STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355084	A. BUILDING _____ B. WING _____	05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN SUNSET HOME	333 EASTERN AVE GRAFTON, ND 58237

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F 000	INITIAL COMMENTS The Standard Medicare/Medicaid recertification survey started 05/03/21 and concluded on 05/06/21.	F 000		
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 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 professional references, and staff interview, the facility failed to ensure residents received treatment and services to maintain the highest practicable physical well-being for 1 of 2 sampled residents (Resident #55) on coumadin (an anticoagulant medication). Failure to observe and implement physician's orders, monitor, and understand side effects has the potential for adverse outcomes such as increased, prolonged, abnormal bleeding and/or increased bruising. Findings include: Berman, Snyder, and Frandsen's "Kozier & Erb's Fundamentals of Nursing: Concepts, Process, and Practice," 10th ed., Pearson Education, Inc., Massachusetts, page 68, stated, ". . . Carrying Out a Physician's Orders . . . If the order is neither ambiguous nor apparently erroneous, the	F 684	Resident #55 was successfully transitioned over to the use of Eliquis in November 2020. Eliquis does not require frequent lab draws. 5/6/2021 the Director of Nursing reviewed records for all current residents in the facility. Three residents were identified to have prescriptions for Coumadin. Review of the records for these three residents was completed by the Director of Nursing to include the past 12 months of PT/INR orders. All orders were carried out as directed by the provider. A policy was created titled "High Alert Medications: Anticoagulants" this document discusses the use of a new flowsheet for PT/INR monitoring that was created by the Director of Nursing and Health Information Management	6/4/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/27/2021

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F 684	Continued From page 1 nurse is responsible for carrying it out. . .." Review of the online resource "Drugs.com" showed, "Consumer: Using ciprofloxacin [a quinolone antibiotic] together with warfarin [coumadin] may cause you to bleed more easily. You may need a dose adjustment based on your prothrombin time [PT] or International Normalized Ratio (INR). Call your doctor promptly if you have any unusual bleeding or bruising, vomiting, blood in your urine or stools, headache, dizziness, or weakness. . . . Professional: Other influences such as fever, infection, malnutrition, and other concomitant underlying conditions on clotting mechanisms and warfarin pharmacokinetics should also be considered. . . . The INR should be checked frequently and coumadin dosage adjusted accordingly, particularly following initiation or discontinuation of quinolone therapy in patients who are stabilized on their anticoagulant regimen. . . ." Review of the medical record for Resident #55 occurred on all days of survey. The record showed a laboratory report, dated 09/15/20, which stated, "INR Value 1.71 (L [low]) Range 2.00 to 3.50" This report identified the blood draw occurred at 7:15 a.m. Physician's orders, dated 09/15/20, stated, "[change] Coumadin to 2.5 mg [milligram] PO [by mouth] on Mondays/Thursdays 5 mg PO all other days. Recheck INR on 09/22/20." Resident #55's medical record lacked documentation the facility rechecked the resident's INR on 09/22/20. Nurse progress notes (NP), physician orders	F 684	manager. All residents with orders for Coumadin will have a separate sheet kept in a binder in the Health Information Management office. Health Information Management will update the binder/flowsheets with all new PT/INR orders and will monitor for PT/INR's at least monthly on all residents with Coumadin orders. The Health Information Management office will notify the Nurse Manager for the need of PT/INR order, if not present in the last 1 month. All licensed nurses were provided with a copy of the mentioned Drugs.com information for both patient and professional. Signatures were obtained to signify understanding of the information provided. All licensed nurses and certified medication tech II's will complete a unit in Healthcare Academy titled "High Alert Medications" by 6/4/2021. The Director of Nursing/designee will perform audits on "completion of PT/INR orders" weekly x 12, monthly x 3, quarterly x 3. The results of these audits will be reported quarterly to the QAPI committee.	

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F 684	Continued From page 2	F 684		

(PO), and laboratory (lab) results showed the following:
- (NP) 09/17/20 at 5:45 p.m., "Call received from [Doctor's] office . . . head wound . . . would like the yellow exudate cultured. . . ."
- (NP) 09/25/20 at 10:38 p.m., "Resident started on Cipro and doxycycline for area to top of scalp. Resident denies pain. . . ."
- (NP) 10/31/20 at 8:40 a.m., "[Family] was informed that (sic) [Resident #55] is positive for COVID-19. [Family name] appreciated update."
- (NP) 11/05/20 at 10:23 a.m., ". . . [family] questioned about when last INR was on 9/15/20 and no further draw since then. Call placed to [Doctor's] office, spoke with nurse [name] and updated her on residents last INR draw date. MD ordered to draw INR today."
* Lab result, 11/05/20: "PT Value 187.9 (HH [high high]) Range 8.7-11.8 seconds INR Value 17.7 (HH) Range 2.00 to 3.50" This report identified the blood draw occurred at 10:30 a.m.
- (PO) 11/05/20, "Hold camadin (sic). Give Vitamin K 5 mg PO X1 [one time] dose now. Draw PT/INR tomorrow 11-6-20"
- (NP) 11/07/20 at 12:04 p.m., "[Doctor] called state [sic] INR today was 1.86. Start Eliquis 5mg (po) bid [twice a day]. Start this evening. No other orders."

Resident #55 nurses notes showed documentation of nausea, statements that eating would cause vomiting, and/or not eating a meal, on seven occasions between 10/31/20 and the INR of 17.7 on 11/05/20, both high levels from the anticoagulant and COVID can cause nausea/vomiting and loss of appetite.

