between 0-7 (Severely Impaired cognition) was then reviewed to see what their level of communication was (B0700 Makes Self Understood) and their Cognitive Skills for Daily Decision Making (C1000). Any individual that had Severely Impaired Cognition and scored a 2, 3 or □ in either B0700 or C1000, was then chosen to be in our list of residents with the potential to be affected. 3. On 03/20/24, the facility policy titled 'One to One Therapeutic Activity Programs' was reviewed and determined to be up to date. To correct the deficient practice, the facility will review the care plans of all identified individuals for accuracy and add any additional preferences that the resident or family has voiced. Staff will run reports of all identified residents to see the number of activities that they have participated in over the last 30 days. Residents with less than 5 activity programs per week will receive additional activity engagement by being added to the 1:1 list to equal 5 activity programs for each week. For instance, if a resident had 4 interactions	

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F 679	Continued From page 10 listening to music, attending Catholic services, going outdoors when the weather is good, social gatherings, small sensory activities, reading group, current events and special events as tolerated. . . ." Observations on all days of survey showed Resident #60 sitting/dozing in her wheelchair in the lounge with the television on in the background and not participating in any individual or group activities. Review of the activity log, dated January 1-March 5, 2024, showed facility staff failed to provide any activity programming and/or provided Resident #60 approximately 15 minutes of programming on 33 of the 65 days reviewed. Staff failed to provide the variety of activities Resident #60 enjoyed as listed in the care plan.	F 679	per week from groups, they would then be scheduled for 1- 1:1 weekly to equal a total of 5 programs. Education initially identified to all staff on March 7, 2024. Additional education was provided on March 20, 2024 to activity staff and all staff will have further education provided by March 29th, 2024. 4. Quality nurse or designee will complete audits ensuring that the residents that were identified are attending an activity (or receiving 1:1) for a minimum of 15 minutes at least 5 out of 7 days. Weeks will start on Sunday AM and end on Saturday PM. These audits will be completed weekly times 4 weeks, monthly times 4 months and the trends and findings will be presented to the QA&A committee for further guidance on audit needs. 5. Plan of Correction Date: April 11th, 2024	
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte	F 692		4/11/24

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	355058	A. BUILDING _____ B. WING _____	03/07/2024

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BAPTIST HEALTH & REHAB	3400 NEBRASKA DRIVE BISMARCK, ND 58503

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F 692	Continued From page 11 balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of professional reference, review of facility policy, and family interview, the facility failed to offer fluids to 1 of 3 sampled residents (Resident #60) who were observed during cares and required staff assistance for fluid intake. Failure to provide assistance with fluid intake may result in dehydration, constipation, and urinary tract infections (UTIs). Findings include: During an interview on 03/05/24 at 10:50 a.m., following cares, a family member (A) indicated staff often fail to offer liquids, stating, "Here [on the bedside table] sits her [Resident #60's] water. She's had three UTIs in the last few months." Review of the facility policy titled "Hydration" occurred on 03/07/24. This policy, dated 04/13/23, stated, ". . . Each resident will receive and the facility will provide fluids, including water and other liquids consistent with resident needs and preferences and sufficient to maintain proper hydration . . . CNA [certified nurse aide] staff will provide and encourage intake of fluids on a daily	F 692	1. For resident #60 identified during survey all staff will support proper hydration and health by offering fluids at each interaction with resident. 2. To identify what residents have the potential to be affected by the deficient practice, all residents were screened using their BIMS Summary Score (C0500) from the most recent MDS that had the BIMS completed, to determine what their cognitive level was. Any resident that fell between 0-7 (Severely Impaired cognition) was then reviewed to see what their level of communication was (B0700 Makes Self Understood) and their Cognitive Skills for Daily Decision Making (C1000). Any individual that had Severely Impaired Cognition and scored a 2, 3 or - in either B0700 or C1000, was then chosen to be in our list of residents with the potential to be affected. 3. Facility policy titled 'Hydration' was reviewed and determined to be up to date as of 3/8/24. To correct the deficient	

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F 692	Continued From page 12 and routine basis as part of daily care. . . ." Review of "Kozier & Erb's Fundamentals of Nursing: Concepts, Process, and Practice," 11th ed., Pearson Education, Inc., Massachusetts, page 677, stated, ". . . Infection Prevention . . . Inform of the importance of maintaining sufficient fluid intake to promote urine production and output. This helps flush the bladder and urethra of microorganisms. . . ." Review of Resident #60's medical record occurred on all days of survey. Diagnoses included dementia, dysphagia, and history of constipation and urinary tract infections (12/19/23, 01/22/24 and 02/08/24). The physician's orders, dated March 2024, identified, ". . . Diet . . . mildly thick liquids. close supervision. Feeding assist . . ." The current care plan also identified, ". . . Encourage intake of fluids . . . Nursing to assess for dehydration . . . decreased urine output, constipation . . . infection . . ." Observations throughout the survey showed staff providing Resident #60's cares without offering liquids and/or Resident #60 sitting in her wheelchair in the lounge with no liquids available.	F 692	practice, the facility will review documentation such as fluid intake and perform direct observations of the identified residents to assess opportunities provided for hydration. Residents identified as dependent on staff for provision of hydration will be offered fluids with each staff interaction. Education initially identified to all staff on March 7th. All staff will have further education provided regarding offering hydration with each interaction by March 29th, 2024. 4. Quality nurse or designee will complete audits to ensure residents identified as potentially affected are provided hydration at regular intervals. Audits will be completed weekly times 4 weeks, monthly audits x 4 months and present trends and findings to QA&A for further guidance on audit needs. 5. Plan of Correction Date: April 11th, 2024	
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced	F 698		4/11/24

