STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355103	A. BUILDING _____ B. WING _____	09/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUR SEASONS HEALTH CARE INC	483 4TH ST SW FORMAN, ND 58032

(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 09/11/22 and concluded 09/14/22.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to ensure the interdisciplinary team assessed the appropriateness to self-administer medications (SAM) for 2 of 2 sampled residents (Resident #17 and #22) and one supplemental resident (Resident #2) with medications left for the resident to self-administer later in the day. Failure to determine whether SAM is a safe practice has the potential to result in a medication error and/or harm to a resident. Findings include: Review of the facility policy titled "Resident Self-Administration of Medication" occurred on 09/13/22. This policy, dated July 2020, stated, ". . . A resident may only self-administer medications after the facility's interdisciplinary team has determined which medications may be self-administered safely. . . . The results of the interdisciplinary team assessment are recorded on the Medication Self-Administration Assessment Form, which is placed in the resident's medical record. . . ."	F 554	483.10(c)(7) Resident Self-Admin Meds-Clinically Appropriate (Long Term Care Facilities) was not met as the facility failed to ensure the interdisciplinary team assessed the appropriateness of self-administer medications for 2 of 2 sampled residents and one supplemental resident with medications left for the resident to self-administer later in the day. Failure to determine whether SAM is a safe practice has the potential to result in a medication error and/or harm to a resident. 1. Resident #17, #22, and #2 had SAM assessments completed by the charge nurse on duty the morning of 9/13/22. The finding were brought to the DON and then discussed with the interdisciplinary team for each resident. Only resident #4 was able to appropriately complete the SAM assessment safely. 2. All resident who take medications are at risk as failure to determine whether SAM is a safe practice has the potential	10/18/22

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

Electronically Signed | 10/14/2022

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F 554	Continued From page 1 - Observation of medication pass on 09/12/22 at 5:15 p.m. showed a medication assistant (MA) (#5) administered medications to Resident #22. The MA obtained Resident #22's Ipratropium-Albuterol nebulizer medication (used for shortness of breath and chest congestion) and set it on the medication cart stating, "I will set this up and she will do it herself." Resident #22's medical record lacked a SAM assessment. - Observation of medication pass on 09/12/22 at 5:20 p.m. showed a MA (#5) administered medications to Resident #17. The MA dished up Tums E-X, set the medication on the table and stated, "Take an hour after you eat." Resident #17's medical record lacked a SAM assessment. - Observation of medication pass on 09/13/22 at 8:00 a.m. showed a MA (#4) administered medications to Resident #2. The MA placed Resident #2's Ipratropium-Albuterol nebulizer medication and Trelegy inhaler (Respiratory Combination Inhaler) into her walker bag with instructions to use in her room. Resident #2's medical record lacked a SAM assessment. During an interview on 09/13/22 at 10:32 a.m., a supervisory nurse (#3) confirmed staff failed to complete SAM assessments for the above residents.	F 554	to result in a medication error and/or harm to a resident. 3. The current policy was reviewed by DON and the interdisciplinary team, updates to be done as warranted. Education to nurses will be given by the DON at the meeting October 25th,2022 on need for a SAM assessment prior to any resident being able to be left with a medication for SAM. Education to MA will be given by the DON at the meeting on October 25th, 2022 on SAM by reviewing of policy, checking on the MAR for instructions if allowed to SAM, and with checking with their charge nurse if questioning if a resident is allowed to take a medication on their own. The SAM assessment will be discussed at the Resident Council meeting on October 20,2022 for resident education. 4. A QA audit was developed to ensure that any resident who request to take medication on their own has a SAM assessment in their electronic record, able to pass the SAM assessment, and has a physician order. The order in the MAR will reflect that they are allowed to take medication on their own. These audits will be completed on new admissions, a sample of 5 residents every 3 months, with results discussed at the quarterly QAA meetings will be completed by the DON. Correction Date: 10/25/22	
F 578	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir	F 578		10/18/22

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F 578 SS=D	Continued From page 2 CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information.	F 578		

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F 578	Continued From page 3 Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy review, and staff interview, the facility failed to ensure the resident's right to request, refuse, and/or discontinue treatment for 1 of 14 sampled residents (Resident #28) reviewed for advanced directives. Failure to ensure all methods of communication and/or documentation of code status accurately reflected the resident/resident representative wishes has the potential to limit his/her access to life-sustaining services or result in unwanted treatment. Findings include: Review of the policy titled "Advance Directives" occurred on 09/14/22. This policy, reviewed/revised May 2019, stated, ". . . It is the policy of this facility to ensure that a resident's choice about advance directives be respected . . . Changes . . . must be submitted to the facility, in writing. . . ." Review of Resident #28's medical record occurred on 09/12/22. A physician's order, dated 03/23/22, stated, "DNR [Do Not Resuscitate]." The most recent Physician's Order For Life Sustaining Treatment (POLST) form, signed and dated by the resident on 10/2/21, identified "Yes CPR [Cardiopulmonary Resuscitation]." The current care plan stated, "I do not want CPR if my heart would stop."	F 578	483.10(c)(6)(8)(g)(12)(I)-(v) Request/Refuse/Discontinue Treatment; Formulate Advanced Directives(Long Term Care Facilities) was not met base on observation, record review, and staff interview, the facility failed to ensure the resident's right to request, refuse, and/or discontinue treatment for 1 of 14 sampled residents (Resident #28) reviewed for advanced directives. Failure to ensure all methods of communication and/or documentation of code status accurately reflected the resident/resident representative wishes has the potential to limit his/her access to life-sustaining services or result in unwanted treatment. 1. Corrective Action The code status of Resident #28 was verified that it had changed in March of 2022. The most current POLST form dated 9/7/22 was scanned under documents within the electronic medical record. The Heart on Resident #28's door name plate was removed to reflect that he/she no longer wished to receive CPR. These were all completed on 9/12/22 by SSD. 2. Determining the code status or presence/absence of Advanced Directives is required for all residents upon admission. The Advanced	

