| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 355080 | A. BUILDING _____ B. WING _____ | 01/31/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| DUNSEITH COM NURSING HOME | 15 1ST ST NE DUNSEITH, ND 58329 |

| (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<br><br>The standard Medicare/Medicaid survey started on 01/29/18 and concluded on 01/31/18. | F 000 | | |
| F 550 SS=D | Resident Rights/Exercise of Rights<br>CFR(s): 483.10(a)(1)(2)(b)(1)(2)<br><br>§483.10(a) Resident Rights.<br>The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.<br><br>§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.<br><br>§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.<br><br>§483.10(b) Exercise of Rights.<br>The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.<br><br>§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. | F 550 | | 3/2/18 |

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

Electronically Signed | 02/15/2018

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 355080 | A. BUILDING _____ B. WING _____ | 01/31/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| DUNSEITH COM NURSING HOME | 15 1ST ST NE DUNSEITH, ND 58329 |

| (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 550 | Continued From page 1<br><br>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, and staff interview, the facility failed to develop and implement interventions to promote dignity for 1 of 1 sampled resident (Resident #16) observed to have continuous drooling. This failure resulted in the resident ambulating throughout the building with the front of his shirt visibly wet.<br><br>Findings include:<br><br>Observations during the survey identified the following:<br>* 01/29/18 at 1:27 p.m.: Resident #16 visited with a friend in his room. Observation showed the resident with a large amount of drool on his chin and the front of his shirt.<br>* 01/29/18 at 2:33 p.m. showed Resident #16 ambulating in the halls. His chin and his shirt remained wet from drooling.<br>* 01/29/18 03:12 PM Resident #16 watched others playing cards in the Activity room. The front of his shirt remained wet.<br><br>Resident #16's medical record, reviewed on all days of survey identified, the resident recently admitted following a hospital stay for respiratory failure and a cardiac arrest. Diagnoses included history of a stroke. An Admission Minimum Data Set, dated 12/20/17, identified unclear speech, | F 550 | 1.) Resident #16's care plan has been revised to include interventions to address his drooling and keeping his clothes dry.<br>2.) All residents have potential to be affected by this deficient practice.<br>3.) The IDT team and Nursing staff will be in-serviced on the resident right to promote dignity and the importance of developing interventions on the care plan to promote this right. (IDT team on 02-15-18 and Nursing staff on 02-20-18). Care Plan Coordinator/Designee will review all current resident's care plans to assure this right has been addressed if indicated.<br>4.) A quality monitor will be implemented to review residents care plans as their MDS comes due starting 03-01-18. The IDT team will review and the Care Plan Coordinator/Designee will be responsible to maintain the quality monitor. This will be weekly for 3 months. This information will be reviewed at the scheduled Quality Assurance Meeting and revised as needed.<br>5.) 03-02-2018 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 355080 | A. BUILDING _____ B. WING _____ | 01/31/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| DUNSEITH COM NURSING HOME | 15 1ST ST NE DUNSEITH, ND 58329 |

| (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 550 | Continued From page 2<br>limited assistance with dressing, and a Brief Interview for Mental Status score of "6" indicating severe cognitive impairment. The record lacked evidence staff developed interventions to address the drooling and/or to keep his clothing dry.<br><br>During an interview on 01/30/18 at 3:25 p.m., an administrative nurse (#2) confirmed staff had not developed interventions for the resident's drooling and/or to keep his clothing dry. | F 550 | | |
| F 637 SS=D | Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii)<br><br>§483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)<br>This REQUIREMENT is not met as evidenced by:<br>THIS IS A REPEAT CITATION FROM THE SURVEY CONDUCTED ON 12/15/2016.<br><br>Based on record review, staff interview, and review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, the facility failed to complete a significant change in status assessment (SCSA) for 2 of 11 sampled residents (Resident #7 and #11) who | F 637 | 1.) Resident #7 and #18's medical records have been updated to include the information to identify why a significant change MDS was not completed.<br>2.) All residents have the potential to be affected by this deficient practice.<br>3.) The IDT team will be in-serviced on the definition of significant change and the federal requirements for submission | 2/15/18 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 355080 | A. BUILDING _____ B. WING _____ | 01/31/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| DUNSEITH COM NURSING HOME | 15 1ST ST NE DUNSEITH, ND 58329 |

