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 _____	07/27/2022

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 07/24/22 and concluded 07/27/22.	F 000		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and	F 583		8/26/22

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

Electronically Signed | 08/24/2022

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F 583	Continued From page 1 administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, review of professional reference, and staff interview, the facility failed to promote privacy and confidentiality of medication administration records (MAR) on 2 of 2 days observed for medication administration. Failure to close the MAR may result in unauthorized viewing of resident records by other residents, unlicensed staff and/or visitors. Findings include: Kozier & Erb's "Fundamentals of Nursing, Concepts, Process and Practice," 11th Edition eText, 2021, Pearson, Boston, Massachusetts, page 234, stated, ". . . ensure the privacy and confidentiality of client information stored in computers. . . . Do not leave client information displayed on the monitor where others may see it. . . ." Observation during medication administration showed the medication cart unattended with a resident's MAR visible on the screen during the following times: * 07/24/22 at 4:10 p.m. to 4:15 p.m. * 07/25/22 at 11:15 a.m. to 11:26 a.m. During an interview on 07/26/22 at 8:26 a.m., an administrative staff member (#7) stated she expected staff to lock the computer screen whenever they leave the medication cart.	F 583	F583- During the annual survey it was noted that the facility failed to promote privacy and confidentiality of medication administration records on 2 of 2 days. All residents who have an electronic medical record have the ability to be affected by this deficient practice. Training /Education will be conducted with all staff that pass medications on signing out of any PHI related records prior to walking away from the computer and cart and/or locking the screens so it can not be accessed by anyone other than the user by using Control+Alt+Delete then Lock on the screen. Education will be completed on or before August 23rd 2022. Audits will be conducted by DON and/or designee at random 5x a week x4 weeks and 3x a week x 3 months on privacy and confidentiality of resident records during medication pass with all audits reviewed through quality council. Audits will continue as deemed by quality council as necessary until substantial compliance has been achieved. The DON is responsible for compliance. Substantial compliance will be achieved by August 26th, 2022.	

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F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.	F 656		8/26/22

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F 656	Continued From page 3 (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and review of the facility policy, the facility failed to develop a comprehensive care plan for 4 of 16 sampled residents (Resident #6, #44, #47, and #201). Failure to develop a comprehensive care plan limited staffs' ability to communicate needs and ensure the continuity of care. Findings Include: Review of the facility policy titled "Comprehensive Assessments and Care Planning" occurred on 07/27/22. This policy, revised 07/02/18, stated, ". . . provide a comprehensive person-centered interdiciplinary care assessment of the resident's condition . . . A facility should use the results of the assessment to develop, review and revise the resident's person-centered comprehensive care plan. . . . Asssessment process must include direct observation . . ." Review of the facility policy titled, "BHS [Benedictine Health System] Restorative Therapy Program" occurred on 07/27/22. This policy, dated 2017, stated, ". . . The Registered Nurse will document in Matrix Care the individualized program including . . . Care plan problem, goal, and approaches. . . ." - Review of Resident #6's medical record occurred on all days of survey. A "Restorative	F 656	F656- During the annual survey it was noted that the facility failed to develop a comprehensive care plan for 4 of 16 residents. Resident #6's was evaluated by therapy to determine an updated restorative therapy program and care plan was updated to reflect recommendations. Resident #44's was evaluated by therapy to determine an updated restorative therapy program and care plan was updated to reflect recommendations. Resident #47's was evaluated by therapy to determine an updated restorative therapy program and care plan was updated to reflect recommendations. Resident #201's care plan was updated to reflect current skin impairment and interventions. All residents who have skin related issues and restorative programming have the ability to be affected by this deficient practice. All residents who have a restorative program in place will be reviewed to ensure their care plan reflects their current program. All residents with current pressure ulcers will be reviewed to ensure proper care planning in place for wound management and prevention.	

