STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355039	A. BUILDING _____ B. WING _____	07/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRIGGS COUNTY CARE CENTER	1200 ROBERTS AVE NE COOPERSTOWN, ND 58425

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey started on 07/17/2017 and completed on 07/20/2017, the sample included two (2) residents for complete review, seven (7) residents for focused review, and one (1) closed record for review. The sample included two (2) supplemental residents to verify specific concerns during the survey.	F 000		
F 203 SS=D	483.15(c)(3)-(6)(8) NOTICE REQUIREMENTS BEFORE TRANSFER/DISCHARGE (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 (b)(5) of this section. (c) (4) Timing of the notice. (i) Except as specified in paragraphs (b)(4)(ii) and (b)(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	F 203		8/24/17

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

Electronically Signed | 08/04/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355039	A. BUILDING _____ B. WING _____	07/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRIGGS COUNTY CARE CENTER	1200 ROBERTS AVE NE COOPERSTOWN, ND 58425

(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 203	Continued From page 1 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 (b)(1)(ii)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (b)(1)(ii)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (b)(1)(ii)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (b)(1)(ii)(A) of this section; or (E) A resident has not resided in the facility for 30 days. (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	F 203		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355039	A. BUILDING _____ B. WING _____	07/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRIGGS COUNTY CARE CENTER	1200 ROBERTS AVE NE COOPERSTOWN, ND 58425

(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 203	Continued From page 2 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 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. (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. (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	F 203		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355039	A. BUILDING _____ B. WING _____	07/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRIGGS COUNTY CARE CENTER	1200 ROBERTS AVE NE COOPERSTOWN, ND 58425

(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 203	Continued From page 3 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: Based on record review, review of facility policy, and staff interview, the facility failed to notify the resident and/or family member/legal guardian, and Office of the State Long-term Care Ombudsman, in writing, of a transfer outside of the facility, including the destination and the reason for the transfer, and the resident's right to appeal the action for 2 of 2 sampled residents (Resident #5 and #7) transferred to the hospital. Failure to provide a notice of transfer does not allow the resident or guardian to make an informed choice regarding the resident's rights. Findings include: Review of the facility policy "Transfer and Discharge (including AMA [against medical advice])" occurred on 07/20/17. The policy, dated 01/17, stated: "This facility . . . permit[s] each resident to remain in the facility, and not transfer or discharge the resident from the facility . . . At least 30 days before the resident is transferred or discharged, the Social Services Director will notify the resident and the resident's representative in writing . . . Emergency Transfers/Discharges - for medical reasons . . . Nursing should complete and send with the resident a Transfer Form . . ." The policy lacked the requirement to send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.	F 203	F 203 1. Nurses working the day that resident #'s 2 and 5 were transferred to the hospital were educated immediately on the facility Transfer and Discharge policy which indicates that even though the resident first went to an ER/hospital/or clinic, the notice still needed to be given since the resident ultimately was admitted to another facility and left the Care Center. The facility policy was updated on 7/31/17 to include the requirement that a copy of the form also should be sent to the State Long Term Care Ombudsman office. 2. All discharged or transferred residents of the Griggs County Care Center have the potential to be affected. 3. Facility Transfer and Discharge policy was updated on 7/31/17 to indicate that the State Ombudsman Office must receive a copy of the transfer form that was provided to the resident or his/her responsible party. Education was provided to nursing staff at an inservice on 8/2/17 regarding the revisions to the policy. At this inservice, nursing staff were also educated on the specific times when it is appropriate to give the Transfer notice to the resident or his/her responsible party.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355039	A. BUILDING _____ B. WING _____	07/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRIGGS COUNTY CARE CENTER	1200 ROBERTS AVE NE COOPERSTOWN, ND 58425

