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 _____	R 07/28/2014

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 on-site revisit was conducted 07/28/14 to determine compliance with the deficiencies identified during the 05/29/14 survey. The revisit sample included eleven residents for focused review of the areas cited during the 05/29/14 survey to verify compliance has been achieved and maintained. The citation numbers enclosed in { } denotes citations that remained not met as determined by the on-site revisit.	{F 000}		
{F 323} SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: SAFE HANDLING OF HOT LIQUIDS: 1. Based on observation, record review, review of facility policy and procedure, review of the facility's Plan of Correction, and staff interview, the facility failed to provide supervision and/or assistive devices necessary to attain the highest degree of safety possible while consuming hot liquids for 2 of 3 sampled residents with concerns regarding hot liquids (Resident #8 - observed handling hot liquids in an unsafe manner) and (Resident #3 - whose husband expressed concerns regarding her safety when consuming hot liquids). Failure to evaluate the residents'	F 323	This plan of correction is this facility's allegation of compliance with applicable regulatory requirements. F 323 FREE OF ACCIDENT HAZARDS SAFE HANDLING OF HOT LIQUIDS: 1) An assessment specifically for hot beverage safety will be completed on all neighbors by 7/29/2014	

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

administrator — 8/5/14

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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{F 323}	Continued From page 1 ability to handle hot liquids, as identified in the facility's Plan of Correction, placed residents consuming hot liquids at risk of sustaining a burn. On 07/28/14 at 2:30 p.m., the team determined a potential Immediate Jeopardy (IJ) situation existed. The team met with facility administrative staff members (#1, #2, and #3) and requested additional information. After review of the information received, the team contacted the State Agency at 3:55 p.m. regarding the potential IJ. Following further review, the team met with administrative staff members (#1, #2, and #3) at 5:05 p.m. and informed the staff members an IJ situation existed. During that meeting, the facility provided a verbal plan of correction. At 5:42 p.m., the team notified the State Agency of the facility's verbal communication and the team's plan to abate the IJ pending review of a written Plan of Correction. At 6:25 p.m. the facility provided a written Plan of Correction. The team reviewed and accepted the written plan at 6:33 p.m. At 7:00 p.m. the team determined the IJ situation abated, reduced the scope and severity level to "D," and informed the administrative staff members (#1, #2, and #3) of this action. Findings include: The facility's Plan of Correction for the deficiencies cited during the 05/29/14 survey, received on 07/09/14, identified the following corrective actions for F323: "Neighbors will be evaluated for ability to handle hot beverages . . . Staff will be educated on hot beverage safety and offered possible	F 323	Review of these completed assessments to be completed by the interdisciplinary care team by 7/29/2014 Care plans updated to reflect recommendations made by IDT. 7/29/2014 2) Communication with staff will be completed through the use of an "at risk" list for those neighbors at greater risk for hot beverage burns. These lists include the neighbor name, and care planned intervention. These lists will be located in all three kitchens as well as the office hub (for use in the coffee nook) Staff educated on our new plan, including new "at risk" lists and locations as well as what to do if they notice someone may no longer be safe to have hot beverages. Started 7/29/14 3) All new neighbors will be assessed for safety with hot beverages upon admission.	

