| 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 _____ | 07/02/2019 |

| 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 |
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| F 000 | INITIAL COMMENTS<br><br>The standard Medicare/Medicaid recertification survey started on 06/30/19 and concluded 07/02/19. | F 000 | | |
| F 658 SS=D | Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)<br><br>§483.21(b)(3) Comprehensive Care Plans<br>The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br>(i) Meet professional standards of quality.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, review of professional reference, and staff interview, the facility failed to ensure staff properly discarded of expired medications, expired laboratory supplies, and sterile supplies for 1 of 2 medication storage areas. Failure to ensure expired medications and sterile supplies are disposed of may result in residents receiving ineffective medication and care with expired or non-sterile supplies.<br><br>Findings include:<br><br>Berman, Snyder, and Frandsen's "Kozier & Erb's Fundamentals of Nursing: Concepts, Process, and Practice," 10th edition, 2016, Pearson, Boston, Massachusetts, page 627, stated, "Principles and Practices of Surgical Asepsis . . . Sterile articles can be stored for only a prescribed amount of time; after that, they are considered unsterile. . . ."<br><br>Observation on 07/02/19 at 10:30 a.m. of the main medication storage room showed arthricream rub, expired May 2018, on the stock | F 658 | No residents were affected.<br><br>All neighbors who use supplies could potentially be affected.<br><br>All medication storage areas that contain medications, laboratory supplies, sterile and non-sterile supplies were cleaned and gone through to remove all expired supplies on 07/10/2019.<br><br>The procedure to monitor and remove expired supplies was reviewed and updated on 07/11/2019.<br><br>DON or designee will ensure and monitor compliance. Audits will be conducted 2 x months for 3 months; than monthly for 3 months. Audits will consist of the checking expiration dates of 10 random supplies in storage areas. Audits began 07/15/2019. Analysis of the observations and facility□s compliance will be presented to our Quality Assurance team | 7/18/19 |

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

Electronically Signed | 07/22/2019

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| F 658 | Continued From page 1<br>medication shelf. This observation also showed multiple intravenous catheters, venous puncture tubes (for collecting blood), and sterile dressings had expired as far back as 2015.<br><br>During an interview on 07/02/19 at 10:40 a.m., two staff nurses (#5 and #6) stated charge nurses reviewed medications weekly in order to identify and dispose of expired medications.<br><br>During an interview on 07/02/19 at 11:00 a.m., an administrative nurse (#1) reported she expected the staff nurse who ordered supplies to look for expired supplies and remove them from circulation. | F 658 | monthly who will recommend changes and ongoing monitoring/auditing after analysis if needed. | |
| F 689 SS=D | Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>1. GAIT BELT USE<br><br>Based on observation, review of facility policy, and staff interview, the facility failed to provide adequate supervision and assistive devices necessary to prevent accidents for 2 of 4 sampled residents (Residents #15 and #16) observed during transfers and repositioning. Failure to properly use a gait belt during transfers placed the residents at risk of accidents and | F 689 | Part 1<br>Resident #15 and 16 were assessed on 07/15/2019 for injuries from not proper use of gait belt.<br><br>All residents who need assistance with transfers could potentially be affected.<br><br>All care plans were reviewed on 07/03/2019 by IDT to assure accuracy. | 7/22/19 |

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| F 689 | Continued From page 2<br>injury.<br><br>Findings include:<br><br>Review of the facility policy titled "Gait Belts" occurred on 07/02/19. This undated policy, stated, . . . If staff needs to physically assist a neighbor [resident] in any way, the neighbor needs to wear a gait belt when ambulating or transferring . . . "<br><br>- Observation on 06/30/19 at 3:59 p.m. showed a certified nurse assistant (CNA) (#2) transferred Resident #15 from the bed to a recliner with gait belt. The CNA (#2) failed to properly transfer while using the gait belt and lifted Resident #15 under her right axilla [arm pit].<br><br>- Observation on 07/01/19 at 9:53 a.m. showed a CNA (#3) transferred Resident #15 from the toilet to the wheelchair with a gait belt. The CNA (#3) failed to properly transfer while using the gait belt and lifted Resident #15 under her right axilla.<br><br>- Observation on 07/01/19 at 4:24 p.m. showed a CNA (#3) transferred Resident #16 from the bed to the wheelchair. The CNA (#3) placed her left arm under Resident #16's left arm pit and placed the other hand on the resident's waistband of her pants to lift and pivot the resident to the wheelchair. The CNA (#3) failed to use a gait belt during the transfer.<br><br>During an interview on 07/02/19 at 8:05 a.m., an administrative nurse (#1) stated she would expect staff to grasp the gait belt from the back and agreed staff should not lift residents under the armpit. | F 689 | Gait belt procedure was reviewed by IDT on 07/03/2019. Staff Education was provided on 07/16/2019. Staff that were not at in-service were trained 07/17/2019 and 07/18/2019 one-one on how and when to use gait belt.<br><br>Physical Therapist or designee will ensure and monitor compliance. Audits will be conducted 3 x week for 2 months; than 2 x week for 2 months; then 1 x week for 2 months; than 2 x month for 3 months. Audits will consist of observing 2 different staff completing transfers with a gait belt. Audits will begin 07/22/2019. 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.<br><br>Part 2<br>No one was affected.<br><br>Any Neighbor who eats in the Sunflower dining room.<br><br>Cabinet was locked immediately.<br><br>Staff was educated on the importance of making sure all cabinets containing Chemicals in common areas are to be locked at all times. Education was provided on 07/15/2019.<br><br>Weekly audits will be conducted in | |

