STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355069	A. BUILDING _____ B. WING _____	01/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVENTIDE HEARTLAND	**620 14TH AVE NE DEVILS LAKE, ND 58301**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The standard Medicare/Medicaid recertification survey started on 01/15/19 and concluded 01/17/19.	F 000		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident	F 565		2/21/19

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

Electronically Signed | 02/11/2019

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F 565	Continued From page 1 representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on Resident Council interview and review of Resident Council Meeting Minutes, the facility failed to act upon grievances expressed by 7 of 9 residents (Resident A, C, E, F, G, H, and I) attending the Resident Council interview. Failure to act upon the grievances regarding the answering of call lights in a timely manner, resulted in the residents' continued dissatisfaction. Findings include: Review of Resident Council Meeting identified the following: * 12/04/18: "Nursing . . . asked how the call lights have been lately and residents say they can still be slow sometimes . . ." * 01/02/19, stated, ". . . Call light wait time-night shift . . . Leaving residents in bathroom too long . . ." During the Resident Council interview on 01/16/19 at 3:20 p.m., seven of the nine residents present (Resident A, C, E, F, G, H, and I) agreed facility staff failed to address concerns with answering call lights in a timely manner and/or ignoring the call lights. These residents, all identified as interviewable by the facility, stated this unresolved concern had been voiced at previous council meetings. The residents made the following statements: * Resident A: Waited for over an hour and a half	F 565	F565 1. Corrected Action a. Resident council grievances related to call lights and progress towards resolution of those grievances will be discussed at resident council. All grievances, including Call light grievances, identified by the Resident council will be documented on an Eventide Grievance form and the resolution will be brought back to the Council at the next meeting and reviewed. 2. identify other residents affected a. All residents who use their call lights have the potential to be affected. 3. Measure implemented to address deficient practice. a. Social Service worker or designee will document resident grievances discussed at resident council regarding call light times. Progress towards resolutions related to call light grievances will be documented and reviewed at next resident council. All staff education given on 2/8/19 4. Audits and QA review of audits a. Random call light Audits and Resident interviews will be conducted 5 X per week X 4 weeks, 2 X per week X 4 weeks then 1 X per week Quarterly X 3. Resolution of Grievances from Resident council will be reviewed with residents 1 x monthly x 12 months. All audits to be	

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F 565	Continued From page 2 for staff to answer the call light for an assist off the commode and weekends were the worst for short staffing. * Resident C: Several times had waited almost an hour or longer to get staff to answer the call light, especially at night. * Resident E: Waited at least an hour for the staff to answer the call light on the night shift and staff all go on break at the same time. * Resident F: Waited several times over an hour on evening shift for a whirlpool bath. When the resident questioned nurse, the resident was told the assigned staff member had already went home due to their shift being over and not having enough time for resident's bath. * Resident G: Waited for long periods of time for staff to answer the call light and stated, "They leave me on the pot and forget to come answer my call light." * Resident H: "Before dinner and supper there is no one on the floor to assist us to the bathroom if we need it because they are feeding in the dining room. Then we wait a long time for our call lights to be answered." * Resident I: Waited an hour and a half for staff to answer the call light and stated, "That's a long time when you need to use the bathroom." During an interview on the morning of 01/17/19 at 11:07 a.m., Resident G stated, "They left me on the toilet again last night for an hour and a half. It was about 11:00 p.m." During an interview on 01/17/19 at 12:25 p.m., an administrative nurse (#1) indicated the facility lacked a policy regarding call lights. The facility failed to make prompt efforts to	F 565	reviewed for effectiveness at monthly Quality Assurance Committee. 5. Substantial compliance will be achieved on or before February 21st.	

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F 565	Continued From page 3 resolve grievances and to keep the residents appropriately informed of progress towards a resolution.	F 565		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas;	F 584		2/21/19

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F 584	Continued From page 4 §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure the cleanliness of Resident #54's wheelchair on 3 of 3 days of survey (January 15-17, 2019) and 1 of 1 sampled resident's (Resident #64) private bathroom. Failure to ensure personal care equipment and private spaces are kept clean does not provide a comfortable living environment for the residents. Findings include: - Observation on all days of survey showed Resident #54's wheelchair arms, seat, sides, and foot pedals to be visibly soiled food. - Observation on 01/16/19 at 11:19 a.m. showed two unidentified certified nursing assistants (CNAs) performed perineal cares on Resident #64, who was incontinent of stool. During cares, stool fell onto the bathroom floor and the toilet seat. The CNAs took Resident #64 to go to the dining room and failed to clean the stool off the floor and the seat of the toilet. During an interview on 01/17/19 at 10:45 a.m., an administrative nurse (#7) stated night staff cleaned wheelchairs the night before a resident's scheduled bath day. She confirmed staff should have cleaned Resident #54's wheelchair Monday	F 584	F584 1. Corrected Action a. Resident #54 Wheelchair was cleaned. b. Resident #64 toilet seat and floor were cleaned. 2. identify other resident affected a. All residents have the potential to be affected. 3. Measure implemented to address deficient practice. a. Resident□s wheel chairs will be cleaned according to bath Schedule the night before scheduled bath. All nursing staff education to be provided on 2/8/19 b. Soiled bathroom surfaces to be cleaned immediately after meeting resident direct care needs. All nursing staff education to be provided on 2/8/19 4. Audits and QA review of audits a. Director of Nursing or designee will audit cleanliness of wheel chairs 5 x weekly 10 wheel chairs each day x 2 months, then 4 x weekly 10 wheel chairs each day x 1 month, then 3 x weekly x 10 wheel chairs each day x 1 month, then 2 x weekly x 10 chairs each day x 1 month, than 2 x weekly x 5 chairs each day x 2 months, than 1 x weekly x 5 chairs x 1	