| (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 637 | Continued From page 3<br>experienced a significant change in status. Failure to determine the need for and complete a SCSA in response to a resident's decline limited the facility's ability to accurately assess the resident's status, and identity and implement appropriate care approaches.<br><br>Findings include:<br><br>The Long-Term Care Facility RAI 3.0 User's Manual (Version 1.15), dated October 2017, page 2-22 stated, ". . . A 'significant change' is a major decline or improvement in a resident's status that: 1. Will not normally resolve itself without staff intervention . . . 2. Impacts more than one area of the resident's health status; and 3. Requires interdisciplinary review and/or revision of the care plan. . . ." and page 2-25 stated, "A SCSA is appropriate if there are either two or more areas of decline or two or more areas of improvement. . . . This may include two changes within a particular domain (e.g., [for example] two areas of ADL [Activities of Daily Living] decline or improvement. . . ."<br><br>- Review of Resident #7's medical record occurred on all days of survey. An admission Minimum Data Set (MDS), dated 11/23/17, identified the resident required limited assistance with bed mobility, transfers, walking in the room and corridor, and locomotion on and off the unit. The medical record identified Resident #7 was hospitalized 12/28/17-12/31/17. A quarterly MDS, dated 01/06/18, identified the resident required extensive assistance with bed mobility, transfers, and locomotion on unit; and walk in room and walk in corridor did not occur. The record lacked evidence why staff failed to | F 637 | on 02-15-18. MDS Coordinator will review the information in the RAI 3.0 User's Manual (Version 1.15) regarding significant changes.<br>4.) MDS Coordinator/Designee will implement a quality monitor starting 02-15-18 to review each residents MDS assessment to assure the significant change guidelines and/or documentation is being followed. This monitor will be weekly and will include every residents MDS assessment that comes due that week for a for 3 months, than 1x/month for 9 months for a total of one year. The data will be reviewed at the scheduled quality assurance meeting and the process revised as needed.<br>5.) 02-15-18 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 355080 | A. BUILDING _____ B. WING _____ | 01/31/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| DUNSEITH COM NURSING HOME | 15 1ST ST NE DUNSEITH, ND 58329 |

| (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 637 | Continued From page 4<br>complete a SCSA following Resident #7's hospitalization and return on 12/31/17.<br><br>During an interview on 01/31/18 at 2:32 p.m., an administrative staff member (#1) stated she was unable to locate any information that would identify why a significant change MDS was not completed on Resident #7 after his hospital return on 12/31/17.<br><br>- Review of Resident #18's medical record occurred on all days of survey. A quarterly MDS, dated 09/15/17, identified the resident required limited assistance with bed mobility, transfers, walking in the room and corridor, locomotion on and off the unit, dressing, toilet use, and personal hygiene. A quarterly MDS, dated 12/15/17, identified the resident required extensive assistance with bed mobility, transfers, locomotion on and off the unit, dressing, toilet use, and personal hygiene. The medical record lacked evidence why staff failed to complete a SCSA for Resident #18's decline. | F 637 | | |
| F 644 SS=D | Coordination of PASARR and Assessments<br>CFR(s): 483.20(e)(1)(2)<br><br>§483.20(e) Coordination.<br>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:<br><br>§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 | F 644 | | 3/7/18 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 355080 | A. BUILDING _____ B. WING _____ | 01/31/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| DUNSEITH COM NURSING HOME | 15 1ST ST NE DUNSEITH, ND 58329 |

