STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355059	A. BUILDING _____ B. WING _____	10/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSOURI SLOPE	2425 HILLVIEW AVE BISMARCK, ND 58501

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F 000	INITIAL COMMENTS The Standard Medicare/Medicaid recertification survey started 10/07/19 and concluded 10/10/19.	F 000		
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.	F 550		11/13/19

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

Electronically Signed | 10/25/2019

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F 550	Continued From page 1 §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, resident interviews, review of facility policy, and staff interview, the facility failed to provide care for 12 of 35 sampled residents (Resident A, #4, #43, #60, #93, #122, #163, #166, #185, #194, #212, and #336) in a manner and environment that maintained, enhanced, and respected each resident's dignity and individuality. Failure to respect residents' personal preferences and announce themselves and wait for permission prior to entering residents' rooms does not preserve the residents' personal dignity or enhance their quality of life and places them at risk of embarrassment and/or emotional harm. Findings include: Review of the policy titled, "Resident's Right" occurred on 10/10/19. This policy, revised July 2019, stated, ". . . each resident has a right to a dignified existence . . . training will be provided to staff regarding the resident's rights . . ." - Observations on 10/07/19 showed the following: * At 9:32 a.m., a nurse (#11) and a certified nursing assistant (CNA) (#13) provided personal cares for Resident #212. A second unidentified CNA knocked on the resident's door and immediately entered the room. The CNA failed to	F 550	1. Staff that care for Residents A, #4, #43, #60, #93, #122, #163, #166, #185, #194, #212, and #336 were re-educated on knocking, resident privacy, resident dignity, and ensuring resident quality of life. 2. All residents have the potential to be affected. 3. Staff were re-educated at the Nurse/MAII/CNA/MTA meeting on October 15, 2019. Nutritional Services staff were re-educated on October 23, 2019. Environmental Services staff were re-educated on October 25, 2019. Maintenance staff were re-educated on October 25, 2019. 4. The Unit Directors, Charge Nurses, and CNA Mentors will be responsible to monitor/audit. The Vice President of Resident Services will compile QAPI data and monitor to assure compliance with knocking and waiting for a response. The first quality assurance monitor will be performed on November 6, 2019. QAPI monitoring will be performed weekly for one month, monthly for three months, and	

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F 550	Continued From page 2 wait for permission to enter the room. * At 9:39 a.m., a CNA (#26) knocked on Resident #185's door, stating, "[Name], just looking for room trays." The CNA failed to wait for permission to enter the room. * At 10:29 a.m., a CNA (#26) knocked, entered Resident #93's room, and exited with an untouched room tray. The CNA failed to wait for permission to enter the room. * At 10:34 a.m., a CNA (#26) knocked on Resident #336's door as she entered the room, turned, and exited the room. The CNA failed to wait for permission to enter the room. * At 4:31 p.m., a CNA knocked twice on Resident #4's door as she entered the room. Once inside, she stated, "Hi [Resident #4]." The CNA failed to wait for permission to enter the room. - During an interview on the afternoon of 10/07/19, Resident #60 stated staff do not "knock very often" or announce themselves before entering the room. - Observations on 10/08/19 showed the following: * At 8:27 a.m., a CNA (#13) knocked as she entered Resident #122's room. Once inside, she greeted the resident. The CNA failed to wait for permission to enter the room. * At 10:25 a.m., a CNA (#4) knocked and entered Resident #166's room. The resident was in the bathroom at the time and the nurse was providing a sitz bath to Resident #166's perineal area. The CNA failed to wait for the resident to give permission to enter the room. * At 10:40 a.m., an unidentified CNA knocked and entered Resident #166's room. The nurse was providing treatment to Resident #166's perineal area at the time. The CNA failed to wait	F 550	then quarterly for one year. If concerns are identified, immediate corrective action will be implemented. The Vice President of Resident Services will submit a report of the monitoring results to the QAPI Committee at each scheduled meeting.	

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F 550	Continued From page 3 for the resident to give permission to enter the room. * At 11:21 a.m., a nurse (#9) provided personal cares for Resident #163. An unidentified maintenance staff member knocked and immediately entered the room. The maintenance staff member failed to wait for permission to enter the room. - During interviews on 10/08/19, Residents identified the following: * At 8:27 a.m., Resident #122 stated, "Most of the time they [staff] knock. They don't always say who they are." She later stated, "I don't like it when the male workers help me in the bathroom. Yes, I've told them I don't want them to help me when I'm going to the bathroom." * In the morning, Resident #43 stated facility staff knock "sometimes, but not all of the time" before entering the room. * In the morning, Resident #194 stated facility staff "knock, but do not wait to be invited in" before entering. She also reported there is a sign hanging on her door instructing visitors that cares are in progress and to please wait. Resident #194 reported despite this sign, facility staff knock and walk in without being invited. - During the group interview on 10/08/19 at 3:45 p.m., Resident A stated, "Privacy is a big issue, they knock and just come in." - During an interview on 10/09/19 at 5:00 p.m., a Unit Director (#20) stated, "Yes, we are aware she [Resident #122] doesn't want male staff sometimes. Her care plan says 'allows male staff sometimes.' Initially, her family said she didn't want male staff, then they said she was okay with	F 550		