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F 584	Continued From page 5 night according to his bath schedule. She also stated she expected staff to clean any visibly soiled resident items when providing cares.	F 584	month. All audits to be reviewed for effectiveness at monthly Quality Assurance committee. b. Director of Nursing or designee will audit bathroom surfaces for cleanliness 5 x weekly x 10 bathrooms each day x 2 months, then 4 x weekly x 10 bathrooms each day x 1 month, than 3 x weekly x 10 bathrooms each day x 1 month, then 2 x weekly x 10 bathrooms each day x 1 month, then 2 x weekly x 5 bathrooms each day x 1 month, then 1 x weekly x 5 bathroom each x 2 month. All audits to be reviewed for effectiveness at monthly Quality Assurance Committee. 5. Substantial compliance will be achieved on or before February 21st.	
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	F 657		2/21/19

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F 657	Continued From page 6 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: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 02/15/18. Based on observation, record review, review of facility policy, resident interview, and staff interview, the facility failed to review and revise the comprehensive care plan to reflect the residents' current status for 4 of 18 sampled residents (Resident #36 and #76). Failure to revise the care plans limited staff's ability to communicate care needs and ensure continuity of care for each resident. Findings include: Review of the facility policy titled "Care Plans" occurred on 01/17/19. This policy, revised September 2017, stated, "Purpose: To develop a person-centered care plan in conjunction with the Interdisciplinary team and resident/resident representative that reflects the actual care, condition, and preferences of each resident . . . must include . . . Medical Condition/Diagnosis . . . Care plans will be updated and changes will be made as they occur to ensure the most current care plan for the resident . . ."	F 657	F657 1. Corrected Action a. Resident # 36 Care plan updated to reflect resident now has a reclining back wheel chair per Occupational therapy on 2/8/19 OT continues with follow up visits for positioning. b. Resident # 76 care plan was updated to reflect diagnosis of diabetes mellitus and ordered treatment to provide continuity of care. 2. identify other resident affected a. All resident who use wheel chairs with one-sided weakness have the potential to be affected. b. All resident with diabetes mellitus have the potential to be affected by this practice. 3. Measure implemented to address this practice. a. All residents with one-sided weakness who use wheelchairs will be assessed by rehab RN for proper seating in wheel chair. These residents will also be assessed on a quarterly basis and as needed for continued proper seating and interventions will be implemented as	

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F 657	Continued From page 7 - Review of Resident #36's medical record occurred on all days of the survey. The medical record included the following diagnosis: hemiplegia affecting left nondominant side, dementia, and traumatic brain injury. The current care plan stated, " . . . left sided weakness . . ." Resident #36's occupational therapy evaluation note, signed and dated 08/17/18, stated, "Left sided hemiparesis. Pt [patient] has no AROM [active range of motion] of his left UE [upper extremity]. . . ." Resident #36's physical therapy evaluation note, signed and dated 08/17/18, stated, "Muscle tone = flaccid left UE . . ." Observation of Resident #36 on all days of survey showed resident sitting in wheelchair and leaning to his extreme left. Resident #36's care plan failed to include interventions for positioning in wheelchair. During an interview on the morning of 01/17/19, an administrative nurse (#1) agreed Resident #36's care plan failed to address interventions for positioning the resident in the wheelchair. - Review of Resident #76's medical record occurred on all days of survey. Diagnosis included Type 2 diabetes mellitus. The current physician's order stated, ". . . Check blood sugar three times a day . . . Give NovoLog Insulin 15 units with meals and Lantus Insulin 75mg (milligram) at bedtime . . ." The care plan failed to address Resident #76's diabetes mellitus and lacked goals and interventions for staff to follow	F 657	needed. All nursing staff education to be provided on 2/8/19 b. All residents with diabetes mellitus have care planned goals and interventions. All current residents and new admission with diabetes Mellitus diagnosis will have care plan goals and intervention to provide continuity of care. 4. Rehab RN or designee will audit 5 residents for proper seating 3X a week for one month, 2X biweekly for 2 months and 1X quarterly for 1 year. a. Director of Nursing or designee will audit Care plans for Diabetes Mellitus on all current residents x 1 and 1 x quarterly x 1 year. Will audit all new admission for diabetes care plan x 2 months, then will audit 4 admission monthly x 2 months, then will audit 3 admission x 2 months, then will audit 2 admission x 2 months. . All audits to be reviewed for effectiveness at monthly Quality Assurance Committee. 5. Substantial compliance will be achieved on or before February 21st.	

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F 657	Continued From page 8 to ensure continuity of care.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to clarify and follow orders for 1 of 1 sampled resident (#64) who wore an ankle foot orthosis (AFO) brace. Failure to clarify and follow orders may result in adverse health effects. Findings include: Observations on 01/16/19 showed Resident #64 wore an AFO brace on her right foot/ankle throughout the day. Review of Resident #64's medical record occurred all days of survey. A "Therapy/Nursing Communication Note," dated 12/18/18, stated, "Discontinue use of AFO until edema & wound to R [right] ankle are resolved. . . ." Resident #64's current care plan stated, "ADLS [activities of daily living]/MOBILITY DEFICITS . . . Resident wears AFO brace to right foot/ankle for all transfers. . . ." The record lacked a physician's order for an AFO. During an interview on 01/16/19 at 4:00 p.m., an administrative nurse (#6) confirmed Resident #64 lacked a physician's order for the AFO and the	F 658	F658 1. Corrected Action a. Physician order received for Resident #64 to utilize AFO to lower left extremity. 2. identify other resident affected a. All resident with orthotic devices have the ability to be affected. 3. Measure implemented to address deficient practice. a. Resident with orthotic devices will have their chart reviewed to ensure physician orders are in place. All OT recommendations will be given to Rehab RN whom will obtain physician order. All nursing staff education to be provided on 2/8/19 4. Audits and QA review of audits b. Director of Nursing or designee will audit OT recommendation 1x weekly x 8 months in Medicare meeting. All audits to be reviewed for effectiveness at monthly Quality Assurance Committee. 5. Substantial compliance will be achieved on or before February 21st.	2/21/19

