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 _____	04/15/2021

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 The Standard Medicare/Medicaid recertification survey started on 04/12/21 and concluded on 04/15/21.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to determine the affect a wanderguard (wander/elopement alarm) had on 1 of 3 sampled resident (Resident #28) observed with a wanderguard. Failure to assess the need for the wanderguard and the ongoing assessment of the device has the potential to act as a restraint by limiting Resident #28's movement. Findings include: Review of the facility policy titled "CODE ALERT WANDERING MANAGEMENT SYSTEM" occurred on 04/14/21. This policy, revised January 2011, stated, ". . . All neighbors with a wanderguard in place are reviewed with the IDT (interdisciplinary team) at minimum monthly." Observations occurred on all days of the survey and identified a wanderguard attached to back of Resident #28's motorized scooter.	F 558	Resident #28 was reviewed by the IDT team on 05/11/2021 and it was determined that the wander guard can be removed. Wander guard was removed and care plan updated. All neighbors with wander guards are potentially at risk and IDT reviewed all neighbors. The policy “code Alert wandering Management system was reviewed by IDT team and deemed appropriate. Education was provided for all licensed nursing personnel and the IDT team on 05/11/2021 to ensure understanding of the policy. IDT did determine that a monthly progress note will be placed in neighbor chart regarding the review of the wander guard.	5/11/21

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

Electronically Signed | 05/14/2021

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F 558	Continued From page 1 Review of Resident #28's medical record occurred on all days of survey. Physician order, dated 02/26/20, directed staff to place wanderguard on his motorized scooter and check function/placement daily. A Significant Change Minimum Data Set (MDS), dated 02/25/21, identified resident cognitively intact and required wanderguard on daily basis. The medical record lacked evidence the facility obtained a diagnosis to support the use of the device. During interview on 04/13/21 at 12:01 p.m., certified nursing assistant (CNA) (#4) indicated Resident #28 no longer utilizes a wanderguard, "because he doesn't need it anymore." The record lacked evidence that Resident #28 required the placement of the device and continues to wander in the facility/exit seek and/or requires continued use of the wanderguard device.	F 558	DON or designee will ensure and monitor compliance. Audit will be conducted monthly for 6 months to ensure the IDT team reviews each neighbor. Analysis of the facility's compliance will be presented to our Quality Assurance Team monthly beginning 5/20/2021, who will recommend changes and on-going monitoring/auditing after analysis.	
F 580 SS=D	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);	F 580		5/11/21

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F 580	Continued From page 2 (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 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 and staff interview, the facility failed to notify the physician of a change in	F 580	Resident # 23 chart was reviewed by provider for all blood sugars for last 6	

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F 580	Continued From page 3 condition for 1 of 3 sampled residents (Resident #23) who had physician ordered blood sugar parameters in place. Failure to notify the physician limited his ability to make informed decisions regarding Resident #23's medical care. Findings include: - Review of Resident #23's medical record occurred on all days of survey. Diagnoses include Type 2 diabetes mellitus with diabetic neuropathy (peripheral nerve disorder causing numbness and weakness). The quarterly Minimum Data Set (MDS], dated 02/10/21, identified Resident #23 required insulin injections for all seven days of the assessment period. Physician's orders, dated 11/28/20 - 04/11/21, identified, ". . . If Blood Sugar is less than 60 [mg (miligrams)/dl (deciliter)], call MD [physician] . . . If Blood Sugar is greater than 404 [mg/dl], call MD . . ." Review of the "Vitals Report", dated January-April 2021, showed facility staff failed to follow the physician's order and notify him of Resident #23's low blood sugar levels (less than 60 mg/dl) on seven occasions and high blood sugar levels (greater than 404 mg/dl) on fifteen occasions. During an interview on 04/15/21 at 12:00 p.m., an administrative nurse (#2) confirmed staff are expected to notify the physician when a resident's blood glucose levels fall outside the parameters set by the physician.	F 580	months. Provider ordered changes to blood sugar parameters and insulin dosage. All neighbors who are diabetic are potentially at risk for this and the provider reviewed their charts. The procedure Blood sugar parameters has been reviewed and updated. Education was provided for all licensed nursing personnel on 05/11/2021 to ensure understanding of the procedure. Education consisted of review of charts along with the policy. DON or designee will ensure and monitor compliance. Audits will be conducted 3x week for 3 months; than 2 x week for 3 months; than weekly for 3 months. Audits will consist of monitoring low/high blood glucose and if proper notifications were made. Analysis of the facility's compliance will be presented to our Quality Assurance Team monthly beginning 5/20/2021, who will recommend changes and on-going monitoring/auditing after analysis.	
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7)	F 584		6/1/21