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F 656	Continued From page 4 Care Communication Form", dated 04/05/22, identified a restorative program for passive range of motion (PROM) to the resident's left upper extremity three times a week. The current care plan failed to include restorative therapy for PROM. - Review of Resident #44's medical record occurred on all days of survey. A "Restorative Care Communication Form", dated 05/25/22, identified a restorative program for PROM to the resident's lower extremities three times a week. The current care plan failed to include restorative therapy for PROM. - Review of Resident #47's medical record occurred on all days of survey. A "Restorative care Communication Form", dated 05/09/22, identified a restorative program for PROM to the resident's upper and lower extremities three times a week. The current care plan failed to include restorative therapy for PROM. - Observation on 07/24/22 at 3:31 p.m., showed Resident #201 lying in bed while two certified nursing assistants (CNAs) (#9) and (#10) provided perineal cares. Observation showed two Mepilex Border (an adhesive foam dressing) on the resident's coccyx/upper right buttock area. The CNA (#10) removed the soiled Mepilex Border, revealing an open area with a pink wound bed. Review of Resident #201's medical record occurred all days of survey. A nursing progress note, dated 06/28/22 at 5:52 p.m., stated, "Neighbor arrived in the facility around 3 in the afternoon. . . . Skin inspection done, noted to	F 656	Education will be completed on or before August 23rd 2022 with all associated nursing staff to ensure understanding on how to update a care plan in matrix. Audits will be conducted by DON and/or designee at random 3x a week x4 weeks and 2x a week x 3 months on residents who have restorative programming and/or pressure wounds to ensure proper care planning is in place. All audits will be reviewed through quality council. Audits will continue as deemed by quality council as necessary until substantial compliance has been achieved. The DON is responsible for compliance. Substantial compliance will be achieved by August 26th 2022	

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F 656	Continued From page 5 have Stage 2 wound on right buttocks near coccyx measuring 3.5cm [centimeter] in length x 4.5cm [in] width. Wound is pinkish and appears healthy. . . ." Resident #201's care plan failed to address the current pressure ulcer.	F 656		
F 658 SS=D	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: Based on record review, review of facility policy, and staff interview, the facility failed to provide care in accordance with professional standards for 1 of 17 sampled residents (Resident #19) and 1 closed record (#52) with a history of falls. Failure to complete neurological assessments following an unwitnessed fall or a fall with a head injury has the potential to delay identification and treatment of a closed head injury. Findings include: Review of the facility policy titled "Neurological Assessment" occurred on 07/27/22. This policy, dated 2018, stated, ". . . a neurological observation and assessment is completed . . . following an unwitnessed fall and/or subsequent to a fall with a suspected head injury. . . ." - Review of Resident #19's medical record occurred all days of survey. The care plan, dated 04/26/22, stated, ". . . I have times of confusion and forgetfulness and may show fluctuations in	F 658	F658- During the annual survey it was noted that the facility failed to provide care in accordance with professional standards for 2 reviewed residents with a history of falls. Resident #19 has been assessed and does not have any current neurological deficits in relation to her falls and/or caused from her falls in the facility. Resident #52 no longer resides in the facility. All residents that have unwitnessed falls or hit their head during falls have the ability to be affected by this deficient practice. Education will be completed with all associated nursing staff on or before August 23rd on falls checklist and when neurological assessments should be completed. Policy on falls management	8/26/22

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F 658	Continued From page 6 cognition due to dx [diagnosis] of encephalopathy [abnormal brain function] and dementia. . . ." The progress notes identified the following: * 05/01/22 at 3:00 a.m., "Neighbor was noted on the fall [sic] by her bed. She could not state how she fell. . . ." * 05/09/22 at 9:00 a.m., "Neighbor was witnessed on the floor in her room by the activity staff this morning around 8:30am. She was leaning on her L [left] side between the foot pedal of her W/C [wheelchair], her left leg was flexed under her R [right] leg. Neighbor was conversant and was sleepy. . . ." * 05/23/22 at 4:18 p.m., "At [7:15 a.m.], [Resident] was found on the floor beside her bed. CNA heard her calling for help. She was lying on her right side. Her feet were towards the head of the bed. . . . She said that she did not hit her head . . ." Review of Resident #19's medical record showed facility staff failed to complete neurological assessments on all three occasions per facility policy. - Review of Resident #52's medical record occurred on 07/27/22. The care plan, dated 04/02/22, identified, ". . . I do need assistance with mobility due to weakness, unsteadiness, dx Pneumocephalus [presence of air or gas in the cranial cavity and can be associated with head trauma] and hx [history] dizziness with falls . . ." The progress notes identified the following: * 01/21/2022 at 1:34 p.m., ". . . At 10:00AM neighbor was witnessed on the floor in her bedroom. She was sitting between her recliner	F 658	and neurological checks have been reviewed with associated nursing staff. Audits will be completed by DON and/or DON designee on every unwitnessed fall or witnessed fall where they have hit their head x 4 weeks and 2 falls a week (if occur) x 3 months. All audits will be reviewed through quality council. Audits will continue as deemed by quality council as necessary until substantial compliance has been achieved. The DON is responsible for compliance. Substantial compliance will be achieved by August 26th 2022	