| (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 644 | Continued From page 5<br>care.<br><br>§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:<br>Based on record review and staff interview, the facility failed to complete the pre-admission screening and resident review (PASARR) for 1 of 2 sampled residents with a mental disorder (Resident #9). Failure to complete the PASARR screening may result in the resident not receiving necessary psychiatric services.<br><br>Findings include:<br><br>Review of Resident #9's medical record occurred on all days of survey and identified diagnoses including obsessive compulsive disorder, anxiety, and depression. The record showed Resident #9 received the following psychotropic medications: Risperdal (antipsychotic), Buspar (antidepressant), Despiramine (antidepressant), Wellbutrin (antidepressant), Lorazepam (antianxiety), and Remeron (antidepressant). The record lacked evidence staff completed a PASARR at the time of her admission or at any time thereafter.<br><br>A psychosocial assessment, dated 03/21/85, stated, "[Resident #9] is a 37 year old . . . . psychiatric treatment for anorexic and bulimic behavior . . . well known chemical dependency . . . history with several suicidal gestures . . . history of ulcers and surgical removal of part of her | F 644 | 1. The facility failed to complete the pre-admission screening and resident review (PASARR) for 1 of 2 sampled residents with a mental disorder (Resident #9). Failure to complete the PASARR screening may result in the resident not receiving necessary psychiatric services. Resident #9 will have a Pre-Admission screening and PASARR completed by 03/07/18.<br>2.All resident have the potential to be affected by this deficient practice.<br>3. The Social Service Director Designee will completed the PASARR screening on Resident #9. The Social Service Director will review all level II residents and all resident with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II residents review upon a significant change in status assessment a PASARR screen will be completed.<br>4. DON/Designee will do a quality monitor on all new admissions for a total of one year to assure the correct screening process is being followed. Results of the monitoring will be Reviewed at the Quality Assurance Meeting.<br>5.03/07/2018 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 355080 | A. BUILDING _____ B. WING _____ | 01/31/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| DUNSEITH COM NURSING HOME | 15 1ST ST NE DUNSEITH, ND 58329 |

| (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 644 | Continued From page 6<br>stomach secondary to aspirin and Midol abuse . . ."<br><br>During an interview on 01/30/18 at 9:56 a.m., an administrative nurse (#2) stated the PASARR was not required at the time of Resident #9's admission. The nurse (#2) confirmed staff did not complete a PASARR when the requirement became effective in 1987 or any time thereafter. | F 644 | | |
| F 658 SS=D | Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)<br><br>§483.21(b)(3) Comprehensive Care Plans<br>The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br>(i) Meet professional standards of quality.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, review of facility policy, review of professional reference, and staff interview, the facility failed to ensure staff followed professional standards of practice for 1 of 6 residents (Resident #3) observed during medication administration. Failure to correctly prime an insulin pen, administer rapid acting insulin within 5-10 minutes of a meal, and monitor a resident's blood pressure before administering a blood pressure medication may result in an adverse consequence for the resident.<br><br>Findings include:<br><br>Review of the facility policy titled "Insulin Injections" occurred on 01/31/18. This policy, undated policy, stated ". . . 6. If using an insulin pen . . . Perform an air shot . . . While the needle | F 658 | 1. The facility failed to ensure staff followed professional standards of practice for 1 of 6 residents. On Resident #3 the facility will ensure staff to follow professional standard by: A.) Correctly priming the insulin pen. B.)Administer rapid acting insulin within 5-10 minutes before meals times. Nursing staff will notify dietary staff when insulin is given to assure residents meals are provided within 5-10 minutes of insulin injection. C.) Medication nurse will follow physician orders according to the MAR and Recertification and assure all required vitals are taken according to Physician orders. Residents #3 blood pressure orders have been discontinued from the MAR per physician orders.<br>2. All resident have the potential to be | 3/2/18 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 355080 | A. BUILDING _____ B. WING _____ | 01/31/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| DUNSEITH COM NURSING HOME | 15 1ST ST NE DUNSEITH, ND 58329 |