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F 584	Continued From page 4 §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and	F 584		

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F 584	Continued From page 5 §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, review of the facility's policy, and staff interview, the facility failed to provide maintenance services necessary to maintain a safe/comfortable environment for 3 of 3 household units (Dakotah, Sunflower, Prairie Rose). Failure to maintain a safe/comfortable environment placed residents at risk for injury. Finding include: Review of the facility policy titled "Safety and Supervision of Residents" occurred on 04/14/21. The policy, revised February 2019, stated, ". . . To provide a safe environment for residents . . . the environment remains as free from accidents and hazards as possible . . . Identifying the hazard(s) and risk(s) . . . modifying interventions when necessary . . . ". -Observation of resident rooms on all household units occurred on all days of survey and showed the following: * Prairie Rose Unit: Rooms 30, 31, 33, 40: Doors and door ways with chipped/gouged areas with splintered wood and sharp edges. Rooms 36, 38: Door/doorways to bathroom with splintered wood with sharp edges, holes in the door. * Sunflower Unit: Rooms 2, 4, 5, 7, 10: Doors/doorways scraped, splintered wood and sharp edges. * Dakotah Unit: multiple areas in dining room with torn or no wallpaper, scuffed walls with paint scraped off. * Dakotah Unit: Rooms 14, 20, 21, 26, 47, 48:	F 584	None of the neighbors in rooms: 2, 4, 5, 7, 10; 14, 20, 21, 26, 47, 48; or 30, 31, 33, 36, 38, 40 were affected. All neighbors in all of the rooms could potentially be affected. All doors listed above will be assessed for repair needs as indicated. Doors that are chipped or gauged areas will be repaired with wood putty, sanded, and painted. Doors that have splintered wood will be glued. Doors that have sharp edges will be covered with edge protectors. Dakotah household areas in the dining room that have torn areas or areas with no wallpaper, scuffed walls or scraped paint will be repaired and painted. Doors: Plant Manager or designee will ensure and monitor compliance. Designated Households: Sunflower rooms 1-11; Dakotah rooms 12-21 and 41-48; Prairie Rose rooms 30-40. Audits will be conducted to one Household of neighbor rooms per month for 3 months. Then semi-annually each Household will be audited. All tracking will be in our TELS (maintenance tracking system). Audits will consist of direct observations of the designated Household neighbor room and bathroom doors. Dakotah dining room walls: Plant	

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F 584	Continued From page 6 Doors/doorways with scraped, chipped wood with splinters. A tour of the living areas occurred on 04/14/21 at 11:04 a.m., with the maintenance manager (#7) and agreed damages to the multiple resident rooms/living areas need repair and it is "on their list to do". During an interview on 04/14/21 at 5:09 p.m., administrative staff (#2 and #6) agreed the repairs are needed and the damaged wood surfaces have the potential to cause injury to the residents.	F 584	Manager or designee will ensure and monitor compliance. Audits will be conducted 1X per week for 2 months than monthly for 3 months, then semi-annually. All tracking will be in our TELS (maintenance tracking system). Audits will consist of direct observations of Dakotah Household dining area walls. Audits will began to all doors and dining room walls 05/18/2021. Analysis of the facility's compliance will be presented to our Quality Assurance Team monthly beginning 5/20/2021, who will recommend changes and on-going monitoring/auditing after analysis.	
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: NEURO-CHECKS 1. Based on record review, review of facility policy and procedure, and staff interview, the facility failed to provide care in accordance with professional standards for 2 of 3 sampled residents (Resident #17 and #40) who experienced an unwitnessed fall and/or fall with head injury. Failure to complete neurological assessments and/or accurately document the results of the assessments following a fall has the potential for a head injury to go undetected.	F 658	1. Neighbors # 17 and 40 were assessed with no issues noted. All neighbors who fall are potentially at risk. The policy titled "neurocheck Procedure" has been reviewed and update. A falls checklist has been implemented. Education was provided for all licensed nursing personnel on 05/11/2021 to	5/11/21