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F 658	Continued From page 7 and Tv stand. Neighbor states that she slide [sic] down from her chair. . . ." * 02/19/2022 at 6:40 p.m., ". . . Neighbor was witnessed on the floor in her room around 6:04pm, culinary staff found her sitting upright on the floor beside her night stand . . ." * 04/15/2022 at 5:42 p.m., ". . . Neighbor was witnessed on the floor in her room by the culinary staff this afternoon around 15:05 [3:05 p.m.]. She was laying on her back between her bed and recliner . . ." Review of Resident #52's medical record showed facility staff failed to complete neurological assessments on all three occasions per facility policy. During an interview on 07/27/22 at 10:45 a.m., an administrative nurse (#7) stated she expects staff to perform neurological assessments with each unwitnessed fall.	F 658		
F 676 SS=E	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b)	F 676		8/26/22

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F 676	Continued From page 8 of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff and resident interviews, the facility failed to provide the care and services necessary to maintain or improve the resident's ability to perform activities of daily living (ADLs) for 4 of 4 sampled resident (Resident #6, #25, #44, #47) with a restorative therapy program in place. Failure of staff to ambulate a resident and complete range of motion (ROM) exercises may result in decreased mobility and contractures. Findings include: Review of the facility policy titled ". . . Restorative	F 676	F676- During the annual survey it was noted that the failed to provide the care and services necessary to maintain or improve the residents' ability to perform ADLs for 4 of 4 sampled residents with a restorative therapy program in place. Resident #6 therapy to evaluate for current restorative nursing needs. Resident #25 therapy to evaluate for current restorative nursing needs. Resident#44 therapy to evaluate for current restorative nursing needs. Resident #27 therapy to evaluate for	

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F 676	Continued From page 9 Program", occurred on 07/26/22. This policy dated July 2017, stated, ". . . To provide a basic outline and guidance for implementation and tracking of restorative programs established so that each resident can "attain and maintain highest physical, mental and psychosocial well-being". Restorative nursing care promotes resident's highest level of independence in each of the following areas: . . . Range of Motion . . . Ambulation . . . The Registered Nurse in collaboration with the therapist(s) will design the individualized restorative program for the resident. . . ." - Review of Resident #6's medical record occurred on all days of survey. A quarterly Minimum Data Set (MDS) dated 07/11/22 identified upper extremity impairment to one side and bilateral impairment to the lower extremities. The "Restorative Care Communication Form", dated 04/05/22, identified diagnoses of hemiplegia and hemiparesis and history of cerebral vascular accident (CVA), decreased strength, decreased mobility, and resident to receive PROM to left upper extremity 10 repetitions each set in shoulder flexion/extension, elbow flexion/extension, pronation/supination, wrist flexion/extension, finger extension three times a week. During an interview on 07/25/22 at 4:32 p.m., Resident #6 stated he had not received restorative therapy for several weeks Review of the restorative charting June 1-July 24, 2022 showed Resident #6 received restorative therapy 5 times.	F 676	current restorative nursing needs. All residents on a restorative nursing program have the ability to be affected by this deficient practice and have been reviewed and evaluated by therapy for updated programming and needs. Nursing staff will be educated on program specifics and documentation. Education was provided to associated nursing staff on or before August 23rd, 2022 in regards to the restorative nursing program and the restorative programs assigned for identified residents on a program. A RN will be identified to monitor progress of the program. Audits will be conducted by DON and/or DON designee on resident's who have a restorative program in place to ensure program is being offered to residents in accordance with the program recommendations by therapy 4x a week x 4 weeks and 2x a week x3 months. All audits will be reviewed through quality council. Audits will continue as deemed by quality council as necessary until substantial compliance has been achieved. The DON is responsible for compliance. Substantial compliance will be achieved by August 26th 2022	

