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	355093	A. BUILDING _____ B. WING _____	C 07/07/2022

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GOOD SAMARITAN SOCIETY - BOTTINEAU	725 E 10TH ST BOTTINEAU, ND 58318

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F 000	INITIAL COMMENTS The standard Medicare/Medicaid recertification survey and complaint investigations started on 06/20/22 and concluded on 06/23/22. Based on the results of the recertification survey, an extended survey was started on 07/06/22 and concluded on 07/07/22.	F 000		
F 550 SS=F	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.	F 550		8/12/22

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

Electronically Signed | 07/24/2022

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F 550	Continued From page 1 §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. §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, record review, resident interviews, Resident's Rights Guide, and review of facility policy, the facility failed to provide care and communicate with residents in a manner that maintained, enhanced, and respected each resident's dignity and individuality for 12 residents on 4 of 4 units (100, 200, 300, and 400 halls). Failure to treat resident with respect and dignity is a violation of their rights and may result in emotional harm and a decreased quality of life for all residents in the facility. Findings include: Review of the facility policy/procedure titled "Routine Practice" occurred on 06/23/22. This policy, dated 05/03/22, stated, " . . . Nursing . . . Encourage toileting routine . . . Anticipate and meet needs . . . Promote dignity by ensuring privacy . . . Will be kept clean and free from odors . . . Spiritual . . . Provide home like environment and person centered care . . . Safety . . . Call light within reach . . ." The North Dakota Long Term Care Ombudsman	F 550	F550 1) R#15, #28, #41, #2, #26, #30, #31, #9, #12, #23, #43, and #3 CNA #4, #5 & #11 no are no longer employed at the facility. On 6/23/22 the DNS and Clinical Care Leader provided immediate staff education on the resident dignity policy, for CNAs #4, #5, #6 & #11, immediate corrective action was validated of understanding and was observed. 2) All residents have the potential to be affected by this deficient practice; no other residents were identified as being negatively impacted. 3) 7/21/2022 Administrator, Director of Nursing, Infection Prevention Specialist/Quality Assurance Performance Improvement Specialist, and Clinical	

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F 550	Continued From page 2 Program Resident's Rights Guide, dated 08/01/19, stated, ". . . The facility staff must treat you courteously, fairly and with dignity. . . . You should have privacy in medical treatment and personal care . . ." *100 hall observations/interviews - During an interview on 06/23/22 at 10:02 a.m., Resident #15 explained she needed to use the bathroom, no one came, she had a bowel movement (BM) in her pants, and the staff yelled at her for it. Resident #15 could not identify the location of the call light and observation showed the call light clipped to her bed across the room from her recliner. The room had an odor of BM and the toilet water showed fecal particles. Resident #15's care plan stated, "TOILET USE: Resident requires 1 staff assist to toilet with routine cares and PRN [as needed]." - Observation on 06/20/22 at 3:31 p.m. showed two CNAs (#4 and #6) assisted Resident #28 with toileting cares. While toileting, the resident passed gas and the CNA (#4) stated, "That's nasty. What did you eat?" While redressing Resident #28 in a clean brief, the CNA (#4) stated, "We [sic] going to put your diaper on" and "You have to let us put your diaper on" as the resident attempted to pull up her pants. - Observation on 06/22/22 at 1:30 p.m. showed two CNAs (#5 and #6) failed to close the window curtain before they transferred Resident #28 to bed. The CNA (#6) left the room with the lift. The CNA (#5) removed the resident's saturated brief and pants and provided perineal care. The CNA (#5) referred to the clean brief as a diaper while	F 550	Learning & Development Specialist provided education at “All Staff” meeting on the requirements of providing care and communicating with residents in a manner that maintained dignity, and the importance of following facility policies. All staff not in attendance will complete education by 8/2/22. 7/21/2022 Administrator, Director of Nursing, Infection Prevention Specialist/Quality Assurance Performance Improvement Specialist, and Clinical Learning & Development Specialist provided education at “All Staff” meeting on “Routine Practice” policy, “Resident dignity” policy, and the North Dakota Long Term Care Residents Rights Guide. All staff not in attendance will complete education by 8/2/22. All nursing staff in-serviced on computer based training, “protecting residents rights in nursing facilities” training has been deployed in addition to yearly completion requirements to be completed by 7/31/22 and all newly hired employees will complete with general orientation. DNS or designee will conduct intentional rounding for families and residents on a consistent basis to ensure compliance that dignity and resident rights are being promoted within the facility. Any concerns will be brought to daily interdisciplinary team meeting. 4) The DNS or designee will conduct an audit/interview of 3 staff and 3 residents including 2 observations of staff interactions with non-interviewable	

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F 550	Continued From page 3 she explained the care provided to Resident #28. The CNA (#5) explained the resident was checked and dry before the morning activity program at 10:00 a.m. After the activity the resident went to lunch as staff are required to have Resident #28 in the dining room in time for the noon meal. After the noon meal, staff transferred the resident to the lounge by the nurses' station until someone could take her to her room for cares and to rest. - Observation on the morning of 06/21/22 showed a CNA (#5) spoke loudly to Resident #41 in the hallway. The CNA told the resident not to use the staff bathroom, stating, "Don't go in there, you can't use this one. Remember last weekend I told you not to use it." The CNA (#5) re-directed the resident to her room to use the bathroom. *200 hall observations/interviews - Observation on 06/21/22 at 1:31 p.m. showed a CNA (#5) assisted Resident #2 to the bathroom using a sit to stand lift. The resident's brief was saturated with urine. The CNA stated Resident #2 often urinates when lifted off the toilet. As the CNA used the lift to raise Resident #2 into a semi-standing position, the resident began to urinate. The CNA stated, "See, I knew she would do that," and allowed the resident to finish urinating while in a semi-standing position. During the observation, the CNA repeatedly referred to Resident #2's incontinence brief as a "diaper." Resident #2 stated, "Help me, help me," while in the lift, to which the CNA replied, "I AM [emphasized] helping you." - Observation on 06/22/22 at 10:44 a.m. showed	F 550	residents at random weekly x 4, then bi-weekly x 2, and then monthly x 3. All findings of concern will be immediately addressed and reported to the QAPI committee monthly for further review. QAPI committee will determine when substantial compliance is obtained.	

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F 550	Continued From page 4	F 550		

Resident #2 seated in the activity room. A CNA (#6), standing approximately six feet away from the resident, stated, "[Resident #2] you want your shake [nutritional supplement]?" while shaking the carton at the resident. Resident #2 did not respond, and the CNA stated, "She don't want it," as she tossed the shake in the trash can.

- Observation on 06/21/22 at 8:52 a.m. showed Resident #26 ate at a table with a CNA (#4) who assisted another resident. Resident #26 blew her nose on her napkin and set it on the table. The CNA (#4) went to Resident #26, spoke in her ear, and Resident #26 responded, "I didn't." The CNA (#4) replied, "You did. It is right there," then picked up the napkin and took it to the garbage. The CNA (#4) did not return with a fresh napkin for Resident #26.

- Observation on 06/23/22 at 11:23 a.m. showed a CNA (#5) transferring Resident #30 from her recliner to the bathroom using a sit to stand lift with the door open and the lift transfer visible from the hallway. The CNA, upon seeing the surveyor, kicked the door closed with her foot.

- Observation on 06/21/22 at 1:18 p.m. showed a CNA (#5) brought Resident #31 to her room and assisted her to lie down using a full body mechanical lift. Without closing the window curtains, the CNA changed the resident's brief and preformed perineal care.