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F 578	Continued From page 4 During an interview on 09/12/22 at 3:10 p.m., an administrative staff nurse (#3) stated, "If there's a heart on the resident's name plate on their door it means to do CPR." Observation on 9/11/22 and 9/12/22 showed a large red heart and a small red heart on Resident #28's name plate outside of her room. During an interview on 09/12/22 at 4:25 p.m., a social service staff member (#11) stated Resident #28's code status changed from CPR to DNR March 2022 and confirmed there is still a heart on Resident #28's name plate indicating CPR. On 09/12/22 3:54 p.m., a social service staff member (#11) presented a copy of an updated POLST document to the surveyor. The POLST form, signed by Resident #28 on 09/07/22 indicated, Comfort measures only. The facility failed to ensure all methods of communication and/or documentation accurately reflected Resident #28's code status wishes and may have resulted in unwanted treatment.	F 578	Directives/code status of residents is reviewed quarterly at care conferences. Therefore, all residents have the potential to be affected. 3. The Director of Nursing educated social service staff and licensed nurses regarding the documentation process for Advanced Directives/code status on 9-22-22. A chart audit of all residents was completed on 9-20-22. Discrepant findings were addressed immediately, and all needed actions were completed on 9-22-22. 4. For a period of three months, the Social Service Designee will perform weekly medical record audits of new admissions and those residents on the MDS assessment schedule for consistent documentation of the resident's Advanced Directive/code status throughout the medical record. After three months, the Social Service Designee will complete a random medical record audit quarterly of a least 10 record for consistent documentation. Results of the audits will be discussed with the QAA committee quarterly for a year by the SSD. A new policy "Communication of Code Status" will be implemented with in-service training on 10/25/22. The policy titled "Advance Directives" and "Hearts on Residents name plate" will be reviewed on 10/25/22 at the in-service training.	

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F 578	Continued From page 5	F 578	5. Correction Date: 10/25/22	
F 582 SS=B	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is	F 582		10/13/22

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F 582	Continued From page 6 transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on review of Medicare Part A letters/notices, facility policy, and staff interview, the facility failed to provide the Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNFABN) form and Notice of Medicare Non-coverage (NOMNC) form two days in advance of discharge for 2 of 3 residents (Resident #16 and #79) reviewed for discharge from Medicare Part A services. Failure to provide Medicare Part A letters/notices within the required time frame has the potential to limit the residents' right to an expedited review of service termination (NOMNC) and to exercise their rights to Medicare Part A services (SNFABN). Findings include: Review of the facility policy titled "Advance Beneficiary Notices" occurred on 09/14/22. This policy, dated 01/02/22, stated, ". . . It is the policy	F 582	483.10(g)(17)(18)(I)-(v) Medicaid/Medicate Coverage/Liability Notice (Long Term Care Facilities) was not met based on review of the Medicare notices provided showed facility staff failed to provide the forms two days before resident #16's services ended on 7/7/22 and before #79's ended on 9/7/22 in accordance with facility policy "Advance Beneficiary Notices". It is the policy of this facility to provide timely notices regarding Medicare eligibility and coverage. 1. Resident #16 and #79 were verbally informed of payment status as of the resident's last covered day. This was not documented in the chart by Social Service Designee or Business Office Manger.	

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F 582	Continued From page 7 of this facility to provide timely notices regarding Medicare eligibility and coverage. . . . For Part A items and services, the facility shall use the Skilled Nursing Facility Advance Beneficiary Notice (SNFABN), Form CMS-10055. . . . Notice of Medicare Non-Coverage (NOMNC), Form CMS-10123, shall be issued to the resident/representative when Medicare covered service(s) are ending, no matter if resident is leaving the facility or remaining in the facility. This informs the resident on how to request an appeal or expedited determination from their Quality Improvement Organization (QIO). . . . To ensure that the resident, or representative, has enough time to make a decision whether or not to receive the services in question and assume financial responsibility, the notice shall be provided at least two days before the end of a Medicare covered Part A stay . . ." Review of the Medicare notices provided showed facility staff failed to provide the forms two days before Resident #16's services ended on 07/07/22 and before Resident #79's ended on 09/07/22. During an interview on 09/13/22 at 2:45 p.m., a managerial staff member (#1) agreed the facility failed to provide two days advance notice to Resident #16 and #79 regarding the end of their Medicare Part A benefits.	F 582	2. The facility has determined that residents with a qualifying hospital stay and Medicare Part A benefit days available have the potential to be affected. An audit was conducted on current residents who were admitted in the past six months, and corrective actions were completed on 10/10/22. 3. The Director of Nursing and Administrator educated the following personnel on the facility's Advanced Beneficiary Notices policy: Business Office Manager, Social Service Designee, MDS Coordinator, and Contract Therapy Staff (PT,OT,ST). Copies of the relevant forms were placed in a binder/folder in the Rehab Room and the offices of the Business Office Manager and Social Service Designee. These actions will be completed on 10-17-22. 4. The Social Service Designee will complete a Advanced Beneficiary Notices Validation Checklists on every Medicare Part A eligible resident for the next year that is admitted to Four Seasons Healthcare Center to ensure compliance. They will be reviewed quarterly at the QAA meetings. The finding of the audit that was conducted on residents from the past six months will be discussed at Resident Council on October 20, 2022. In-Service training will be completed on	

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F 582	Continued From page 8	F 582	the facility policy "Advance Beneficiary Notices" and F-582 Failure to Issue a Skilled Nursing Facility Advanced Beneficiary Notice on 10-25-22. 5. Correction Date: 10-25-22	
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review, facility policy, and staff interview, the facility failed to complete a status change assessment for 1 of 1 sampled residents (Resident #19) reviewed for Preadmission Screening and Resident Review (PASARR). Failure to complete a change in status assessment with a newly diagnosed mental illness may result in the delivery of care and	F 644	483.20(e)(1)(2) Coordination of PASARR and Assessments (Long Term Care Facilities) was not met as the facility failed to complete a change in status assessment with a newly diagnosed mental illness may result in the delivery of care and services that are inconsistent with the resident's needs. Resident #19's	10/18/22