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F 658	Continued From page 9 facility failed to follow the order from occupational therapy.	F 658		
F 677 SS=E	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, review of facility policy, and staff interview, the facility failed to assist with activities of daily living (ADLs) for 5 of 11 sampled residents (Resident #22, #32, #54, #64, and #72) who required staff assistance for grooming and personal cares. Failure to provide assistance to residents who cannot perform the task independently may result in decreased self-esteem and poor grooming and hygiene. Findings include: PERINEAL CARES Review of the facility policy titled "Perineal Care" occurred 01/17/19. This policy, revised 05/13, stated, "Refer to Perry & Potter Clinical Nursing Skills & Techniques." "PROCEDURAL GUIDELINE 18.1 Perineal Care . . . Perineal care for a female: . . . Wash labia majora. . . . Clean thoroughly over labia minora, clitoris, and vaginal orifice. . . . Clean from perineum to rectum [front to back]. . . . For perineal care for a man: . . . If patient is uncircumcised, retract foreskin. . . . Wash tip of penis at urethral meatus first. Using circular motion, clean from meatus outward. . . ."	F 677	F677 1. Corrected Action a. Resident #22 Education was given to staff on proper peri Cares. b. Resident # 32 Education was given to staff on proper peri Cares. c. Resident # 54 Education was given to staff on proper peri Cares. d. Resident # 64 Education was given to staff on proper peri Cares. e. Resident # 72 Education was given to staff on proper peri Cares. 2. identify other resident affected a. All residents who are incontinent and dependent of staff for peri cares have the potential to be affected. 3. Measure implemented to address deficient practice. a. Perineal Care policy and Standard of Care policy to be reviewed with all nursing staff on 2/8/19. 4. Audits and QA review of audits c. Director of Nursing or Designee will audit peri cares on incontinent residents. 25 residents weekly x 2 months, then 15 resident weekly x 2 months, then 10 residents weekly x 2 months, then 5	2/21/19

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F 677	Continued From page 10 - Observation on 01/15/19 at 11:41 a.m. showed a certified nursing assistant (CNA) (#4) assisted Resident #22, who was incontinent of stool, to the toilet to perform perineal cares. - Observation on 01/16/19 at 8:59 a.m. showed a CNA (#5) transferred Resident #32, who was incontinent of stool, to the toilet to perform perineal cares. - Observation on 01/15/19 at 3:08 p.m. showed CNAs (#2 and #3) performed perineal cares for Resident #54 who was incontinent of urine. - Observation on 01/16/19 at 11:19 a.m. showed two unidentified CNAs transferred Resident #64, who was incontinent of stool, to the toilet to perform perineal cares. The above observations identified facility staff failed to perform adequate perineal cares for Resident #22, #32, #54, and #64 as per facility policy. - Observation on 01/15/19 at 4:15 p.m. showed a CNA (#13) entered Resident #72's room. The resident was seated in his recliner with his pants/brief down around ankles. The CNA asked Resident #72 if he had just taken himself to the bathroom, and he stated "yes." Observation showed the resident's brief was wet. The CNA stated, "We should go to the bathroom, you have wet pants." Resident #72 stood, and the CNA pulled up his pants/brief and ambulated with him to the bathroom. Observation showed a smear of stool on the recliner cushion. The CNA put on gloves and changed the resident's brief in the bathroom, but failed to provide assistance with	F 677	residents weekly x 2 months. All audits to be reviewed for effectiveness at monthly Quality Assurance Committee. 5. Substantial compliance will be achieved on or before February 21st. Second Part 1. Corrected Action a. Resident #32 with facial was removed. 2. identify other resident affected a. All residents with unwanted facial hair have the potential to be affected. 3. Measure implemented to address deficient practice. a. Nursing staff re-educated on the standards of care policy regarding facial hair. All nursing staff education will be provided on 2/8/19 4. Audits and QA review of audits d. Director of Nursing or Designee will audit residents for presence of facial hair. 25 residents weekly x 2 months, then 15 resident weekly x 2 months, then 10 residents weekly x 2 months, then 5 residents weekly x 2 months. All audits to be reviewed for effectiveness at monthly Quality Assurance Committee. 5. Substantial compliance will be achieved on or before February 21st.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVENTIDE HEARTLAND	**620 14TH AVE NE DEVILS LAKE, ND 58301**

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F 677	Continued From page 11 perineal care. The CNA then washed her hands. During an interview on 01/17/19 at 10:45 a.m., an administrative nurse (#7) stated she expected staff to perform perineal care according to facility policy. GROOMING Review of the facility policy titled "Standards of Care" occurred on 01/17/19. This policy, revised 10/16, stated, "Faces are to be kept free of facial hair [unless a male resident has a beard or mustache]. . . ." Observations on 01/15/19 and 01/16/19 showed Resident #32 with visible hair on her face. During an interview on 01/16/19 at 4:00 p.m., an administrative nurse (#6) stated she expected staff to offer shaving to both male and female residents.	F 677		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by:	F 679		2/21/19

