STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355064	A. BUILDING _____ B. WING _____	C 01/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING CENTER OF GARRISON	**609 4TH AVE NE GARRISON, ND 58540**

(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 An unannounced onsite complaint survey was completed on January 13, 2021. The team conducted observations, interviews, and reviewed five records. Deficiencies were cited at F580, F658, and F686.	F 000		
F 580 SS=G	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment	F 580		2/5/21

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

Electronically Signed | 02/09/2021

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F 580	Continued From page 1 as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, policy review, and staff interview, the facility failed to notify the physician of a deterioration in skin condition for 1 of 3 sampled residents (Resident #5) with a pressure ulcer. Failure to notify the physician of a deterioration in skin condition resulted in complications to the resident and prevented the physician from evaluating the effectiveness of the current treatment plan. Findings include: Review of the facility policy titled "Prevention and Treatment of Skin Breakdown" occurred on 01/13/21. This policy, dated September 2018, stated, ". . . 10. Weekly the licensed nurse will . . . and examine the wound bed and surrounding skin. If wound bed has deteriorated; notify	F 580	F580 SS=G Notification of Changes (Injury/Decline/Room/Etc) During the complaint survey it was noted through records review, and staff interview, the facility failed to notify the physician of a deterioration in skin condition for one sampled residents with a pressure ulcer. Failure to notify the physician of a deterioration in skin condition resulted in complications to the resident and prevented the physician from evaluating the effectiveness of the current treatment plan Res #5 Neighbor chart reviewed and Physician was notified of all further changes in skin condition.	

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F 580	Continued From page 2 provider. 11. Notify the attending provider, . . . if the pressure injury has not shown progress in 2 weeks and/or is deteriorating unexpectedly. . . ." Review of Resident #5's medical record occurred 1/13/21, and showed diagnoses of multiple sclerosis and history of pressure ulcer sacral region. Review of progress notes showed: *10/09/20 2:57 p.m., ". . . 3 cm x 2 cm . . .stage: stage II. . . ." *10/19/20 2:40 p.m., ". . . 6 cm x 6 cm . . . exudate amount: light . . . exudate color: bloody . . . stage: stage II . . . skin surrounding wound: erythema (redness)/blanchable . . . wound healing status: declining . . . ." *10/28/20 9:33 p.m., ". . . 11 cm x 8 cm. Wound bed composed of 70% pink in color and 30% colored purple which is located in the middle. . . . Surrounding area of the wound is color red warm to touch and no drainage. Cavilon paint applied. . . . Condition relayed to night nurse. . . ." *11/16/20 4:19 p.m., ". . . 11 cm x 7 cm . . . exudate amount: light . . . exudate color: serous (clear, amber, thin and watery) . . . tissue type: slough . . . ." *12/21/20 1:44 p.m., ". . . 12 cm x 11.5 cm . . . exudate amount: none . . . ." *12/28/20 3:48 p.m., "Called [power of attorney] and informed of status of wound on coccyx and starting on abx [antibiotic], wound cultures and consult to wound specialist. . . ." *12/29/20 2:43 p.m., "[Physician's Assistant] called to report that Resident #5 is growing in [his/her] wound culture and would like to send [him/her] to hospital for further evaluation and treatment. POA [name] notified and is in	F 580	All neighbors are potentially at risk for this and charts have been reviewed for the need to update MD and notification of family or family representative. The facility procedure titled Change in Neighbor Status has been reviewed and was revised 01/27/2021 Education was provided for all licensed nursing personnel on 2/01 and 02/02 2021 to ensure understanding of the policy titled Change in Neighbor Status. Education consisted of use of wound management in electronic medical record. New licensed nursing staff will receive education regarding policy and procedure listed above during new employee orientation. DON or designee will ensure and monitor compliance. Audits will be conducted weekly x 6 months on neighbors with pressure ulcers; then 2x month for 3 months; then monthly x 3 months. Audits will consist of checking all wound documentation to ensure weekly measurements and proper notifications are made. Analysis of the observations and facility□s compliance will be presented to our Quality Assurance Team monthly beginning 02/04/2021, who will recommend changes and on-going monitoring/auditing after analysis.	