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F 644	Continued From page 9 services that are inconsistent with the resident's needs. Findings include: Review of the facility policy titled "Resident Assessment - Coordination with PASARR Program" occurred on 09/14/22. This policy, revised July 2021, stated, ". . . 9. Any resident who exhibits a newly evident or possible serious mental disorder, intellectual disability, or a related condition will be referred promptly to the state mental health intellectual disability authority for a level II resident review. Examples include: . . . a. A resident who exhibits behavioral, psychiatric, or mood related symptoms suggesting the presence of a mental health disorder . . ." Review of Resident #19's medical record occurred on all days of survey and identified an original PASARR completed on 07/18/22. A physician's order, dated 07/25/22, included Seroquel (antipsychotic medication) 25 milligrams related to a new diagnosis of unspecified psychosis. Another physician's order, dated 07/28/22, included Mitrazapine {antidepressant medication) 15 milligrams related to a new diagnosis of suicidal ideations. The record lacked evidence of an updated PASARR which included the diagnosis of schizophrenia with psychotic disorder. During an interview on 09/14/22 at 8:50 a.m., an administrative staff member (#3) agreed the facility failed to complete a new level 1 screen when Resident #19 received a new mental health diagnosis.	F 644	record lacked evidence of an updated PASARR which included a diagnosis of schizophrenia with psychotic disorder. 1. Resident #19 had a new PASARR completed on 9/23/22 with the application being accepted on 10/4/22. The new PASARR had no changes from the original admission PASARR completed on 7/18/22. 2. All resident are at risk if failure to complete a change in status assessment with a newly diagnosed mental illness is not completed. This can result in the delivery of care and services that are inconsistent with the resident's needs. 3. The facility policy "Resident Assessment-Coordination with PASARR Program" is being reviewed and revised if warranted by the DON and SSD. Education and review of facility policy on when to notify the DON and/or SSD on new mental illness diagnosis or psychotropic medications will be scheduled for the next staff meeting October 25, 2022. 4. A PASARR Level II Tracking Tool will be utilized by the SSD and/or DON to complete when a PASARR is completed per facility policy to ensure that all follow up is completed. A QA audit tool will be developed to check for new mental illness diagnosis and medications on Physician and Mental	

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F 644	Continued From page 10	F 644	Health Rounds monthly by the DON for a year. The findings of the QA will be reviewed at the QAA Meetings quarterly for a year by the DON. Correction Date: 10/25/22	
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: 1. Based on observation, policy review, review of the Volaro Operator's Manual, record review, and staff interview, the facility failed to provide adequate assistance for 3 of 5 sampled residents (Resident #1, #4, and #6) observed during a sit-to-stand mechanical lift transfer. Failure to ensure proper use of the stand lift, and use the leg strap caused the residents unnecessary pain/discomfort and placed them at risk of possible injury. Findings include: Review of the facility policy titled "POLICY AND PROCEDURE ON USING PAL [mechanical] LIFT" occurred on 09/14/22. This policy, reviewed October 2021, stated, ". . . POLICY . . .	F 689	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices (Long Term Care Facilities) 1) This was not met by failure to ensure proper use of the stand lift, and use the leg strap caused the residents unnecessary pain/discomfort and placed them at risk of possible accidents with/or without injury. Corrective Action: 1. Resident's #1, #4, and #6 will have all straps fastened as stated in the operator manual for all transfers while using the stand lift to ensure proper position and reduce risk of injury to the resident. All	10/20/22

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F 689	Continued From page 11 ensure that each resident is safely transferred using the pal lift. . . . 1. All straps will be buckled unless resident specifically requests no straps. . . ." Review of the "Volaro Operator's Manual" occurred on 09/14/2022. These operator's instructions, stated, ". . . ATTACHING SLING TO LIFT . . . have him hold onto the handle grips. . . . attach the colored loops to the positive-locking "J" hooks. NOTE: Make sure you use the same colored loops on each "J" hook. . . ." - Review of Resident #1's medical record occurred on all days of survey and included the diagnoses of bursitis (inflammation) to right and left shoulders. The current care plan stated, "I have . . . shoulder pain at all times. . . I am alert and able to report pain . . . I need assistance with my activities of daily living . . . I need the stand-up lift and one assist for transfer . . ." Observation on 09/11/22 at 4:31 p.m. showed a certified nursing assistant (CNA) (#8) assisted Resident #1 out of the recliner using the sit to stand lift. The CNA applied the sling around the resident's abdomen, secured the buckle, attached the gray colored loops to the handle bars and not the J hooks, and told the resident to put her hands on the handle bars. Utilizing the lift, the CNA transferred the resident onto the toilet. During the transfer, the harness sling slid up the resident's back to the axilla area, and the resident leaned forward, causing the resident's elbows to bow outward above the shoulders. While lowering the resident onto the toilet and pulling the resident's pants down the resident	F 689	new staff were trained prior to their next shift on the Volero stand lift. 2. All residents who use the stand lift are at risk of experiencing pain/discomfort and/or possible accidents with/or without injury. 3. The current policy and procedure was reviewed. Staff Education will be given on the facility policy and procedure on the use of the stand lift on October 25, 2022 at the all staff meeting. All new staff and traveling staff will have education on each of our facility sit to stand and Hoyer lifts in orientation sign and date forms when completed. New staff will have to demonstrate use of each lift during orientation prior to using on a resident to ensure safety. 4. A QA audit will be completed to ensure transfers with the stand lift on residents is completed according to policy and procedure, unless care planned. It will be completed on four residents weekly, then on four residents every two weeks, and then on four residents monthly for one year by DON/Charge Nurse. The audit will be reviewed at the QAA meetings quarterly by the DON. 2)This was not met as the facility failed to ensure residents received adequate supervision and/or monitoring to prevent elopement from the facility for 1 of 1	