- Observation on 06/21/22 at 4:55 p.m. showed Resident #31 in her room in her wheelchair. A CNA (#4) combed the resident's hair, using water to wet it down, which resulted in a large wet area on the front of Resident #31's sweatshirt. The

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F 550	Continued From page 5 CNA failed to change the resident's shirt before assisting her to the dining room for dinner. - Observation on 06/22/22 at 10:44 a.m. showed Resident #31 seated in the activity room. A CNA (#6) gave the resident a cookie, wrapped with plastic. The resident struggled to open the plastic, and the CNA made no attempt to assist the resident. - Observation on 06/23/22 at approximately 9:00 a.m. showed Resident #31 seated near the nurses' station with a large wet stain on the front of her sweatshirt. The resident remained that way until staff brought her to the dining room for lunch at approximately 11:30 a.m. *300 hall observations/interviews - Observation on 06/21/22 at 12:52 p.m. showed two CNAs (#4 and #8) transferred Resident #9 from the wheelchair to the bed via a sling/full body lift. A CNA (#8) turned the resident on her left side using the lift pad. A second CNA (#4) turned the resident on her right side by grasping onto the resident's wrist. After performing perineal cares, a CNA (#4) again grasped the resident's wrist to turn her toward her to finish applying a clean brief. The CNA (#4) failed to use the lift pad when turning Resident #9. - During an interview on 06/20/22 at 1:47 p.m., Resident #12 stated, "Last night a 'big guy' [identified as certified nurse assistant (CNA) #11] wasn't very nice to us. For one thing, I put it [call light] on and the CNA (#11) said he didn't have time to assist me stating, "I have reports to do." Resident #12 then stated, "When he did help me	F 550		

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F 550	Continued From page 6	F 550		

and I was done [in the bathroom], he stated stand up straight so I can wipe you." Resident #12 stated that she has a hard time standing straight because of her back but she did it.

- During an interview on 06/20/22 at 2:33 p.m., Resident #23 identified a concern regarding a CNA (#11) who worked the night before, and stated, "I need help turning in bed and I feel like he's going to roll me into the next room." She reported when she needs assistance to the bathroom the CNA (#11) will ignore her call light, and she has sometimes waited for hours to go to the bathroom.

- Observation on 06/20/22 at 4:41 p.m. showed two CNAs (#4 and #7) assisted Resident #43 with a transfer from the bed to the wheelchair. With the bed in a high position, the two CNAs placed the full body lift sling under the resident. The CNA (#4) reached across and leaned her axilla in Resident #43's face as she placed the upper loop of the lift sling into one of the four cross-bar hooks. Resident #43 commented, "I didn't enjoy smelling your armpit." The CNA (#4) again reached across and leaned with her axilla in Resident #43's face to place the second upper loop of the lift sling into the cross-bar hook.

*400 hall interview

- During an interview on 06/21/22 at 8:05 a.m., Resident #3 reported an incident when staff assisted her into the recliner chair at 11:00 a.m. and at 5:00 p.m., she requested to use the bathroom and have her brief changed. Staff told her it was too close to supper time, and they would change her brief after supper. Around 8:00

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F 550	Continued From page 7 p.m., Resident #3 again asked to use the bathroom and have her brief changed, and staff told her they would come back. At 11:00 p.m., staff assisted Resident #3 with toileting and a brief change. Resident #3 stated, "I was soaked!" Facility staff failed to provide care and speak to residents in a dignified and respectful manner. These failures, which affected residents throughout the facility, are a violation of residents' rights and may result in emotional harm and a decreased quality of life.	F 550		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, staff and resident interview, the facility failed to ensure the interdisciplinary team assessed the appropriateness to self-administer medications (SAM) for 1 of 1 resident (Resident #3) with medications observed in the room. Failure to determine whether SAM is a safe practice has the potential to limit a resident's right to SAM or result in a medication error and/or harm to a resident. Findings include: Review of the facility policy titled "Resident Self-Administration of Medication" occurred on 06/22/22. This policy, dated 10/15/21, stated, ". . . Complete the Resident Self-Administration of	F 554	F554 1) R#3 6/23/22 medications were removed from R#3's room. R#3 will not self-administer medications until self-administration evaluation is completed and self-administration order is obtained. 2) All residents that request or are able to self-administer medications have the potential to be affected by this deficient practice; no other residents were identified as being negatively impacted.	8/12/22

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F 554	Continued From page 8 Medications UDA [User-Defined Assessment] to determine if the resident can safely administer medications and to create a plan to assist the resident to be successful in this process. . . . A physician's order must be obtained prior to the resident self-administering medications. . . . The care plan must indicate which medications the resident is self-administering, where they are kept, . . ." Observations on June 20-22, 2022, showed two eight-ounce spray bottles of Dakota Muscle Relief (topical analgesic) located in Resident #3's room. During an interview on 06/20/22 at 1:50 p.m. Resident #3 stated, "I use the spray for arthritis pain in my neck and the staff help me to use it on my back and knees." When asked the frequency of use, Resident #3 reported she uses the spray up to three times a day. Review of Resident #3's medical record occurred on June 20-22, 2022. The record lacked a SAM assessment, a provider order, and documentation on the care plan indicating Resident #3 can safely self-administer medications. During an interview on 06/23/22 at 8:05 a.m., an administrative nurse (#3) confirmed staff failed to complete the SAM for Resident #3.	F 554	3) 6/30/22 Self-Administration assessment was completed for R#3. 6/30/22 Self-Administration order for medication was obtained for R#3. 7/21/22 R#3's care plan was updated to reflect self-administration of medication. 7/21/22 interdisciplinary team reviewed all residents who self-administer medication to ensure clinically appropriate and that proper documentation is in place. 7/21/22 Administrator, Director of Nursing, Infection Prevention Specialist/Quality Assurance Performance Improvement Specialist, and Clinical Learning & Development Specialist provided education at "All Staff" meeting on actions taken if medication is found in resident rooms. All staff not in attendance will complete education by 8/2/22. 4) 6 resident rooms will be audited at random weekly x4, then bi-weekly x2, and then monthly x3. All findings of concern will be addressed and reported to DNS or designee and reported to the QAPI committee monthly for further review. All new admissions will be evaluated for desire or capability to self-administer medications. All findings of concern will be immediately addressed and reported to the QAPI committee monthly for further review. QAPI committee will determine when substantial compliance is obtained.	
F 582 SS=C	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v)	F 582		

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F 582	Continued From page 9 §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any	F 582		

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F 582	Continued From page 10 deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on review of the Medicare Part A letters/notices, Centers for Medicare and Medicaid Services instructions, and staff interview, the facility failed to provide the Notice of Medicare Non-Coverage (NOMNC) form CMS-10123 in advance for 1 of 3 residents (Resident #24) discharged from Medicare Part A services. Failure to provide Medicare A services termination notice within the required time frame has the potential to limit the residents' right to an expedited review of a service termination. Findings include: Review of [Medicare Advantage/Health Plan] Expedited Determination Notices (MA) webpage at https://www.cms.gov/Medicare/Medicare-General-Information/BNI/MAEDNotices states, " . . . The NOMNC must be delivered at least two calendar days before Medicare covered services end or the second to last day of service if care is not being provided daily. . . ."	F 582	1) R#24, continues to remain in the facility. 6/23/22 education provided by DNS to designated staff that issues Notice of Medicare Non-Coverage (NOMNC) form. 2) Residents who receive Medicare Part A covered services have the potential to be affected by this deficient practice; no other residents were identified as being negatively impacted. 3) 7/19/22 DNS provided education to the Medicare team regarding the guidelines for issuing NOMNC. Minimum Data Set Coordinator or designee maintains a list of all residents who receive Medicare Part A covered services and verifies completion via a checklist.	

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F 582	Continued From page 11 Review of the Medicare Part A letters/notices occurred the afternoon of 06/21/22. The review showed the NOMNC form CMS-10123 form dated/provided on 06/06/22 to Resident #24 and the Medicare Part A services discontinued on 06/06/22. The facility failed to provide the required advanced notice of Medicare Part A at least two days before termination. During an interview on the afternoon of 06/21/22, an administrative staff person (#3) confirmed the facility failed to provide advance notice of Medicare Part A termination to Resident #24 and/or the Resident Representative.	F 582	All residents who receive Medicare Part A covered services since 6/23/22 have been reviewed and are in compliance 7/21/22. 4) Medicare team holds a weekly meeting to review Medicare coverage compliance. All residents requiring Medicare Part A services will have their charts/NOMNC forms audited for correct documentation of being issued in a timely matter at weekly Medicare meeting. All findings of concern will be immediately addressed and reported to the QAPI committee monthly for further review. QAPI committee will determine when substantial compliance is obtained.	
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section.	F 623		8/12/22

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	355093	A. BUILDING _____ B. WING _____	C 07/07/2022

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F 623	Continued From page 12 §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and	F 623		

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F 623	Continued From page 13 telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by:	F 623		