| (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 658 | Continued From page 7<br>is pointing up, tap the cartridge gently with your finger a few times to make a any air bubbles collect at the to of the cartridge. Push the button and verify a drop of insulin appears at the tip. . . ."<br><br>Prescribing information for NovoLog insulin, found at www.novo-pi.com/novolog.pdf , stated, ". . . NOVOLOG® is rapid acting human insulin analog indicated to improve glycemic control in adults and children with diabetes mellitus . . . Inject subcutaneously within 5-10 minutes before a meal into the abdominal area, thigh, buttocks or upper arm. . . ."<br><br>Observation on 01/29/18 at 4:17 p.m. showed a licensed nurse (#5) administered 23 units of NovoLog insulin to Resident #3. Observation showed Resident #3 received his meal tray at 4:39 p.m., 22 minutes after receiving NovoLog insulin.<br><br>Observation on 01/30/18 at 8:33 a.m. showed a licensed nurse (#7) administered lisinopril (a blood pressure medication) 2.5 milligrams (mg) to Resident #3. The medication administration record and the physician's order stated, lisinopril 2.5 mg daily, call MD if systolic blood pressure less than 90 or dizziness or falling. The nurse failed to check Resident #3's blood pressure or inquire about dizziness or falling prior to administering the medication.<br><br>Observation on 01/30/18 showed a licensed nurse (#6) obtained Resident #3's NovoLog insulin pen, the nurse primed the insulin pen holding the pen horizontal and without removing the cap. Observation at 11:20 a.m., showed the | F 658 | affected by these deficient practices.<br>3. A.) All facility nursing staff will be in-serviced by DON/Designee on the DCNH Policy on insulin injection and the importance of following the procedure for insulin pen. B.) Nursing staff will be in serviced by DON/Designee on the proper administration of rapid acting insulin within 5-10 minutes of meal time. C.) Nursing staff will be in-serviced by DON/Designee on administering medications according to the Physicians orders. Physicians orders will have specific parameters for medication. ( For example, anti-hypertensive, digoxin, etc.) All in-services will be provided by DON at Nursing meeting on 02/20/18<br>4. DON/Designee will do a quality monitor nursing staff on proper use of insulin pens, insulin injection before meals and following MAR according to the physician orders weekly x 4 weeks, than bi weekly x 4, followed by monthly for a total of 1 year. All the above monitoring will be initiated starting 03/01/2018. Results of the monitoring will be reviewed at the Quality Assurance Meeting.<br>5. 03/02/18 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 355080 | A. BUILDING _____ B. WING _____ | 01/31/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| DUNSEITH COM NURSING HOME | 15 1ST ST NE DUNSEITH, ND 58329 |

| (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 658 | Continued From page 8<br>licensed nurse administered 20 units of NovoLog to Resident #3. The resident received his meal tray at 11:40 a.m., 20 minutes after receiving NovoLog insulin.<br><br>During an interview on 01/31/18 at 2:45 p.m., an administrative nurse (#2) confirmed staff are expected to hold an insulin pen upright when priming the pen with the cap off to visualize the insulin stream. | F 658 | | |
| F 684 SS=D | Quality of Care<br>CFR(s): 483.25<br><br>§ 483.25 Quality of care<br>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 accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, review of professional literature, review of facility policy, and staff interview, the facility failed to ensure 2 of 3 sampled residents (Resident #2 and #21) received the care and services necessary to attain the highest degree of safety possible while being fed in the dining room and drinking fluids in their rooms. Failure to ensure staff provided proper positioning and cueing when giving foods and liquids placed Resident #2 at risk for aspiration; and failure to provide the appropriate thickened liquids placed Resident #21 and #2 at risk for aspiration. | F 684 | 1.The facility failed to ensure 2 of 3 sampled residents (Resident #2 and Resident #21)received the care and services necessary to attain the highest degree of safety possible while being fed in the dining room and drinking fluids in their rooms. A.)Nursing and Dietary staff will be educated on the proper positioning and cueing to prevent aspiration when giving foods and liquids to Resident #2 and other residents who have aspiration precautions. B.)Nursing staff and Dietary staff will be educated on providing the appropriate thickened liquids per | 3/2/18 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 355080 | A. BUILDING _____ B. WING _____ | 01/31/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| DUNSEITH COM NURSING HOME | 15 1ST ST NE DUNSEITH, ND 58329 |

