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	355111	A. BUILDING _____ B. WING _____	09/12/2019

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ST LUKES SUNRISE CARE CENTER	705 SE 4TH ST CROSBY, ND 58730

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F 000	INITIAL COMMENTS The Standard Medicare/Medicaid recertification survey started 09/09/19 and concluded 09/12/19.	F 000		
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 for Preadmission Screening and Resident Review (PASARR) and Level of Care Screening Procedures For Long Term Care Services, review of facility policy, and staff interview, the facility failed to complete a Resident Review (PASARR) for 1 of 1 sampled resident (Resident #25) with a diagnosis of major mental illness. Failure to complete the PASARR screening may result in the resident not receiving necessary psychiatric services.	F 644	1) Social Services will change their practice and make sure to do a PASARR when there is a significant change in the residents physical or mental condition. 2) Any resident who has a significant change in physical or mental condition has the potential to be affected. 3) Social work designee will be instructed on 10/10/2019 on the importance of doing	10/17/19

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

Electronically Signed | 10/04/2019

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F 644	Continued From page 1 Findings include: The North Dakota PASARR Provider Manual page 13 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 facility policy titled "PASRR [Preadmission Screening and Resident Review]" occurred on 09/12/19. This undated policy, stated, " . . . If the resident is diagnosed with a mental illness while in the center, the social worker will contact the designated state agency for a Level Two screening. . . ." Review of Resident #25's medical record occurred on all days of survey. The record identified Resident #25 was admitted to the facility in August 2011. The record showed he received a new diagnosis of anxiety and mood disorder in 2017, agitation, dementia with behavioral disturbance, and depression in 2018, and conduct disorder, personality disorder, and psychosis in 2019. The record lacked evidence facility staff completed a PASARR at the time of these diagnoses or any time thereafter.	F 644	a PASARR on resident #25 who had a significant change in mental condition, any other resident who has a significant change in physical or mental condition and was also instructed on the updated "PASARR" policy. This will be accomplished by Health Information Specialist or MDS Coordinator informing Social Services of any residents having a significant change in physical or mental condition. Resident #25 PASARR was submitted on 10/4/2019. 4) Social Work designee will monitor resident #25 and any other resident that has a significant change in physical or mental health that triggers a PASARR screening. Monitoring will be done weekly x 4, monthly x3 then quarterly x 1 year. Monitoring to begin on 10/07/2019. If concerns are identified, immediate corrective action will be implemented. Social work designee will submit a report of the monitoring results to the QA committee at each scheduled meeting. 5) 10/17/2019	

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F 644	Continued From page 2 During an interview on the morning of 09/12/19, a social services staff member (#9) confirmed facility staff failed to complete an updated Level I PASARR following Resident #25 new diagnoses.	F 644		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based record review, review of facility policy,	F 657	1)The interdisciplinary team (care plan	10/17/19

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F 657	Continued From page 3 and staff interview, the facility failed to review and revise the comprehensive care plan for 2 of 14 sampled residents (Resident #3 and #23). 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 facility policy titled "SNF [skilled nursing facility] Resident Care Planning" occurred on 09/12/19. This undated policy, stated, " . . . any revisions and/or additions will be done by [the] Interdisciplinary Team within the required time frame . . . the care plan will be reviewed and revised by the Interdisciplinary Team after each assessment and as needed. . . ." - Review of Resident #3's medical record occurred on all days of survey. The care plan, revised on 03/28/18, stated, ". . . Advance Directives: [Resident name] is a Code Level I [full code] per her medical record . . . Staff will respect my wishes. New staff will orient themselves to my advance directives. . . ." Review of Resident #3's physician orders, dated 04/03/19, stated, ". . . Change code status to DNR [do not resuscitate] . . ." During an interview on 09/12/19 at 9:00 a.m., an administrative nurse (#1) stated she would expect staff to update care plans to reflect residents current code status. The facility failed to review and revise Resident #3's care plan to reflect a change in code status	F 657	team) will change their practice and make sure care plans are reviewed, updated, and revises and also they will make sure on hospice residents we have the most current copy of the hospice care plan. 2)Any resident requiring a care plan review and any hospice resident who does not have ac current care plan on file has the potential to be affected. 3)The interdisciplinary team (care plan team)will be instructed on 10/11/2019 on the importance of updating all care plans to reflect the residents current status, the importance of making sure all hospice residents have a current care plan, and on the policy titled "Skilled nursing facility resident care planning". This instruction was for resident #3 and #23 and any other resident requiring care plan revisions or needing current care plans. Resident #3 care plans was updated on 9/11/2019 in regards to the code status and resident #23 has a current care plan on file from hospice as of 9/17/19. 4) MDS coordinator or designee will monitor resident #3 and #23 and any other residents for ensuring care plans are updated and hospice care plans are current and on file. Monitoring will be done weekly x4, monthly x3 then quarterly x 1 year. Monitoring to begin 10/07/2019. If concerns are identified, immediate corrective action will be implemented. MDS coordinate will submit a report of the monitoring results to the	