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F 698	Continued From page 13 by: Based on record review, policy and procedure review, professional reference review, and resident and staff interviews, the facility failed to provide the care and services consistent with professional standards of practice for 2 of 3 sampled residents (#79 and #99) on hemodialysis with an arterial-venous fistula (vascular access for hemodialysis). Failure to assess the hemodialysis vascular access site (fistula) may result in complications and adverse effects, such as clotting and possible loss of the access site. Findings include: Review of the facility policy titled "Dialysis" occurred on 03/05/24. This policy, dated 11/06/23, stated, "Responsibility: Licensed Nurse 1. Residents who require dialysis will receive this service consistent with professional standards of practice . . . 2. Facility will provide ongoing assessment of the resident's condition and will monitor for complications before and after each dialysis treatment received at a certified dialysis facility. . . . 4. The coordinated, person-centered care plan will include: . . . f. Adverse responses/complications to dialysis and treatment of these complications included how to manage concerns with the vascular access device. . . . " Review of the "Core Curriculum for the Dialysis Technician - A Compressive Review of Dialysis," Fifth Edition, page 121 and 127 states, ". . . Vascular access makes chronic hemodialysis (HD) possible . . . An access is an HD patient's lifeline. Each access must be cared for as if it is	F 698	1. For resident #99, fistula will be monitored at a minimum of daily by licensed nursing staff for thrill and bruit. For resident #79, fistula will be monitored daily by licensed nursing staff for thrill and bruit. 2. Residents who have the potential to be affected by the same deficient practice will be identified by determining all residents who receive dialysis treatment. 3. Facility policy 'Dialysis' reviewed by interdisciplinary team on 3/8/24 and determined to be up to date at this time. Education initially identified to all nursing staff on 3/7/24 regarding the need for ongoing monitoring of dialysis access site. Quality Assurance nurse contacted local dialysis centers on 3/13/24 who provide care to the residents identified in the facility receiving dialysis treatment, who agreed with our plan of care for monitoring dialysis access site. All staff will have further education provided by March 29th, 2024. 4. Quality nurse or designee will complete audits to determine ongoing monitoring of dialysis access sites weekly times 4 weeks, monthly audits x 4 months and present trends and findings to QA&A for further guidance on audit needs. 5. Plan of Correction Date: April 11th, 2024	

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F 698	Continued From page 14	F 698		

the last one a patient can have. . . . access failure means loss of the HD life-line. The access must be repaired or replaced - if the patient has a site left. Access problems can cause hospital stays, surgery illness, limb loss, and death. . . . Examine the fistula [vascular access] . . . listen for Bruit - the sound and pitch of "whooshing" (a higher or louder pitch may mean stenosis [a narrowing of the blood vessel]). . . . Feel for: skin temperature - more warmth (could be infection) or cold (could mean less blood flow). Thrill - should be present and constant, not a strong pulse. A fistula should have a strong flow of blood. . . . Teach . . . patients to feel their thrill at least once a day . . . a change in the thrill (or the volume of the bruit) can mean blood flow through the access is slowing down. The fistula may be clotting, and quick action could help save it. . . ."

- During an interview on 03/04/24 at 3:03 p.m., Resident #79 stated he has a fistula in his arm for hemodialysis.

Review of Resident #79's medical record occurred on all days of survey. Resident #79's current care plan stated, "Approach Start Date: 08/29/2023 . . . Resident is scheduled for hemodialysis 3 days a week. Check fistula site every shift. Monitor bruit in fistula every HS [bedtime] . . . "

Review of Resident #79's nurses' progress notes, from December 1st, 2023 to March 4th, 2024, identified nursing staff failed to monitor the resident's fistula for bruit and/or thrill on 30 of 31 days in December, 27 of 31 days in January, 27 of 29 days in February, and 0 of 4 days in March.