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{F 323}	Continued From page 2 interventions if a neighbor is thought to be unsafe in handling hot beverage . . ." The facility identified 07/15/14 as the compliance date for this deficiency. Review of the policy "Hot Beverages" occurred on 07/28/14. This policy, not dated, stated, "Coffee, or hot water, should be between 150-170 degrees when coming out of liquid coffee machines. Staff observation and assessment of risk will be completed upon admission and periodically. Therapy will screen new neighbors for the need for adaptive equipment. Assessments are completed by various disciplines per IDT [interdisciplinary team] Assessment Guide provided by BHS [Benedictine Health System]. The care plan will identify individual interventions needed. Safety interventions should be put into place for those neighbors who may have difficulty with holding a hot cup of coffee or other hot beverage. Examples: *Lid on cup *2 handled cup *Chill cup slightly prior to pouring coffee to drop the temp faster *If neighbor does not mind ice cube in coffee to help cool it *If neighbor does not mind adding cold cream *If neighbor does not mind pre-pouring coffee to allow it to cool *Only pour cup half full or less *Add cool water to coffee to cool it down" During the entrance conference on 07/28/14 at 9:30 a.m., the survey team requested a list of all residents deemed unsafe to handle hot beverages. A dietary staff member (#3) stated the facility did not maintain a list of residents deemed unsafe to handle hot beverages, but stated the	F 323	All current neighbors will continue to be reviewed at least quarterly, as part of their regular MDS schedule, as well as on any significant change, or any time staff feel an individual may no longer be safe. Beginning 8/1/14. Any completed hot beverage safety assessments will be reviewed by the interdisciplinary care team to ensure the best interventions are put into place. Appropriate changes to care plans will be made as necessary, and "at risk" lists updated as needed. Starting 8/1/14. 4) Culinary Director will be the owner of this process. Audits will be completed to ensure that the appropriate interventions (as outlined by the care plan and "at risk" lists) are being followed by staff. These audits will be completed 2xweek x 6 weeks for each neighbor identified as "at risk". And then monthly for 3 months to ensure continued compliance. Hot water and coffee temperatures will continue to be monitored once a week/coffee maker for a minimum of 1 year.	

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F 323	Continued From page 3 facility considered Resident #1 and #3 at higher risk. During interview on 07/28/14 at 11:20 a.m., an administrative dietary staff member (#3) stated she does quarterly mini-nutritional assessments and annual nutritional assessments to determine the resident's ability to feed self. The staff member (#3) stated these nutritional assessments are the assessments the facility has always used and they have not changed the format since the survey completed on 05/29/14. The staff member (#3) stated not all of the residents in the facility have been assessed, but will be assessed when their quarterly assessments are due. - Observation on 07/28/14 at 11:40 a.m. showed Resident #8, drinking from a cup of coffee at the dining room table with no staff members present and steam rising from the cup of coffee. A certified nursing assistant (CNA #8) sat down briefly next to the resident, identified the placement of the food on the resident's plate, and then left. Observation then showed a staff member (#9) sitting across the table from Resident #8 feeding another resident. This staff member stated, "Oh you missed it," to Resident #8 as she attempted to use her fork to pick up a meatball. The staff member (#9) verbalized the location of the meatball on the plate to Resident #8. Observation showed Resident #8 picked up the cup of coffee, drank a few sips, and placed the coffee at the edge of the table. The resident continued to eat her meal with constant cuing as to the location of the food on the plate from the staff member across the table. Another staff member (#10) then sat next to the resident, moved the coffee cup away from the edge of the	F 323	5) Date Certain 8/5/14	8/5/14

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{F 323}	Continued From page 4 table, and verbally cued the resident for the remainder of the meal. Observation on 07/28/14 at 5:00 p.m. showed Resident #8 eating her meal in the dining room. A staff member sat across the table from Resident #8 feeding another resident. Observation showed Resident #8 feeding herself, with the edge of her plate approximately one and one-half inch over the edge of the table. Review of Resident #8's medical record occurred on 07/28/14. Medical diagnoses included dementia and central hearing loss. Resident #8's quarterly Minimum Data Set, dated 07/15/14, identified moderately impaired vision. Resident #8's current care plan identified "Culinary: I need help with meals because I have trouble seeing. . . . Approach: . . . I can use a plate with a lip as needed. . . . Deliver my meals to me. Help me set up my food and tell me where it is. . . ADLS [activies of daily living]: I do need assistance with my ADLS r/t [related to] dementia and impaired vision. . . ." Review of Resident #8's "Mini-Nutritional Assessment," dated 07/16/14 identified, "Quarterly assessment complete. . . . She is able to feed herself, but because of her poor vision, does need some help and supervision from staff. She utilizes a plate with lip to keep her food from falling onto the table or her lap and also is using built up silverware per her families request. [Name of resident] doesn't necessarily use the built up silverware r/t [related to] functional limitation, but rather, it is easier for her to see the dark black handles of the . . . silverware. . . ." The mini-nutritional assessment and the care	F 323		