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F 623	Continued From page 14 Based on record review and staff interview, the facility failed to notify the resident and/or the resident's representative and the ombudsman of a transfer outside of the facility for 2 of 2 sampled residents (Resident #27 and #31) with a recent hospital transfer and 1 closed record reviewed (Resident #44). Failure to provide a notice of transfer does not allow the resident and/or representative to make an informed choice regarding the resident's rights. Findings include: Record review identified the following hospital transfers: *Resident #27 on 06/20/22 *Resident #31 on 01/21/22 *Resident #44 on 04/18/22 The residents' medical records lacked evidence of a transfer notice given to the resident and/or their representative, or the ombudsman. During an interview on 06/22/22 at 5:45 p.m., an administrative nurse (#3) stated they were unable to find transfer notices for the residents, and confirmed they had not sent them to the ombudsman.	F 623	F623 1) R#27, R#31, & R#44 7/21/22 all staff were educated on the requirements of F623, to notify the resident, resident's representative, and the ombudsman of transfer outside the facility. 7/21/22 Administrator, Director of Nursing, Infection Prevention Specialist/Quality Assurance Performance Improvement Specialist, and Clinical Learning & Development Specialist provided education at "All Staff" meeting on "Discharge and Transfer" policy specific to resident transfers outside of the facility and notification to the ombudsman. All staff not in attendance will complete education by 8/2/22. 2) All residents who transfer from the facility have the potential to be affected by this deficient practice; no other residents were identified as being negatively impacted. 3) Transfer to hospital checklist was created for staff to follow and remain in compliance, bed-hold and notification to ombudsman will be given to administrator or designee. The administrator or designee will be tasked with compliance of notification of the ombudsman. 4) The DNS or designee will conduct an	

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F 623	Continued From page 15	F 623	audit of all transfers out of the facility that occur for bed-hold and notification to ombudsman completion weekly x 4, then bi-weekly x 2, and then monthly x 3. All findings of concern addressed and reported to DNS or designee and reported to the QAPI committee monthly for further review. QAPI committee will determine when substantial compliance is obtained.	
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the	F 625		8/12/22

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F 625	Continued From page 16 resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to provide a bed-hold notice to 1 of 2 sampled residents (Resident #31) with a transfer to the hospital. Failure to provide the facility's bed-hold notice does not allow residents or their legal representatives to make informed choices regarding their readmission rights. Findings include: Review of Resident #31's medical record identified a transfer to the hospital on 01/21/22. The record lacked evidence the facility provided a bed hold notice to the resident and/or their representative. During an interview on 06/22/22 at 5:45 p.m., an administrative nurse (#3) confirmed Resident #31's medical record lacked a bed hold notice.	F 625	F625 1) R#31 7/21/22 all staff were educated on the requirements of F625, to provide bed-hold notice when resident transfers out of the facility. 7/21/22 Administrator, Director of Nursing, Infection Prevention Specialist/Quality Assurance Performance Improvement Specialist, and Clinical Learning & Development Specialist provided education at “All Staff” meeting on “Bed-Hold” policy specific to resident transfers outside of the facility. All staff not in attendance will complete education by 8/2/22. 2) All residents who transfer from the facility have the potential to be affected by this deficient practice; no other residents were identified as being negatively impacted. 3) Transfer to hospital checklist was created for staff to follow and remain in compliance, bed-hold and notification to ombudsman will be given to the administrator or designee. 4)	

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F 625	Continued From page 17	F 625	The DNS or designee will conduct an audit of all transfers out of the facility that occur for bed-hold and notification to ombudsman completion weekly x 4, then bi-weekly x 2, and then monthly x 3. All findings of concern addressed and reported to DNS or designee and reported to the QAPI committee monthly for further review. QAPI committee will determine when substantial compliance is obtained.	
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review, review of the North Dakota Provider Manual Preadmission Screening and Resident Review (PASARR) and Level of	F 644	F644 1)	8/12/22

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F 644	Continued From page 18 Care Screening Procedures for Long Term Care Services, and staff interview, the facility failed to complete a status change assessment for 2 of 4 sampled residents (Resident #24 and #28) reviewed for PASARR. Failure to complete a change in status assessment with a newly diagnosed psychotic disorder may result in the delivery of care and services inconsistent with the resident's needs. Findings include: The North Dakota PASARR Provider Manual states, ". . . Change in Status Process . . . Whenever the following events occur, nursing facility staff must contact Ascend to update the Level I screen for determination of whether a first time or updated Level II evaluation must be performed. These situations suggest that a significant change in status has occurred: . . . If an individual with MI, ID, and/or RC (mental illness, intellectual disability, and conditions related to intellectual disability [referred to in regulatory language as related conditions or RC]) was not identified at the Level I screen process, and that condition later emerged or was discovered. . . ." - Review of Resident #24's medical record occurred on all days of survey. The psychiatrist identified a new diagnosis of psychotic disorder with delusions on 10/19/2021 and ordered Risperdal (an antipsychotic). The medical record lacked a change in status PASARR to include the diagnosis of psychotic disorder with delusions. - Review of Resident #28's medical record occurred on all days of survey. The psychiatrist	F 644	R#24 & R#28 7/18/22 PASRR screening was completed for R#24. 7/19/22 PASRR screening was completed for R#28. 2) All residents who has a change in mental illness, intellectual disabilities, and conditions related to intellectual disabilities have the potential to be affected by this deficient practice; no other residents were identified as being negatively impacted. 3) 6/24/22 appointed individual was provided with education on “Pre-Admission Screening Review” policy from Clinical Learning Developmental Specialist, specific to when a PASRR screening should be completed. The individual completing PASRR screening will also be completing psychiatric provider rounds to ensure continuity in communication of change in mental status, diagnosis, or medication. 4) The DNS or designee will conduct an audit of 2 residents a week seen by mental health providers at random weekly x 4, then bi-weekly x 2, and then monthly x 3. All findings of concern addressed and reported to DNS or designee and reported to the QAPI committee monthly for further review.	

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F 644	Continued From page 19 identified a new diagnosis of unspecified psychosis not due to a substance or known physiological condition on 01/19/21. The medical record lacked a change in status PASARR to include the diagnosis of psychosis. During an interview on the afternoon of 06/21/22, an administrative staff member (#3) confirmed the facility failed to complete a change in status PASARR for Residents #24 and #28.	F 644	QAPI committee will determine when substantial compliance is obtained.	
F 657 SS=F	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (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	F 657		8/12/22

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F 657	Continued From page 20 comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to review and revise the comprehensive care plans for 12 of 13 sampled residents (Resident #2, #9, #15, #19, #23, #24, #28, #29, #31, #33, #41, and #43). Failure to review and revise the care plan limits the ability of staff to communicate care needs and ensure continuity of care for each resident. Findings include: Review of the facility policy titled "Care Plan" occurred on 06/23/22. This policy, dated 05/03/22, stated, ". . . Each resident will have an individualized, person-centered, comprehensive plan of care that will include measurable goals and timetables directed toward achieving and maintaining the resident's optimal medical, nursing, physical, functional, spiritual, emotional, psychosocial, and educational needs. . . . The plan of care will be modified to reflect the care currently required/provided for the resident. . . ." Review of Residents #2, #9, #15, #19, #23, #24, #28, #29, #31, #33, #41, and #43's comprehensive care plans occurred on all days of survey. The comprehensive care plans lacked problems, goals, and interventions related to the facilities COVID-19 mitigation actions such as resident screening, testing, source control, etc. which may affect each resident's care, emotional, and psychosocial wellbeing. During an interview on the afternoon of 06/22/22	F 657	F657 1) R#15, #28, #41, #2, #26, #30, #31, #9, #12, #23, #43, and #3 7/18/22 all current resident care plans were updated to reflect COVID-19 psychosocial needs. 2) All residents have the potential to be affected by this deficient practice; no other residents were identified as being negatively impacted. 3) 7/18/22 designated staff member completed audit of all current care plans COVID-19 psychosocial focus, goal and intervention. 7/18/22 DNS provided education to the admission team, to include a COVID-19 psychosocial wellbeing focus goal and intervention to be added to comprehensive care plan. 4) All admissions and readmissions will be audited weekly x4, then bi-weekly x2, and then monthly x3 for COVID-19 psychosocial goal, focus and intervention by DNS or designee. All findings of concern will be immediately addressed and reported to the QAPI	