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F 676	Continued From page 10	F 676		

- Review of Resident #25's medical record occurred on all days of survey. "The Restorative Care Communication Form", dated 09/15/21, identified diagnosis of dementia, adult failure to thrive, decreased strength/endurance, a decreased mobility, and a walk to dine program daily with assist of one and front wheeled walker with the wheel chair to follow.

Observations included the following:
* 07/25/22 at 4:33 p.m.: a certified nurse assistant (CNA) (#9) assisted Resident #25 to stand-pivot from the bed to the wheelchair utilizing a gait belt. Resident #25 had difficulty moving her feet. The CNA (#9) failed to ambulate the resident to the supper meal.
* 07/25/22 at 4:42 p.m.: Resident #25 self-propelled her wheelchair into the dining room.
* 07/26/22 at 11:24 a.m.: Resident #25 self-propelled her wheelchair into the dining room.
* 07/26/22 at 4:28 p.m.: Resident #25 self-propelled her wheelchair into the dining room.
Staff failed to ambulate Resident #25 to meals as per her restorative program.

Review of the restorative charting for Resident #25 identified the resident received walk-to-dine assistance 6 out of 27 days in July.

- Review of Resident #44's medical record occurred on all days of survey. The "Restorative Care Communication Form", dated 05/25/22, identified diagnosis of Multiple Sclerosis, decreased mobility, and resident to receive passive range of motion to bilateral knees in

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F 676	Continued From page 11	F 676		

flexion and extension 15 repetitions (reps) each knee, complete sustained stretch in knee extension, hold knee extension stretch 15-20 seconds, repeat with other leg three times a week for 15 minutes.

During an interview on 07/24/22 at 2:03 p.m., Resident #44 stated his legs were tightening at night, and reported he had not received restorative therapy for about 2 weeks.

A nursing progress note dated 07/19/22 at 2:49 p.m., stated, "Annual MDS completed. . . . Neighbor is alert and oriented. . . . He is on an RC [restorative care] PROM [passive range of motion] program and utilizes the stander [a device to assist with standing]. . . ."

Review of the restorative charting for June 1-July 24, 2022 showed Resident #44 received restorative therapy 7 times.

- Review of Resident #47's medical record occurred on all days of survey. A quarterly MDS, dated 06/30/22, identified an upper extremity impairment to one side and bilateral impairment to the lower extremities. The "Restorative Care Communication Form", dated 05/09/22, identified diagnoses of Multiple Sclerosis, stage 4 sacral pressure ulcer, decreased mobility/ROM (range of motion), and contractures of bilateral knees, with recommendations for PROM to bilateral upper extremities 10 reps times 2 in shoulder flexion/extension, shoulder abduction and adduction, shoulder horizontal abduction and adduction, elbow flexion and extension, and PROM with sustained stretch in knee extension and ankle plantar/dorsiflexion x 10 reps x 2.

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 _____	07/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 676	Continued From page 12 Frequency identified as three times a week. During an interview on 07/26/22 at 2:36 p.m., Resident #47 stated she experiences knee pain when lying on her right side an reported she had not received restorative therapy for some time. Review of the restorative charting for June 1-July 24, 2022 identified Resident #47 received restorative therapy 6 times. During an interview on 07/25/22 at 10:51 a.m., an occupational therapist (#1) and a physical therapist (#8) stated the facility had been without a restorative certified nursing assistant for at least two weeks and admitted no one is currently completing the residents restorative therapy programs.	F 676		
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	F686-	8/26/22