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F 679	Continued From page 12 Based on observation, review of facility policy, record review, and staff interview, the facility failed to provide individualized, meaningful activities for 1 of 1 sampled resident (Resident #21) observed for activity participation in the Special Care Unit (SCU). Failure to develop and implement an activities program to meet the interests of residents may result in decreased well-being and affects all residents residing in the SCU. Findings include: Review of the facility policy titled "Activity Programming" occurred on 01/17/19. This policy, revised May 2017, stated, ". . . The Activity Program provides individualized physical, intellectual, social, spiritual, and emotional challenges in a planned, structured, and coordinated manner while still allowing spontaneity and flexibility. Activity programming will include individual resident specific programs, resident groups, unit specific groups, etc. . . ." Review of the facility policy titled "Activity Visits - One to One" occurred on 01/17/19. This policy, revised May 2017, stated, ". . . Purpose: To offer one to one activities to residents who have decreased attendance in group activities or their participation level has decreased to a passive participant. . . . If the resident attends group activities but are non-responsive or a spectator he/she will be assessed for one to one activity visits or other small group activities that are appropriate. . . ." Observation in the SCU on all days of survey showed no activity calendar posted. A staff	F 679	F679 1. Resident 21□s Activity Care Plan was reviewed and adjusted to reflect individual preferences by family/staff interviews and the Therapeutic Recreation Assessment. Both individualized and group activities were added to Resident 21□s Activity Care Plan. A Memory Care Unit Activity calendar was created and posted in the Unit for Resident review. 2. Director of Life Enrichment or designee will update all Memory Care residents Activity Care Plans with individualized and group activities 3. Director of Life Enrichment or designee will complete a Therapeutic Recreation Assessment initially and on a quarterly basis to reflect all Memory Care Residents current needs. Activity staff will lead both group and individual activities identified on the MCU monthly calendar. All staff (Nursing, dietary and activities) will encourage participation and assist the residents with their attendance in activities. Activities staff will document residents□ participation in daily and evening activities. All residents not participating in 3 or more scheduled group activities will have a one on one form completed monthly for individualized activities. Individual activities will be available at all times that residents are alert and able to participate. 4. Audits will be done Quarterly X 4 of the Memory Care Residents Activity Care Plan and Therapeutic Recreation Assessments. Audits will be done monthly X 12 for Activity participation. All Audits	

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F 679	Continued From page 13 member stated they do not have a specific SCU activity calendar. Review of Resident #21's medical record occurred on all days of survey. Diagnoses included dementia with behavioral disturbance. The record identified a therapeutic recreation assessment, completed upon admission in April 2018. The last documented one to one visit occurred on 11/09/18. Resident #21's current care plan stated, "ACTIVITIES: resident is new to facility and adjusting to new environment. Resident is not able to plan own leisure time and staff must anticipate his need [sic] daily. Resident is in memory care unit," and included the following interventions initiated on 04/30/18: *Family visits daily *Haircut with barber monthly (he is here the 3rd Monday of each month unless otherwise posted) or as needed *It is very important to resident to be able to use the telephone in private *It is very important to resident to be around animals such as pets *It is very important to resident to engage in spiritual activities including but not limited to Worship with communion, devotions, hymn sing, bible study *It is very important to resident to go outside to get fresh air when the weather is good *It is very important to resident to have a family member or close friend involved in discussion about his care here *It is very important to resident to have a place to lock up his things to keep them safe *It is very important to resident to have snacks	F 679	and the monthly Activity calendar will be submitted to the QA committee for review and comment. 5. February 21, 2019	

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F 679	Continued From page 14 available between meals *It is very important to resident to keep up with the news *Resident likes to be outside working when it is nice out (initiated 05/15/18) Resident #21's care plan lacked individualized activities specific to his interests and designed to meet his needs and enhance his well-being. Observation on 01/16/19 at 10:30 a.m. showed a small group of residents participated in exercises while Resident #21 dozed nearby in a chair. Observation in the SCU on the afternoons of 01/15/19 and 01/16/19 showed no group or individual activities available. A movie played on a TV and a radio played near the dining room. Resident #21 dozed off and on throughout both afternoons. During an interview on 01/17/19 at 10:11 a.m., an activities staff member (#14) stated they do not have a regular afternoon/evening activities staff for the SCU. The staff member stated activities staff from the other units try to get to the SCU to conduct activities. The staff member agreed Resident #21's care plan lacked individualized activities and updates.	F 679		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in	F 684		2/21/19

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F 684	Continued From page 15 accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of a professional reference, and staff interview, the facility failed to ensure appropriate positioning for 3 of 15 sampled residents (Resident #12, #18, and #36) observed while seated in a rock-n-go/wheelchair. Failure to properly position Resident #12 in a rock-n-go wheelchair during meal time has the potential to negatively affect swallow/safety and increase the risk of aspiration. Failure to provide assistance and properly position Resident #18 and #36's upper body in their wheelchair, placed both residents at risk for falls/safety and/or discomfort. Findings include: Review of the facility policy titled "Aspiration Pneumonia, Identification & Prevention Protocol" occurred on 01/17/19. This policy, dated February 2016, stated, ". . . Encourage residents to consume all food, beverages, and medications when in an upright position . . ." Swigert's "The Source for Dysphagia," 3rd ed., Pro-Ed, Inc., Texas, 2007, pages 9, 10, 125, and educational handouts, identified, ". . . Signs and Symptoms of Dysphagia . . . coughing . . . during a meal . . . Some patients cough and choke when they aspirate . . . During the oral intake of . . . food and/or liquids, it is optimal for a patient to be seated at a 90 degree angle, whether in bed or in a chair. . . . Even a slightly reclined position while eating greatly increases the risk of premature	F 684	F684 1. Corrected Action a. Resident # 12 Care plan updated to reflect residents rock and go to be at 90 degree while eating. b. Resident # 18 OT treating resident to address leaning while in wheel chair. c. Resident # 36 OT treating resident to address leaning while in wheel chair 2. identify other resident affected a. All resident to be seating at a 90 degree position while eating. 3. Measure implemented to address deficient practice. a. All resident to be seating at a 90 degree position while eating. Nurse will to observe for proper positioning at meal times. All staff to be educated on 2/8/19 b. Resident who need assistance with positioning will be assessed by OT if leaning in wheel chair is noted. Residents with impaired upper body strength to be assessed quarterly and PRN by rehab nurse. OT order will be obtained when needed. All staff to be educated on 2/8/19 4. Audits and QA review of audits e. Director of Nursing or designee will audit residents on thickened liquids at meal times for 90 degree position in wheel chair. 10 residents weekly x 2 months, then 5 residents weekly x 2 months, then 5 resident biweekly x 2 months, then 5 residents monthly x 1	