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| F 689 | Continued From page 3<br><br>2. CHEMICAL STORAGE<br><br>Based on observation, review of Safety Data Sheets (SDS), and staff interview, the facility failed to ensure an environment free of accident hazards on 1 of 3 households (Sunflower household). Failure to ensure chemicals are stored in a locked cupboard placed residents in this household at risk for injury.<br><br>Findings include:<br><br>Review of the SDS for the ECO-SAN stated, ". . . Harmful if swallowed. Causes severe burns and eye damage . . ."<br><br>Observation on the afternoon of 07/01/19 showed an unaccompanied resident wandering in the Sunflower household kitchen area.<br><br>A tour of the open kitchen area in the Sunflower household occurred on 07/02/19 at 9:53 a.m. with a dietary supervisor (#4). Observation showed an open container of ECO-SAN (a liquid sanitizer) in an unlocked cupboard adjacent to the dishwasher. The dietary supervisor (#4) stated, "The cupboard is to remain locked at all times. This is not good." | F 689 | households with chemical storage for 3 months; than Bi monthly audits for 3months; than monthly audits will be conducted for 3 months. Audits began 7/15/19. 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. | |
| F 725 SS=E | Sufficient Nursing Staff<br>CFR(s): 483.35(a)(1)(2)<br><br>§483.35(a) Sufficient Staff.<br>The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial | F 725 | | 8/5/19 |

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| F 725 | Continued From page 4<br>well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).<br><br>§483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:<br>(i) Except when waived under paragraph (e) of this section, licensed nurses; and<br>(ii) Other nursing personnel, including but not limited to nurse aides.<br><br>§483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.<br>This REQUIREMENT is not met as evidenced by:<br>Based on policy review, review of facility's call light response report, an anonymous concern, resident interviews, resident council interview, and staff interview, the facility failed to ensure the availability of sufficient nursing staff to promptly respond to residents' needs for 4 of 13 residents interviewed (Residents A, B, C, and D), 1 resident from resident council (Resident E), and 1 anonymous concern (Resident F). Failure to provide sufficient staffing for assistance may result in residents experiencing falls, injuries, and/or incontinence and may negatively affect the residents physical, mental and psychosocial well-being. | F 725 | During the survey process it was noted that based on observation, record review, resident council, resident interviews and an anonymous concern that the facility failed to ensure the availability of sufficient staff to promptly respond to the residents needs for residents A, B, C, D E and F.<br><br>All residents that have the ability to use their call light have the potential to be affected.<br><br>Staffing levels were reviewed and our process for communication was reviewed. | |