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F 658	Continued From page 7 Findings include: Review of the facility policy titled "Neurocheck Procedure" occurred on 04/15/21. This undated policy, stated ". . . Anytime someone falls and hits their head or is suspected to have hit their head, neurochecks should be completed. The initial neurocheck is completed at the time of the fall and documented under the fall event. Four subsequent neurochecks are completed [4 hours after fall, 4 hours after last check, 8 hours after last check and 8 hours after last check] . . ." - Review of Resident #17's medical record occurred on all days of survey. A progress note, dated 03/12/21 at 10:11 a.m., stated, "AT 7:40 AM, CNA [certified nursing assistant] staff reported that neighbor was on the floor. Received [Resident #17] on the floor lying on her back beside her bed. No footwear on nor socks. Call light not ON. She is awake and conversant but not moaning nor grimacing. Bruise noted on her forehead which extends to the middle of nose bridge. It measures 10.3 cm [centimeters] x [times] 7.8 cm Slight bump noted and no skin tears noted on the site. Pain accompanied when pressure is applied. Sling was placed on her back and hoyered back to her bed. Neighbor was unable to narrate what have happened prior to the fall. Vitals taken and recorded. PERRLA [eye exam]. Neighbor denies any pain aside from her head. She was transported to the spa room and given a bath. Skin assessment done after. No skin issues on other parts of her body. She was then dressed up and was able to walk toward dining area without difficulty. No changes on gait and balance. No shortening nor limitations. She	F 658	ensure understanding of the policy titled Neurocheck Procedure, the Neuro-Check Assessment flow sheet and the falls checklist. New licensed nursing staff will receive education regarding procedures listed above during new employee orientation. DON or designee will ensure and monitor compliance. Audits will be conducted 3 x week for 2 months; than 2 x week for 2 months; than 1 x week for 2 months; than 2 x month for 3 months. Audits will consist of reviewing all falls to assure neurochecks were implemented correctly. Audits began 05/12/2021. Analysis of the facility's compliance will be presented to our Quality Assurance Team monthly beginning 5/20/2021, who will recommend changes and on-going monitoring/auditing after analysis. 2. Neighbor's # 14 and 23 blood sugars were reviewed by provider with changes made to orders. All neighbors who need insulin could potentially be affected and the provider reviewed orders. Policy Diabetic Management has been reviewed. Education was provided to all licensed nursing personnel on 05/11/2021 to ensure understanding of the policy Diabetic management, the new orders from the provider and how to enter a single one time order in Matrix.	