| (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 684 | Continued From page 9<br>Findings include:<br><br>Review of the facility policy titled "Thickened Liquids and Dysphagia Products" occurred on 01/31/18. The undated policy stated, "All individuals requiring thickened liquids as recommended by the speech language pathologist [SLP] and ordered by the physician will be served liquids in a form to minimize the risk of choking and aspiration. . . ."<br><br>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 loss of food over the back of the tongue.<br><br>- Resident #2's medical record, reviewed on all days of survey identified diagnoses including traumatic brain disorder and aphasia. The quarterly Minimum Data Set (MDS), dated 09/05/17, identified coughing or choking during meals or when swallowing medications. The annual MDS, dated 12/04/17, identified short and long term memory loss, a mechanically altered diet, and required extensive assistance of one person for eating.<br><br>Resident #2's current care plan identified a problem: " . . . I need assistance to eat. . . . I am on aspiration precautions . . . Approach . . .Staff to watch for aspiration when eating. Thicken | F 684 | physician orders to Resident #2, #21 and other residents who are required to have the appropriate thickened liquids.<br>2.All residents have the potential to be affected by this deficient practice.<br>3. A. Nursing staff will be in-serviced on the proper positioning of residents who are at risk of aspiration according to their care plan. In-service will be provided on 02/20/2018 and 02/27/18<br>B. Dietary will use a validation checklist to monitor preparation of thickened liquid according to Physician/Occupation therapies recommendations. Dietary and Nursing staff will be in-serviced on 02/20/2018 and 02/27/2018.<br>4. Director of Nursing/Designee will do quality monitoring on proper positioning of resident #21 and resident #2 in the dining room and while in bed/chair. Dietary Manger/Designee will do quality monitoring on preparation of thickened liquids according to residents care plans. Both areas will have random monitoring 3x/week for 4 weeks, then 2x/week for 4 weeks, then 1x a week for 4 weeks, followed by 1x/month for 9 months for a total of one year starting 03/01/2018. Results of the monitoring will be Reviewed at the Quality Assurance Meeting.<br>5. 03/02/18 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 355080 | A. BUILDING _____ B. WING _____ | 01/31/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| DUNSEITH COM NURSING HOME | 15 1ST ST NE DUNSEITH, ND 58329 |

| (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 684 | Continued From page 10 | F 684 | | |

[nectar consistency] liquids are being used to avoid swallowing problems. Staff will be sure I am sitting up well when feeding me. Encourage me to tuck my chin when taking liquids . . . Staff to offer me extra fluids throughout the day. . . ."

The resident's Physician's orders, dated 05/16/12, and tray card identified nectar thickened liquids, regular diet, chopped meat, encourage fluid intake, and small portions.

The most recent Occupational Therapy referral, dated 02/04/11, stated, "referral received to evaluate resident during mealtime as he has had an increased incidence of coughing/choking during mealtimes . . Currently is on regular diet with ground meats and thickened liquids . . . Currently is dependant upon others to be fed most of his meal . . . Very slight cough noted following presentation of liquids . . . Plan: At this time . . . 1. resident to sit up as much as is possible, may need to reposition before each meal, 2. frequent cues will be needed to use chin tuck while taking liquids. . . ."

Observation showed the following:
* 01/29/18 at 11:42 a.m.: Resident #2 seated in his geri-chair at an approximate 40 degree angle at the table in dining room. The meal consisted of hamburger, chopped consistency, three glasses of thin liquid consistency of milk, juice and water. An unidentified certified nursing assistant (CNA) fed Resident #2, and when prompted, he would lift his head off the geri-chair to take the small bites of food and swallow. When the CNA offered Resident #2 liquids, he would swallow, followed by a cough/clearing of his throat.
*01/29/18 at 3:49 p.m.: Resident #2 in his room

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 355080 | A. BUILDING _____ B. WING _____ | 01/31/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| DUNSEITH COM NURSING HOME | 15 1ST ST NE DUNSEITH, ND 58329 |

| (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 684 | Continued From page 11 | F 684 | | |

sitting in his geri-chair. A CNA (#8) gave the resident a drink of water out of his mug, and resident started to cough. The liquid in his mug was of thin consistency.
* 01/30/18 at 8:48 a.m.: Resident #2's mug of water on his bedside table in his room was of thin consistency.
* 01/30/18 at 9:50 a.m.: A CNA (#10) passed out a snack and fresh water in Resident #2's room. Water was nectar thick with ice in his mug.