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F 686	Continued From page 13 STANDARD SURVEY COMPLETED 04/15/21. Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide the necessary treatment/services to prevent the occurrence and promote the healing of pressure ulcers for 2 of 3 sampled residents (Resident #47 and #201) identified with pressure ulcers. Failure to turn/reposition residents and measure pressure ulcers may result in worsening of existing pressure ulcers and additional pressure ulcers/skin breakdown. Findings include: Review of the facility policy titled "Prevention and Treatment of Skin Breakdown" occurred on 07/27/22. This policy, dated 09/01/18, stated, ". . . Care and service are delivered to maintain skin integrity and promote skin healing if skin breakdown should occur. . . . 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. . . . Treatment of impaired pressure injury . . . Notify attending provider . . . Attending provider determines wound type and may provide additional orders. . . . Weekly the licensed nurse will stage, measure . . . the wound bed and surrounding skin . . . Documentation reflects areas as addressed above. . . ." Review of Resident #47's medical record occurred on all days of survey and identified a stage IV ulcer on the sacrum and a stage IV ulcer on the right hip. The current physician orders stated, ". . . Change	F 686	During the annual survey it was noted that the facility failed to provide the necessary treatment and services to prevent the occurrence and promote the healing of pressure ulcers for 2 of 3 residents with pressure ulcers. Resident #47 had a skin assessment completed to ensure no other skin issues have developed due to lack of repositioning. Resident #201's stage 2 pressure ulcer has been measured and documented in the wound management tab with orders to document on wound progress and measurements weekly. All residents with pressure related injuries have the ability to be affected by this deficient practice. All residents with pressure related injuries will have a wound management tab and event opened to monitor and track their wound progress. A resident list will be compiled of all residents who need a turning and repositioning intervention in place. Education provided on or before Aug 23rd 2022 to licensed nurses regarding facility skin impairment process and checklist along with how to enter weekly measurements and documentation will be provided. Education will be provided to all nursing staff on which residents need to be turned and repositioned with a list available to staff. Audits will be conducted by DON and/or DON designee on all residents that have	

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F 686	Continued From page 14 wound vac dressing 3 x [times] a week to right hip and sacral ulcer. . . . Reposition every 2 hrs [hours] (AL,R,L,R only) [alternate right, left, right] on even hours . . ." Observations of positioning showed the following: * 07/26/22 at 8:13 a.m.: A certified nurse assistant (CNA) #11 completed incontinent cares. Resident #47 had a red line with indentation across the resident's back from the Vac tubing to her right hip wound. * 07/26/22 at 9:41 a.m.: Resident #47 lying on her left side. * 07/26/22 at 11:34 a.m.: Resident remains on her left side. * 07/26/22 at 12:50 p.m.: Resident remains on her left side. * 07/26/22 at 2:12 p.m.: Resident remains on her left side. * 07/26/22 at 3:06 p.m.: Staff repositioned Resident #47 on to her right side. (The resident was not repositioned for over 5 hours). - Observation on 07/24/22 at 3:31 p.m. showed Resident #201 lying in bed while two CNAs (#9 and #10) provided perineal cares. Observation showed two Mepilex Border (an adhesive foam dressin) on the resident's coccyx/upper right buttock area. The CNA (#10) removed the soiled Mepilex Border, revealing an open area with a pink wound bed. Review of Resident #201's medical record occurred all days of survey. A nursing progress note, dated 06/28/22 at 5:52 p.m., stated, "Neighbor arrived in the facility around 3 in the afternoon. . . . Skin inspection done, noted to have Stage 2 wound on right buttocks near	F 686	a pressure related skin issue for weekly measurements and documentation in their resident record x 2 months. Audits will also be conducted on 3 residents per week x 2 months that require physical turning and repositioning every 2 hours to ensure turning and repositioning has been completed and/or offered. Both audits will continue as deemed by quality council as necessary until substantial compliance has been achieved. The DON is responsible for compliance. Substantial compliance will be achieved by August 26th 2022.	