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F 689	Continued From page 12 stated, "Oh I'm going down, I'm slipping" and both of the resident's hands fell off the handle bars. The resident fell approximately 3 inches onto the toilet. The CNA left the sling loops connected to the handle bars while the resident used the toilet. When the resident finished, the CNA instructed the resident to place her hands on the square handle bar and attempted to lift the resident off the toilet. The resident stated, "I'm slipping again, my arms, oh mercy." The CNA then lowered the resident to the toilet again. The CNA stated, "Let's try using the blue loops," and changed the gray loops to the blue loops, attaching them again to the handle bar. The CNA attempted to lift the resident with the sit to stand. The resident stated, "My arms and shoulders hurt, oh my arms, ouch (expletive) it hurts ouch ouch." The CNA lowered the resident to the toilet again and stated, "Let's try a different lift that's not so hard on your arms and shoulders." The CNA called for assistance with the transfer and requested staff bring a different lift. At 4:45 p.m., a nurse (#16) entered the resident's room with a different sit to stand lift. Using the new lift, observation showed the nurse attached the loops to the correct hooks, secured the feet strap and proceeded to transfer the resident to her wheelchair. Once seated in the wheelchair the resident stated, "Oh does that feel good." - Review of Resident #4's medical record occurred on all days of survey and included the diagnoses of osteoporosis and dementia. The current care plan stated, "I have . . . shoulder pain at all times. . . I am alert and able to report pain . . . I need assistance with my activities of daily living . . . I need the Pal [sit to stand] lift and one assist with transfers. . . ."	F 689	sampled residents coded for elopement. Failure to provide adequate supervision and monitoring may result in avoidable accidents and/or injury. Correction Action: 1. Resident #19 had a follow-up elopement risk assessment completed to assess for elopement risk and further need for a wander guard by DON. Care plans were reviewed to reflect those that are at risk and who have wander guards in place. 2. All residents who have a wander guard in place are at risk of avoidable accidents and/or injury if a wander guard is removed without a elopement assessment being completed prior to removal and being reviewed by the interdisciplinary team. 3. The current Elopement Policy and Procedure was reviewed, updates are being made to include when to complete follow-up Elopement Risk Assessments. The policy and procedure updates will be reviewed with staff on October 25,2022. These assessment will be completed by the SSD or DON with the interdisciplinary care team reviewing them yearly. These assessments can be done sooner at the discretion of the DON and/or SSD if a change of condition is noted to a resident with a wander guard brought to them by nursing staff. 4. A QA audit was developed to ensure	

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F 689	Continued From page 13 Observation on 09/11/22 at 4:16 p.m. showed a CNA (#8) used the sit to stand lift and transferred Resident #4 from her recliner to the toilet. The CNA applied the sling around the resident's abdomen, secured the buckle, attached the gray colored loops and not the J hooks, and told the resident to put her hands on the square handle bar. During the transfer, the harness sling slid up the resident's back to the axilla area, and the resident leaned forward, causing the resident's elbows to bow outward above the shoulders. When the resident finished using the toilet, the CNA attempted to lift the resident off the toilet. The resident stated, "Oh boy, that hurts." The CNA then lowered the resident to the toilet again. The CNA changed from the gray loops to the blue loops, attaching them again to the handle bar. The CNA transferred the resident from the toilet to the wheelchair. Again during the transfer, the harness sling slid up the resident's back to the axilla area, and the resident leaned forward, causing the resident's elbows to bow outward above the shoulders. When the CNA was placing the resident in the wheelchair, the resident's buttocks were lower than the wheelchair and the CNA had to tip the wheelchair forward to get the resident seated. - Observation of care on 09/12/22 at 9:26 a.m. showed a CNA (#2) transferred Resident #6 from the toilet to his wheelchair using a sit to stand lift. As the CNA (#2) transferred the resident, observation showed the sling around Resident #6's torso loose, and the velcro strap not closed, the CNA (#2) failed to tighten the loose belt. As Resident #6 semi- squatted in the lift, his elbows rose almost level with his shoulders. The CNA	F 689	that the elopement risk assessments are completed prior to admission, care planned to reflect risk, interventions, and when a follow-up risk assessment will be completed. These audits will be completed as follows, a sample of 10 residents in the last 4 months with findings brought to QAA meetings quarterly by the SSD. These audits will also be used for all new admits for the next year and will be completed by the SSD. 5. Correction Date: 10/25/22	

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F 689	Continued From page 14	F 689		

(#2) failed to ensure the torso strap was fitted properly before transferring the resident, which may put him at risk for injury.

During an interview on 09/12/22 at 2:30 p.m., an administrative nurse (#3) stated she expected staff to use the sit to stand lift correctly by securing the sling loops to the positive-locking J hooks (and not the handle bar) and using the leg straps at all times when transferring a resident.

2. Based on observation, record review, facility policy, and staff interview, the facility failed to ensure residents received adequate supervision and/or monitoring to prevent elopements from the facility for 1 of 1 sampled resident (Resident #19) coded for elopement. Failure to provide adequate supervision and monitoring may result in avoidable accidents and/or injury.

Findings include:

Review of the facility policy titled "ELOPEMENT ASSESSMENT FOR NEW ADMITS" occurred on 09/14/22. This policy, dated May 2020, stated, ". . . POLICY . . . To ensure the safety of new residents on admission. . . . 2. If resident is at high risk for elopement a Wanderguard will be placed. . . ."