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F 684	Continued From page 16 loss of food over the back of the tongue. . . ." - Review of Resident #12's medical record occurred on all days of survey. Diagnoses included dysphagia and respiratory infection. The current physician's orders identified, ". . . regular diet, pureed texture, pudding thick consistency . . ." The current care plan identified, ". . . Aspiration precautions: Res. [resident] to remain upright in chair for 45 minutes after all meals, head of bed to remain elevated 45 degrees during waking hours and to be elevated 30 degrees at noc [night]. . . . Dining room for all meals. Requires supervision/occasionally cueing to extensive assist varying from day to day. Pudding thick fluids; She is able to independently consume her fluids when served in a bowl. May need to occasionally assist or provide encouragement and cueing . . ." Observation on 01/15/19 at 11:50 a.m. showed Resident #12 in a rock-n-go wheelchair leaned back at approximately a 150-degree angle feeding his/her self while coughing. An unidentified staff member tilted the wheelchair up to about a 120-degree angle. The resident continued to feed his/herself and cough. At 12:10 p.m. an unidentified certified nurse aide (CNA) assisted Resident #12 with eating while the resident continued to cough. Another unidentified staff member tilted Resident #12's wheelchair up to a 90-degree angle. During an interview on 01/17/19 at 8:15 a.m., an administrative nurse (#6) confirmed residents should be seated as close to 90 degrees while	F 684	month. All audits to be reviewed for effectiveness at monthly Quality Assurance Committee. f. Residents with impaired upper body strength will audited 15 residents weekly x 2 months, then 10 residents weekly x 2 months, then 5 residents weekly x 2 months, then 5 residents biweekly x 2 months. All audits to be reviewed for effectiveness at monthly Quality Assurance Committee. 5. Substantial compliance will be achieved on or before February 21st.	

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F 684	Continued From page 17	F 684		

eating or drinking.
- Review of Resident #18's medical chart occurred on all days of the survey. Diagnoses included multiple sclerosis, paraplegia, pain, osteoporosis, and dementia.

Review of Resident #18's current care plan stated, ". . . needs assist with ADL's [activities or daily living] R/T [related to] MS [Multiple Sclerosis] with paraplegia, muscle spasms, tremors . . ." The facility staff failed to address Resident #18's positioning needs in the wheelchair.

Observation in the afternoon on 01/15/19 and 01/16/19 showed Resident #18 seated in the wheelchair and leaning to her extreme left over the arm of the wheelchair. The resident stated, "This position sure doesn't do my body any good, that's for sure."

- Review of Resident #36's medical record occurred on all days of the survey. Diagnoses included hemiplegia affecting left nondominant side, dementia, and traumatic brain injury. The current care plan stated, " . . . physical deficits secondary to TBI [traumatic brain injury] now with left sided weakness and cognitive impairment . . ." The facility staff failed to address Resident #36's positioning needs in the wheelchair.

A significant change Minimum Data Set (MDS), dated 01/02/19, indicated occasional very severe pain and two falls.

Resident #36's occupational therapy evaluation note, signed and dated 08/17/18, stated, ". . . Left sided hemiparesis. Pt [patient] has no AROM

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F 684	Continued From page 18 [active range of motion] of his left UE [upper extremity]. . ." Resident #36's physical therapy note dated 08/17/18, stated, ". . . Muscle tone = flaccid left UE [upper extremity]. . ." Observation of Resident #36 on all days of survey showed the resident seated in a wheelchair and leaning extremely to the left. During an interview on 01/17/19 at 10:33 a.m., and administrative nurse (#1) indicated the facility had no policy addressing positioning in wheelchairs.	F 684		
F 686 SS=D	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 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 observation, record review, and staff interview, the facility failed to provide the necessary care and services to prevent the development and promote healing of pressure	F 686	F686 1. Corrected Action a. Physician updated on status of Residents #64 pressure ulcer and order	2/21/19

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F 686	Continued From page 19 ulcers for 1 of 2 sampled resident (Resident #64) with a current pressure ulcer. Failure to obtain a physician's order and follow occupational therapy's recommendation may result in further skin breakdown and/or prevent healing. Findings include: Review of Resident #64's medical record occurred all days of survey. A "Wound Care Flow Sheet 1.0," dated 12/06/18, stated, ". . . Site . . . Right ankle [outer] . . . Type . . . Pressure . . . Stage . . . Unstagable . . . " A "Wound Care Flow Sheet 1.0," dated 12/09/19, stated, ". . . Pressure Relief Measures . . . She is only wearing AFO [ankle foot orthosis] to right lower extremity for transfers. This has helped the healing process. The ulcer was caused from the AFO present upon admit. . . ." An admission Minimum Data Set (MDS), dated 12/13/18, identified an unhealed pressure ulcer. A "Therapy/Nursing Communication Note," dated 12/18/18, stated, "Discontinue use of AFO until edema & wound to R [right] ankle are resolved. . . ." Resident #64's current care plan stated, "ADLS [activities of daily living]/MOBILITY DEFICITS . . . Resident wears AFO brace to right foot/ankle for all transfers. . . ." The record lacked a physician's order for an AFO. Resident #64's current care plan stated, "ADLS [activities of daily living]/MOBILITY DEFICITS . . . Resident wears AFO brace to right foot/ankle for all transfers. . . ." Observations on 01/16/19 showed Resident #64 wore an AFO brace on her right foot/ankle throughout the day. During an interview on 01/16/19 at 4:00 p.m., an	F 686	obtained for AFO to be worn daily. 2. identify other resident affected a. Residents with pressure ulcer or a risks for pressure ulcers have the ability to be affected. 3. Measure implemented to address deficient practice. a. Resident will have weekly skin assessments to address potential skin concerns. Residents with orthotic devices will have skin assessment weekly to address potential skin concerns at orthotic site. All nursing staff to be educated on 2/8/19 4. Audits and QA review of audits a. Director of Nursing or designee will audit residents with orthotic devices for pressure ulcers concerns. 1 x weekly x 12 months. All audits to be reviewed for effectiveness at monthly Quality Assurance Committee. 5. Substantial compliance will be achieved on or before February 21st	