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{F 323}	Continued From page 5 plan did not address the safety of Resident #8 handling hot liquids. During an interview on the afternoon of 07/28/14, an administrative dietary staff member (#3) stated hot liquids are included in this assessment, but confirmed it is not documented. The facility provided documentation the afternoon of 07/28/14 which identified staff had assessed 33 of the facility's 50 residents using the nutritional assessment form, which does not include documentation of the residents ability to handle hot liquids. - Review of Resident #3's record occurred on 07/28/14. A dietary progress note, dated 06/18/14 at 1:24 p.m., stated, "CNA working with [Resident #3] came to me yesterday and stated taht [sic] [Resident #3's] husband has noticed that [Resident #3] is struggeling [sic] some with her liquids. He is worried that she is a risk for spilling. I had OT [Occupational Therapy] take a quick look at her and they are recommending that she utilize kennedy cups [covered cups] when she is eating meals. I have notified the Dakotah homakers [sic] and will update her care plan." On the afternoon of 07/28/14, a dietary staff member (#3) stated OT staff document their assessments in a different computer program which can't be accessed by other staff members. The staff member (#3) stated she would attempt to obtain a copy of the assessment completed by OT for Resident #3. During an interview, on 07/28/14 at 5:05 p.m., an OT staff member (#4) provided the assessment completed on 06/18/14. The assessment stated, "Kennedy cups due to [increased] risk for spilling	F 323		

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{F 323}	Continued From page 6 related to decline in medical status - shakey @ [at] times." The record indicated staff failed to assess Resident #3's safety when consuming hot liquids until after the resident's husband expressed his concerns regarding her safety and risk for spilling. During an interview on 07/28/14 at 5:05 p.m., the OT staff member (#4) stated she had completed no assessments for residents other than Resident #3 since the survey. The survey completed on 05/29/14 identified two residents with burns from hot liquids. The facility's Plan of Correction stated the residents would be assessed for their ability to handle hot liquids and identified a completion date of 07/15/14. The facility failed to assess all residents as identified in the Plan of Correction and failed to address each residents ability to safely consume hot liquids. Failure to assess all residents, including their safety regarding hot liquids, placed residents at risk of obtaining a burn. SAFE ENVIRONMENT: 2. Based on observation and staff interview, the facility failed to maintain an environment free of hazardous chemicals on 1 of 1 special care unit (Sunflower). Accessible hazardous chemicals, and scissors; and personal items of residents' living in the secured unit, placed cognitively impaired and wandering residents at risk for accidents and injury and the potential for personal items of residents to become misplaced. Findings include:	F 323	F 323 FREE OF ACCIDENT HAZARDS SAFE ENVIRONMENT – LOCKED STORAGE 1) All cabinets, drawers, closets, and offices containing hazardous chemicals and materials will be locked within the Sunflower household.	

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F 323	Continued From page 7 Observation on 07/28/14 at 10:20 a.m., showed a set of cabinets and drawers located in the dining/day area of the Sunflower unit. The unlocked cabinets and drawers contained the following items: *upper large two door cabinet contained individual bins for residents' eye glasses, and hearing aides; three denture cups containing dentures; a container of Super Sani-cloth germicidal wipes; Saf Clens Derma Wound Cleaner in a spray bottle, and finger nail polish *drawers located on the right side below the cabinets contained a pair of scissors and assorted items for wound care *drawers located on the left side below the cabinets contained assorted electric razors, several finger nail clippers, finger nail polish and finger nail polish remover Observation showed each drawer and cabinet had the ability to be locked. During an interview on 07/28/14 at 10:25 a.m., a certified nursing assistant (CNA) (#7) stated, regarding the cabinets and drawers, "it should all be locked but we have been so busy." Observation on 07/28/14 at 11:35 a.m., showed the same set of cabinets and drawers unlocked, with only the right side bottom two drawers locked, which contained staff items. Observations at 3:30 p.m., showed the cabinet and all the drawers locked. Observations throughout the times listed above showed residents in the area and one resident wandering throughout the unit. During an interview on 07/28/14 at 7:15 p.m., an	F 323	2) Any neighbor in Sunflower Household could be affected by having access to hazardous chemicals or materials. 3) All cabinets, drawers, closets, and offices containing hazardous chemicals and materials will be locked within the Sunflower Household. All staff will be educated at staff meeting 8/4/14. 4) Sunflower Household Coordinator (LSW) will be owner of this process. Audits will begin on 8/4/14 and will continue twice daily x 5 days per week x 1 week, then once daily x 5 days per week x 1 week, and then monthly for 3 months to ensure all cabinets, drawers, closets, and offices containing hazardous chemicals and materials are locked. Audits will be reviewed at quarterly QA meetings. 5) Cabinets locked effective 7/29/14. Date certain 8/4/14.	8/4/14