Review of Resident #19's medical record occurred on all days of the survey and identified an admission date of 07/19/22. The record included the diagnoses of cognitive communication deficits, delirium, suicidal ideations, and unspecified psychosis. The current care plan stated, ". . . I have behaviors. I try to leave the building, I hit out at staff, am very

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F 689	Continued From page 15	F 689		

paranoid. . . . Staff needs to monitor me closely . . . I have tried to go out the window multiple times. Staff has a wanderguard on me to alert staff if I am trying to leave out the door. Staff monitors often to make sure I do not go out the window. I have removed the wanderguard so staff needs to try to reapply and check often to make sure that I still has this on. . . ."

Review of Resident #19's electronic treatment record showed on 08/30/22 the facility discontinued monitoring the resident's wanderguard twice a day.

Observations on all days of survey showed Resident #19 without a wanderguard.

The admission Minimum Data set (MDS), dated 07/26/22 identified the resident wandered 1-3 times a week.

Review of Resident #19's "Risk Assessment," dated 07/19/22, indicated the resident scored a 9 out of 10 potential risk factors and was at risk for elopement.

Nursing progress notes included the following:
* 07/30/22 at 9:07 p.m., " . . . Resident becomes more restless after family leaves. Resident is trying to exit out door 8 x 2 [attempted to exit out of door 8 twice]. . . ."
* 07/31/22 at 6:31 a.m., ". . . Resident is up in the hall early this am looking for her husband. . . . Resident has her clothes packed up in boxes and folded on her bed. Other personal items also packed up. She is looking for [husband's name] to take her home. . . ."
* 07/31/22 at 9:15 a.m., ". . . Resident declined to

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F 689	Continued From page 16 allow staff to assist her with am cares until now. She has a couple staff only today that she is trusting. Increased delusions noted this morning . . ." * 8/10/22 at 5:40 a.m., ". . . Attempted Elopement. CNA was walking on the B wing hall way when she saw someone standing in front of the exit door in A wing. She notified writer through the walkie and writer ran after the resident. resident [sic] was pushing the door to go out and had also tried to push the automatic door button for the door to open. . . ." * 8/30/22 at 11:34 a.m., ". . . Resident has shown no signs of elopement behaviors since initial admit, Resident has exhibited no behaviors. Current medication schedule has been working effectively for resident. . . ." During an interview on 09/14/22 at 10:00 a.m., an administrative staff member (#3) confirmed the facility failed to adequately assess the resident's current elopement risk and did not complete another risk assessment prior to removing her wanderguard.	F 689		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; 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 a medication error rate of less than five percent for 1 of 7 residents (Resident #14)	F 759	483.45 (f)(1) Free of Medication Error Rts 5 Prct or More (Long Term Care Facilities) was not met as observed by the facility failed to ensure a medication error rate of	10/20/22

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F 759	Continued From page 17 observed during medication administration. Two medication errors occurred during staff administration of 29 medications, resulting in a 6% error rate. Failure to properly administer medications may result in residents receiving an ineffective dose and experiencing adverse consequences. Findings include: Review of the facility policy titled "Medication Administration" occurred on 09/13/22. This policy, revised 09/13/22, stated, ". . . Medications are administered . . . as ordered by the physician . . . Compare medication . . . with MAR [medication administration record] to verify resident name, medication name, form, dose, route and time. . . ." Review of Resident #14's medical record occurred on 09/12/22. A physician's order stated, "GenTeal Tears solution . . . (Artificial Tear Solution) instill 2 drop [sic] in both eyes every 4 hours as needed for dry eyes" Observation on 09/12/22 at 11:45 a.m. showed a medication assistant (MA) (#5) administered Genteal eye drops to Resident #14. The MA administered one drop in each eye. Observation on 09/13/22 at 8:20 a.m. showed a MA (#5) administered Genteal eye drops to Resident #14. The MA administered one drop in each eye. The MA failed to compare the medication to the MAR or read the directions on the eye drop box which stated, ". . . Instill two drops in both eyes . .	F 759	less than five percent for 1 of 7 residents observed during medication administration. PRN eye drops were not given as ordered by the physician, MA did not compare the medication to the MAR or read the directions on the eye drop box. 1. Resident #14's eye drop box direction were read by MA reading Artificial Tear Solution instill 2 drops in both eyes every 4 hours as needed for dry eyes on 9/13/22 when interviewed. MA noted the medication error she had made by not comparing or reading the order. 2. All residents receiving medications have the potential to be affected by this practice. 3. Nurses and MA will be in-serviced on preventing medication errors October 25, 2022 by the DON. The DON will audit all nurses and MA individually by November 4, 2022. The current policy will be reviewed and updated as warranted, reviewed with nurses and MA by DON on October 25, 2022. 4. Random medication administration audits will be conducted for one nurse/MA weekly on each shift for 2 weeks, then two nurses/MA monthly for 3 months, then one nurse/MA monthly on-going to ensure compliance with the facility policy for a total of a year.	

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F 759	Continued From page 18 ." During an interview on 09/13/22 at 8:22 a.m., the MA (#5) stated, "Oh he is supposed to get two drops."	F 759	Audit results will be reviewed at the QAA meetings quarterly for a year by the DON. Medication errors will continue to be reviewed by MD and/or Facility Medical Director through the DON. 5. Correction Date: 10/25/22 5.	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced	F 761		10/18/22