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F 686	Continued From page 20 administrative nurse (#6) confirmed Resident #64 lacked a physician's order for the AFO and the facility failed to follow the order from occupational therapy. She stated the AFO brace caused the pressure ulcer. Observation on 01/16/19 at 5:45 p.m. showed Resident #64 still wearing an AFO brace on her right foot/ankle while sitting in her wheel chair. The facility failed to remove the AFO despite lacking a physician's order and the recommendation from occupational therapy. During an interview on 1/16/19 at 5:50 p.m., an administrative nurse (#1) confirmed the AFO brace caused Resident #64's pressure ulcer. She removed the brace and stated it wouldn't be used until the facility received an order.	F 686		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;	F 692		2/21/19

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F 692	Continued From page 21 §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to ensure residents received sufficient fluid intake to maintain proper hydration and health for 2 of 18 sampled residents (Resident #12 and #18) needing staff assistance with fluids. Failure to frequently offer fluids placed residents at risk for dehydration, urinary tract infections (UTI) and fluid/electrolyte imbalances. Findings include: Review of the facility policy titled "Standards of Care" occurred on 01/17/19. The policy, dated April 2006, stated, ". . . Offer fluids when completing scheduled cares (toileting, turning, etc.) . . ." - Review of Resident #12's medical record occurred on all days of survey. The current care plan identified, ". . . Monitor for s/sx [signs/symptoms] of dehydration . . . offer and encourage fluids throughout the day . . . pureed diet with pudding thick liquids . . ." Observation on 01/16/19 at 2:57 p.m. showed a certified nursing assistant (CNA) (#3) transferred Resident #12 from the bed to the wheelchair, covered the resident with a blanket, and exited the room. The CNA failed to offer fluids before exiting the resident's room.	F 692	F692 1. Corrected Action a. Resident # 12 staff re-educated on the standard of care policy in relation to offering fluids. b. Resident # 18 staff re-educated on the standard of care policy in relation to offering fluids. 2. identify other resident affected a. All residents have the potential to be affected. 3. Measure implemented to address deficient practice. a. All staff educated on offering fluids during cares per standard of care policy. All nursing staff to be educated on 2/8/19 4. Audits and QA review of audits g. Director Nursing or designee will audit fluids offered during cares 25 residents weekly x 2 months, then 15 resident weekly x 2 months, then 10 residents weekly x 2 months, then 5 residents weekly x 2 months. All audits to be reviewed for effectiveness at monthly Quality Assurance Committee. 5. Substantial compliance will be achieved on or before February 21st.	

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F 692	Continued From page 22 During an interview on 01/07/19 at 8:06 a.m., an administrative nurse (#6) expected staff to offer fluids after cares. - Review of Resident #18's medical record occurred on all days of survey. Diagnoses included dementia and paraplegia. The current care plan stated, ". . . Encourage adequate fluid intake . . . ." The discharge return anticipated Minimum Data Set (MDS), dated 10/13/18 and a quarterly MDS, dated 10/24/18, identified the resident had a urinary tract infection (UTI). The fluid intake log indicated Resident #18 consumed between 480 milliters (mL) to 1080 mLs daily from January 3-15, 2019. Observation on 01/15/19 at 11:28 a.m. showed an unidentified CNA and CNA (#11) failed to offer fluids to Resident #18 after assisting her from the bed to the wheelchair. Resident #18 had two empty water glasses and a "sippy cup" with a small amount of water noted in the bottom. No water pitcher/jug observed in the resident's room. Observation on 01/15/19 at 2:38 p.m. showed two CNAs (#8 and #9) failed to offer fluids to Resident #18 after assisting her from the wheelchair to the bed. A "sippy cup" located on the bedside table was half filled with water. No water pitcher/jug observed in the resident's room. During an interview on 01/17/19 at 12:40 p.m., an administrative nurse (#1) expected staff to offer fluids with every resident interaction.	F 692		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff.	F 725		2/21/19

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	355069	A. BUILDING _____ B. WING _____	01/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVENTIDE HEARTLAND	**620 14TH AVE NE DEVILS LAKE, ND 58301**

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F 725	Continued From page 23 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 at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 02/15/18. Based on resident interviews and resident council interview, the facility failed to ensure sufficient nursing staff to provide services to meet residents' needs for 1 of 20 sampled residents (Resident J), 2 supplemental residents (Resident K and L) and 7 of 9 residents attending the resident council interview (Resident A, C, E, F, G,	F 725	F725 1. Corrected Action a. Resident council meeting held on 2/5/19 discussed plan to resolve long call light times. 2. Identify other resident affected a. All resident who use their call lights have the potential to be affected. 3. Measure implemented to address deficient practice.	