- Review of Resident #21's record occurred on all days of survey. Physician's orders, dated 09/18/17, and tray card identified nectar thickened liquids except for milk.

A "Speech Therapy Swallow Eval [Evaluation] Form," dated 12/01/17, stated,"Mechanical, Nectar, Allow extra time to swallow, Alternate solids and liquids, Feed only when alert, Remain upright after meals 30 minutes, Small bites of food, Small sips of liquid, Moderate Supervision, may need assist with feeding. . . ."

A "Resident Assessment Form," dated 12/05/17, stated, "Cueing, Assist, Fed part of meal, Nectar thickened liquids, has had tendency to cough et [and] spit if eats or drinks too fast."

Resident #21's current care plan stated, ". . . Staff will assist me to dining room for meal as I eat better there. . . . 12/14/17 Nectar thickened liquids. Regular milk - Refuses thickened milk. . . ."

Observations for Resident #21 showed the following:
* 01/29/18 at 3:56 p.m.: Resident #21's mug sat

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 355080 | A. BUILDING _____ B. WING _____ | 01/31/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| DUNSEITH COM NURSING HOME | 15 1ST ST NE DUNSEITH, ND 58329 |

| (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 684 | Continued From page 12<br>on his bedside table. Observation showed the mug contained thin liquid.<br>* 01/30/18 at 8:20 a.m.: Resident #21 received his breakfast tray in the dining room. Observation showed all liquids on the tray were thin consistency.<br>* 01/30/18 at 11:49 a.m.: Resident #21's glass sat on his bedside filled with thin liquid.<br>* 01/31/18 at 8:01 a.m.: Resident #21 received his breakfast tray in the dining room including thin liquids.<br>* 01/31/18 at 4:20p.m.: Observations in the resident's room showed a sheet of paper hanging on the wall above the bedside stand, indicating liquids need to be thickened to nectar.<br><br>During an interview on 01/31/18 at 2:54 p.m. two administrative nurses (#1 and #2) stated:<br>* Staff should not put ice in thickened liquids<br>* Residents who are on thickened liquids have a sign in their room<br>* Residents should be seated in an upright position when staff assist with feeding<br>* Residents should be seated as close to 90 degrees as possible | F 684 | | |
| F 730 SS=C | Nurse Aide Peform Review-12 hr/yr In-Service<br>CFR(s): 483.35(d)(7)<br><br>§483.35(d)(7) Regular in-service education.<br>The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g).<br>This REQUIREMENT is not met as evidenced by:<br>Based on review of performance evaluations, | F 730 | 1. The facility failed to provide twelve | 3/6/18 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 355080 | A. BUILDING _____ B. WING _____ | 01/31/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| DUNSEITH COM NURSING HOME | 15 1ST ST NE DUNSEITH, ND 58329 |