(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 203	Continued From page 4 - Review of Resident #5's medical record occurred July 18-19, 2017 and identified the resident seen in the clinic and admitted to the hospital on the afternoon of 05/09/17. The record lacked evidence the facility provided the resident and/or the resident's family member/legal guardian a written notice of transfer. - Review of Resident #7's medical record occurred 07/20/17 and identified the resident transferred to the emergency room and admitted to the hospital on 06/10/17. The "NOTICE OF TRANSFER FOR HOSPITALIZATION" form included an area to document "a copy of this notice has been sent to a representative of the Office of the State Long-Term Care Ombudsman on _____(date)". The form within the medical record lacked evidence the facility sent the notice to a representative of the Office of the State Long-Term Care Ombudsman. During an interview on 07/17/17 at 1:30 p.m., a supervisory nurse (#1) stated staff should complete transfer notices when a resident transfers to another facility including the hospital, and confirmed the facility failed to provide the family/legal guardian of Resident #5 a written notice of transfer and discharge. The staff member acknowledged the ombudsman should also receive a copy of the notice.	F 203	4. All transfers from the facility will be reviewed by the facility DON, or designee, to ensure that transfer notices were given appropriately per policy to the resident or his/her responsible party. These reviews will also include checking to see that a copy of the notice was sent to the State Ombudsman for all transfers. The QA monitoring will begin immediately following staff in-service on 8/2/17. These reviews will include all transfers weekly 4 weeks, every 2 weeks x2 and then monthly x 4 months. Any problems with the Quality Assurance checks will be reported immediately to the appropriate supervisors so that correction/education can be performed, if needed. Results of all monitoring will be reviewed at the facility Quality Improvement Committee meetings and determination for continued further monitoring will be made by the Committee. 5. 8/24/17	
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (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.	F 312		8/24/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355039	A. BUILDING _____ B. WING _____	07/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRIGGS COUNTY CARE CENTER	1200 ROBERTS AVE NE COOPERSTOWN, ND 58425

(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 312	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide activities of daily living (ADL) assistance to 1 of 3 sampled residents (Resident #2) who required staff assistance with pericares. Failure to provide assistance to residents who cannot perform ADLs independently may result in poor hygiene, skin breakdown, and discomfort. Findings include: Review of the facility policy titled "Perineal Care" occurred on 07/19/17. This policy, revised in 2010, stated, "PROCEDURE: ". . . 5. Wash perineum from front to back with disposable wash cloth. . . ." Review of Resident #2's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease and dementia. Resident #2's quarterly Minimum Data Set (MDS), dated 06/10/17, identified extensive assistance required for personal hygiene. The current care plan stated, "Open area to scrotum . . . Tx [treatment] as ordered. Monitor . . ." The care plan also stated, "Problem: Resident is at risk for skin breakdown R/T [related to] incontinence . . . Approach: . . . Provide incontinence care after each incontinent episode . . ." Observation on 07/18/17 at 10:25 a.m. showed two certified nursing assistants (CNAs) (#2 and #3) assisted Resident #2 to the bathroom. As the CNAs lowered the resident onto the toilet he	F 312	F 312 1. CNA #'s 2 and 3 were provided immediate education by the DON on the correct way to provide perineal cares to a resident that is incontinent of bowel or bladder. Agency staffing company was also notified of the problems identified to ensure they also reinforced the education provided by GCCC staff to their employees. 2. All residents who require assistance with ADL's that are incontinent of bladder or bowel have the potential to be affected. 3. Education was provided to all CNA staff by the facility DON at an inservice on 08/02/17. The Griggs County Care Center policy on Perineal Care was reviewed with the staff and education was provided that the policy must be followed for both bladder and bowel incontinence, and that staff must ensure that a resident's skin is always clean and dry before placing a clean incontinence product. 4. Quality Assurance monitoring will be done by randomly observing cares provided to residents by CNAs, by the facility DON, or designee. This QA monitoring will begin immediately following staff training 8/2/17 and will be done randomly on all shifts every day x2 weeks, then will be done randomly 3x/week x2 weeks, then weekly x 8 weeks and then monthly x3 months. If any problems are found with the QA	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355039	A. BUILDING _____ B. WING _____	07/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRIGGS COUNTY CARE CENTER	1200 ROBERTS AVE NE COOPERSTOWN, ND 58425