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F 550	Continued From page 4 somethings to have male staff, like for transfers. No, I haven't asked her when she is okay with male staff helping her." - During an interview on 10/10/19 at 1:04 p.m., a Unit Director (#10) stated she would expect staff to knock on a resident's door and wait for a response before entering.	F 550		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, resident interview and staff interview, the facility failed to assist with activities of daily living (ADLs) for 2 of 16 sampled residents (Resident #180 and #196) dependent on staff for cares. Failure to provide assistance and/or complete scheduled cares for residents who cannot perform the task independently may result in decreased quality of life. Findings include: Review of facility policy titled "Oral Hygiene" occurred on 10/09/19. This policy, revised September 2016, stated, ". . . Residents will receive oral hygiene in the AM, PM and PRN [as needed] . . . ." - Review of Resident #180's medical record occurred on all days of survey. Diagnoses include Alzheimer's Disease, and muscle	F 677	1. Staff that care for Resident #180 and #196 were re-educated on oral care and ensuring baths are completed according to the bath schedule. 2. All residents have the potential to be affected. 3. Staff were re-educated on oral care and bathing schedules at the Nurse/MAII/CNA/MTA meeting on October 15, 2019. Guidelines for staffing the day shift were developed to guide nursing leaders, schedulers, and charge nurses when making staffing adjustments to help ensure Bath Aides are not pulled to fill other open CNA positions. 4. The Unit Directors, Charge Nurses, and CNA Mentors will be responsible to monitor/audit oral cares. The Vice	11/13/19

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F 677	Continued From page 5 weakness. The current care plan stated, ". . . pockets food . . . oral cares after meals. . . . Resident requires assistance with oral cares. . . ." Resident #180's current kardex stated, ". . . "ORAL CARE: Resident requires assistance with oral cares . . . Oral cares after meals. . . ." The resident's current annual Minimum Data Set (MDS), dated 09/06/19, identified physical assistance of two staff for personal hygiene. Observation on 10/08/19 at 1:38 p.m. showed a CNA (certified nursing assistant) (#17) answer Resident #180's call light. The CNA asked the resident if he wanted to get up, he stated, "YES". Upon approaching the bed, the CNA (#17) asked the resident if he had food in his mouth and Resident #180 nodded his head up and down. The CNA (#17) retrieved a toothbrush, mouth swabs, mouthwash and a rinse basin. The CNA (#17) swabbed Resident #180's mouth three times, and each time removed visible pieces of food. The CNA (#17) continued with full oral cares. The CNA (#17) asked Resident #180 "Do you still have food in your mouth?" Resident #180 stated, "Yes." The CNA (#17) retrieved a fourth swab and removed remaining food from the resident's mouth. Staff failed to perform oral cares on Resident #180 after he finished eating his lunch on 10/08/19 to check for pocketed food, and oral cares. Review of the facility policy titled "CNA Routine Care for Residents" occurred on 10/09/19. This policy, revised November 2018, stated, ". . . Read resident Kardex [quick summary of individual resident needs]. . . . each item is based	F 677	President of Resident Services will monitor/audit the bath schedule. The Vice President of Resident Services will compile QAPI data and monitor to assure compliance with oral cares and bathing schedules. The first quality assurance monitor will be performed on November 6, 2019. QAPI monitoring will be performed weekly for one month, monthly for three months, and then quarterly for one year. If concerns are identified, immediate corrective action will be implemented. The Vice President of Resident Services will submit a report of the monitoring results to the QAPI Committee at each scheduled meeting.	

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F 677	Continued From page 6	F 677		

on the abilities of the resident to participate in their care based on physical and mental limitations. . . ."

Review of Resident #180's medical record occurred on all days of survey. The current care plan stated, ". . . having a decline in his physical/cognitive abilities and needs more assistance with ADL's [activities of daily living]". . . 2nd staff must be present for toileting, dressing, hygiene-due to unpredictable behaviors . . . Bed mobility . . . Assist of 2 to pull up in bed . . . Dressing-assist of 1. 1 person assisting and 2nd staff there to help if needed . . . decline in transfers, leans to side. . . ." The resident's current annual Minimum Data Set (MDS), dated 09/06/19, identified physical assistance of two staff for bed mobility and dressing.