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F 580	Continued From page 3 agreement to the plan." *12/30/20 4:24 p.m., "[Nurse Practitioner] with order to continue follow up with [wound nurse practitioner], consult general surgery for possible need for debridement, first available appointment. They will determine if palastic [sic] surgery is needed. Cancel plastic surgery for now. Dressing change [sic] to wet to dry with Dakins solution, soaked, fluffed, change twice daily then cover with ABD pad. To start antibiotic(s) Flagyl 500mg TID PO [per oral] x 10 days, Doxycycline 100mg cap PO BID x 10 days, Augmentin 875/175 [mg] PO BID x 10 days, DC [discontinue] Keflex. Floragen [probiotic] 1 PO BID x 30 days." *1/04/21 2:06 p.m., "Wound bed on coccyx area measures 12 cm x 15 cm. 1.3 cm undermining Bed is 100% necrotic slough. No drainage. With foul smell. Surrounding area is red/purple in color. . . . . " Review of the medical record showed the facility failed to notify Resident #5's physician of the deterioration of the pressure ulcer. During an interview on 1/13/21 at 1:48 p.m., a provider (#2) stated, "Miscommunication on multiple levels between the providers and the facility resulted in probable delay in treatment." During an interview on 1/13/21 at 3:00 p.m., an administrative nurse (#1) agreed the facility failed to notify the provider of the deterioration in Resident #5's pressure ulcer.	F 580		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans	F 658		2/5/21

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F 658	Continued From page 4 The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, review of professional references, and staff interview, the facility failed to follow professional standards for Foley catheter use for 1 of 3 sampled residents (Resident #5) with a Foley catheter. Failure to follow physician's orders related to Foley catheter size may have resulted in chronic leakage from and prolonged wound healing. Findings include: Berman, Snyder, and Frandsen's "Kozier & Erb's Fundamentals of Nursing: Concepts, Process, and Practice," 10th ed., Pearson Education, Inc., Massachusetts, page 68, stated, ". . . Carrying Out a Physician's Orders . . . If the order is neither ambiguous nor apparently erroneous, the nurse is responsible for carrying it out. . . ." Review of Center of Disease Control (cdc.gov) "Guideline for Prevention of Catheter Associated Urinary Tract Infections 2009" stated, "Appropriate Urinary Catheter Use . . . To assist in healing of open sacral or perineal wounds in incontinent patients. Patient requires prolonged immobilization . . . To improve comfort for end of life care if needed. . . ." Review of Resident #5's medical record identified a physician's order, dated January 7, 2020 through January 7, 2021 for an 18 French (Fr) 30cc (cubic centimeter) bulb catheter to be	F 658	During the complaint survey it was noted through record review, review of professional references, and staff interview, the facility failed to follow professional standards for Foley catheter use for 1 of 3 sampled residents (Resident #5) with a Foley catheter. Failure to follow physician's orders related to Foley catheter size may have resulted in chronic leakage from and prolonged wound healing. Res #5 Neighbor chart reviewed and correct catheter size being used and no further issues noted on physician orders. All neighbors with Foley catheters are potentially at risk for this and charts have been reviewed for compliance with physician orders. The facility policy title Physician Services has been reviewed with no revision at his time and on 01/27/2021. Education was provided for all licensed nursing personnel on 2/1/2021 and 02/02/2021 to ensure understanding of the policy titled Physician Services. Education consisted of licensed nursing staff reading the policy, answering questions, and teaching how to clarify physician orders. New licensed nursing staff will receive education regarding	

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F 658	Continued From page 5 changed as needed (PRN). The current care plan identified "I am at risk for skin breakdown related to . . . leaking catheter. . . . Provide peri [perineal] care after each episode that I have leakage from my foley catheter." A summary of Resident #5's progress notes identified the following: * 07/16/20 Foley catheter leaking. Repositioned. Reassess in the morning. * 07/07/20 Catheter changed related to leaking. Brief moderately soaked. New 16 Fr catheter inserted. (16 Fr catheter has a smaller diameter than an 18 Fr catheter) * 08/06/20 Are on coccyx measuring 7 centimeters (cm) x 3 cm * 09/12/20 Catheter leaked. Irrigated. * 09/17/20 16 Fr catheter removed due to leaking. New catheter inserted. * 09/28/20 Resident had a bath this morning. Area on coccyx measures 3.5 c. x 3 cm * 10/09/20 Resident does wear an incontinent product as catheter chronically leaks. New 16 Fr catheter placed as previous catheter out. 10cc water in balloon. (Order stated 30 cc balloon). * 10/28/20 Open skin area on coccyx 11cm x 8 cm. Wound bed 70% pink in color and 30% colored purple in middle. Surrounding area of wound is color red, warm to touch. Open to air. During an interview on the afternoon of 01/13/21, an administrative nurse (#1) stated she is unaware of why staff used a 16 Fr catheter instead of an 18 Fr catheter as per physician's orders. The use of the incorrect Foley catheter size (16 Fr instead of 18 Fr) led to chronic urine leakage	F 658	policy listed above during new employee orientation. DON or designee will ensure and monitor compliance. Audits will be conducted 2 times monthly for 6 months then monthly for 6 months on all neighbors with Foley catheters. Audits will consist of the checking all Foley catheter orders and Foley catheters inserted in each neighbor.. Analysis of the observations and facility□s compliance will be presented to our Quality Assurance team monthly who will recommend changes and ongoing monitoring/auditing after analysis if needed.	