(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 312	Continued From page 6 dribbled urine. The CNA (#2) stated the resident has a sore on his scrotum. Observation showed redness and drops of urine on his scrotum. The CNA (#2) then pulled up Resident #2's brief and pants. The CNA failed to provide pericares after he voided. Observation on 07/18/17 at 12:00 p.m. showed two CNAs (#2 and #3) toileted Resident #2 in a hallway bathroom. The resident sat on the toilet and observation showed the resident voided. After Resident #2 finished voiding, the CNAs (#2 and #3) raised the resident to a standing position, lifted up the resident's incontinence pad and pants, and transferred him to his wheelchair using a mechanical lift. The CNA's failed to provide perineal care to Resident #2 after he voided. During an interview on 07/19/17 at 3:45 p.m., an administrative nurse (#1) stated she expected facility staff to perform pericares on all residents whether they voided or had a bowel movement.	F 312	checks, the CNA on will be educated immediately and the process will be corrected at that time. Appropriate supervisors will be notified of problems so that additional correction/education can be performed, if needed. Results of all monitoring will be reviewed at the facility Quality Improvement Committee meetings and determination for continued further monitoring will be made by the Committee. 5. 8/24/17	
F 431 SS=D	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and	F 431		8/24/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355039	A. BUILDING _____ B. WING _____	07/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRIGGS COUNTY CARE CENTER	1200 ROBERTS AVE NE COOPERSTOWN, ND 58425

(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 431	Continued From page 7 biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355039	A. BUILDING _____ B. WING _____	07/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRIGGS COUNTY CARE CENTER	1200 ROBERTS AVE NE COOPERSTOWN, ND 58425

(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 431	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to identify the open date of two opened insulin pens on 2 of 2 days of observation (July 18 and 20, 2017). Failure to identify an open date on insulin pens increases the risk of residents receiving insulin with reduced efficacy. Findings include: Review of the facility policy titled "Insulin Pens" occurred on 07/20/17. This policy, revised in 2011, stated, "POLICY: Insulin Pens should be stored in fridge until ready for first use. After rubber stopper has been punctured, keep Insulin Pens at room temperature. . . . Humalog pens are good for 28 days after first use . . . Lantus pens are good for 28 days after first use . . . Make sure to date the pen when taking out for first use." - Observation on 07/18/17 at 11:50 a.m. showed an opened Humalog insulin pen without an open date in the medication cart. The nurse (#5) could not identify the open date. - Observation on 07/20/17 at 9:20 a.m. showed an opened Lantus insulin pen without an open date in the medication cart. The nurse (#6) could not identify the open date. During an interview on 07/20/17 at 10:10 a.m., an administrative nurse (#1) stated she expected facility staff to date insulin pens when they are removed from the refrigerator and placed in the medication cart.	F 431	F 431 1. Insulin pens that were not dated were immediately removed from service. 2. All residents who receive injections from insulin pens have the potential to be affected. 3. Education was provided to all staff that administer insulin injections that all pens must be dated when removed from the refrigerator, per Griggs County Care Center policy. This education was provided to all nursing staff at an inservice on 08/02/17. 4. Quality Assurance monitoring will be done by observing insulin pens that are in use to see if they have dates on them. This monitoring will be done by the facility DON, or designee. The QA monitoring will begin immediately following staff in-service on 8/2/17 and will be monitored 2x/day x2 weeks, then will be done 3x/week x6 weeks, then weekly x8 weeks, and then monthly x 2 months. If any problems are found with the QA checks, the nurse on duty will be provided immediate education. Appropriate supervisors will be notified of problems so that additional correction/education can be performed, if needed. Results of all monitoring will be reviewed at the facility Quality Improvement Committee meetings and determination for continued further monitoring will be made by the Committee. 5. 8/24/17	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355039	A. BUILDING _____ B. WING _____	07/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRIGGS COUNTY CARE CENTER	1200 ROBERTS AVE NE COOPERSTOWN, ND 58425