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F 761	Continued From page 19 by: Based on observation, review of facility policy, and staff interview, the facility failed to store all medications in a secure manner in 1 of 1 medication cart. Failure to store all medications securely may result in unauthorized access to medications and/or medication errors. Findings include: Review of the facility policy titled "Medication Storage" occurred on 09/14/22. This policy, dated 07/28/21, stated, ". . . All drugs and biologicals will be stored in locked compartments . . . During a medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage/cart. . . ." Observation on 09/12/22 at 11:45 a.m. showed a medication assistant (MA) (#5) passing medications in the dining room, the medication cart remained unlocked in a nearby room out of view of the MA. Observation on 09/13/22 at 4:56 p.m. showed a MA (#15) passing medications in the dining room, the medication cart remained unlocked in a nearby hallway out of view of the MA. The MA (#15) left a medication cup containing several medications on top of the cart as the MA walked away to assist visitors at the front door. During an interview on the morning of 09/14/22, an administrative staff member (#3) stated she expected staff to lock the medication cart when it is not within view and not leave medications unattended on the medication cart.	F 761	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals (Long Term Care Facilities) was not met as the facility failed to store medications in a secure manner in 1 of 1 medication cart. Failure to store all medications securely may result in unauthorized access to medications and/or medication errors. 1. MA #5 and #15 educated on the facility policy "Medication Storage" that during a medication pass all medications must be under direct observation of the person administering medications or locked in the medication cart. 2. This practice puts all MA and Nurses at risk of failing to store all medications securely may result in unauthorized access to medications and/or medication errors. 3. The current policy was reviewed and will be reviewed with all nurses and MA at the next monthly staff in-service on October 25, 2022. The Policy has until then been posted in the Med Room and in the Communication Book at the nurses station. 4. A QA audit was developed to ensure that the medication cart is locked when left unsupervised by the MA or nurse during medication pass. This QA will be on random shift and random times of day with all Department Heads being able to conduct observation(Dietary Manager,	

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F 761	Continued From page 20	F 761	SSD, Administrator, MDS Coordinator can be asked to audit a shift by the DON). The observations will be conducted 3 times a week for 3 months, then 2 times a week for 3 months, then 1 time a week for 6 months. The QA audits will be reviewed at the quarterly QAA meeting by the DON. 5. Correction Date: 10/25/22	
F 880 SS=E	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,	F 880		10/18/22

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F 880	Continued From page 21 but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (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	F 880		

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	355103	A. BUILDING _____ B. WING _____	09/14/2022

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F 880	Continued From page 22 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 standards of infection control for 2 of 8 sampled residents (Residents #7 and #12) and 2 supplemental residents (Resident #2 and #5) observed during cares and/or treatments. Failure to follow infection control standards has the potential for transmission of communicable diseases and infections to residents, staff, and visitors. Findings include: Review of the facility policy/procedure titled "Hand Hygiene" occurred on 09/14/22. This policy, dated August 2019, stated, ". . . Hand hygiene is indicated and will be performed under the conditions listed in, but not limited to, the attached hand hygiene table. TABLE: After handling items potentially contaminated with blood, body fluids, secretions, or excretions . . . After assistance with personal body functions (e.g., elimination, hair grooming, smoking,) . . . Additional considerations: . . . The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves. . . ." HAND HYGIENE - Observation on 09/11/22 at 3:19 p.m. showed a certified nurse aide (CNA) (#6) donned gloves and provided perineal care for Resident #12. The CNA (#6) cleansed the frontal perineal area then	F 880	1. Corrective Action The facility will immediately implement an appropriate infection prevention and intervention plan consistent with the requirements of ¿483.80 for the affected resident(s)/neighborhood(s) identified in the deficiency. The infection preventionist (IP), director of nursing (DON), in conjunction with applicable interdisciplinary team (IDT) members, shall identify and implement a consistent system for ensuring a system for: (1) Ensuring staff wear personal protective equipment (PPE) required type of face masks, in accordance with facility practice and CDC guidelines. (2) Ensuring staff have adequate knowledge of hygienic practices in relation to bare hand contact with medications. (3) Ensuring staff hand hygiene or handwashing when donning PPE, moving between tasks, residents, and after touching potentially contaminated surfaces, in accordance with CDC guidelines. The DON, staff development coordinator (SDC), IP or designee, in conjunction with applicable IDT members, will: (1) Educate all staff on selecting, donning, doffing and disposing of PPE while working in the facility. To verify each	

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F 880	Continued From page 23 reached up with a soiled glove and moved Resident #12's neck pillow. The CNA (#6) cleaned the resident of stool, placed a new brief, redressed the resident, and removed her gloves. Without performing hand hygiene, the CNA (#6) pulled up the resident's covers, gave her the call light, lowered the bed, and assisted with placement of the neck pillow. The CNA (#6) then gathered the garbage and left the room without performing hand hygiene. The CNA (#6) failed to perform hand hygiene after perineal care and before moving to other tasks. - Observation on 09/11/22 at 4:57 p.m. showed Resident #5 lying in bed as a CNA (#6) donned gloves, completed perineal care, and without removing her gloves, assisted the resident to turn in bed by holding the resident's hand. The CNA (#6) removed her gloves, pulled up the resident's pants, placed the hoyer sling under the resident, and left the room without performing hand hygiene. - Observation on 09/11/22 at 05:19 p.m. showed two CNAs (#7 and #8) donned gloves and provided perineal care for Resident #12. The CNA (#7) provided cleansing and without removing her gloves, assisted Resident #12 to a sitting position so the other CNA (#8) could place a sling for a stand lift transfer. The CNA (#7) used the controls on the lift while the other CNA (#8) positioned the resident into the wheelchair. The CNAs (#7) failed to remove her gloves and perform hand hygiene after perineal care and before moving to other tasks. - Observation on 09/12/22 at 9:36 a.m. showed a CNA (#9) assisted Resident #7 with toileting in a	F 880	of these staff understands the procedure, each staff member will perform a successful return demonstration of selecting, donning, doffing and disposing of PPE for providing cares and/or per facility expectations. (2) Educate nurses and medication aides on hygienic technique to prevent cross contamination when handling medications. To verify each nurse and medication aide understands the training, the staff will complete a return demonstration of medication pass explaining what to do if they drop a medication. (3) Educate nursing staff members on correctly completing hand hygiene after changing tasks, moving between residents, changing gloves, and touching potentially contaminated surfaces. To verify these staff understand hand hygiene and handwashing, these staff will perform a successful return demonstration of identifying the need and correct procedure for performing hand hygiene and handwashing. 2. Identification of Others The IP and DON, in conjunction with the applicable the interdisciplinary team (IDT) members, will review current COVID-19 nursing facility guidelines from CDC and CMS. The IP, DON and applicable IDT members will evaluate the facility's compliance with the guidelines. The facility will develop action plans to address any newly identified non-compliance.	