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F 657	Continued From page 21 two administrative nurses (#3 and #12) confirmed the resident's comprehensive care plans lacked the care and actions facility staff provide related to COVID-19 infection/prevention.	F 657	committee monthly for further review. QAPI committee will determine when substantial compliance is obtained.	
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, review of facility policy, and staff interview, the facility failed to follow professional standards of practice regarding medication administration for 1 of 7 residents (Resident #22) observed during medication pass. Failure to correctly identify the resident before administering medications may result in a serious adverse reaction and place the unintended resident in imminent danger. Findings include: Review of the facility policy titled "Medication: Administration Including Scheduling and Medication Aides- R/S [rehabilitation/skilled], LTC [long term care]" occurred on 06/23/22. This policy, dated 2022, stated, ". . . PURPOSE . . . To administer medications correctly and in a timely manner . . . PROCEDURE . . . Follow the "Six Rights": Right medication, right dose, right resident, right route, right time and right documentation. . . ." Observation on 06/22/22 at 8:17 a.m., identified a	F 658	F658 1) R#22 & R#43 6/24/22 Nurse #10 was provided with education on the “Six Rights of Medication Administration”. 2) All residents have the potential to be affected by this deficient practice; no other residents were identified as being negatively impacted. 3) 7/21/22 Administrator, Director of Nursing, Infection Prevention Specialist/Quality Assurance Performance Improvement Specialist, and Clinical Learning & Development Specialist provided education at “All Staff” meeting on “Six Rights of Medication Administration”. All staff not in attendance will complete education by 8/2/22.	8/12/22

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F 658	Continued From page 22 nurse (#10) prepared medications for Resident #22. The nurse then approached Resident #43 with the medication cup and asked, "[Resident #43] are you ready for your medications?" The surveyor questioned if the medications were prepared for Resident #43 or Resident #22 and the nurse (#10) immediately responded, "Oh no, they are for [Resident #22]." The nurse then approached Resident #22 and administered the medications. During an interview on 06/23/22 at 8:30 a.m., an administrative nurse (#3) stated she expected staff to follow the "Six Rights of Medication Administration" to identify the correct resident.	F 658	Signs posted on medication carts as a reminder of “Six Rights of Medication Administration”. Signs have been posted on medication carts to remind staff to not disturb during medication administration. 4) Three medication administration passes will be audited for distractions and compliance of the “Six Rights of Medication Administration” at random weekly x4, then bi-weekly x2, and then monthly x3. All findings of concern addressed and reported to DNS or designee and reported to the QAPI committee monthly for further review. QAPI committee will determine when substantial compliance is obtained.	
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, information received from the complainant, record review, review of facility policy, family interview, and staff interview, the facility failed to provide activities of daily living (ADL) assistance with toileting and nail care for 3 of 13 sampled residents (Resident #2, #15, and #31). Failure to assist residents who cannot independently carry out ADLs may result in skin breakdown, urinary tract infections (UTIs), and	F 677	F677 1) 6/24/22 R#15 nail care was completed. R#2 & R#31 6/23/22 DNS provided staff education on shift checklist expectations, regarding toileting for CNAs #4, #5, #6 & #11.	8/12/22

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOTTINEAU	725 E 10TH ST BOTTINEAU, ND 58318

(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 677	Continued From page 23 poor self-esteem. Findings include: Information received from the complainant identified concerns with resident incontinence and lack of staff assistance with toileting. During a confidential family interview, the family identified concerns with their mother's lack of nail care/dirty fingernails and her inability to care for her nails herself. Review of the facility policy/procedure titled "Routine Practice" occurred on 06/23/22. This policy, dated 05/03/22, stated, ". . . Nursing . . . Encourage toileting routine . . . Check nail length and trim and clean on bath day and as necessary. . . . Provide nail care with bath . . ." A certified nursing assistant (CNA) checklist identified: ". . . After meal cares (ensure clothes, hands & face are clean, check/change/toilet, and reposition . . ." - Review of Resident #2's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease, a current UTI, and dehydration. The resident's current care plan stated, ". . . The resident has an ADL self care performance deficit . . . TOILET USE: Resident requires assist of 1 staff with routine cares and PRN [as needed] using sit to stand and medium sling . . ." Observation on 06/21/22 from approximately 8:00 a.m. until 11:40 a.m. showed facility staff transported Resident #2 to the dining room for	F 677	CNA #4, #5 & #11 no are no longer employed at the facility. 2) All residents who are unable to toilet or preform nail care on their own have the potential to be affected by this deficient practice; no other residents were identified as being negatively impacted. 3) 7/21/22 Administrator, Director of Nursing, Infection Prevention Specialist/Quality Assurance Performance Improvement Specialist, and Clinical Learning & Development Specialist provided education at “All Staff” meeting on “Routine Practice” policy, “Resident dignity” policy, “Activities of Daily Living” policy. All staff not in attendance will complete education by 8/2/22. All unlicensed nursing staff in-serviced on facility policies, “Restorative Program Dressing, Grooming and Bathing” computer training has been deployed in addition to yearly completion requirements to be completed by 8/31/22. 4) The DNS or designee will conduct an audit/interview of 3 staff and 3 residents to observe toileting and nail care, at random weekly x 4, then bi-weekly x 2, and then monthly x 3. All findings of concern will be immediately addressed and reported to the QAPI committee monthly for further review.	

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F 677	Continued From page 24 breakfast, to the TV area after breakfast, to Bible study, and then back to the dining room for lunch. At 1:31 p.m., a CNA (#5) assisted Resident #2 to the bathroom. Observation showed the resident's brief was saturated with urine. The CNA stated the night staff got Resident #2 up sometime before she arrived at 6:00 a.m. Facility staff failed to toilet Resident #2 between meals. Observations throughout the morning of 06/22/22 showed Resident #2 in the TV area after breakfast and then transported to the activities room for devotions. At 11:30 a.m., an unidentified staff member brought Resident #2 to the dining room for lunch. Facility staff failed to toilet Resident #2 between meals. - Review of Resident #31's medical record occurred on all days of survey. Diagnoses included a history of UTI, and a history of cerebrovascular disease (stroke). The current care plan stated, ". . . The resident has an ADL self care performance deficit . . . TOILET USE: Assist x1 staff with routine cares and PRN . . ." Observation on 06/21/22 from approximately 8:00 a.m. until 11:37 a.m. showed facility staff transported Resident #31 to the dining room for breakfast, to the TV area after breakfast, to Bible study, and then back to the dining room for lunch. At 1:18 p.m., a CNA (#5) assisted Resident #31 to lie down and checked and changed her brief. Observation showed the resident's brief was saturated with urine. The CNA stated Resident #31 gets up early, and the night shift staff got her up sometime prior to 6:00 a.m. Facility staff failed to toilet Resident #31 between meals.	F 677	All findings of concern addressed and reported to DNS or designee and reported to the QAPI committee monthly for further review. QAPI committee will determine when substantial compliance is obtained.	

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F 677	Continued From page 25 Observations throughout the morning of 06/22/22 showed Resident #31 in the TV area after breakfast and then taken to the activities room for devotions. At 11:27 a.m., staff brought Resident #31 to the dining room for lunch. Facility staff failed to toilet Resident #31 between meals. During an interview on 06/23/22 at 9:23 a.m., a CNA (#15) stated if residents do not have specific toileting times listed on their care plan, the staff toilet them routinely between meals. During an interview on 06/23/22 at 8:20 a.m., an administrative nurse (#3) stated she expected staff to toilet residents between meals and identified there is a reminder on their CNA checklist. - Observation showed a CNA (#9) assisted Resident #15 to the bathing area on 06/21/22 at 10:20 a.m. The resident stated, "She wants to get me clean." Observation on 06/23/22 at 10:23 a.m. showed Resident #15's nails were dirty underneath with long edges that needed filing. Staff failed to assist Resident #15 with nail care during her bath.	F 677		
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	F 689		8/12/22