| (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 730 | Continued From page 13<br>review of twelve months of education records, and staff interview, the facility failed to provide twelve hours of in-service education per year for 3 of 3 certified nursing assistants (CNAs) (CNA A, B, and C). Failure to provide twelve hours of in-service education per year to CNA A, B, and C may result in unpreparedness to provide care and services to meet residents needs.<br><br>Findings include:<br><br>Review of staff performance evaluations and twelve months of education records occurred on 01/30/18. The records showed the facility failed to provide twelve hours of in-service education for 3 of 3 CNA files (CNA A, B, and C) reviewed.<br><br>During an interview on 01/31/18 at 1:45 p.m. an administrative nurse (#2) confirmed the facility failed to ensure all CNAs members were provided and/or completed twelve hours of in-service education during the period between January 2017-January 2018. | F 730 | hours of in-service education per year for 3 of 3 certified nursing assistants.<br>In-service will be conducted to these nurse aides on 02/28/2018 and 03/06/2018, 2018 followed by monthly in-service training for all nurse aides to successfully complete annual training requirements.<br>2. The facility has determined that all residents have the potential to be affected.<br>3. An audit of all nurse aide performance reviews and education was conducted to assure on-going competence including annual education requirements. The Director of Nursing/Designee will provide 12 hours of annual in-service for all nurse aides to include information based on performance reviews and resident needs.<br>4. Beginning February 20th 2018, the Director of Nursing will conduct performance reviews of nurses aides during the month prior to his/her annual employment date. An evaluation of nurse aide performance will be conducted by the Director of Nursing who will offer in-service education 1-2 hours per month. Educational programs will include an emphasis on weakness identified during performance reviews and in-service to provide quality care towards the residents. Director of Nursing/Designee will audit performance reviews monthly for one year or until consistent substantial compliance is achieved starting 03/06/2018. Results will be reviewed by the Quality Assurance Committee until such time consistent substantial | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 355080 | A. BUILDING _____ B. WING _____ | 01/31/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| DUNSEITH COM NURSING HOME | 15 1ST ST NE DUNSEITH, ND 58329 |

| (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 730 | Continued From page 14 | F 730 | compliance has been achieved as determined by the committee.<br>5. 03/06/2018 | |
| F 812 SS=D | Food Procurement,Store/Prepare/Serve-Sanitary<br>CFR(s): 483.60(i)(1)(2)<br><br>§483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br>(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.<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, review of facility policy/procedure, and staff interview, the facility failed to ensure food was stored, and served under sanitary conditions, and kitchen equipment kept clean in 1 of 1 kitchen used to prepare food for all residents, as well as staff and visitors. Failure to label food taken out of the original container, discard outdated foods, effectively clean kitchen equipment, and failure to safely handle food has the potential to result in | F 812 | 1.) Dietary staff will be in-serviced on food storage, distributing/serving food and sanitary conditions for food service safety.<br>2.) All residents and staff are potentially affected by this deficient practice.<br>3.) Dietary Manager will conduct an in-service on 02-21-18 and 03-02-18 on distributing/serving food, sanitation, labeling and dating of foods to be stored and procedures for cleaning equipment | 3/2/18 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 355080 | A. BUILDING _____ B. WING _____ | 01/31/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| DUNSEITH COM NURSING HOME | 15 1ST ST NE DUNSEITH, ND 58329 |

| (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 812 | Continued From page 15<br>foodborne illness to residents, staff, and visitors.<br><br>Finding include:<br><br>Review of the facility policy titled, "Food Handling of Leftovers" occurred on 01/31/18. This policy, dated 12/01/17, stated, ". . . Cover containers, label and date. . . ."<br><br>The initial tour of the kitchen occurred on 01/29/18 at 11:40 a.m. Observation of the walk-in freezer showed an undated zip lock bag of cooked sliced ham. Observation of the walk-in cooler showed a container of pumpkin sauce covered with plastic wrap and dated 01/22/18. During the tour, a dietary staff member (#2), stated all containers are dated for when the item was placed in the cooler/freezer. She agreed the pumpkin sauce, dated 1/22/18 should have been discarded after 1/25/18.<br><br>Observation of the meal tray line occurred on 01/30/17, and showed a dietary staff member (#2) placed food on residents' trays. While wearing the same gloves the staff member touched the serving counter, resident meal card/holders, and removed bread from the bread bag repeatedly.<br><br>The main tour of the kitchen occurred on 01/31/18 at 2:00 p.m. with a dietary supervisor (#2). Observation of the kitchen ovens identified one oven with food spills on the bottom of the oven and on the oven door. During an interview, the dietary supervisor (#2), stated the oven had not been used today on anything that would have left the spill, and the spill must have been from the prior day. The dietary supervisor expected | F 812 | and surfaces. Dietary will utilize a cleaning schedule to inspect kitchen equipment prior to leaving shift. Dietary Manager/Designee will use a validation checklist to monitor labeling/dating of food, sanitation procedures observed on the tray line and utilizing the cleaning schedule.<br>4.) Dietary Manager/designee will implement a quality monitor to monitor the cleaning schedule, the validation checklist and observations of the sanitation on the tray line. Random monitoring will be 3 x week for 4 weeks, 2 x week for 4 weeks, weekly for 4 weeks, than once a month for 9 months for a total of one year starting 03/02/2018 The Dietary Manager/designee will make adjustments as needed from information gathered. The results of the monitoring will be reviewed at the scheduled Quality Assurance Meeting and the monitors revised as needed.<br>5.)03-02-18 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 355080 | A. BUILDING _____ B. WING _____ | 01/31/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| DUNSEITH COM NURSING HOME | 15 1ST ST NE DUNSEITH, ND 58329 |