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F 880	Continued From page 24 communal bathroom. The CNA (#9) used a dry towel type product sprayed with a cleanser for perineal care. The CNA (#9) sprayed cleanser on each towel as she used them, holding the spray bottle with the hand she used to complete perineal care. At one point, the CNA (#9) wiped stool off her gloved hand then picked up the spray bottle and sprayed the cleanser onto a towel. The CNA (#9) performed hand hygiene, took the resident to her room, and returned to the bathroom to clean up. The CNA (#9) repeatedly used a communal bottle of cleansing spray with soiled gloves and failed to sanitize the bottle at the end of care. During an interview on 09/14/22 at 09:45 a.m.. a supervisory staff member (#3) stated she expected staff to remove gloves and perform hand hygiene after cares and before leaving the room. MEDICATION PASS Observation during medication pass on 09/13/22 at 4:42 p.m. showed a medication aide (MA) (#4) obtained Resident #2's medications and dropped two of the pills on top of the medication cart. The MA (#4) picked up the pills, using her bare hand, placed them into the medication cup, and administered the medications to Resident #2. MASKS - Observation on 09/12/22 at 12:10 p.m. showed an unidentified housekeeper going in and out of a resident's room wearing a surgical mask below their nose.	F 880	3. System Changes On or before 10/19/2022 the facility shall complete the following actions: (1) DON, IP and applicable IDT members will conduct root-cause analysis to identify and address the reasons for non-compliance related to: a. Failure to select, don and utilize the necessary PPE to prevent spread of potentially hazardous diseases in accordance with CDC guidelines. b. Failure to ensure handling of medications was completed in a hygienic manner to prevent cross contamination, hands to medications. c. Failure to complete handwashing or hand hygiene in accordance with CDC guidelines. Information about root cause analysis can be found at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/GuidanceforRCA.pdf (2) The DON, SDC, IP or suitable designee will ensure the following: a. Educate all staff whose duties require them to work within the facility on the correct procedure for selecting, donning, using and doffing PPE while in the facility. This education will include the CDC's lesson on personal protective equipment developed for nursing home staff available at https://youtu.be/YYTATw9yav4. This education will be completed on October 25,2022. b. Educate all staff whose job duties	

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F 880	Continued From page 25 - Observation on 09/12/22 at 5:00 p.m. showed an unidentified dietary aide in the dining room wearing a surgical mask below their nose. - Observation on 09/13/22 at 8:26 a.m. showed a MA (#4) going in and out of resident rooms passing medications with the surgical mask below their nose. - Observation on 09/13/22 at 1:53 p.m. showed the charge nurse (#12) at the nurses' station with the N95 mask on their chin, talking with two unidentified staff members. - Observation on 9/14/22 at 8:20 a.m. showed a staff nurse (#12) at the nurse's station with the N95 mask under their chin. - Observation on 09/14/22 at 8:33 a.m. showed a CNA (#9) in the hallway with a surgical mask below their nose. - Observation on 09/14/22 at 8:57 a.m. showed a CNA (#9) standing by the medication cart with a surgical mask below their nose. During an interview on 09/13/22 at 5:10 p.m., an administrative nurse (#3) identified she expects all staff to be wearing their masks appropriately.	F 880	include medication pass on hygienic procedures to prevent cross contamination during medication pass on October 25, 2022. c. All nursing staff will receive education keeping hands clean between tasks, contacts with potentially contaminated surfaces and between residents. This education will include the CDC's lesson on clean hands available at https://youtu.be/xmYMUly7qiE on October 25, 2022. (3) The facility leadership will contact the ND Quality Improvement Organization (QIO), [QIO Great Plains], to inquire about the assistance and services available from the QIO in improving infection prevention and control within the facility through quality assurance process improvement (QAPI) methods. 4. Monitoring Weekly for no less than 12 weeks, the DON, IP, SDC or a designee will conduct on-going monitoring to ensure, via observation, the approaches to correct deficient practice related to infection control and prevention are consistently implemented and effective. Such monitoring will include: (1) Observations of all staff types to ensure correct selection, donning, use and doffing of PPE when working within the facility. (2) Observations of nurses and medication aides providing medications in a hygienic manner and preventing cross contamination.	

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F 880	Continued From page 26	F 880	(3) Observations of all nursing staff types to ensure performance of proper handwashing and hand hygiene, when indicated, in the course of their routine duties. Observations will be made across all shifts. Observations of noncompliance with the above will result in ad hoc education for the involved staff. Such education will be documented on monitoring forms. After twelve weeks of monitoring, provided that such monitoring demonstrates expectations are consistently met, monitoring may be reduced to monthly. Monthly monitoring will continue for no less than three months. All monitoring will be reported to the quality assurance process improvement (QAPI) committee as part of QAPI activities. Monitoring will not be discontinued until the facility completes three consecutive rounds of monthly monitoring that demonstrate sustained compliance as approved by the QAPI committee and medical director. 5. Correction Date 10/25/2022	
F 887 SS=D	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the	F 887		10/20/22

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F 887	Continued From page 27 facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses; (v) The resident or resident representative, has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; Note: States that are not subject to the Interim Final Rule - 6 [CMS-3415-IFC], must comply with requirements of 483.80(d)(3)(v) that apply to staff under IFC-5 [CMS-3414-IFC] and (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and	F 887		