Observation on 10/08/19 at 1:49 p.m. showed CNA (#17) assisted Resident #180 from the position of laying to sitting on the edge of his bed. The CNA (#17) removed the resident's gown and started washing his back. Resident #180 was unable to sit upright and repeatedly leaned to the left. After repeated attempts to keep Resident #180 seated upright, the CNA (#17) at 1:59 p.m., ten minutes later, called on her radio for assistance. At 2:02 p.m. a second unidentified staff member arrived and assisted the CNA (#17) in completing cares and dressing for Resident #180.

Review of the facility policy titled "CNA Routine Care for Residents" occurred on 10/09/19. This policy, revised November 2018, stated, ". . . Bathing/Hygiene 1. Shower, whirlpool . . . according to schedule. . . ."

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F 677	Continued From page 7 - Review of Resident #196's medical record occurred on all days of survey. The care plan stated ". . . [Residents name] has an ADL Self Care Performance Deficit . . ." The most recent comprehensive assessment, dated 09/10/19 showed the resident requires extensive assist with bathing. During an interview on 10/07/19 10:47 a.m., Resident #196 stated, "I didn't get my whirlpool bath a few times on Mondays because they were working short." Resident #196's bathing summary showed the resident did not receive his scheduled whirlpool bath on two Mondays in September, 09/09/19 and 09/30/19. During an interview on 10/09/19 2:11 p.m., an administrative nurse (#1) confirmed that Resident #196's scheduled whirlpool bath days are Monday and Thursday and that the resident did not receive his whirlpool bath on two Mondays in September. She stated "We pull staff from the bath house to cover the floor when we are short staffed on the floor. I know how important [Resident #196's] baths are to him . . ." Staff failed to provide Resident #196's whirlpool baths as scheduled.	F 677		
F 692 SS=E	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	F 692		11/13/19

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F 692	Continued From page 8 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 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 facility policy, and staff interview, the facility staff failed to offer fluids to 6 of 16 sampled residents (Resident #4, #107, #120, #122, #213, and #223) who required staff assistance for fluid intake and are at risk for dehydration. Failure to provide assistance with fluid intake may result in dehydration, constipation, and urinary tract infections (UTIs). Findings include: Review of the facility policy titled "Hydration Program" occurred on 10/10/19. This policy, revised June 2017, stated, ". . . Will attempt to provide residents with sufficient amounts of fluids to prevent dehydration and maintain health. . . " - Review of Resident #4's medical record	F 692	1. Staff that care for Resident #4, #107, #120, #122, #213, and #223 were re-educated on the importance of offering fluids to residents. 2. All residents have the potential to be affected. 3. Staff were re-educated on the importance of offering fluids to residents at the Nurse/MAII/CNA/MTA meeting on October 15, 2019. 4. The Unit Directors, Charge Nurses, and CNA Mentors will be responsible to monitor/audit. The Vice President of Resident Services will compile QAPI data and monitor to assure compliance with offering fluids. The first quality assurance	

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F 692	Continued From page 9 occurred on all days of survey. The current care plan stated, " . . . [Resident #4] has altered nutrition and potential for fluid volume deficit . . . Failure to consume all/almost all . . . fluids at meals. . . . Other pertinent dx [diagnoses] Alzheimer's dementia . . . constipation . . . HTN [hypertension] . . . macular degeneration, glaucoma . . . Offer adequate fluids daily . . . Offer meals in assisted dining room . . . Provide eating supervision, cues, and assistance as necessary. . . ." Observations showed the following: * 10/08/19 at 4:00 p.m., two certified nursing assistants (CNAs) (#17 and #18) provided cares before transferring Resident #4 into his wheelchair utilizing a Hoyer lift. The staff members failed to offer Resident #4 fluids before or after cares. * 10/09/19 at 10:35 a.m., two CNAs (#21 and #22) provided cares before transferring Resident #4 into his wheelchair utilizing a Hoyer lift. The staff members failed to offer Resident #4 fluids before or after cares. - Review of Resident #107's medical record occurred on all days of survey. The most recent quarterly Minimum Data Set (MDS), showed the residents cognition as severely impaired and requires extensive assist with dining. Observation on 10/08/19 at 8:52 a.m., showed two CNA's (#5 and #7) transfer Resident #107 from the wheelchair to the bed. Staff failed to offer fluids before or after cares. - Review of Resident #120's medical record occurred on all days of survey. Diagnoses	F 692	monitor will be performed on November 6, 2019. QAPI monitoring will be performed weekly for one month, monthly for three months, and then quarterly for one year. If concerns are identified, immediate corrective action will be implemented. The Vice President of Resident Services will submit a report of the monitoring results to the QAPI Committee at each scheduled meeting.	