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F 725	Continued From page 24 H, and I) all required staff assistance and when interviewed complained of long call light response, and insufficient staffing. Failure to provide sufficient staffing and answer call lights in a timely manner does not promote each resident's right to physical, mental and psychosocial well-being and may result in residents experiencing falls and/or incontinence. Findings include: - During an interview on 01/15/19 at 1:53 p.m., Resident L identified the call light response was slow after supper and he got to bed later than he preferred due to insufficient staffing. - During an interview on 01/15/19 at 2:05 p.m., Resident K stated, "They are short staffed and leave me on the commode for half hour or longer. They are so busy taking care of others they forget about me and that makes my legs go numb." - Review of Resident Council Meeting Minutes, identified the following: * 12/04/18, ". . . Nursing . . . asked how the call lights have been lately and residents said they can be slow sometimes. . . ." * 01/02/19, " . . . Call light wait time-night shift. . . Leaving residents in bathroom too long. . . ." During the Resident Council interview on 01/16/19 at 3:20 p.m., when asked if staff provided cares in a timely manner, seven residents, identified by the facility as interviewable, responded as follows: * Resident A: Waited for over an hour and a half for staff to answer the call light for an assist off	F 725	a. Random audits on every shift. Resident interviews, daily review of previous days call light times, Review staffing assignments and work locations. 4. Audits and QA review of audits h. Director of Nursing or Designee will audit electronic call light times in the last 24 hours 5 x weekly x 3 months, then 3 x weekly x 2 months, then 2 x weekly x 2 months, then weekly x 1 month, then biweekly x 2 months, then 1x monthly. All audits to be reviewed for effectiveness at monthly Quality Assurance Committee. 5. Substantial compliance will be achieved on or before February 21st.	

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F 725	Continued From page 25 the commode and weekends were the worst for short staffing. * Resident C: Several times had waited almost an hour or longer to get staff to answer the call light, especially at night. * Resident E: Waited for at least an hour for staff to answer the call light on the night shift, and stated, "staff all go on break at the same time." * Resident F: Waited several times over an hour on evening shift for whirlpool bath. On one occasion when the resident questioned the nurse, the nurse indicated the assigned bath certified nurse aide (CNA) shift had ended and the resident would not receive a bath that day. * Resident G: Waited for long periods of time for staff to answer the call light and stated, "They leave me on the pot and forget to come answer my call light." * Resident H: "Before dinner and supper there is no one on the floor to assist us to the bathroom if we need to because they are all feeding in the dining room. Then we wait a long time for our call lights to be answered due to short staffing." * Resident I: Waited for an hour and half for staff to answer the call light and stated, "That's a long time when you need to use the bathroom." Failure to ensure sufficient staffing resulted in residents' decreased quality of life which included delayed call light responses, late bed times, missed baths and the risk for increased pain, incontinence, skin breakdown, and falls/injury for residents dependent on staff assistance.	F 725		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident	F 756		2/21/19

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F 756	Continued From page 26 must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by:	F 756		

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F 756	Continued From page 27 Based on record review, facility policy review, and staff interview, the facility failed to ensure the attending physician or medical director reviewed the consultant pharmacist's recommendations for 2 of 5 sampled resident (Resident #1 and #45) with a rejected GDR (gradual dose reduction). Failure of the physician or medical director to review the drug irregularities identified by the consultant pharmacist may result in adverse consequences. Findings include: Review of the facility policy titled "Medication Regimen Review (MRR)" occurred on 01/17/19. This policy, revised September 2017, stated, ". . . Any irregularities will be reported to the Director of Nursing, attending physician, and medical director . . ." - Review of Resident #1's medical record occurred on all days of survey. Medication included Lexapro (antidepressant). Consultant Pharmacist's Medication Review for December 2018, stated there has not been any recent dose reduction for Lexapro. A physician assistant accepted the recommendation and decreased Lexapro to 10 mg (milligram) by mouth daily. The record lacked evidence the resident's physician or medical director provided rationale and/or confirmed the physician assistants rationale of why a GDR was accepted. - Review of Resident #45's medical record occurred on all days of survey. A Consultant Pharmacist's Medication Review, dated 07/20/18, stated there has not been any recent dose reduction for Venlafaxine (antidepressant). A	F 756	F756 1. Corrected Action a. Resident # 1 Pharmacy Review for GDR sent to Primary Physician for review and signature. b. Resident # 45 Pharmacy Review for GDR sent to Primary Physician for review and signature. 2. identify other resident affected a. All Resident who are followed by the Physician Assistant for psychiatric rounds and medication management have the potential to be affected. 3. Measure implemented to address deficient practice. a. All Pharmacy Drug Review will be sent to physician for review and signature when gradual dose reduction is being completed by Psychiatric physician assistant. All Nursing staff will be educated on 2/8/19. 4. Audits and QA review of audits i. Director of Nursing or designee will audit Pharmacist drug Reviews for physician signature 3 x weekly x 2 months, then 2 x weekly for 2 months, then 1 x weekly x 1 month, then monthly x 1 month. All audits to be reviewed for effectiveness at monthly Quality Assurance Committee. 5. Substantial compliance will be achieved on or before February 21	

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F 756	Continued From page 28 physician assistant rejected the recommendation and stated, ". . . Client is endorsing intermittent depressive symptoms with escapist thinking . . ." A Consultant Pharmacist's Medication Review, dated 10/12/18, showed a recommendation to consider whether reducing Quetiapine would be appropriate in this patient. The Review stated the patient has been taking current dose of Quetiapine (antipsychotic) 25 mg since November 2017. A physician assistant rejected the recommendation and stated, ". . . family declined GDR on Seroquel (antipsychotic) on 11/06/18. History of failed reduction attempts . . ." The record lacked evidence the resident's physician or medical director provided rationale and/or confirm the physician assistant's rationale of why a GDR was rejected. During an interview on 01/17/19 at 10:30 a.m., an administrative nurse (#1) confirmed the attending physician failed to review all of the consultant pharmacist's recommendations and some recommendations were reviewed by the physician assistant.	F 756		
F 840 SS=D	Use of Outside Resources CFR(s): 483.70(g)(1)(2) §483.70(g) Use of outside resources. §483.70(g)(1) If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility must have that service furnished to residents by a person or agency outside the facility under an arrangement described in section 1861(w) of the Act or an agreement described in paragraph (g)(2) of this section.	F 840		2/21/19