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F 658	Continued From page 8 refused Tylenol 325 mg [milligrams]/tab [tablets] 2 tabs together with her due morning pills. At 10:10 AM, she still refused of [sic] pain pill. Neurocheck will start at 11:20 AM. Provider on Duty . . . made aware." Review of Resident #17's "Neurological Checks" event record identified nursing staff completed all four neuro-checks; however three of the four entries lacked documentation of a date or time. - Review of Resident #40's medical record occurred on all days of survey. Review of progress notes showed the following: * 12/03/20 at 2:13 p.m. - "Neighbor was witnessed on the floor this morning around 8:40am in his room, he was laying on his left side near the TV stand. He is wearing his shoes and pants was half way [sic] down. Neighbor was not able to tell what he is doing prior to fall. NO bump/lumps noted on the head. ROM [range of motion] X [times] 4 with out [sic] pain noted. . . ." * 12/05/20 at 3:29 a.m. - "Neighbor was noted on the floor in the dining room. No apparent injury noted. ROM x4 without pain. . . ." * 12/11/20 at 11:51 a.m. - "Neighbor was witnessed on the floor this morning around 9:40am, he was laying prone near bedside. Prior to fall he was sitting in his wheelchair for breakfast. Neighbor is alert and talking this time, no bumps or bruise noted on the head. . . . He has R [right] hip ORIF [open reduction internal fixation]. ROMX4 on upper extremities, L [left] leg and has some pain on R leg. Medicated with prn [as needed] oxycodone. . . ." * 12/15/20 at 7:00 p.m. - "Neighbor was found lying on his left side on the floor with his head on	F 658	DON or designee will ensure and monitor compliance. Audits will be conducted 2x week for 3 months; than weekly for 3 months; than monthly for 3 months. Audits will consist of monitoring all blood glucose and notifying the MD when appropriate and following the orders for repeat blood glucose checks and insulin administration. Analysis of the facility's compliance will be presented to our Quality Assurance Team monthly beginning 5/20/2021, who will recommend changes and on-going monitoring/auditing after analysis. 3. Neighbors 14 and 20 were not affected. All neighbors who use insulin pens could potentially be affected. The insulin Pen competency was reviewed and updated to reflect the cleaning of the rubber stopper with alcohol swab. Education was provided for all licensed nursing personnel on 05/11/2021 to ensure understanding of the change. All licensed nursing personnel had a competency completed to assure their knowledge. DON or designee will ensure and monitor compliance. Audits will be conducted weekly x 3 months; than 2 x month for 3 months. Audits will consist of direct observations of the licensed nurse preparing the insulin injection. Analysis of the facility's compliance will be presented	

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F 658	Continued From page 9 the pillow. Neighbor appears to have slid out of his wheelchair. No redness or opened areas noted. Denies hitting head. Neighbor sustained a small light blue bruise to his right elbow. . . ." * 12/24/20 at 12:21 p.m. - "Neighbor was witnessed on the floor this morning around 9:10am [sic] in his room. He was sitting in his wc prior to fall, neighbor is laying on his L side and his head is place near the tray table. Neighbor is alert this time. No lumps/bumps noted on his head. ROMX4, no shortening of extremities noted. . . ." * 02/23/21 at 3:11 p.m. - "At 11:10 AM, author received neighbor lying on the floor on his right side in the garden room with his head being supported by Culinary staff. He was awake that time. . . . No bumps/skin issues noted on the head and on other limbs. Culinary staff described him to have his right hand on top of the table, head was under the table, left hand was on the floor and [resident] was sitting on the pedal while WC [wheelchair] is tip over. . . . Range of motion of upper and lower extremities are unchanged upon checking. No pain upon palpation of hips. No skin issues nor bumps noted when skin assessment was done. . . ." The staff failed to complete neurological checks on 12/03/20, 12/05/20, 12/11/20, 12/15/20, 12/24/20, and 02/23/21 per facility policy. During an interview on 04/15/21 at 12:00 p.m., an administrative nurse (#2) confirmed staff should perform neuro-checks per facility policy. BLOOD GLUCOSE LEVEL 2. Based on record review, review of facility	F 658	to our Quality Assurance Team monthly beginning 5/20/2021, who will recommend changes and on-going monitoring/auditing after analysis. 4. Neighbor 17 bowel regime was reviewed by provider with no changes made. Neighbor 40 was reviewed by provider with a change made to bowel regime. All neighbors could potentially be affected and charts have been reviewed for the need to change bowel regime. The facility policy Bowel monitoring and interventions policy has been reviewed and updated. Education was provided for all licensed nursing personnel on 05/11/2021 to ensure understanding of the policy. Education was also provided to license nursing personnel to assure their understanding of counting BM days and signing off PRN orders even when it was offered and refused. DON or designee will ensure and monitor compliance. Audits will be conducted weekly x 6 months. Audits will consist of monitoring the BM report and assuring proper procedure is followed. Analysis of the facility's compliance will be presented to our Quality Assurance Team monthly beginning 5/20/2021, who will recommend changes and on-going monitoring/auditing after analysis.	