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| F 725 | Continued From page 5<br>Findings include:<br><br>Review of the facility policy titled "Staffing and Daily Work Assignments" occurred on 07/02/19. This policy, dated 2018, stated, "Purpose: To ensure staff provide cares in accordance with resident needs. . . . Procedure: . . . 3. Staffing numbers and the skill requirements of direct care staff are determined by the needs of the residents based on each resident's plan of care. . . ."<br><br>- During an interview on the afternoon of 06/30/19, Resident A reported call light response times lasted as long as one hour with nights being the longest.<br><br>- During an interview on 06/30/19 at 9:51 a.m., Resident D stated, "There's not enough staff at night. I have had to wait a long time, sometimes longer than 30 minutes."<br><br>- During an interview on 06/30/19 at 10:12 a.m., Resident C stated the facility is short staffed and he/she has waited up to an hour to get help out of the bathroom.<br><br>- During an interview on 06/30/19 at 2:39 p.m., Resident B stated, "Not enough people working. Sometimes I wet my brief because [staff] aren't here to take care of me."<br><br>- During the Resident Council meeting held the morning of 07/01/19 when asked about call light wait times, Resident E stated, "I've had to wait up to 30 minutes."<br><br>- On the morning of 07/02/19, an anonymous | F 725 | A new communication device, dek phones, for staff will arrive and be implemented by Aug 5th. A call light is activated by a resident, the CNAs carry dek phones notifying of call light at time of activation by resident. The nurses and DON will carry escalating dek phones. This process is to ensure that call lights are answered in a timely manner at all times.<br><br>Education was provided on staffing, call light process and call light response time, which is 15 min or less to associated staff on July 17, 2019. Residents will be informed at the next resident council meeting.<br><br>DON or designee will ensure and monitor compliance. Call lights response time report will be monitored daily. Audits on customer satisfaction/call lights will be completed on each resident that has ability to use call light by the DON or designee. Random audits will be completed on 5 residents per week for 6 months; results will be reviewed by Quality Council monthly for monitoring and assured compliance and audits may continue if needed based on the audits. | |

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| F 725 | Continued From page 6 | F 725 | | |

source reported a family member of Resident F complained he/she "walked the hall for 20 minutes to find someone to help" one evening when Resident F displayed aggressive behavior and the family needed staff assistance to calm the resident. The source stated the family member "could often not find staff when the resident wanted help."

Review of the call light response report from 06/27/19 through 07/02/19 showed the following:
* 06/27/19 start time 4:28 a.m., wait time 32 minutes.
* 06/28/19 start time 3:29 a.m., wait time 53 minutes.
* 06/28/19 start time 3:41 a.m., wait time 43 minutes
* 06/28/19 start time 3:45 a.m., wait time 40 minutes.
* 06/28/19 start time 8:56 p.m., wait time 40 minutes.
* 06/29/19 start time 3:05 a.m., wait time 1 hour 11 minutes.
* 06/30/19 start time 1:50 a.m., wait time 33 minutes.
* 06/30/19 start time 8:22 p.m., wait time 49 minutes.
* 06/30/19 start time 9:15 p.m., wait time 50 minutes.
* 06/30/19 start time 9:25 p.m., wait time 38 minutes.
* 06/30/19 start time 10:19 p.m., wait time 32 minutes.

During an interview on 07/02/19 at 11:57 a.m., an administrative staff member (#1) stated he/she would expect staff to answer call lights in 10 minutes or less, but no longer than 30 minutes.

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| F 812 SS=E | Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)<br><br>§483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to store food under sanitary conditions in 1 of 1 walk-in coolers in the main kitchen. Failure to prevent melting ice from dripping onto stored food items increases the risk of foodborne illness and can affect all residents who eat food stored in these areas.<br><br>Findings include:<br><br>Observation during the initial main kitchen tour on 06/30/19 at 9:29 a.m. showed a large thick area of ice with frozen drip marks on it located underneath the walk-in cooler refrigeration unit. A | F 812 | No residents were affected<br><br>All neighbors who eat could potentially be affected.<br><br>Items that were being dripped on were removed on 07/03/2019. A repair ticket was submitted to Heating and Cooling Unlimited on July 5, 2019. Ice matter was removed on 07/03/2019.<br><br>Audits will be done 5 days a week for 2 week; than 3 times week for 2 weeks; than 2 times per week for 2 months; than | 7/18/19 |

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| F 812 | Continued From page 8<br>food storage rack located under the refrigeration unit contained various resident food/drink items.<br><br>Observation during the final kitchen tour on 07/02/19 at 9:53 a.m. showed the same area of ice build-up thawing and noted the following:<br>* Water dripping and pooling on top of approximately 6 boxed containers of prune juice on the top shelf of the food storage rack<br>* Water splatters on approximately 6 plastic bottles of orange juice located on the second shelf of the food storage rack<br>* Water pooled into the lids of two food containers on the third shelf of the food storage rack<br>* Water splashed on packaged meat stored on the bottom shelf of the food storage rack<br>* Two pools of water on the floor in front of the food storage rack<br>* A pool of water on the floor inside and to the right of the cooler door. Unable to determine the source of this pool of water<br><br>During an interview on 07/02/19 at 9:53 a.m., a dietary supervisor (#4) stated, "There used to be a white bucket underneath here [the refrigeration unit to catch any dripping water]. I'm not sure where that went." She then removed the affected items from the dripping water. | F 812 | once week for 2 months; than 2 times month for 2 months; than monthly for 2 months. Audits began 7/15/19. 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. | |