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BENEDICTINE LIVING CENTER OF GARRISON	609 4TH AVE NE GARRISON, ND 58540

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F 686	Continued From page 15 coccyx measuring 3.5cm [centimeter] in length x 4.5cm [in] width. Wound is pinkish and appears healthy. . . ." The medical record lacked weekly documentation of Resident #201's Stage 2 pressure ulcer. During an interview on 07/27/22 at 09:30 a.m., an administrative nurse (#7) confirmed the staff failed to document weekly measurements of Resident #201's pressure ulcer.	F 686		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these	F 758		8/26/22

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F 758	Continued From page 16 drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review, policy review, and staff interview, the facility failed to ensure each resident's medication regimen remained free from unnecessary medications for 2 of 4 sampled residents (Resident #15 and #19) reviewed for psychotropic medication use. Failure to evaluate Resident #15 for evidence of tardive dyskinesia (a side effect of antipsychotic medication) and Resident #19 for continued use of an as needed (prn) psychotropic medication may have resulted in these residents receiving unnecessary medications and experiencing adverse drug effects related to their use.	F 758	F758- During the annual survey it was noted that the facility failed to ensure each resident's medication regimen remained free from unnecessary medications for 2 of 4 residents reviewed for psychotropic medication use. Resident #15 has been assessed by the use of the AIMS assessment completed on 8/2/2022 for any side effects from current use of the antipsychotic medication prescribed. Resident #19's Ativan has been discontinued and reordered with a 14 day	

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F 758	Continued From page 17 Findings include: Review of the facility policy titled "Abnormal Involuntary Movement Scale (AIMS) Tardive Dyskinesia (TD) Monitoring" occurred on 07/27/22. This policy, dated 2020, stated, ". . . Residents will be assessed for potential side effects from psychotropic medication use. The Abnormal Involuntary Movements Scale (AIMS) . . . will be used to assist in identification of tardive dyskinesia . . . Residents will have a baseline AIMS . . . completed at initiation of any antipsychotic medication . . . AIMS will be completed with a change in dose of medication. . . . AIMS test will be completed . . . every 6 months at a minimum with continued use of psychotropic medication . . ." Review of Resident #15's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease, irritability, and anger. A quarterly Minimum Data Set (MDS), dated 05/04/22, identified three days of antipsychotic medication use. Review of physician orders identified the following: * 02/15/22 - 02/28/22 quetiapine [an antipsychotic medication]; 25 mg [milligram]; twice a day * 02/28/22 - 05/10/22 quetiapine tablet; 25 mg; at bedtime * 05/10/22 - 07/11/22 quetiapine tablet; 12.5 mg; at bedtime Review of nursing progress notes identified the following: * 02/15/22 at 10:24 a.m., "Seen on psych	F 758	end date. All residents who receive antipsychotic medications have the potential to be affected by this deficient practice. All residents on PRN antipsychotics have had their orders reviewed to ensure there is no extended use beyond the 14 days without physician review. All residents who receive antipsychotic medications will have a new AIMS completed with any dose change or start of new antipsychotic. Education will be completed on or before Aug 23rd 2022 for all licensed nurses on the facility policy for psychotropic drug use and AIMS policy on when to complete AIMS assessments in matrix. Audits will be conducted by DON and/or DON designee on 2 residents per week that receive a PRN antipsychotic medication to review for 14 day end dates x 3 months. Audits will also be conducted on all residents who receive antipsychotic medications who have a dose change or start a new antipsychotic medication for completion of AIMS assessment within the facility policy timeframe. Substantial compliance will be achieved by August 26th 2022.	

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F 758	Continued From page 18 [psychiatric] rounds, new order to start with quetiapine 25mg BID [twice a day]. . . ." * 02/28/22 at 3:35 p.m., "Psych provider phoned back, order received to decrease Seroquel [quetiapine] to daily. . . ." * 05/10/22 at 12:10 p.m., ". . . Seroquel decreased to 12.5mg tab . . ." Review of Resident 15's medical record identified staff completed one AIMS assessment on 05/04/22. Staff failed to do a baseline AIMS assessment and failed to complete AIMS assessments with the dose adjustments on 02/28/22, and 05/10/22. During an interview on 07/27/22 at 9:00 a.m., an administrative nurse (#7) confirmed staff failed to complete an AIMS assessment on initiation of Resident #15's antipsychotic medication, and with each subsequent dose change. - Review of Resident #19's medical record occurred all days of survey. A physician's order for Ativan [an anti-anxiety medication], dated 06/27/22, stated, "Give 0.25 mg [milligram] by mouth for anxiety every 6 hours as needed." Review of Resident #19's July medication administration records showed continued administration of PRN Ativan beyond the 14 days of the physician's order. The record failed to show the prescribing practitioner's rationale for continued use of the PRN Ativan. Staff failed to obtain a new physician's evaluation and order for the PRN Ativan after 14 days.	F 758		