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F 658	Continued From page 10	F 658		

policy, and staff interview, the facility failed to ensure staff followed standards of practice for 2 of 5 sampled residents (Resident #14 and #23) receiving insulin. Failure to reassess blood glucose for residents with abnormal levels may result in adverse effects related to hypoglycemia or hyperglycemia (low or high blood sugar levels).

Findings include:

Review of the facility policy titled "Diabetic Management" occurred on 04/15/21. This policy, dated 2021, stated, ". . . The provider will order the frequency of glucose [blood sugar] monitoring. . . ."

- Review of Resident #14's medical record occurred on all days of survey. Diagnoses included Type 1 diabetes mellitus with ketoacidosis without coma. The quarterly Minimum Data Set (MDS), dated 01/25/21, identified Resident #14 required insulin injections for all seven day of the assessment period.

The physician's orders, dated 11/28/20 - 04/11/21, identified the following:
If blood sugar is > [greater than] 415 give 11 units of insulin and recheck in 2 hours . . ."

The current care plan, revised 01/20/21, identified ". . . My blood sugars fluctuate and need to be monitored . . . Administer insulin as ordered . . . Observe for s/sx [signs and symptoms] of hyper/hypoglycemia and report. Follow provider orders for abnormal blood sugars and provide meds as ordered. S/S [signs and symptoms] Hyper [high] (extreme thirst, frequent

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urination, dry skin, hunger, blurred vision, drowsiness, nausea) Hypo [low] (shaking, fast heartbeat, sweating, anxious, dizziness, hunger, impaired vision, weakness, fatigue, headache, irritable)."

Review of the "Vitals Report", dated March 21-31, 2021 and April 1-4, 2021, showed facility staff failed to follow the physician's order and perform 2-hour blood glucose rechecks on 13 occasions when Resident #14's blood sugar levels were more than 415 mg (miligrams)/dl (deciliter).

- Review of Resident #23's medical record occurred on all days of survey. Diagnoses include Type 2 diabetes mellitus with diabetic neuropathy (peripheral nerve disease causing numbness or weakness). The quarterly MDS, dated 02/10/21, identified Resident #23 required insulin injections for all seven days of the assessment period.

Physician's orders, dated 11/28/20 - 04/11/21, identified the following:
* If Blood Sugar is less than 60, call MD.
* If Blood Sugar is greater than 404, call MD.

Review of the "Vitals Report", dated January-April 2021, showed facility staff failed to follow the physician's order and perform 2-hour blood glucose rechecks on two occasions when Resident #23's blood sugar levels were less than 60 mg/dl and on ten occasions when her levels were greater than 404 mg/dl.

During an interview on 04/15/21 at 12:00 p.m., an administrative nurse (#2) confirmed staff should

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perform 2-hour blood glucose rechecks per facility policy.

PREPARATION OF INSULIN PEN

3. Based on observation and manufacturer's guidelines, the facility failed to meet professional standards when preparing insulin pens for 2 of 6 residents (Resident #14 and # 20) observed receiving insulin. Failure to disinfect the rubber stopper prior to attaching the needle may result in contamination.

Review of manufacturer's guidelines for NovoLog insulin occurred on 04/15/21. This guideline stated, ". . . Preparing your NovoLog FlexPen. Pull off the pen cap . . . Wipe the rubber stopper with an alcohol swab. . . ."

Review of the facility policy titled "Insulin Administration" occurred on 04/15/21. This policy, revised 01/2011 failed to include the manufacturer's guidelines for disinfecting the NovoLog insulin pen prior to use.