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F 657	Continued From page 4 from a full code I to do not resuscitate. - Review of Resident #23's medical record occurred on all days of survey. The current care plan, identified, ". . . I am on hospice for my end of life wishes . . . . Work cooperatively with hospice team to ensure my spiritual, emotional, intellectual, physical and social needs are met. . . ." During an interview on 09/11/19 at 8:45 a.m., when asked what services Hospice staff were providing, an administrative nurse (#1) located a copy of the May 15-August 12, 2018 Certification for Hospice Benefit and Plan of Treatment. Resident 23's medical record failed to contain a copy of more recent and/or the current Hospice care plan. The administrative nurse (#1) confirmed Resident #23's medical record should contain a copy of the most recent Hospice care plan to ensure facility staff are able to collaborate/coordinate services. 2/14 with out updates regarding advanced directives and hospice Resident #23	F 657	QA committee at each scheduled meeting. 5) 10/17/2019	
F 686 SS=G	FTag Initiation Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with	F 686		10/17/19

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F 686	Continued From page 5 professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record review, policy review, resident and staff interview, the facility failed to provide the necessary care and services to prevent/minimize the potential for the development of a pressure ulcer for 1 of 1 sampled residents (Resident #30) with a pressure ulcer. Failure to identify/report a skin injury in a timely manner and thoroughly assess and appropriately treat the injury, resulted in Resident #30 experiencing increased pain/discomfort after her wound was aggravated by the therapy applied. the wound being aggravated by the inappropriate treatment applied by the staff, resulting in the wound increasing in size and causing the resident additional pain/discomfort. Findings include: Review of the facility policy titled "Skin Assessment" occurred on 09/12/19. This undated policy, stated, ". . . The Charge Nurse has the primary responsibility for monitoring and ensuring appropriate and timely skin care . . ." Review of the facility's Certified Nursing Assistant	F 686	1) Nursing staff including CNA's will change their practice and make sure if a resident complains of pain or a blister/wound is noted on a resident he/she will report it to the nurse in a timely manner. The nurse will thoroughly assess the site/skin at which the residents complains of the pain, thoroughly investigate the reason why the resident has a wound/blister, and treat the wound/blister appropriately. 2) Any resident who experiences pain or has a wound/blister in a certain location has the potential to be affected. 3) Nursing staff including CNA's will be instructed on 10/10/2019 on the Certified Nursing Assistant Job Description as it states the CNA will check for reddened areas or skin breakdown and report to the nurse, the policy titled " Skin Assessment", The new policy titled " Documentation Standards for Wounds in Long-Term Care, the correct way to fill out an investigation report, nurses educated on making sure if resident does	

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F 686	Continued From page 6 Job Description occurred on 09/12/19. This document dated, 06/01/17, stated, "Job Title: Skilled nursing facility Certified Nursing Assistant . . . Checks for reddened areas or skin breakdown and reports to Registered Nurse [RN] or Licensed Practical Nurse [LPN] . . ." Review of Resident #30's medical record occurred on all days of survey. Resident #30's weekly skin observation showed: * 05/31/19, " . . . Resident skin is intact . . ." * 06/01/19, " . . . intact with indention on right sole/heel. Noted pain . . ." Progress notes showed: * 06/01/19 at 22:49 p.m., " . . . Resident was complaining of pain on her ankle toward her heel. Skin is intact with indention on right sole/heel . . . Warm compress applied initially. Cold compress after . . . Tylenol was given at HS [bedtime] . . ." * 06/02/19 at 00:22 a.m., " . . . Still with pain on right ankle and heel noted . . ." * 06/02/19 at 00:53 a.m, " . . . fluid filled blister under right heel . . ." This is the first indication in the record facililty staff identified a blister on Resident #30's heel. * 06/02/19 at 04:39 a.m., " . . . [Tylenol] Ineffective, Resident stated "It's (sic) still feels sore when I step on it" Follow up Pain Scale was 8 . . ." * 06/02/19 at 01:02 p.m., " . . . I will send e-mail to nursing staff to educate about use of hot packs with towel . . ." This is the first indication a hot pack had been applied to the blistered area. * 06/03/19 at 10:52 a.m., " . . . Late entry . . . After speaking with all those involved with [Resident #30's] direct care the past couple days,	F 686	complain of pain in a certain are we assess the area thoroughly before we do an intervention, the importance of assessing pain prior to treatments and notify provider if additional pain treatment may be needed, and also to make sure if you do any staff education that you have them sign in and take notes. 4) Director of Nursing or Designee will monitor any new skin issues that arise to ensure that wound was reported timely, treated and assessed correctly, pain is assessed, and investigation of wound area is filled out correctly. Monitoring will be done weekly x4, monthly x3 then quarterly x 1 year. Monitoring to begin on 10/07/2019. If concerns are identified, immediate corrective action will be implemented. Director of Nursing will submit a report of the monitoring results to the QA committee at each scheduled meeting. 5) 10/17/2019	