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F 758	Continued From page 19 During an interview on 07/27/22 at 9:00 a.m., an administrative nurse (#7) agreed Resident #19 received PRN Ativan beyond the 14 days and confirmed the medical record did not contain a rationale and/or duration for continued use of PRN Ativan.	F 758		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (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. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, review of professional literature, and staff interview, the facility failed to prepare and serve foods under sanitary conditions in 3 of 3 kitchens and in the main lobby. Failure to store and serve food in a proper manner and maintain clean kitchens may result in contamination of food/dishware and forborne	F 812	F812=D Food Procurement, Store/Prepare/Serve-Sanitary 1)All culinary staff were educated on proper cleaning procedures for sanitizers, stove, oven, refrigerator grill vent, handwashing sink, all ice machines, and	8/26/22

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F 812	Continued From page 20 illness to residents, staff, and visitors. Findings include: EQUIPMENT Observation on the morning of 07/24/22 in the main kitchen showed the following: * The dish machine with areas of buildup of mineralization, dust, and debris. * The steel countertop attached to the dish machine with mineralization, corrosion, and rust. Observation on the morning of 07/24/22 in the Prairie Rose kitchen showed the following: * The dish machine with peeling corrosion and rust on the outside frame and areas of rust inside the machine. * The stove/oven with loose food particles inside the oven and in the bottom drawer of the stove and the outside sticky and grimy. * The refrigerator with dark dust and grime on the bottom grill/vent. * The handwashing sink with grime around the edges of the sink. Observation on all days of survey showed the ice machines in the Dakota, Sunflower, and Prairie Rose dining rooms and in the main lobby with buildup of mineralization/corrosion around the ice/water dispensing spouts and catch trays. FOOD SERVICE The "Food Code, U.S. Public Health Service, Food and Drug Administration," U.S. Department of Health and Human Services, 2017, page 78,	F 812	water dispensing spouts at staff meeting 8-23-2022. 2)Corrosion and rust areas were cleaned off of dish machines 8-23-2022. After a deep cleaning of all dish machines it was determined that none of the main working components were rusted they just needed to have mineralization removed. The stove/oven was cleaned of all loose food particles inside the oven & in the bottom drawer of stove 7-28-2022. All sticky and grimy areas were scrubbed and cleaned 7-28-2022. The refrigerator bottom grill vent was cleaned of all dark dust and grime 7-28-2022. The handwashing sink was scrubbed clean of grime 7-28-2022. All ice machines and water dispensing spouts were scrubbed to clean off mineralization & corrosion 7-28-2022. All freezers were checked for outdated food 7-28-2022. Culinary staff were in-serviced on proper infection control procedures with glove usage. 3)Cleaning checklist was developed to assure equipment & kitchen areas are kept clean. Cleaning checklist will be marked off daily. 4)Culinary director will audit compliance with proper cleaning, procedures for dish machines, stove, oven, refrigerator grill vent, handwashing sink, all ice machines, and water dispensing spouts for infection control and checking for outdated food and glove usage 2x/wk., per household, x	

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F 812	Continued From page 21 stated, ". . . SINGLE-USE gloves shall be used for only one task . . . used for no other purpose, and discarded when damaged or soiled, or when interruptions occur in the operation. . . ." Observation on 07/24/22 at 11:21 a.m. in the Prairie Rose kitchen freezer showed a tray of pre-dished ice cream with visible ice crystals loosely covered with plastic wrap, dated 07/13. When asked about the ice cream, a dietary staff member (#2) stated, "It [the ice cream] shouldn't be served," he/she removed the tray from the freezer and discarded the ice cream. Observation on 07/24/22 at 11:43 a.m. showed a dietary staff member (#2) touched multiple surfaces (cupboard and drawer handles, various food packages/containers, meal trays and dishes) with gloved hands, and with the same gloves, sliced buns and reached into a potato chip bag and placed the food items onto multiple resident meal plates.	F 812	6 weeks; then monthly, per household x 3 months. QA Team will review audits quarterly. 5)Date Certain 8/26/22	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880		8/30/22