Observation on 04/15/21 at 9:04 a.m. showed a nurse (#1) prepped two insulin pens for injection for Resident #20. After pulling off the pen cap, the nurse failed to wipe both rubber stoppers with alcohol prior to attaching the insulin needles.

Observation on 04/15/21 at 9:10 a.m. showed a nurse (#1) prepped an insulin pen for injection for Resident #14. After pulling off the pen cap, the nurse failed to wipe the rubber stopper with alcohol prior to attaching the insulin needle.

The facility staff failed to prepare the insulin pens

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following the manufacturer's guidelines to prevent contamination.

BOWEL PROTOCOL

4. Based on record review, review of professional reference, review of facility policy, and staff interview, the facility failed to meet professional standards for 2 of 4 sampled residents (Resident #17 and #40) who received scheduled and/or as needed (PRN) laxatives. Failure to follow the facility's bowel protocol for residents with constipation may result in the residents experiencing adverse effects such as hemorrhoids, fecal impaction, bowel obstruction, and/or abdominal pain.

Findings include:

Review of the facility policy titled "Bowel Monitoring and Interventions Policy" occurred on 04/15/21. This undated policy, stated, ". . . The purpose of this policy is to provide for quick detections of bowel concerns . . . Each resident is assessed every shift for bowel function . . . Staff documents bowel results every shift . . . Should a resident go two (2) days without having a bowel movement, resident is offered Milk of Magnesia. If no results by day three (3), neighbor is given a suppository. Nursing provides interventions per standing orders . . ."

- Review of Resident #17's medical record occurred on all days of survey. The current physician's orders identified Resident #17 received Fentanyl and Ibuprofen (pain medications), Colace, Dulcolax, Milk of Magnesia, and MiraLAX (constipation

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F 658	Continued From page 14 medications). Review of Resident #17's bowel records and medication administration records (MARs) identified the staff failed to offer Milk of Magnesia on the second day without a bowel movement for January 4th, 25th; February 3rd, 8th, 11th, and 14th; and March 8th and 14th, 2021. - Review of Resident #40's medical record occurred on all days of survey. The current physician's orders identified Senna Plus (constipation medication) daily and Milk of Magnesia, Miralax, and Bisacodyl suppository (constipation medication) as needed (PRN). Review of Resident's bowel records and MARs identified the staff failed to offer Milk of Magnesia on the second day without a bowel movement for March 5th, 8th, 11th, 15th, and 22nd; and April 2nd and 10th, 2021. The facility failed to follow their "Bowel Protocol" to ensure Resident #17 and #40 received effective interventions to prevent constipation. During an interview on 04/15/21 at 12:00 p.m., an administrative nurse (#2) confirmed staff should administer bowel medications per facility policy.	F 658		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in	F 684		5/11/21

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F 684	Continued From page 15 accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, review of the facility's written agreement with hospice, and staff interview, the facility failed to coordinate care for 2 of 2 sampled residents (Resident #98 and #197) receiving hospice services. The facility's failure to retain a copy of the hospice care plan may affect the staffs' ability to implement those aspects of care that are not related to the duties of the hospice. Findings include: Review of the facility's written agreement with hospice occurred on 04/15/21. The agreement, signed 09/06/13, stated ". . . hospice shall retain overall professional management responsibility for directing the implementation of each Patient's JPOC [joint plan of care]. Facility shall be responsible for implementing those portions of the Patient's JPOC for which Facility is responsible. Hospice and Facility each shall maintain a copy of each Patient's JPOC in the respective clinical records maintained by each party. Hospice and Facility each shall designate a registered nurse responsible for coordinating the implementation of the JPOC for each Patient. . . ." - Review of Resident #98's medical record occurred on all days of survey. The facility failed to provide a copy of Resident #98's hospice care plan upon request.	F 684	Neighbors #98 and 197 were not affected. All neighbors who are on hospice could potentially be affected. The written agreement with hospice was reviewed in IDT; the hospice care plans were requested and reviewed. DON or designee will ensure and monitor compliance. Audits will be conducted with each hospice neighbor for 6 months to assure we received their care plan and a joint plan of care is implemented. Analysis of the audits will be presented to our Quality Assurance team monthly beginning 05/20/2021 who will recommend changes and on-going monitoring after analysis.	