(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 441 SS=E	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (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: (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 (facility assessment implementation is Phase 2); (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 441		8/24/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355039	A. BUILDING _____ B. WING _____	07/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRIGGS COUNTY CARE CENTER	1200 ROBERTS AVE NE COOPERSTOWN, ND 58425

(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 441	Continued From page 10 (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. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: 1. Based on observation, review of facility policy, and staff interview, the facility failed to follow infection control practices for 2 of 3 sampled residents (Resident #2 and #6) observed during cares. Failure to follow infection control practices related to hand hygiene/glove use and perineal cares has the potential to spread infection within the facility.	F 441	F 441 1. a. CNA #'s 2, 3, and 4 were provided immediate education by the facility DON on the proper procedures for handwashing/hand hygiene per Griggs County Care Center policy. b. Nurse #5 was provided with immediate education by the DON on the proper procedure for usage and disinfecting of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355039	A. BUILDING _____ B. WING _____	07/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRIGGS COUNTY CARE CENTER	1200 ROBERTS AVE NE COOPERSTOWN, ND 58425

(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 441	Continued From page 11 Findings include: Review of the facility policy titled "Perineal Care" occurred on 07/19/17. This policy, revised in 2010, stated, "PROCEDURE: . . . 2. Wash hands . . . 3. Put gloves on . . . 5. Wash perineum . . . Cleanse anal area . . . 7. Remove gloves. 8. Wash hands . . . 12. Wash hands before leaving the room. . . ." Review of the facility policy titled "Handwashing" occurred on 07/19/17. This policy, revised in 2011, stated, "PURPOSE: . . . Proper handwashing helps prevent the spread of infection from person to person or from one part of the body to another. POLICY: INDICATIONS FOR HANDWASHING: . . . 3. Before and after resident/patient contact (for which hand hygiene is indicated by acceptable professional practice); . . . 8. Before and after assisting a resident/patient with personal care . . . 14. Before and after assisting a resident/patient with toileting; . . . 21. After removing gloves . . . 22. After completing duty . . ." - Observation on 07/18/17 at 10:25 a.m. showed two certified nursing assistants (CNAs) (#2 and #3) donned gloves and assisted Resident #2 to the toilet. After the resident voided, the CNAs assisted him to his wheelchair and transported him to the solarium. The CNAs (#2 and #3) failed to perform hand hygiene. - Observation on 07/18/17 at 12:00 p.m. showed two CNAs (#2 and #3) toileted Resident #2 in a hallway bathroom. The resident sat on the toilet and voided. Without providing perineal care, the CNAs raised the resident to a standing position	F 441	the glucometer machine per policy. 2. All residents at Griggs County Care Center have the ability to be affected. 3. a. All CNA staff were provided education at an inservice on 08/02/17 regarding proper procedure for handwashing and hand hygiene. This education was done by reviewing the current policy with staff and having them demonstrate proper procedure. b. All nursing staff were provided education on the proper procedure for usage of the glucometer machine on 08/02/17. This education was done by reviewing the current policy with nursing staff and having them demonstrate proper procedure. 4. a. Quality Assurance monitoring will be done to ensure proper handwashing/hand hygiene techniques are being followed by CNAs by randomly observing CNAs providing care, by the facility DON, or designee. This QA monitoring will begin immediately upon completion of staff in-service and will be done randomly on all shifts every day x4 weeks, then will be done randomly 3x/week x8 weeks, then weekly x4 weeks, and then monthly x2 months . If any problems are found with the QA checks, the CNA will be educated immediately and the process will be corrected at that time. Appropriate supervisors will be notified of problems so that additional correction/education can be performed, if needed. Results of all monitoring will be reviewed at the facility	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355039	A. BUILDING _____ B. WING _____	07/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRIGGS COUNTY CARE CENTER	1200 ROBERTS AVE NE COOPERSTOWN, ND 58425