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{F 323}	Continued From page 8 administrator (#1), stated that area of storage should be locked.	F 323		
{F 441} SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of	{F 441}	F 441 INFECTION CONTROL: Hand Hygiene 1) Neighbor #1 had no negative consequences related to improper hand hygiene. 2) All neighbors are put at risk to develop or transmit disease/infections due to poor hand hygiene of the staff working with them. 3) The Hand washing/Hand Hygiene policy will be reviewed with all staff at a meeting on 8/4/14. A demonstration of proper peri care technique, hand washing and gloving will be done at the meeting.	

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{F 441}	Continued From page 9 infection. This REQUIREMENT is not met as evidenced by: Based on observation and review of facility policy, the facility failed to follow standard infection control practices for 1 of 1 sampled resident (Resident #1) observed during cares with a suprapubic catheter and incontinence of bowel. Failure to follow infection control practices related to hand hygiene and glove usage has the potential to cause or spread infection within the facility. Findings include: Review of the facility policy titled "Handwashing/Hand Hygiene" occurred on 07/28/14. This policy, revised April 2012, stated, "This facility considers hand hygiene the primary means to prevent the spread of infections . . . Implementation: . . . 5. Employees must wash their hands . . . using antimicrobial or non-antimicrobial soap and water under the following conditions: . . . b. When hands are visibly soiled (hand washing with soap and water); . . . n. Before and after assisting a resident with toileting (hand washing with soap and water); . . . q. After contact with a resident's . . . body fluids . . . u. After removing gloves . . . 8. The use of gloves does not replace handwashing/hand hygiene. . . ." On 07/28/14 at 4:05 p.m., observation showed two certified nursing assistants (CNAs #5 and #6) providing cares for Resident #1. The CNA #5 emptied the urine from Resident #1's catheter	{F 441}	4) The DON will be the owner of this process, but will be assisted by the Infection Control Nurse and Care Coordinator, to monitor and ensure that staff is compliant with hand hygiene and dressing change policies. Starting August 5, 2014 four staff will be observed per day x 2 weeks for proper peri care, hand washing and gloving. Then an audit will be completed on 6 staff per week x3 weeks, then 3 staff per week x1 month, then 1 staff per week x2 months. If any issues are discovered within the audit, the length of the time will be extended. The Infection Control nurse will submit a report of the monitoring results to the QA Committee at each scheduled meeting. 5) Date certain will be 8/5/14	8/5/14

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{F 441}	Continued From page 10 bag into a container and gave the container to the other CNA (#6) to dispose. The CNA (#6) emptied the urine into the toilet and then wiped out the container with a paper towel. The CNA (#6) removed her gloves, and without performing hand hygiene donned another pair of gloves. Observation showed Resident #1 incontinent of a large bowel movement (BM), covering his entire perineal and perianal area. Both CNAs (#5 and #6) wiped Resident #1's perineal area several times with wipes and disposed of the wipes in the garbage can. The CNA (#6) removed her gloves, immediately donned new gloves, picked up a container of cream from the bedside table and dispensed the lotion onto the resident's perineal area. The CNA failed to perform hand hygiene after removing her gloves. After turning Resident #1 to the side, the CNA (#5) wiped BM from the resident's rectal area and discarded the wipe. The CNA (#6) dispensed lotion into the gloved hand of CNA #5 and the CNA #5 applied the lotion onto the areas of skin breakdown on the resident's buttocks. The CNA (#5) failed to remove her gloves and perform hand hygiene prior to applying the lotion to the open areas. The CNA (#5) then removed her gloves, performed hand hygiene and applied new gloves. The CNA's turned Resident #1 onto his back again and CNA (#5) cleaned BM from the resident's inner thigh area and discarded the wipe. The CNA (#5) then used a new wipe and began cleaning the suprapubic catheter from the insertion site to the end. The CNA (#5) failed to remove her gloves, perform hand hygiene, and don new gloves before cleaning the suprapubic catheter.	{F 441}		