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F 658	Continued From page 6 which may have caused increased irritation to Resident #5's sacral ulcer.	F 658		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to provide appropriate treatment and services to prevent the deterioration of pressure ulcer for 1 of 3 sampled residents (Resident #5) with pressure ulcers. Failure to implement interventions as ordered, and ensure adequate monitoring/assessment resulted in the delayed treatment/deterioration of Resident #5's pressure ulcer. Findings include: Review of the facility policy titled "Prevention and Treatment of Skin Breakdown" occurred on 01/13/21. This policy, dated September 2018, stated, ". . . Those residents' who experience a break in skin integrity or wounds are provided	F 686	F686 SS=G Treatment/Svcs To Prevent/Heal Pressure Ulcer During the complaint survey it was note through record review, review of facility policy, and staff interview, the facility failed to provide appropriate treatment and services to prevent the deterioration of pressure ulcer for one residents (Resident #5) with a pressure ulcer. Failure to implement interventions as ordered, and ensure adequate monitoring/assessment resulted in the delayed treatment/deterioration of Resident #5'spressure ulcer. Res #5 Neighbor chart reviewed and	2/5/21

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F 686	Continued From page 7 care and service to heal the skin according to professional standards of care. . . . 10. Weekly the licensed nurse will stage, measure, and examine the wound bed and surrounding skin. If wound bed has deteriorated; notify provider. 11. Notify the attending provider . . . if the pressure injury has not shown progress in 2 weeks and/or is deteriorating unexpectedly. Re-evaluated plan of care as appropriate. 12. Documentation reflects areas as addressed above. . . ." Review of Resident #5's medical record occurred on 1/13/21 and showed medical diagnoses of multiple sclerosis (MS), cerebral palsy (CP), type 1 diabetes mellitus, protein calorie malnutrition, and history of pressure ulcer sacral region. A quarterly Minimum Data Set (MDS), dated 9/28/20, showed extensive assist of two staff members for bed mobility and toileting, total dependence for transfers, one stage 2 pressure ulcer, one venous or arterial ulcer, and moisture associated damage to the skin. The current care plan, updated 10/14/20, identified "Problem Skin: I am at risk for skin breakdown due to immobility, catheter/ostomy use, dx's [diagnoses] of Diabetes, MS, CP and leaking catheter. I have a non-pressure chronic ulcer on my left ankle. . . . Long Term Goal: My skin will remain intact. Any skin alterations I develop will heal without complications. . . . Approach: Prevalon boots bilaterally. Individual skin interventions: air mattress, ROHO [brand name] cushion in w/c [wheelchair], reposition regularly in chair, encourage to lay down in bed in afternoon, treat skin issues as ordered. Keep skin clean and dry. Avoid shearing/friction with positioning, transfers. . . . Provide peri care after	F 686	weekly documentation is completed and communicated to provider. Care plan has been updated All neighbors who have pressure ulcers could potentially be affected- all orders for current resident with pressure ulcers were reviewed to ensure accuracy and care plans updated. All care plans were reviewed by IDT, zero others were affected. The facility policy titled Prevention and Treatment of Skin Breakdown/Pressure Injury has been reviewed on 01/27/2021 Education was provided for all licensed nursing personnel on 2/1/20 and 02/02/21 to ensure understanding of the policy titled Prevention and Treatment of Skin Breakdown/Pressure Injury and the procedure Change in neighbor status provided on weekly wound assessments and documentation provided to all nurses on 02/01/2021. DON or designee will ensure and monitor compliance. Audits will be conducted weekly for 3 months; then 2 times monthly for 3 months then monthly for 6 months on all neighbors with pressure ulcers. Audits will consist of the checking all wound documentation and assessments and all orders for wound care received to ensure weekly documentation is being meet and care plans being reviewed and updated. Analysis of the observations and facility□s compliance will be presented to our Quality Assurance team monthly who	