(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 441	Continued From page 12 using a mechanical lift and pulled up the resident's incontinence pad and pants. The CNAs removed their gloves and left the bathroom without washing their hands. In the hall, one CNA (#3) applied foot pedals and the other CNA (#2) wheeled the mechanical lift to the storage room, disinfected it, and washed her hands. - Observation on 07/18/17 at 12:15 p.m. showed Resident #6 incontinent of a large amount of soft bowel movement (BM) in her brief when toileted by two CNAs (#2 and #3). Both CNAs, wearing gloves, used wipes to clean the resident's perineal area, the backs of her legs, and the seat of the toilet, which was smeared with BM. Next, the CNAs held onto the resident's gait belt and pivot transferred her to the wheelchair. Both CNAs then removed their gloves and one of the CNA's (#3) washed her hands. The other CNA (#2) wheeled Resident #6 into her room, gave her a drink of water from a cup, brushed her hair, and wheeled her to the dining room. The CNA (#2) walked to another table, pulled a resident's chair away from the table, and then left the dining room to wash her hands. - Observation on 07/19/17 at 8:50 a.m. showed two CNAs (#3 and #4) assisted Resident #2 from bed into the bathroom. The CNA (#4) removed the resident's soiled brief (stool), washed her hands, and applied clean gloves while the other CNA (#3) provided pericares. The CNAs dressed Resident #2, removed their gloves, and assisted him to his wheelchair. One CNA (#4) exited the room with the mechanical lift without performing hand hygiene and the other CNA (#3) assisted the resident with his glasses and hearing aid, combed his hair, and obtained the garbage from	F 441	Quality Improvement Committee meetings and determination for continued further monitoring will be made by the Committee. b. Monitoring will be done by facility DON, or designee, to ensure that nurses are properly cleaning and storing the glucometers after use. This monitoring will begin immediately upon completion of staff inservice on 8/2/17 and will be done 2x/day x2 weeks, then will be done 3x/week x2 weeks, then will be done weekly x2 months, and then monthly x3 months . If any problems are found with the QA checks, the nurse will be provided immediate education. Appropriate supervisors will be notified of problems so that additional correction/education can be performed, if needed. Results of all monitoring will be reviewed at the facility Quality Improvement Committee meetings and determination for continued further monitoring will be made by the Committee. 5. 8/24/17	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355039	A. BUILDING _____ B. WING _____	07/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRIGGS COUNTY CARE CENTER	1200 ROBERTS AVE NE COOPERSTOWN, ND 58425

(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 441	Continued From page 13	F 441		

the bathroom. The CNA (#3) exited the room with the garbage in hand, transported Resident #2 to the dining room, and then washed her hands in the soiled utility room. The CNA (#3) failed to wash her hands after providing pericares and before exiting the resident's room.

- Observation on 07/19/17 at 10:45 a.m. showed two CNAs (#3 and #4) assisted Resident #2 to the bathroom. One CNA (#4) removed the resident's soiled brief (stool) and the other CNA (#3) provided pericares. Without changing gloves, the CNA (#3) applied bag balm (a protective ointment) to the resident's reddened scrotum. The CNAs removed their gloves and assisted the resident to his wheelchair. One CNA (#4) applied gloves, disinfected the mechanical lift, and transported Resident #2 to the solarium while the other CNA (#3) obtained the bathroom garbage. Both CNAs failed to wash their hands after providing personal cares for Resident #2 and failed to wash their hands before leaving the room.

During an interview on 07/19/17 at 3:45 p.m., an administrative nurse (#1) stated she expected facility staff to perform hand hygiene after bowel movement (BM) cares and before exiting a resident's room.

2. Based on observation, review of facility policy, and staff interview, the facility failed to follow infection control practices for 2 of 3 observations of of residents who required blood glucose monitoring. Failure to follow infection control practices related to disinfecting the glucometer has the potential to spread infection to other residents.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355039	A. BUILDING _____ B. WING _____	07/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRIGGS COUNTY CARE CENTER	1200 ROBERTS AVE NE COOPERSTOWN, ND 58425