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F 880	Continued From page 22 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed	F 880		

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F 880	Continued From page 23 by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation and review of professional reference, the facility failed to follow infection control practices on 2 of 4 days of survey (July 24 and July 25, 2022) in resident care areas and during resident cares. Failure to follow infection control practices related to use of Personal Protective Equipment (PPE), has the potential for transmission of communicable diseases and infections to residents and staff. Findings include: Review of professional reference found at https://www.cdc.gov/coronavirus/2019-ncov/easy-to-read/mask-guidance.html, updated March 2022, stated, ". . . The mask must cover your nose . . . The mask must be snug on your face . . ." Observations showed the following: * 07/24/22 at 11:43 a.m.: CNA (#9) deliver resident meal trays and assist residents with their	F 880	1. Corrective Action The facility will immediately implement an appropriate infection prevention and intervention plan consistent with the requirements of §483.80 for the affected resident(s)/neighborhood(s) identified in the deficiency. The infection preventionist (IP), director of nursing (DON), in conjunction with applicable interdisciplinary team (IDT) members, shall identify and implement a consistent system for ensuring a system for: (1) Ensuring staff consistently wear a facemask in accordance with guidelines from the CDC and facility policy when in resident care areas and during resident cares. The DON, staff development coordinator (SDC), IP or designee, in conjunction with applicable IDT members, will:	

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 _____	07/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 24 meal while wearing her surgical mask below her nose. * 07/24/22 at 4:10 p.m.: CNA (#9) walked down the facility hallway wearing her surgical mask below her nose * 07/25/22 at 8:17 a.m.: CNA (#9) assisted a resident with cares wearing her surgical mask below her nose. * 07/25/22 at 8:35 a.m.: CNA (#9) assisted a resident with cares wearing her surgical mask below her nose * 07/25/22 at 10:00 a.m.: CNA (#9) completed incontinent care for a resident wearing her surgical mask below her nose.	F 880	(1) Educate all staff on the importance of correct technique for wearing facemasks when in resident care areas and during resident cares. 2. Identification of Others The IP and DON, in conjunction with the applicable the interdisciplinary team (IDT) members, will review current COVID-19 nursing facility guidelines from CDC and CMS. The IP, DON and applicable IDT members will evaluate the facility's compliance with the guidelines. The facility will develop action plans to address any newly identified non-compliance. 3. System Changes On or before 08/30/2022 the facility shall complete the following actions: (1) DON, IP and applicable IDT members will conduct root-cause analysis to identify and address the reasons for non-compliance related to: a. Failure of staff to wear facemasks as per CDC guidelines and facility policy when in resident care areas and during resident cares. Information about root cause analysis can be found at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/GuidanceforRCA.pdf (2) The DON, SDC, IP or suitable designee will ensure the following: a. Educate all staff on the proper technique for wear facemasks in resident care areas and during resident cares.	

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F 880	Continued From page 25	F 880	4. Monitoring Weekly for no less than 12 weeks, the DON, IP, SDC or a designee will conduct on-going monitoring to ensure, via observation, the approaches to correct deficient practice related to infection control and prevention are consistently implemented and effective. Such monitoring will include: (1) Observations of all staff types to ensure correct wearing of facemasks in resident care areas and during resident cares. Observations will be made across all shifts and neighborhoods/units. Observations of noncompliance with the above will result in ad hoc education for the involved staff. Such education will be documented on monitoring forms. After twelve weeks of monitoring, provided that such monitoring demonstrates expectations are consistently met, monitoring may be reduced to monthly. Monthly monitoring will continue for no less than three months. All monitoring will be reported to the quality assurance process improvement (QAPI) committee as part of QAPI activities. Monitoring will not be discontinued until the facility completes three consecutive rounds of monthly monitoring that demonstrate sustained compliance as approved by the QAPI committee and medical director. 5. Correction Date	

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F 880	Continued From page 26	F 880	08/30/2022	