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F 887	Continued From page 28 (B) Each dose of COVID-19 vaccine administered to the resident; or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is not met as evidenced by: Based on record review, and staff interview, the facility failed to offer the COVID19 vaccine and provide education to unvaccinated residents (and/or their legal representatives) regarding the benefits and potential side effects of receiving the vaccination for 1 of 5 sampled residents (Resident #19) reviewd for immunizations. Failure to offer the COVID19 vaccine to all residents, provide education to residents (or their legal representatives), and document the refusal of the vaccine has the potential for non-immunized residents to contract COVID19 and spread the infection to other residents, visitors, and staff. Findings include: Review of Resident #19's medical record occurred on all days of survey. The record failed	F 887	483.80(d)(3)(i)-(vii) COVID-19 Immunization (Long Term Care Facilities) was not met as the facility failed to offer the COVID-19 vaccine and provide education to unvaccinated residents (and/or their legal representatives) regarding the benefits and potential side effects of receiving the vaccination for 1 of 5 sampled resident reviewed for immunizations. 1. Resident #19 was offered to be given education on the risks and benefits of receiving the COVID-19 vaccine on 9-14-22. Resident had received the education prior to this date with no documentation or formal signed declination placed in her chart. Documentation of conversation on	

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F 887	Continued From page 29 to show the facility assessed contraindications to the vaccine, provided the resident/resident representative with risks and benefits of receiving the vaccine, or a signed declination. During an interview on 09/14/22 at 10:15 a.m., an administrative nurse (#3) confirmed the facility lacked documentation for Resident #19 COVID19 vaccine refusal.	F 887	COVID-19 vaccine placed in her electronic medical record. 2. Failure to offer the COVID-19 vaccine to all residents, provide education to residents (or their legal representatives), and document the refusal of the vaccine has the potential for non-immunized residents to contract COVID-19 and spread the infection to other residents, visitors, and staff. 3. The current Immunization policy was reviewed and is being updated to include the COVID-19 vaccine, education to residents-family representatives-staff, and declination documentation guidelines on admit/hire. This will be completed by 10-17-22. Forman Drug, Pharmacist provides immunizations to facility, consultation on education discussed, forms provided for consent/declination use are provided by him on new COVID-19 vaccines. The updated policy will be reviewed at the Resident Council Meeting on 10-20-22. The updated policy will be reviewed at the in-service on 10-25-22. 4. A QA audit will be completed to ensure that COVID-19 vaccination status is documented, education has been completed with resident and/or resident representative, and that all declination documents are signed in residents electronic records. It will be completed on	

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F 887	Continued From page 30	F 887	5 residents weekly for two weeks, then 5 residents monthly until all residents have been reviewed from the last 6 months by the DON. These finding will be brought to QAA meetings for review quarterly by the DON. This includes documentation in electronic record under immunization if received or declined. This will include all new vaccine variants for COVID-19. 5. Correction Date: 10-25-22	
F 921 SS=E	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, review of the North Dakota Plumbing Code, and staff interview, the facility failed to provide an air gap for 2 of 2 food handling fixtures located in the kitchen area. Failure to provide the required air gap for the food preparation sink and the ice machine has the potential to allow contamination of these food preparation areas during a sewer back up. Findings include: Review of the 2018 North Dakota Plumbing Code, section 801.2 Air Gap or Air Break Required, stated, "Indirect waste piping shall discharge into the building drainage system through an air gap or air break as set forth in this	F 921	483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and public was not met as observed by a food prep sink drainpipe that lacked an air gap and a the drainpipe for the ice machine lacked an air gap. 1. The 2018 ND Plumbing Code, section 801.2 Air Gap reviewed by Dietary Manager and Maintenance Director. Swede's Plumbing contacted for parts and date that air gap can be fixed. 2. Failure to provide the required air gap	10/13/22

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F 921	Continued From page 31 code. Where a drainage air gap is required by this code, the minimum vertical distance as measured from the lowest point of the indirect waste pipe or the fixture outlet to the flood-level rim of the receptor shall be not less than 1 inch (25.4 mm)." Section 801.3.3 Food-Handling Fixtures, stated, "Food-preparation sinks, steam kettles, potato peelers, ice cream dipper wells, and similar equipment shall be indirectly connected to the drainage system by means of an air gap. Bins, sinks, and other equipment having drainage connections and used for the storage of unpackaged ice used for human ingestion, or used in direct contact with ready-to-eat food, shall be indirectly connected to the drainage system by means of an air gap. Each indirect waste pipe from food-handling fixtures or equipment shall be separately piped to the indirect waste receptor and shall not combine with other indirect waste pipes. The piping from the equipment to the receptor shall be not less than the drain on the unit and in no case less than 1/2 of an inch (15 mm)." Observations on 09/13/22 at 3:05 p.m. showed the following: * The food prep sink drainpipe lacked an air gap. * The drainpipe for the ice machine lacked an air gap. Observations on 09/14/22 at 10:30 a.m. showed the following: * A small drainpipe extended from the food preparation sink almost to the bottom of a receptor pipe (larger pipe a small pipe drains into). The facility failed to ensure a one-inch air gap between the food preparation sink drainpipe and the rim of the receptor pipe.	F 921	for the food preparation sink and the ice machine has the potential to allow contamination of these food preparation areas during a sewer back up effecting the health of residents and staff. 3. The food prep sink drainpipe air gap will be repaired by 10/18/22. The ice machine drainpipe air gap will be repaired by 10/18/22. These repairs will be completed by Swede's plumbing. 4. The air gap will be in compliance with the 2018 ND Plumbing Code, section 801.2. Correction date:10/19/22	

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F 921	Continued From page 32 * The ice machine drainpipe extended into the floor sink in the janitor closet off the kitchen. The pipe ended two inches past the lip of the floor drain sink. The facility failed to ensure a one-inch air gap between the ice machine drainpipe and the rim of the floor drain sink. During interviews on 09/13/22 at 3:05 p.m. and 09/14/22 at 10:30 a.m., the dietary manager (#14) and maintenance director (#13) confirmed the food preparation sink and the ice machine failed to have the required air gaps.	F 921		