(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 441	Continued From page 14 Findings include: Review of the facility policy titled "Equipment Cleaning/Decontamination for Equipment Potentially Exposed to BloodBorne Pathogens" occurred on 07/18/17. This policy, revised in 2010, stated, ". . . BLOOD GLUCOSE MONITOR (Assure Pro [brand name]): This monitor is to be cleaned before and after resident use. . . ." Observation on 07/18/17 at 11:55 a.m. showed a nurse (#5) opened a storage pouch which contained a glucometer, placed the pouch/glucometer on a tray, and carried it into Resident #11's room. The nurse checked the resident's blood sugar, placed the glucometer back on the opened pouch and tray, and carried it out to the medication cart. The nurse (#5) disinfected the glucometer and the tray with a bleach wipe and placed the glucometer back on the pouch. The nurse failed to disinfect the glucometer prior to checking Resident #11's blood sugar. On 07/18/17 at 12:00 p.m., the nurse (#5) then carried the pouch/glucometer on a tray into Resident #12's room, checked his blood sugar, placed the glucometer back on the opened pouch and tray, and carried it out to the medication cart. The nurse disinfected the glucometer and the tray, placed the glucometer in the storage pouch, and zipped it closed. The nurse (#5) failed to disinfect the glucometer prior to checking Residnet #12's blood sugar. During an interview on 07/19/17 at 3:45 p.m., an administrative nurse (#1) stated she expected	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355039	A. BUILDING _____ B. WING _____	07/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRIGGS COUNTY CARE CENTER	1200 ROBERTS AVE NE COOPERSTOWN, ND 58425

(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 441	Continued From page 15 nursing staff to carry the glucometer into a resident's room on a tray and not the storage pouch, and to disinfect the glucometer before and after checking a resident's blood sugar. The facility failured to disinfect the glucometer after it laid in/on the pouch and before checking a resident's blood sugar. This practice has the potential to spread infection to other residents.	F 441		
F 456 SS=C	483.90(d)(2)(e) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION (d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. (e) Resident Rooms Resident rooms must be designed and equipped for adequate nursing care, comfort, and privacy of residents. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to ensure safe operating conditions for 2 of 2 laundry dryers in the laundry room. Failure to clean the lint accumulated from use of the dryers on a regular basis has the potential for fire. Findings include: Review of an untitled facility policy occurred on 07/19/17. This policy, dated 2001, stated, ". . . Dryers are maintained regularly to prevent excess build-up of lint in filter and exhaust ducts. . . ." A tour of the facility occurred on 07/19/17 at 2:20	F 456	F 456 1. Laundry personnel #8 was educated immediately by the Laundry supervisor on the importance of cleaning the lint trap on the dryer on a daily basis. All lint screens/vents/traps were cleaned immediately by employee #8 and the Laundry Supervisor. 2. All residents of the Griggs County Care Center have the potential to be affected. 3. A new policy was written 07/31/17 titled “Maintenance of Laundry Dryers”. An inservice was done for all Laundry staff on 8/4/2017. Education provided included reviewing the new policy and	8/24/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355039	A. BUILDING _____ B. WING _____	07/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRIGGS COUNTY CARE CENTER	1200 ROBERTS AVE NE COOPERSTOWN, ND 58425

(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 456	Continued From page 16 p.m. with an environmental manager (#7). Observation in the laundry room showed two large dryers and, upon removal of the vent covers, a thick layer of lint laid on the floor of both dryers. When asked how often staff removed the lint from the dryer vents, the manager (#7) and a laundry staff member (#8) stated they were unsure how often staff remove lint, and staff member (#8) stated he/she has never cleaned them.	F 456	informing staff of a new requirement of signing off on a checklist that the lint screens/vents/traps has been checked and cleaned daily. 4. Quality Assurance monitoring will be done by the Laundry department supervisor, or designee, to ensure that lint screens/vents/traps are cleaned appropriately on a daily basis and that documentation indicating completion of the task has been done. This QA monitoring will begin immediately following staff inservice 8/4/17 and will be done Monday-Friday every day x2 weeks, then 3x/week x2 weeks, then weekly x8 weeks, and then monthly x3 months. Any problems found will be immediately addressed by the Department Manager with any personnel involved. Results of all monitoring will be reviewed at the facility Quality Improvement Committee meetings and determination for continued further monitoring will be made by the Committee. 5. 8/24/17	