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F 686	Continued From page 7	F 686		

it is noted CNA [#6] noticed fluid filled blister before any heating was applied. Felt blister before notifying nurse about pain . . ." The CNA (#6) failed to report the injury to a registered nurse or licensed practical nurse as outlined on the CNA job description.
* 06/04/19 at 18:58 p.m., " . . . Resident complained of pain to touch on right ankle. Resident stated "It's like radiating down to the heel . . ."

Weekly skin observation showed:
* 06/07/19, " . . . Right heel . . . open blister . . . 6.2 x 8 cm . . ."

The progress notes showed:
* 06/18/19 at 08:45 a.m., " . . . Please ask resident if they are experiencing any level of pain every day and evening shift for observation of pain right foot/heel pain due to blister . . ."
* 06/18/19 at 04:41 p.m., " . . . Dressing changed to right heel . . . c/o (complains of) pain when touched . . ."

Physician orders dated 06/19/19, stated, " . . . Tylenol Tablet (Acetaminophen) Give 500 mg by mouth four times a day related to pain, unspecified . . ." (This is an increase from the 05/01/19 order of Tylenol three times a day). The progress notes and current order reflect an increase in pain following development of blister/pressure ulcer.

Progress note showed:
* 06/29/19 at 04:42 p.m., " . . . Wound to right heel . . . 4.8 cm wide by 2.5 cm high . . ."

Weekly skin observation showed:

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F 686	Continued From page 8 * 07/01/19, " . . . heel, right . . . Full Thickness . . . Pressure ulcer - Unstageable . . . 2.50 X 4.60 . . . Facility Acquired . . ." Progress note showed: * 07/01/19 at 02:17 p.m., " . . . Resident seen by wound care nurse and RN . . ." Weekly skin observation showed: * 07/17/19, " . . . Right heel . . . Pressure . . . 4.5 CM X 2.2 CM . . .Unstageable . . ." * 08/30/19, " . . . Right heel . . . Pressure . . . 1.7 X 3.4 . . . Stage 3 . . ." A physician note, dated 09/10/19, stated, " . . . right heel wound . . . has potential for total resolution but will take additional weeks to months to completely heal . . ." Review of the undated, unsigned facility internal investigation occurred on 09/11/19. The investigation stated: * " . . . Spoke with CNA [#6] about her assistance with resident [#30] yesterday evening . . . Resident [#30] reported she had foot pain. CNA [#6] notified floor nurse [#3] . . . nurse [#3] delegated to [CNA#6] to apply a heating pad . . . she [CNA #6] applied a heating pad to [Resident #30's] right foot . . . * After speaking with CNA [#7] . . . he reports he noted a small blister on her [Resident #30's] right heel. He states this was noted by him before nurse [#3] was notified and before any heat was applied. When asked if he notified nurse [#3] about [the] blister he replied "No, she was notified about the pain and she went to go look at the foot . . . * Nurse[#3] resorts (sic) she was notified by CNA	F 686		

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F 686	Continued From page 9 [#6] that resident [#30] complained of pain . . . she [nurse#3] replied she did not look under [Resident #30's] foot and at the heel. Reports she asked CNA [#6] to apply heat to the area . . ." The nurse failed to thoroughly assess Resident #30's heel, and directed CNA staff to apply an inappropriate treatment (heating pad without a cover). * ". . . Provided education to staff on notifying nurse on what resident reports and what is visually noted to ensure nurse is notified thoroughly. Provided education to nurses about the importance of a full assessment before beginning interventions. Explained, for future instances, begin with applying heat blankets vs. heat pads. Educated staff about proper pressure relief . . ." During an interview on the morning of 09/10/19, Resident (#30) stated, "I was burned by a heating pad without a cover . . . [a CNA] put a heating pad on my heel without anything between the [heating] pad and [my]heel . . ." During an interview on 09/11/19 at 11:14 a.m., a staff physical therapist (#4), stated, " . . . heat would not be appropriate for a blister. . . ." During an interview on the morning of 09/12/19, nurse (#2), stated she conducted the internal investigation. She stated that staff education was provided to CNAs and/or nurses. CNAs were instructed to notify nurses of what they note along with pain so that the nurse can assess the resident. Nurses were instructed to do a full assessment of the resident. In the future staff are to use a warm blanket and if more heat is needed to have physical therapy or a nurse stay with the	F 686		