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F 689	Continued From page 26 by: 1. Based on observation, record review, and staff interview, the facility failed to provide adequate assistance for 1 of 6 sampled residents (Resident #28) who required a full body lift for transfers. Failure to ensure the correct use of transfer devices places residents at risk for pain and/or injury. Findings include: Observation on 06/20/22 at 3:31 p.m. showed two certified nurse aides (CNAs) (#4 and #6) assisted Resident #28 with toileting. The CNAs placed the resident's walker in front of her wheelchair, positioned themselves on each side of the wheelchair, reached under the resident's arms, told her to stand, and lifted the resident to a standing position in front of her walker. The CNAs failed to use a gait belt. The CNAs ambulated the resident to the bathroom holding her arms and waist band of her pants and assisted her to the toilet. When the CNAs identified Resident #28 as ready, they placed the walker in front of the resident, and the resident did not hold onto the walker as directed. One CNA (#4) directed the other CNA (#6) to lift Resident #28 by her arms. When the CNAs completed cares, they walked with Resident #28 to her wheelchair and directed her to sit, failing to use a gait belt. Review of Resident #28's care plan occurred following the above observation and identified, "TRANSFER-total lift with assist of 2 staff and medium sling". The CNAs (#4 and #6) failed to follow the care plan and use a full body lift for Resident #28.	F 689	F689 1) 6/27/22 a “Sit Stand Walk” assessment to determine mobility and transfer needs was completed on R#28 and care plan was updated per recommended guidance. R#2, R#9, R#17, R#23, R24, R#31, R#33, R#43 Signs reminding staff to complete “time-out” were placed on all facility lifts. 2) All who are transferred with a gait belt or mechanical lift have the potential to be affected by this deficient practice; no other residents were identified as being negatively impacted. 3) 7/21/22 all staff were educated on the requirements of F689, adequate supervision and use of assistive device to prevent accident and the importance of following a resident’s plan of care and facility policies. 7/21/22 Administrator, Director of Nursing, Infection Prevention Specialist/Quality Assurance Performance Improvement Specialist, and Clinical Learning & Development Specialist provided education at “All Staff” meeting on “Mobility Support and Positioning” policy, specific to gait belt use and using “time outs” with transfers with mechanical	

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GOOD SAMARITAN SOCIETY - BOTTINEAU	725 E 10TH ST BOTTINEAU, ND 58318

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F 689	Continued From page 27 During an interview on the morning of 06/23/22, an administrative nurse (#3) confirmed staff are to use a full body lift for Resident #28's transfers. 2. Based on observation and policy review, the facility failed to follow their policy for mechanical lift transfers for 8 of 8 sampled residents (Resident #2, #9, #23, #24, #28, #31, #33, and #43) and 1 supplemental resident (Resident #17) observed transferred with a mechanical lift. Failure to utilize lift devices as per facility policy may increase a resident's risk for pain and/or injury. Review of the facility policy/procedure titled "Mobility Support" occurred on 06/23/22. This policy, dated 05/03/22. stated,". . . Safety . . . TIME OUT is done prior to lifting the resident off the bed or the transfer surface. TIME OUT is done as follows: a. Raise the lift arm until the strap loops are taut, but the resident has not left the surface. b. Stop, check and verbalize all loops are secure. Continue to observe all loops remain secure and attached to the hooks on the hanger bar." The policy included the use of this step for full body lifts, sit-to-stand lifts, and stand aids. Transfer observations on 06/20/22 showed the following: * 1:33 p.m., two CNAs (#6 and #13) transferred Resident #33 with a full body lift. * 3:27 p.m., the CNA (#11) transferred Resident #17 with a sit to stand lift. * 4:41 p.m., two CNAs (#4 and #7) transferred Resident #43 with a full body lift. * 4:54 p.m., the CNA (#7) transferred Resident	F 689	lifts, and cleaning lifts after use. All staff not in attendance will complete education by 8/2/22. All nursing staff yearly competencies of “safe resident handling” for lift use and adhering to “time out” will be verified and completed by 8/31/22. 4) The DNS or designee will conduct an audit/interview of 3 staff and 3 residents to observe resident transfers at random weekly x 4, then bi-weekly x 2, and then monthly x 3. All findings of concern will be immediately addressed and reported to the QAPI committee monthly for further review. All findings of concern addressed and reported to DNS or designee and reported to the QAPI committee monthly for further review. QAPI committee will determine when substantial compliance is obtained.	

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F 689	Continued From page 28 #24 with a sit to stand lift. Transfer observations on 06/21/22 showed the following: * 7:56 a.m., two CNAs (#6 and #8) transferred Resident #33 with a full body lift. * 9:09 a.m., the CNA (#6) transferred Resident #23 with a sit to stand lift. * 12:52 p.m., two CNAs (#4 and #8) transferred Resident #9 with a full body lift. * 1:18 p.m., a CNA (#5) and a nurse (#14) transferred Resident #31 with a full body left. * 1:31 p.m., a CNA (#5) transferred Resident #2 with a sit to stand lift. An observation on 06/22/22 at 1:30 p.m. showed two CNAs (#5 and #6) transferred Resident #28 with a full body lift. Observations showed staff failed to perform the time out step during all transfers.	F 689		
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 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;	F 692		8/12/22

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F 692	Continued From page 29 §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, information received from the complainant, record review, review of facility policy, and staff interview, the facility failed to provide sufficient fluid intake to maintain optimal hydration for 3 of 6 sampled residents (Resident #2, #28, and #31) dependent on staff for hydration. Failure to offer/encourage fluids may result in dehydration, electrolyte imbalance, and urinary tract infections (UTIs). Findings include: Information received from the complainant identified concerns regarding inadequate fluid intake/staff assistance to consume fluids. Review of the facility policy titled "Routine Practice" occurred on 06/23/22. This policy, dated 05/03/22, stated, ". . . Encourage fluid intake of at least 1500 cc [cubic centimeters] per 24 hrs [hours] . . ." A certified nursing assistant (CNA) checklist identified: "AM [morning] cares . . . OFFER HYDRATION! . . . After meal cares . . . OFFER HYDRATION! . . ." - Review of Resident #2's medical record occurred on all days of survey. Diagnoses	F 692	F692 1) R#2, R#28, R#31 6/23/22 DNS provided staff education for CNAs #4, #5, #6 & #11 on daily expectations and checklist, with focus on offering hydration. CNA #4, #5 & #11 no are no longer employed at the facility. 2) All residents that are dependent on staff for hydration have the potential to be affected by this deficient practice; no other residents were identified as being negatively impacted. 3) 7/21/22 all staff were educated on the requirements of F689, of providing sufficient fluid intake to maintain optimal hydration and the importance of following a resident's plan of care and facility policies. 7/21/22 Administrator, Director of Nursing, Infection Prevention Specialist/Quality Assurance Performance	

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F 692	Continued From page 30 included Alzheimer's disease, a current UTI with antibiotic treatment, and dehydration. Current physician's orders included, "House Supplement with meals related to URINARY TRACT INFECTION . . . DEHYDRATION . . . 4oz, -Start Date- 06/14/2022 1200 [noon]." The resident's current care plan identified, ". . . The resident has an ADL [activities of daily living] self care performance deficit R/T [related to] dementia, arthritis, spinal stenosis . . . Resident has personal water cup she requests d/t [due to] ease of use in room. Cup holds 360cc . . ." Observations identified the following: *06/20/22 at 3:08 p.m.: Resident #2 in bed without fluids in reach. *06/21/22: Between the breakfast meal (approximately 9:30 a.m.) and lunch (approximately 12:00 p.m.), Resident #2 sat in the TV area and then went to Bible study, no fluids offered/encouraged during this time *06/21/22 at 12:47 p.m.: Resident #2 had finished lunch and was no longer in the dining room. Observation showed the resident failed to consume her strawberry shake (supplement). Review of the medication record for 06/21/22 at noon showed staff documented the resident consumed all of the shake (120 cc). *06/21/22 at 1:31 p.m.: Staff assisted Resident #2 to lie down and failed to offer fluids. Observation showed the resident's water cup was located across the room. Observations throughout the afternoon showed Resident #2 in bed and no fluids in reach. *06/22/22 at 10:44 a.m.: Resident #2 sat in the activities room. A CNA (#6), standing approximately six feet away from the resident, stated, "[Resident #2] you want your shake	F 692	Improvement Specialist, and Clinical Learning & Development Specialist provided education at “All Staff” meeting on “Routine Practice” specific to offering fluids with each care encounter policy. All staff not in attendance will complete education by 8/2/22. Interdisciplinary team will assess and identify all residents that are dependent for hydration and will monitor at risk residents through clinical review at daily interdisciplinary team meeting. 4) The DNS or designee will conduct an audit of 3 staff offering hydration with resident interaction at random weekly x 4, then bi-weekly x 2, and then monthly x 3. All findings of concern will be immediately addressed and reported to the QAPI committee monthly for further review. All findings of concern addressed and reported to DNS or designee and reported to the QAPI committee monthly for further review. QAPI committee will determine when substantial compliance is obtained.	