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F 686	Continued From page 8 each episode that I have leakage from Foley catheter." The certified nursing assistant care card showed the following, "Keep in bed with HOB [head of bed] elevated for meals only. . . Reposition Q [every] 2 hours." The facility failed to care plan the sacral ulcer and update the care plan as interventions changed. The facility failed to provide repositioning logs when asked. Review of progress notes/wound management/referral forms showed the following: *10/09/20 2:57 p.m., ". . . 3 cm x 2 cm . . . exudate [drainage] amount: none . . . stage: stage II . . . skin surrounding wound: erythema (redness)/blanchable . . . wound healing status: stable . . . comments: continue Q2 [every 2] hour turn and using Cavilon paint [skin treatment]." *10/19/20 2:40 p.m., ". . . 6 cm x 6 cm . . . exudate amount: light . . . exudate color: bloody . . . stage: stage II . . . skin surrounding wound: erythema (redness)/blanchable . . . wound healing status: declining . . . ." The facility failed to measure and document the condition of the ulcer for 10 days. The facility failed to notify the physician with the deterioration of the ulcer. *10/28/20 9:33 p.m., ". . . 11 cm x 8 cm. Wound bed composed of 70% pink in color and 30% colored purple which is located in the middle. . . . Surrounding area of the wound is color red warm to touch and no drainage. Cavilon paint applied. . . . Condition relayed to night nurse. . . ." The facility again failed to notify the provider of the deterioration of the pressure ulcer. Review of the referral form from Resident #5's	F 686	will recommend changes and ongoing monitoring/auditing after analysis if needed.	

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F 686	Continued From page 9 appointment at [Name] Wound Clinic on 11/04/20 stated: " . . Do not position Resident #5 on left side to prevent ongoing pressure, consult dietician, PT/OT [physical therapy/occupational therapy] to evaluate chair cushion. Noticed sacral ulcer, who is managing this? Consider Medihoney & Mepilex border [wound treatment & dressing] and change every other day." *11/16/20 4:19 p.m., ". . . 11 cm x 7 cm . . . exudate amount: light . . . exudate color: serous (clear, amber, thin and watery) . . . tissue type: slough . . . Percent of wound covered by granulation tissue: 25 . . . percent of wound covered by slough tissue: 75. . . skin surrounding wound: erythema (redness)/blanchable . . . wound healing status: stable . . .comments: area is macerate with serous drainage, slough and granulated tissue present. Surrounding tissue is intact and blanchable. No s/s [signs/symptoms] of infection. No pain or odor. Continue Mepilex to wound and Q2 hour turning." 12/19/20 Dietary note: "2nd Qtr [second quarter] Nutrition assessments meds added are lasix 40 mg [milligrams], Levemir BID [twice a day] 19U [units], Novolog 3U TID [three times a day], plus s/s Vit [vitamin] C, Vit D, Zinc Coccyx ulcer, ADA [American Diabetic Association] diet with 76% ave [average] intake 166 lbs [pounds] (11/10/2020). Adding protein scheduled ONS [oral nutritional supplement] to promote wound healing." The facility failed to follow the physician order for a dietary consult on 11/04/20. Routine assessment for MDS completed 45 days later. *12/21/20 1:44 p.m., ". . . 12 cm x 11.5 cm . . . exudate amount: none . . . ." *12/30/20 4:24 p.m., "[Nurse Practitioner] with	F 686		

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F 686	Continued From page 10	F 686		

order to continue follow up with [wound nurse practitioner], consult general surgery for possible need for debridement, first available appointment. They will determine if palastic [sic] surgery is needed. Cancel plastic surgery for now. Dressing change [sic] to wet to dry with Dakins solution, soaked, fluffed, change twice daily then cover with ABD pad. To start antibiotic(s) Flagyl 500mg TID PO [per oral] x 10 days, Doxycycline 100mg cap PO BID x 10 days, Augmentin 875/175 [mg] PO BID x 10 days, DC [discontinue] Keflex. Floragen [probiotic] 1 PO BID x 30 days."
*01/04/21 2:06 p.m., "Wound bed on coccyx area measures 12 cm x 15 cm. 1.3 cm undermining Bed is 100% necrotic slough. No drainage. With foul smell. Surrounding area is red/purple in color. . . . . "
*01/05/21 9:06 a.m., "[POA] informed that neighbor would be sent to [Hospital Name] this am per [PA] orders. . . ."
*01/05/21 "Resident transferred to [Name] Hospital in Bismarck."

During an interview, on 1/13/21 at 3:00 p.m., an administrative nurse (#1) agreed the facility failed to measure, stage, and document Resident #5's pressure ulcer per facility policy. The administrative nurse (#1) agreed the facility failed to inform the physician of the deterioration of Resident #5's pressure ulcer.

The facility failed to provide consistent monitoring of Resident #5's sacral pressure ulcer, including staging and measuring of the area which limited the facility's ability to identify worsening of the sacral pressure ulcer, as well as contact the physician when the facility noted deterioration of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355064	A. BUILDING _____ B. WING _____	C 01/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING CENTER OF GARRISON	**609 4TH AVE NE GARRISON, ND 58540**

(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 686	Continued From page 11 Resident #5's sacral pressure ulcer. The facility also failed to care plan and update interventions for healing of Resident #5's sacral pressure ulcer. These failures led to the deterioration and increase in the size and depth of the pressure ulcer leading to the need for further treatment, care and hospitalization of resident #5.	F 686		