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F 686	Continued From page 10 resident. Nurse (#2), assigned to investigate this incident, failed to identify the dates/times she interviewed and educated staff, failed to identify who was in attendance at each inservice, and failed to date/sign her final investigation. During an interview on 09/12/19 at 02:50 p.m., an administrative nurse (#1) stated, "I would expect the CNA to report pain and a blister if the blister was observed. I would expect the nurse to assess the entire foot including the heel." The facility staff failed to: * report the injury to an RN or LPN in a timely manner, * thoroughly assess Resident #30's heel, * appropriately treat the blister on her heel, and * thoroughly investigate the cause/worsening of the injury. These failures resulted in the wound being aggravated by the inappropriate treatment applied by the staff, resulting in the wound increasing in size and causing the resident additional pain/discomfort.	F 686		
F 801 SS=D	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e) This includes:	F 801		10/17/19

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F 801	Continued From page 11 §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services who- (i) For designations prior to November 28, 2016,	F 801		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355111	A. BUILDING _____ B. WING _____	09/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 801	Continued From page 12 meets the following requirements no later than 5 years after November 28, 2016, or no later than 1 year after November 28, 2016 for designations after November 28, 2016, is: (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is not met as evidenced by: Based on staff interview, the facility failed to ensure the dietary manager received the necessary education to obtain the required qualifications to hold the director of food and nutrition for 1 of 1 dietary manager (#5). Failure to ensure qualified staff with the appropriate competencies and skill sets to carry out the functions of the food and nutrition services has the potential to result in foodborne illness to residents, staff, and visitors. During a interview on 09/09/19 at 02:45 p.m., a dietary manager (#5) stated, "I have started the process of getting my CDM [certified dietary manager]."	F 801	1)The Dietary Manager will be instructed on 10/10/2019 on the importance of receiving the necessary education to hold the Dietary Manager position. 2)Any dietary manager that does not have the correct education has the potential to be affected. 3)The current dietary manager is enrolled in the master certified food executive course and will be completed on 10/11/2019. The dietary manager has been enrolled in the CDM course online since July, 2019.	

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F 801	Continued From page 13 Upon request on 09/12/19, the facility failed to provide evidence of staff member (#5) completing the required education of a CDM, a certified food service manager, or a national certification for food service management and safety from a national certifying body. The facility failed to provide the necessary training in food and nutrition services to carry out daily operation duties.	F 801	4) The consultant dietician or designee will monitor the dietary manager weekly x4, monthly x3, then quarterly x 1 year to ensure the progress is being made in the CDM course along with obtaining the CDM certification. Monitoring to begin on 10/07/2019. If concerns are identified immediate corrective action wil be implemented. Consultant Dietician will submit a report of the monitoring results to the QA committee at each scheduled meeting. 5)10/17/2019	
F 812 SS=E	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.	F 812		10/17/19

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F 812	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to serve foods in a safe and sanitary manner for 1 of 2 meals observed (09/09/19 and 09/10/19). Failure to follow proper food handling and food service safety guidelines may result in contamination of food and foodborne illnesses. Findings include: Review of the facility policy titled "Sanitation - Gloves" occurred on 09/11/19. This undated policy stated, ". . . Gloves are to be changed . . . Before handling 'ready to eat' foods . . . When coming in contact with something that is contaminated . . . Do not use food contact gloves for non-food tasks . . . Remember, gloves are used to protect the consumer from cross contamination . . ." Observation on 09/09/19 at 05:35 p.m., showed a dietary staff member (#8) wore gloves while she plated food for meal service. The dietary staff member (#8) touched residents' diet cards, a microwave control panel and handle, and opened a soup can while she wore the same pair of gloves. She then handled ready-to-eat foods for residents without changing her gloves. During an interview on 09/12/19 at 9:00 a.m., an administrative nurse (#1) stated she expected dietary staff to change contaminated gloves prior to handling ready-to-eat foods.	F 812	1) The Dietary Department will change their practice and will make sure if they are going to handle ready to eat foods for residents that they change their glove and was their hands. 2) Anyone who eats at our facility both staff and residents have the potential to be affected by a food borne illness. 3) Dietary Manager and Dietary Staff will be instructed on 10/10/2019 by the Dietician on the policy titled "Sanitation-Gloves". Staff will instructed on the proper use of gloves and when to wear them and not wear them. 4) The dietary manager will monitor appropriate glove use. Monitoring will be done weekly x 4, monthly x3, then quarterly x 1 year. Monitoring will start on 10/07/2019. If concerns are identified immediate corrective action will be implemented. Dietary Manager will submit a report of the monitoring results to the QA committee at each scheduled meeting. 5) 10/17/2019	