| (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 812 | Continued From page 16<br>dietary staff to clean any oven spills daily and as needed. | F 812 | | |
| F 880 SS=D | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>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.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§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;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be | F 880 | | 2/14/18 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 355080 | A. BUILDING _____ B. WING _____ | 01/31/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| DUNSEITH COM NURSING HOME | 15 1ST ST NE DUNSEITH, ND 58329 |

| (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 880 | Continued From page 17<br>reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(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<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, review of the facility's policy/procedure, and staff interview, the facility failed to ensure staff followed appropriate infection control practices for 1 of 1 soiled utility | F 880 | 1.) Gowns, gloves and face protection were placed in the soiled utility room for staff to use when rinsing soiled linen/clothing. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 355080 | A. BUILDING _____ B. WING _____ | 01/31/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| DUNSEITH COM NURSING HOME | 15 1ST ST NE DUNSEITH, ND 58329 |

| (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 880 | Continued From page 18<br>room used to rinse soiled linen and resident clothing. Failure to follow appropriate infection control practice related to use of personal protective equipment (PPE) may result in the spread of infection within the facility.<br><br>Findings include:<br><br>Review of the facility policy/procedure titled "Soiled Laundry" occurred on 01/31/18. This policy, updated April 2001, stated, "Definition: Laundry is considered soiled when there is visible BM [bowel movement] or emesis. Procedure: Soiled laundry shall be transported to the soiled utility room in a clean bag. Appropriate protective equipment will be worn as necessary. Gloves will always be worn. Soiled laundry will be rinsed in the hopper to remove any loose material then placed in a clear bag. . . . "<br><br>During an interview on 01/31/18, two certified nursing assistant's (CNAs) (#3 and #4), stated soiled clothing/linen was rinsed in the hopper room, bagged, and placed in large yellow containers to go over to the offsite laundry building. The CNAs (#3 and #4), stated they wore no gowns or goggles when rinsing soiled clothes/linen.<br><br>Observation of the soiled and clean utility rooms on the afternoon of 01/31/18, showed no gowns or goggles located for staff to use when rinsing soiled clothing/linen<br><br>During an interview on 01/31/18 at 2:34 p.m., two administrative staff members (#1 and #2), stated gowns and goggles should be located in the soiled and clean utility rooms for staff to wear | F 880 | 2.) All residents have potential to be affected by this deficient practice.<br>3.) Nursing staff will be in-serviced on the policy in place for Soiled Laundry by 02-23-18.<br>4.) DON/Designee will do a quality monitor to assure that there is PPE in the soiled utility room available for staff use. This monitor will be weekly x 4, biweekly x 4 and monthly x 4.The monitoring will be initiated starting 02/14/2018 for total of 7 months. The date will be reviewed at the scheduled quality assurance meeting and revised as needed.<br>5.) 02-23-18 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 355080 | A. BUILDING _____ B. WING _____ | 01/31/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| DUNSEITH COM NURSING HOME | 15 1ST ST NE DUNSEITH, ND 58329 |

| (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 880 | Continued From page 19<br>when rinsing soiled clothing/linen.<br><br>The facility failed to provide adequate PPE to prevent the spread of infection within the facility. | F 880 | | |