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F 840	Continued From page 29 §483.70(g)(2) Arrangements as described in section 1861(w) of the Act or agreements pertaining to services furnished by outside resources must specify in writing that the facility assumes responsibility for- (i) Obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and (ii) The timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on review of facility documentation and staff interview, the facility failed to obtain a written agreement or arrangement between the nursing home and the Medicare Certified Dialysis Facility regarding the roles and responsibilities for the provision of dialysis care/services for 1 of 2 facilities providing dialysis services. Failure to ensure an agreement/arrangement has the potential to place dialysis residents at risk for not receiving care and services in accordance with current standards of practice. Findings include: Review of documentation provided by the facility regarding dialysis occurred on the morning of 01/17/19. The documentation included a written agreement between the nursing home and a local facility providing dialysis services. The documentation lacked an agreement between the nursing home and a second remote facility providing dialysis services. During interview on the morning of 01/17/19, an administrative staff member (#10) confirmed the facility failed to ensure an agreement with the	F 840	F840 1. Outside Facility agreements (Dialysis) which affected one resident was signed by facility on January 18, 2019. Copies were sent to Sanford Health, Bismarck for their signature. 2. No other residents were affected by the Dialysis agreement 3. Administrator or Designee will review existing services and all new outside services for any agreements required and put in Agreement Binder 4. QA committee will review Agreement Binder Quarterly X 3 and Annually thereafter for completeness. 5. February 21, 2019	

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F 840	Continued From page 30 second remote facility providing dialysis services had been reached and signed.	F 840		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and 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	F 880		2/21/19

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F 880	Continued From page 31 reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to follow infection control practices for 3 of 11 sampled residents observed during cares (Resident #21,	F 880	F880 1 Corrected Action a. Resident #21 immediate staff education on hand hygiene per hand	

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F 880	Continued From page 32 #22, and #66). Failure to follow infection control standards related to cleaning of transfer equipment (mechanical stand lift) and hand hygiene after personal cares has the potential to transmit communicable diseases and infections to residents and staff. Findings include: Review of the facility policy titled "Hand Hygiene" occurred on 01/16/19. This policy, revised 11/20/13, stated, "Hand hygiene will be done: a. Before and after resident contact [before you leave the room] . . . " - Observation on 01/16/19 at 8:53 a.m. showed a certified nursing assistant (CNA) (#12) assisted Resident #21 to ambulate to the bathroom. The CNA put on gloves and assisted Resident #21 to wash/dry his face, hands, arms, and back. The CNA then assisted Resident #21 with dressing. Upon completion of toileting, the resident stood, and the CNA performed perineal care and removed her gloves. Without performing hand hygiene, the CNA combed the resident's hair, donned new gloves, and assisted Resident #21 to use mouthwash. The CNA then brushed the resident's dentures and handed them to the resident. The CNA failed to completed hand hygiene after assisting with perineal care and before completing other tasks. - Observation on 01/15/19 at 11:41 a.m. showed a CNA (#4) assisted Resident #22 to the toilet. The CNA (#4) donned gloves and performed perineal cares on Resident #22. The CNA then removed her gloves and left the room with the resident, failing to perform hand hygiene.	F 880	washing policy and procedure. b. Resident # 22 immediate staff education on hand hygiene per hand washing policy and procedure. c. Resident # 66 immediate staff education to disinfect lift after each use. 2 identify other resident affected a. All resident have the potential to be affected by improper hand hygiene. All residents who use mechanical lifts have the potential to be affected by lack of lift cleaning. 3 Measure implemented to address deficient practice. a. Hand washing policy and procedure to be reviewed at all staff meeting on 2/8/19. All nursing staff to be educated to clean all lift with Sani wipes after each resident use on 2/8/19. 4 Audits and QA review of audits a. Director of Nursing or Designee will audit hand hygiene with personal cares. 25 residents weekly x 2 months, then 15 resident weekly x 2 months, then 10 residents weekly x 2 months, then 5 residents weekly x 2 months. All audits to be reviewed for effectiveness at monthly Quality Assurance Committee. b. Director of Nursing or Designee will audit lift cleaning after each use 20 residents weekly x 2 months, then 10 residents weekly x 2 months, then 5 residents weekly x 2 month, then 2 residents weekly x 1 month, then 1 resident weekly x 1 month. All audits to be reviewed for effectiveness at monthly Quality Assurance Committee. 5 Substantial compliance will be	

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F 880	Continued From page 33 - Observation on 01/15/19 at 4:33 p.m. showed Resident #66 sat on a bedside commode. Two CNAs (#8 and #9) transferred the resident to her wheelchair using a mechanical stand lift. Following the transfer, the CNAs placed the lift in the hallway and failed to disinfect it. During an observation on 01/16/19 at 4:15 p.m., two CNAs (#8 and #9) transferred Resident #66 from her recliner to a bedside commode and then to her wheelchair using a mechanical stand lift. Following the transfer, the CNAs placed the lift in a storage room and failed to disinfect it. During an interview on 01/17/19 at 9:50 a.m., an administrative nurse (#1) stated she would expect staff to disinfect lift equipment after each use.	F 880	achieved on or before February 21st.	