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F 692	Continued From page 31	F 692		

[nutritional supplement]?" while shaking the carton at the resident. Resident #2 did not respond, and the CNA stated, "She don't want it," as she tossed it in the trash can. The CNA then gave the resident a glass of juice. Without waiting to see if the resident finished it, the CNA walked away and stated to another CNA (#5), "120 mills [milliliters] for [Resident #2]."
*06/22/22: Observations throughout the afternoon showed Resident #2 in bed without fluids in reach.

Review of Resident #2's intake records/MAR for June 2022 showed Resident #2 failed to consume 1500 cc of fluid on 12 of 21 days reviewed.

- Review of Resident #31's medical record occurred on all days of survey. Diagnoses included constipation, a history of UTI, and a history of cerebrovascular disease (stroke). The current care plan stated, ". . . The resident has dehydration or potential fluid deficit R/T poor fluid intake with and between meals E/B Poor intake . . . Offer resident drinks of choice with meals . . ."

Observations identified the following:
*06/20/22 at 3:08 p.m.: Resident #31 in bed without fluids in reach
*06/21/22 during the breakfast meal: Resident #31's fluids included 180 ml coffee, 120 ml of orange juice, 120 ml of water, and 240 ml of milk. Resident #31 made a face when the CNA offered her a drink of milk. The CNA asked if she liked milk and the resident shook her head no. The resident failed to consume the milk.
*06/21/22 at 9:06 a.m.: A CNA took Resident #31 out of dining room and seated her in front of a

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F 692	Continued From page 32 TV. At 11:37 a.m., staff transported Resident #31 to the dining room for lunch. Facility staff failed to offer/encourage fluid intake during this time. *06/21/22 at 12:15 p.m.: Resident #31 seated at dining room table, asleep, with her lunch tray in front of her. At 12:21 p.m., a CNA (#4) assisted Resident #31 to eat. At the end of the meal, observation showed the resident consumed approximately 120 ml of juice and 240 ml of water. A 240 ml glass of milk remained untouched. *06/21/22 at 1:18 p.m.: A CNA assisted Resident #31 to lie down. The CNA (#5) failed to offer/encourage fluids. A mug of water sat on a bedside table not within reach of the resident. *06/21/22 at 3:19 p.m.: Resident #31 in bed without fluids in reach. *06/21/22 at 4:55 p.m.: A CNA (#4) assisted Resident #31 out of bed and failed to offer/encourage fluids. *06/22/22 at 10:44 a.m.: A CNA (#6) gave Resident #31 a glass of juice. Without waiting to see if the resident finished it, the CNA walked away and stated to another CNA (#5), "120 [milliliters] of juice for [Resident #31]." *06/22/22: Observations throughout the afternoon showed Resident #31 in bed without fluids in reach. Review of Resident #31's intake records/MAR for June 2022 showed Resident #31 failed to consume 1500 cc of fluid on 18 of 21 days reviewed. - Review of the medical record for Resident #28 occurred on all days of survey. The current care plan stated "The resident has dehydration or potential fluid deficit R/T needs encouragement	F 692		

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GOOD SAMARITAN SOCIETY - BOTTINEAU	725 E 10TH ST BOTTINEAU, ND 58318

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F 692	Continued From page 33 to consume adequate hydration E/B Poor intake." Observations on 06/20/22 at 3:31 p.m. with two CNAs (#4 and #6) and 06/22/22 at 1:30 p.m. with two CNAs (#5 and #6) showed the CNAs failed to offer Resident #28 fluids during cares. During an interview on 06/23/22 at 8:20 a.m., a supervisory nurse (#3) stated she expected staff to offer fluids between meals and with cares and identified there is a reminder on the CNA checklist.	F 692		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy and procedure, and staff interview, the facility failed to provide respiratory care consistent with professional standards of practice for 1 of 1 supplemental resident (Resident #32) observed receiving respiratory care. Failure to administer nebulizer medications according to policy and professional standards may result in complications and compromise of residents' respiratory status. Findings include:	F 695	F695 1) R#32 6/24/22 electronic medication record was updated to reflect proper documentation of pre and post assessment for R#32 nebulizer treatment. 6/24/22 Clinical Lead Developmental Specialist preformed education to all nurses and CMAs on “nebulizer” policy	8/12/22

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	355093	A. BUILDING _____ B. WING _____	C 07/07/2022

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GOOD SAMARITAN SOCIETY - BOTTINEAU	725 E 10TH ST BOTTINEAU, ND 58318

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F 695	Continued From page 34 Review of the facility policy, "Nebulizer-Rehab [Rehabilitation]/Skilled" occurred on 06/23/22. This policy, dated 2021, stated, . . ."Policy . . . To assist in loosening lung secretions . . . To administer bronchial medications and humidifying agents into the lungs. . . . PROCEDURE . . . 4. Listen to breath sounds and count pulse. . . . 11. Monitor resident for presence of side effects (e.g. [for example] tachycardia [rapid heartbeat], tremor and nausea). . . . 13. Obtain post-treatment data (pulse, breath sounds and any side effects) and record in the medical record. (If pulse is increased more than 20 beats per minute over baseline, notify physician). . . .16. Record treatment given. Rehabilitation/skilled care locations will document resident's reaction and tolerance to nebulizer treatment in the legal medical record. It is suggested to use the eAdmin [electronic administration] Record . . ." Review of Resident #32's medical record occurred on June 22-23, 2022. Diagnoses included chronic cough and asthma. A physician's order, dated 03/14/22, and revised on 06/22/22, stated, "DuoNeb Solution [a bronchodilator] 1 inhalation inhale orally via nebulizer four times a day for Rhonchi [wheezing in the lungs] related to COUGH. . . . Please Document O2 [oxygen] saturation, pulse, respirations, and LS [lung sounds] pre & post administration and record the total time (min.) [minutes] nursing spent with resident on treatment. All other observations document in e-Admin progress note." Observation on 06/22/22 at 11:06 a.m., showed a	F 695	and verified competencies. 2) All residents who receive respiratory care have the potential to be affected by this deficient practice; no other residents were identified as being negatively impacted. 3) 7/21/22 all nurses were educated on the requirements of F695, to provide respiratory care consistent with professional standards of practice and the importance of following a resident's plan of care and facility policies. 7/21/22 Administrator, Director of Nursing, Infection Prevention Specialist/Quality Assurance Performance Improvement Specialist, and Clinical Learning & Development Specialist provided education at "All Staff" meeting on "Nebulizer" policy specific to pre and post assessment. All staff not in attendance will complete education by 8/2/22. 4) The DNS or designee will conduct an audit of 1 resident receiving nebulizer treatment for pre and post assessment at random weekly x 4, then bi-weekly x 2, and then monthly x 3. All findings of concern addressed and reported to DNS or designee and reported to the QAPI committee monthly for further review. QAPI committee will determine when substantial compliance is obtained.	