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F 698	Continued From page 15 - Review of Resident #99's medical record occurred on all days of survey. The current care plan stated, ". . . Dialysis on Tue [Tuesday], Thur. [Thursday], and Saturday . . . Type of dialysis access: Left upper arm Arteriovenous fistula . . . Monitor for S/SX [signs/symptoms] of fluid excess such as . . . increased blood pressure, full bounding pulse . . . No blood pressure readings in Left arm d/t [due/to] shunt . . . If Dialysis access dislodges, is bleeding or develops a hematoma, apply pressure to the site and notify the provider. In the event of uncontrolled bleeding, call 911 . . . Monitor access site for S/SX of infection . . ." Review of the nurses' progress notes, dated February 6-March 5, 2024, identified nursing staff failed to monitor Resident #99's fistula for bruit on 15 of the 29 days. During an interview on 03/07/24 at 12:00 p.m., an administrative nurse (#1) agreed facility staff failed to monitor Resident 99's fistula for complications, stating, "Since there is no order, they [nursing staff] would not be prompted to write a progress note." The facility failed to obtain a physician's order/ensure staff assessed Resident #79 and #99's fistula sites consistent with professional standards for dialysis vascular access.	F 698		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and	F 880		4/11/24

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F 880	Continued From page 16 comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and	F 880		

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F 880	Continued From page 17 (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review, facility policy review, and staff interview, the facility failed to follow standards of infection control for 3 of 10 sampled residents (#60, #124, and #131) observed during cares. Failure to follow infection control standards during perineal cares and with transmission-based precautions (TBP) has the potential to transmit infections to residents, staff, and visitors. Findings include: TRANSMISSION BASED PRECAUTIONS	F 880	1. For resident # 131, daily education on weekdays will be provided via email to all nursing staff caring for the resident during her isolation period to identify appropriate PPE. For resident #124 education will be provided to all staff members who may provide perineal care. For resident #60 education will be provided to all staff members regarding opportunities for hand hygiene. 2. All residents have the potential to be affected by the deficient practice.	

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F 880	Continued From page 18 Review of the facility policy titled "COVID -19 protocol" occurred on 03/05/24. This policy, dated 09/16/20, stated, ". . . Employees providing care for COVID-19 positive residents will wear N-95 masks, gown, gloves and eye protection . . ." Review of Resident #131's medical record occurred on all days of survey. The progress notes identified the following: * 03/01/2024 at 4:22 p.m., " . . . [resident] is being admitted to the hospital. . . . tested Covid + [positive] . . . " * 03/03/2024 at 6:53 p.m., "Resident returned from the hospital. Resident was diagnoses [sic] with COVID on 3/01/24. . . . Resident is on Droplet and contact isolation . . ." Observations showed the following: * 03/04/24 at 9:48 a.m., signage on Resident #131's door for contact and droplet/contact precautions. The signage directed staff to wear gown, gloves, face mask and eye protection before entering the resident's room. Observation also showed isolation supplies stored outside the resident's room. * 03/05/24 at 9:15 a.m., a certified nurse aide (CNA) (#5) entered Resident #131's room without eye protection. * 03/05/24 at 9:30 a.m., a CNA (#5) entered Resident #131's room and sat at the resident's bedside with no eye protection in place. Facility staff failed to use the appropriate personal protective equipment for encounters with Resident #131 who was on contact/droplet precautions.	F 880	3. Facility policies titled 'Perineal Care', 'Covid-19 Protocol SNF', and 'Hand Hygiene' reviewed by interdisciplinary team on 3/8/24 and determined to be up to date. Education initially identified to all staff on 3/7/24. All staff will have receive further education focused on infection prevention and control related to perineal care, hand hygiene and appropriate PPE for Covid-19 isolation by March 29th, 2024. 4. Quality nurse or designee will complete audits ensuring appropriate PPE is in use while caring for residents in isolation, and perineal cares and hand hygiene are provided consistent with the associated policies and include ongoing interventions for monitoring these activities weekly times 4 weeks, monthly audits x 4 months and present trends and findings to QA&A for further guidance on audit needs. 5. Plan of Correction Date: April 11th, 2024	

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F 880	Continued From page 19 PERINEAL CARE Review of the facility policy titled "Perineal care" occurred on 03/07/24. This policy, dated 05/01/19, stated, ". . . Wash the perineal area [groin] . . . Wash and rinse the rectal area thoroughly. . . ." Observation on 03/05/24 at 9:50 a.m. showed a CNA (#2) provided perineal care for Resident #124 by cleansing the rectal area prior to the perineal area. The CNA failed to provide perineal care in the correct order to prevent the risk of infection for Resident #124. During an interview on 03/07/24 at 1:28 p.m., two administrative staff members (#1 and #3) confirmed the CNA should clean the perineal area before the rectal area. HAND HYGIENE Review of the facility policy titled "Hand Hygiene" occurred on 03/07/24. This policy, dated 01/11/24, stated, ". . . Hand washing/sanitizing is necessary . . . Before and after providing care to resident . . . After handling . . . urine . . ." Observation on 03/06/24 at 4:06 p.m. showed two CNAs (#8 and #9) assisted Resident #60 with toileting. One CNA (#8) donned gloves, provided perineal care, adjusted Resident #60's clothing, transferred/lowered her into the wheelchair utilizing a stand lift, removed the sling, placed Resident #60's glasses on her face and feet on the foot pedals, straightened and then patted Resident #60's hair into place, made	F 880		

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F 880	Continued From page 20 the bed, removed her gloves, and washed her hands. The CNA (#8) failed to remove her gloves and perform hand hygiene after toileting the resident and prior to performing other tasks.	F 880		