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F 684	Continued From page 16 - Review of Resident #197's medical record occurred on all days of survey. The facility failed to provide a copy of Resident #197's hospice care plan upon request. During an interview on 04/14/21 at 5:15 p.m., when asked questions pertaining to services hospice provided, a social services staff member (#5) stated, "hospice staff talk with [facility] staff and the residents and update the medications. They do not provide any cares. The chaplain and social worker also see the residents. They have never provided us with a care plan." During an interview on 04/15/21 at 12:00 p.m., an administrative nurse (#2) acknowledged the facility should retain a copy of each resident's hospice care plan.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE	F 686	Neighbor # 20's skin was assessed on	5/11/21

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F 686	Continued From page 17 SURVEY COMPLETED ON 01/07/21. Based on record review, review of facility policy, and staff interviews, the facility failed to provide the necessary treatment/services to prevent the occurrence and promote the healing of pressure ulcers for 1 of 2 sampled residents (Resident #20) identified with pressure ulcers. Failure to implement interventions as ordered and ensure adequate monitoring/assessment contributed to the inconsistent, delayed treatment/deterioration of Resident #20's pressure ulcer(s). Findings include: Review of the facility policy titled "Prevention and Treatment of Skin Breakdown/Pressure Injury" occurred on 04/14/21. This policy, dated 2018, stated, ". . . Those residents' who experience a break in skin integrity or wounds are provided care and service to heal the skin according to professional standards of care. . . . Weekly the licensed nurse will stage, measure, and examine the wound bed and surrounding skin. If wound bed has deteriorated; notify attending provider. . . . Notify the attending provider . . . if the skin injury has not shown progress in 2 weeks and/or is deteriorating unexpectedly. Re-evaluated plan of care as appropriate. . . ." Review of Resident #20's medical record occurred on all days of survey. The admission MDS, dated 02/02/21, showed extensive assist of two staff members required for bed mobility, total dependence for transfers and toileting, one stage 2 pressure ulcer present on admission/reentry, and moisture associated damage to the skin.	F 686	05/10/2021 neighbor has no skin breakdown. All neighbors are potentially at risk for this and all neighbors with skin integrity issues have been reviewed with appropriate treatment. The Policy Prevention and Treatment of skin breakdown/pressure injury has been reviewed. Education was provided to Licensed nursing personnel on 05/11/2021to ensure proper understanding of pressure injury vs arterial/venous/neuropathy/diabetic injury vs maceration. How to document these injuries and how to use the tool wound documentation/treatment guidelines. DON or designee will ensure and monitor compliance. Audits will be conducted 5 x week for 3 months; than 3x week for 3 months; than weekly for 3 months. Audits will consist of reading progress notes to identify any new skin related issues and properly documenting on them weekly. Analysis of the observations and facility's compliance will be presented to our Quality Assurance team monthly beginning 05/20/2021 who will recommend changes and on-going monitoring/auditing after analysis.	

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F 686	Continued From page 18 Review of Resident #20's progress notes and wound management forms from 02/12/21 to 04/14/21 identified the following: * 02/15/21, "Maceration to R [right] buttock . . . 0.7 cm x 0.9 cm . . ." * 03/10/21, ". . . redness still noted on buttocks, no open area observed. Right back of the thigh has redness and open area measure 1cm x 5cm." *The record identified staff failed to take measurements for right buttock and right back of thigh wound per policy. During an interview on 04/14/21 at 10:58 a.m., an administrative nurse (#3) confirmed staff measure wounds on a weekly basis. During an interview on 04/15/21 at 3:09 a.m., an administrative nurse (#2) confirmed staff performed inconsistent wound care and failed to measure, stage, and document Resident #20's pressure ulcer(s) per policy.	F 686		