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F 695	Continued From page 35 nurse (#10) administered a nebulizer treatment to Resident #32. Prior to the treatment, the nurse stated, "I usually don't do all of the assessments on a regularly scheduled nebulizer, but I would if it was a PRN [as needed] treatment." The nurse (#10) failed to obtain an oxygen saturation, pulse, respirations or assess lung sounds prior to the treatment, failed to check the resident's pulse during the treatment, and failed to obtain an oxygen saturation, pulse, respirations or assess lung sounds post treatment. Review of Resident #32's medication administration record (MAR) for June 2022 showed the date, time, length of administration, and initials of the nurse administering the nebulizer treatment. The MAR or eAdmin record lacked documentation of oxygen saturations, pulse, respirations or pre and post lung sounds for Resident #32. During an interview on 06/23/22 at 8:30 a.m., an administrative nurse (#3) stated she expected staff to follow the order as written.	F 695		
F 726 SS=F	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required	F 726		8/12/22

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F 726	Continued From page 36 at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and review of facility policy, the facility failed to ensure certified nurse aide and nursing staff demonstrated techniques to care for resident needs during 4 of 4 days of survey (June 20-23, 2022) during care observations. Failure to follow resident care plans and to provide care per facility policy has the potential to result in pain, injury, and psychosocial distress for residents. Refer to F 550 for observations regarding failure to treat residents in a manner and environment that maintained, enhanced, and respected each resident's dignity and individuality. Refer to F 677 for observation and interview regarding failure to provide activities of daily	F 726	F726 1) R#15, #28, #41, #2, #26, #30, #31, #9, #12, #23, #43, and #3 Please refer to F550, F677, F689, & F692. On 6/23/22 the DNS and Clinical Care Leader provided immediate staff education on the resident dignity policy, for CNAs #4, #5, #6 & #11, immediate corrective action understanding was validated by observation. 6/23/22 DNS provided staff education on CNA shift checklist expectations, regarding toileting for CNAs #4, #5, #6 &	

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F 726	Continued From page 37 living (ADL) assistance with toileting and nail care. Refer to F 689 for observations of failure of certified nurse aide staff to ensure the use of care planned devices for transfers and failure of staff to utilize lift devices per facility policy. Refer to F 692 for observations and facility records regarding failure of the facility to provide sufficient fluid intake to maintain optimal hydration.	F 726	#11. CNA #4, #5 & #11 no are no longer employed at the facility. 6/27/22 a "Sit Stand Walk" assessment to determine mobility and transfer needs was completed on R#28 and care plan was updated per recommended guidance. Signs reminding staff to complete "Time-out" were placed on all facility lifts. 6/23/22 DNS provided staff education for CNAs #4, #5, #6 & #11 on daily expectations and CNA checklist, with focus on offering hydration. 2) F550 - All residents have the potential to be affected by deficient practice regarding dignity and respect. F677 - Residents who are unable to toilet or perform nailcare on their own have the potential to be affected by this deficient practice F689 - All residents who transfer with a mechanical lift have the potential to be affected by this deficient practice' F692 - Residents who are dependent on staff for hydration have the potential to be affected by this deficient practice. 3) F550 surveyor observations were related to unlicensed nursing staff, competency will be validated for all unlicensed nursing staff for observations noted in F550 for	

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	355093	A. BUILDING _____ B. WING _____	C 07/07/2022

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F 726	Continued From page 38	F 726	dignity and respectful treatment during resident cares by 8/12/22. F677 surveyor observations were related to unlicensed nursing staff; competency will be validated for all unlicensed nursing staff for observations noted in F677 for toileting and nail care by 8/12/22. F689 surveyor observations were related to unlicensed nursing staff; competency will be validated for all unlicensed nursing staff for observations noted in F689 for appropriate transfer with mechanical lifts by 8/12/22. F692 surveyor observations were related to unlicensed nursing staff; competency will be validated for all unlicensed nursing staff for observations noted in F689 to provide sufficient hydration by 8/12/22 All new hired employees will demonstrate competencies as noted above during orientation. 4) Please refer to F550, F677, F689, & F692. DNS or designee will audit that all unlicensed nursing staff have completed competencies as determined above by 8/12/22. The DNS or designee will conduct an audit monthly to verify new hired employees have completed competencies for dignity, toileting, nail care, transfers	

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F 726	Continued From page 39	F 726	with mechanical lifts and sufficient hydration. All findings of concern addressed and reported to DNS or designee and reported to the QAPI committee monthly for further review. QAPI committee will determine when substantial compliance is obtained.	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to prepare, store, and serve food in a sanitary manner in 1 of 1 kitchen. Failure to monitor "use by" dates, refrigerator and freezer temperatures, the	F 812	F812 1) No residents were found to have been affected by the deficient practice.	8/12/22

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F 812	Continued From page 40 mechanical ware washing machine, and the quaternary (quat) sanitizer concentration may result in unsafe food storage/preparation and foodborne illness. Findings include: Review of the facility policy titled "Food Storage" occurred on 06/23/22. This policy, revised July 2018, stated, ". . . USE by/USE or Freeze By* (expiration date) - This is used on Time/temperature Control for Safety Foods (TCS). . . . The product should not be consumed after the date on the package due to the product's perishable nature and the product should be disposed of. . . . Use By and Freeze By (expiration) dates are checked on a regular basis; foods/fluids that have expired or are otherwise unsafe for use are discarded . . . In the refrigerator, the temperature is kept between 35 degrees Fahrenheit and 40 degrees Fahrenheit. . . . In the freezer, the temperature is 0 degrees Fahrenheit or lower. . . . Internal temperatures of all refrigerators and freezers in the food and nutrition department, dining room, and nourishment areas are recorded twice daily . . ." The facility policy titled "Date Marking" occurred on 06/23/22. This policy, revised July 2018, stated, ". . . Ensure TCS [time/temperature control for safety] foods are held a [sic] temperature of 5 degrees Celsius (41 degrees Fahrenheit) or less for a maximum of seven days. . . ." The facility policy titled "Sanitizing Food Contact Surfaces" occurred on 06/23/22. This policy, revised December 2017, stated, ". . . Sanitizing	F 812	2) All resident have the potential to be affected by this deficient practice 3) By 8/12/22 Dietary Manager/Administrator or designee will provide education to all dietary staff on dating, labeling, and discarding out-of-date food; all food items upon delivery will have a received date, open date and used by date. All exposed and undated food will be discarded immediately. By 8/12/22 Dietary Manager/Administrator or designee will provide education to all dietary staff on monitoring and completing temperature log for the walk-in cooler, walk-in freezer and refrigerators. By 8/12/22 Dietary Manager/Administrator or designee will provide education to all dietary staff on monitoring and completing the automatic dispenser log for the quaternary sanitizer at the three-compartment sink. By 8/12/22 Dietary Manager/Administrator or designee will provide education to all dietary staff on temperature check requirement for the dishwasher. 4) The administrator or designee will audit weekly x 4, then bi-weekly x 2, and then monthly x 3 to ensure all policies for labeling, discarding out of date food, monitoring walk-in cooler/freezer, and completing temperature and quaternary sanitizer logs per policy. Results of audits	

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F 812	Continued From page 41 solution: Mix sanitizing chemicals in the recommended concentration levels for maximum efficacy. Refer to manufacturer's information for proper concentrations measured in parts per million (ppm). . . . Check solution concentrations frequently with an appropriate test kit . . ." Review of the facility policy titled "Ware Washing (Mechanical and Manual) occurred on 06/23/22. This policy, revised July 2018, stated, ". . . Check compliance for wash and rinse cycles each meal service. High temp [temperature] - Wash: 150 to 165 degrees Fahrenheit depending on type of machine . . . Rinse: 180 degrees Fahrenheit (160 degrees Fahrenheit or greater at the rack and dish/utensil surfaces) . . . Record temperature and/or chemical level on Dish Machine Temperature Log . . . Per the food code, when hot water mechanical ware washing is in use, an irreversible registering temperature indicator shall be readily accessible for measuring the surface temperature to ensure that 160 degrees Fahrenheit is reached in the rinse cycle. . . ." Observations in the main kitchen occurred on 06/20/22. The June temperature logs showed the following: *Walk-in freezer: No temperatures documented (a.m. or p.m.) on 12 of 19 days, no p.m. temperatures documented on 3 of 19 days *Walk-in cooler: No temperatures documented (a.m. or p.m.) on 11 of 19 days, no p.m. temperatures documented on 6 of 19 days *Reach-in freezer: No temperatures documented (a.m. or p.m.) on 12 of 19 days, no p.m. temperatures documented on 4 of 19 days On 06/20/22, observation in the walk-in cooler	F 812	will be presented monthly by administrator or designee to the QAPI committee until QAPI determines compliance is attained.	