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F 692	Continued From page 10 included Alzheimer's Disease. The care plan states ". . . Eats with assist of one. . . ." Observation on 10/08/19 at 3:20 p.m., showed two CNA's (#6 and #7) transfer Resident #120 from the bed to the wheelchair. Staff failed to offer fluids before or after cares. - Review of Resident #122's medical record occurred on all days of survey. The current care plan stated, " . . . [Resident #122] has potential to demonstrate physical/combative behaviors r/t [related to] Dementia, dehydration . . . Assess and anticipate [Resident #122's] needs . . . thirst . . . [Resident #122] has altered nutrition and potential for fluid volume deficit . . . Other pertinent dx: h/o [history of] UTI . . . HTN . . . glaucoma . . . constipation . . . Offer adequate fluids daily. . . ." Observation on 10/08/19 at 8:30 a.m. showed a CNA (#23) transferred Resident #122 into the bathroom, provided cares, transferred her into her wheelchair, and then into her recliner. The staff member failed to offer Resident #122 fluids before or after cares. - Review of Resident #213's medical record occurred on all days of survey. The current care plan stated, " . . . [Resident #213] has altered nutrition and potential for fluid volume deficit . . . Severely impaired cognition . . . diagnoses hemiplegia, hemiparesis, HTN . . . Offer adequate fluids daily. . . ." Observation on 10/08/19 at 8:53 a.m. showed two CNAs (#24 and #25) transferred Resident #213 into the bathroom, provided cares,	F 692		

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F 692	Continued From page 11 transferred him into his wheelchair, and then into his bed. Staff failed to offer Resident #213 fluids before or after cares. - Review of Resident #223's medical record occurred on all days of survey. The current care plan stated, " . . . has impaired cognitive function r/t diagnoses of Alzheimer's disease and dementia . . . Needs are met by staff . . . Offer adequate fluids daily . . . Anticipate and meet needs . . . Provide oral cares with swab every 2-3 hrs [hours] and prn [as needed] . . ." Observation on 10/08/19 at 3:12 p.m., showed two CNA's (#14 and #15) transfer Resident #223 from the bed to the wheelchair. Staff failed to offer fluids before or after cares. During an interview on 10/10/19 at 1:04 p.m., the unit director (#10) stated she expected staff to provide fluids during cares.	F 692		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to ensure residents remained free of significant medication errors for 1 of 1 sampled resident (Resident #146) who experienced a significant medication error. Failure of staff to administer medications as ordered may have a negative impact on a resident's quality of life.	F 760	1. For Resident #146, the physician order was clarified and the medication was obtained from pharmacy the day the deficiency was noted by the survey team. 2. All residents with medication order changes have the potential to be affected. 3. Nurses and MAIIs were re-educated on	11/13/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355059	A. BUILDING _____ B. WING _____	10/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSOURI SLOPE	2425 HILLVIEW AVE BISMARCK, ND 58501

(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 760	Continued From page 12 Findings include: Review of the facility policy titled "Medication Errors" occurred on 10/09/19. This undated policy stated, ". . . Medications should be administered . . . according to medical provider order. . . ." Review of Resident #146's medical record occurred on all days of the survey. Current medications included olanzapine (an antipsychotic) that was decreased from 5 mg (milligrams) to 2.5 mg on 10/02/19. A provider's note, dated 10/08/19, stated," . . . She was seen 6 days ago per pharmacy review to consider GDR [gradual dose reduction] of olazapine [sic]. . . olanzapine was decreased to 2.5 mg daily from 5 mg. . . She did incidentally not receive any olanzapine at all for the last 5 days, since medication error was made and the lower dose of olanzapine was not ordered or filled, per nursing . . . She has been more irritable and refusing cares. . . ." During an interview on the afternoon of 10/09/19, an administrative nurse (#3) stated she expected nursing staff to verify new orders and administer medications as ordered.	F 760	timely clarification of orders and missed medication doses at the Nurse/MAII/CNA/MTA meeting on October 15, 2019. 4. The Vice President of Resident Services will monitor/audit medication errors. The Vice President of Resident Services will compile QAPI data and monitor to assure compliance with medication administration orders. The first quality assurance monitor will be performed on November 6, 2019. QAPI monitoring will be performed weekly for one month, monthly for three months, and then quarterly for one year. If concerns are identified, immediate corrective action will be implemented. The Vice President of Resident Services will submit a report of the monitoring results to the QAPI Committee at each scheduled meeting.	