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F 812	Continued From page 42 showed two packages of lunch meat (one opened, one unopened) date marked by staff with 04/15/22 and manufacturer's "use by" dates of 05/19/22. The opened package also had a date marking of "6/11" (10 days prior). A dietary staff member (#2) stated 04/15/22 is the date staff pulled the lunch meat from the freezer, and 06/11/22 is the date staff opened the meat. The staff member agreed she should throw away both packages. Observation of the three-compartment sink showed an automatic dispenser for quat sanitizer. The manufacturer's guidelines indicated 150-400 ppm as an acceptable strength. The June log showed staff failed to monitor the concentration of quat on 8 of 19 days. Observation of the high temperature dish machine occurred on 06/20/22. The machine lacked a monitoring log for June 2022. The log staff last used was dated May 2022 and titled "Manual Ware Washing-Chemical Sanitizing Log." A dietary staff member (#1) identified it was the wrong log, but staff could not find the correct one. She confirmed they did not have a log for June and stated they do not run a temperature measuring device through the dish machine. The May 2022 log showed staff failed to monitor temperatures on 15 of 31 days in May, and the dish machine failed to reach 180 degrees (sanitizing cycle) on 13 of the 16 days staff did monitor temperatures.	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control	F 880		7/28/22

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F 880	Continued From page 43 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; (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:	F 880		

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F 880	Continued From page 44 (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: THIS IS A REPEAT DEFICIENCY FROM THE PREVIOUS STANDARD SURVEY CONDUCTED ON 05/13/21. Based on observation, review of facility policy, and staff interview, the facility failed to follow infection control practices for 3 of 9 sampled residents observed during cares (Residents #28, #33, and #43) and one supplemental resident (Resident #26). Failure to follow infection control	F 880	1. Corrective Action The facility will immediately implement an appropriate infection prevention and 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	

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F 880	Continued From page 45 practices has the potential for transmission of communicable diseases and infections to residents and staff. Findings include: Review of the facility policy titled "Hand Hygiene" occurred on 06/23/22. This policy dated 03/29/22, stated, ". . . To establish hand hygiene as the single most important factor in preventing the spread of disease-causing organisms to patients and personnel in healthcare settings . . . Hand hygiene: a general term that applies to either handwashing or applying hand sanitizer. . . . Gloves are a protective barrier for the HCW [healthcare worker] according to standard precautions. 1. Gloves are never to be reused or sanitized. 2. Hand hygiene should be performed after glove removal. . . . HCW will use waterless alcohol-based hand sanitizer or soap and water to clean their hands: When entering patient room . . . After removing gloves regardless of the task completed . . . When moving from contaminated body site to a clean body site during patient care . . . When exiting patient room . . ." Review of the facility policy titled "Environmental Cleaning Principles" occurred on 06/23/22. This policy dated 10/19/21, stated, ". . . Non-Critical Items - Surfaces and items that come in contact with intact skin, but not mucous membranes. . . . Examples of non-critical items . . . lift equipment . . . Environmental cleaning plays an important role in an infection control program. . . . Adequate safety levels can be achieved for most non-critical and low touch areas by keeping the surfaces visibly clean using water and a detergent or a low-level disinfectant. . . ."	F 880	applicable interdisciplinary team (IDT) members, shall identify and implement a consistent system for ensuring a system for: (1) Ensuring staff complete hand hygiene or handwashing when donning gloves, moving between tasks, residents, and after touching potentially contaminated surfaces, in accordance with CDC guidelines. (2) Ensuring staff dispose of bodily fluids appropriately and disinfect contaminated surfaces, in accordance with CDC guidelines. (3) Ensuring staff disinfect equipment between resident use, in accordance with CDC guidelines The DON, staff development coordinator (SDC), IP or designee, in conjunction with applicable IDT members, will: (1) Educate all staff on the importance of and techniques for hand hygiene when changing gloves, when going from dirty to clean task, and after 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. (2) Educate all staff on the importance of and techniques for disinfecting equipment used by multiple residents, such as a mechanical lift. (3) Educate all staff on the importance of and techniques for disinfecting surfaces	

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	355093	A. BUILDING _____ B. WING _____	C 07/07/2022

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F 880	Continued From page 46 HAND HYGIENE - Observation on 06/20/22 at 4:41 p.m. showed a CNA (#4) applied gloves, emptied Resident #43's urine collection bag, dumped the urine into the commode, rinsed and wiped the urine collection container with a paper towel, removed gloves and donned clean gloves without performing hand hygiene. The CNA (#4) moved the resident's wheelchair next to the bed, assisted Resident #43 with a transfer from the bed to the chair, placed the mechanical lift next to the wall, and adjusted the blanket on the resident's bed. The CNA (#4) failed to perform hand hygiene between glove changes. - Observation on 06/21/22 at 8:52 a.m. showed Resident #26 blew her nose on a napkin and set it on the dining room table. The CNA (#4) removed the napkin from the table and placed it in the garbage. The CNA (#4) failed to perform hand hygiene before she returned to assist Resident #26's tablemate to eat. - Observation on 06/22/22 showed a CNA (#6) donned gloves and provided perineal care to Resident #28 in her bed. After cares, the CNA removed her soiled gloves, and without performing hand hygiene, donned clean gloves, and applied a clean brief. The CNA (#4) placed the wet brief into the garbage can and closed the clean brief. Wearing the same gloves, the CNA (#4) removed Resident #28's wet pants, applied clean pants, and covered her with a blanket. The CNA (#4) then lowered the bed, gathered the garbage, and exited the room. The CNA (#4)	F 880	where body fluids and/or secretions have been in contact with. 2. Identification of Others The IP and DON, in conjunction with the applicable interdisciplinary team (IDT) members, will evaluate the facility's compliance with the guidelines from CDC. The facility will develop action plans to address any newly identified non-compliance. 3. System Changes On or before 07/28/2022 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 complete hand hygiene and/or change gloves before/after tasks, moving between tasks, and after touching potentially contaminated surfaces in accordance with CDC guidelines. b. Failure to ensure disinfecting of equipment between resident use was completed in accordance with CDC guidelines and/or manufacturer instructions. c. Failure to ensure disinfecting surfaces contaminated with body fluids and/or secretions was completed in accordance with CDC guidelines. Information about root cause analysis can be found at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloa	

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F 880	Continued From page 47 failed to perform hand hygiene after removing the soiled gloves and before donning clean gloves and failed to remove gloves and perform hand hygiene before exiting the room. CLEANING AND DISINFECTING - Observation on 06/20/22 at 4:41 p.m. showed a CNA (#4) donned gloves, emptied Resident #43's urine collection bag into a graduated container, dumped the urine into the toilet, rinsed the graduated container in the bathroom sink and dumped the contents into the sink drain. The CNA (#4) failed to disinfect the sink. - Observation on 06/21/22 at 7:56 a.m. showed two CNAs (#6 and #8) used a sit to stand mechanical lift and transferred Resident #33 from the bed to the bathroom toilet and then to the wheelchair. Upon completion of the transfer, the CNA (#8) removed the lift from the room and placed it in the storage room across the hall. The CNA (#8) failed to disinfect the mechanical lift after use. During an interview on 06/23/22 at 10:40 a.m. an administrative nurse (#3) stated she expected staff to empty urine collection contents into the toilet.	F 880	ds/GuidanceforRCA.pdf (2) The DON, SDC, IP or suitable designee will ensure the following: a. Educate all staff, including agency 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. b. Educate all staff, including agency staff, on the importance of and technique for disinfecting equipment between resident use and/or when used by multiple residents. c. Educate all staff, including agency staff, on the importance of and technique for disinfecting surfaces contaminated with body fluids and/or secretions. (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. Monitoring Weekly for no less than 12 weeks, the DON, IP, SDC or a designee will conduct	

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F 880	Continued From page 48	F 880	on-going monitoring to ensure, via observation, the approaches to correct deficient practice related to infection control and prevention are consistently implemented and effective. Such monitoring will include: a. Observations of all staff types to ensure performance of proper handwashing and hand hygiene, when indicated, in the course of their routine duties. b. Observation of staff, trained to use resident equipment, to ensure proper disinfecting of equipment between resident use. c. Observation of staff to ensure performance of proper surface cleaning/disinfecting of surfaces contaminated and/or potentially contaminated with body fluids/secretions. 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 the quality assurance process improvement (QAPI) committee as part of QAPI activities. Monitoring will not be	

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F 880	Continued From page 49	F 880	discontinued until the facility completes three consecutive rounds of monthly monitoring that demonstrate sustained compliance as approved by the QAPI committee and medical director. 5. Correction Date 07/28/2022	