A physician progress note, dated 11/13/2020,

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F 684	Continued From page 3 stated, "Spoke with patient's [family]. She reports patient has been complaining of increased abdominal pain this week. She is concerned about the eliquis (sic) (an anticoagulant) and wants it stopped. Discussed the reasoning for change from warfarin to Eliquis. which (sic) was given that his INR became extremely supratherapeutic and that I was concerned about leaving him unanticoagulated given his recent Diagnosis of COVID. Also, INR was in the therapeutic range at 2.75 on 11/6, the day following the elevated INR of 17 (11/5). On 11/7 was 1.86 and Eliquis was initiated. She is very concerned that he could have had bleeding in his abdomen causing his complaints of abdominal pain. Will have him seen in ED [emergency department] for evaluation." The facility failed to complete the physician's order to complete the necessary lab test to monitor Resident #55's medical condition. Facility staff may have prevented the INR from becoming supratherapeutic if they had completed the INR as ordered, recognized the potential medication interactions of warfarin and cipro, and the potential effects of infections on warfarin, and requested the completion of an INR for monitoring purposes.	F 684		
F 880 SS=E	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.	F 880		6/4/21

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F 880	Continued From page 4 §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: §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.	F 880		

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F 880	Continued From page 5 (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 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: 1. Based on observation, record review, and staff interview, the facility failed to follow infection control standards for 1 of 1 supplemental resident (Resident #49) with a COVID-19 positive status. Failure to properly sanitize/store personal protective equipment (PPE) and ensure appropriate isolation precautions has the potential to spread the COVID-19 virus to other residents, personnel, and visitors. Finding include: Review of Resident #49's medical record, on 05/06/21, identified the resident as fully vaccinated for COVID-19. Resident #49 tested positive for COVID-19 with a rapid test completed	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 clean/sanitize mechanical lifts between each resident	

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F 880	Continued From page 6 at the hospital on 05/04/21. Resident #49 had a PCR (polymerase chain reaction) COVID-19 test the morning of 05/04/21 prior to the hospital visit, which came back negative. Observation on 05/06/21 at 9:00 a.m. showed Resident #49 propelling herself in a wheelchair in the dining room area towards the nurse's station, with no other residents observed in the area. An unidentified staff member re-directed the resident back to the COVID unit/room. Observation on 05/06/21 at 09:30 a.m. showed a CNA (certified nurse aide) (#6) wearing a surgical mask and goggles worn to care for all residents, joined the CNA (#7) already wearing full PPE to assist Resident #49 with cares. The CNA (#6) donned a gown, removed her surgical mask and placed it in a paper bag, and removed her goggles. The CNA (#6) then donned a N95 mask, the same goggles, gloves, and entered Resident #49's room with a mechanical lift. When doffing PPE, the CNA (#6) removed her gloves, gown, N95 mask, placed the mask into the same paper bag she removed her surgical mask from, donned the surgical mask, removed the goggles, put on her glasses, and put on the goggles. The CNA (#6) then exited the COVID unit. During an interview, at the exiting of the COVID unit, the CNA (#6) was asked about the care and use of the goggles she wore. The CNA (#6) stated she should have cleaned the goggles after exiting Resident #49's room at the end of doffing and disposing of the used PPE. While standing outside the COVID unit, the doors to the unit had glass widows in the top half,	F 880	use; store surgical and N95 masks appropriately; sanitize personal protective equipment (PPE) (goggles/faces shields) appropriately; and ensure staff follow appropriate Covid- 19 isolation precautions in accordance with CDC guidelines. 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 06/05/2021 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 to ensure staff clean/sanitize mechanical lifts, store surgical masks and N95 masks appropriately, sanitize PPE (goggles/face shields), and ensure staff follow appropriate Covid-19 isolation precautions in accordance with CDC guidelines. Information about root cause analysis can be found at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloa	

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F 880	Continued From page 7 observation showed the doors lacked signage designating the area as a COVID unit. During an interview on 05/06/21 at 10:45 a.m., two administrative nurses (#1 and #8) identified they expect the staff to have two paper bags, one for storage of the surgical mask and one for the N95 mask. They also confirmed staff should cleanse the goggles before leaving the unit. During an interview on 05/06/21 at 11:30 a.m. with the CNA (#7), who was now off the COVID unit, when asked if she cleaned the goggles she wore before leaving the COVID unit, she stated, "I'll be honest with you, I did not." 2. Based on observation, policy review, and staff interview, the facility failed to ensure staff followed standard infection control practices for 3 of 6 sampled residents (Resident #23, #45, and #55) and 1 supplemental resident (#7) observed transferred with a mechanical lift. Failure to follow standard infection control practices related to cleaning mechanical lifts has the potential to spread infections within the facility. Findings include: Review of the facility policy/procedure titled "Cleaning and Disinfection of Equipment" occurred on 05/06/21. This policy, dated 05/15/96, stated, "POLICY: All objects whose use requires disinfection are cleaned and disinfected between residents. OBJECTIVE: To reduce the risk of infection. . . . PROCEDURE: 1. Semi-critical items will be cleaned and disinfected between uses. . . . SPECIAL CONSIDERATIONS: 1. Semi-critical items are	F 880	ds/GuidanceforRCA.pdf (2) The DON, IP or suitable designee will ensure the following: a. All staff will receive education on cleaning/sanitizing mechanical lifts, storage of surgical masks and N95 masks, sanitizing goggles/face shields, and following appropriate Covid-19 isolation precautions in accordance with CDC guidelines. 4. Monitoring Weekly for no less than 12 weeks, the DON, IP, 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 nursing staff to ensure proper cleaning/sanitizing of mechanical lifts, storage of surgical and N95 masks, sanitizing of PPE (goggles/face shields) and to ensure staff are following appropriate Covd-19 isolation precautions. 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	

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F 880	Continued From page 8 those which come in contact with mucous membranes or with skin that is not intact. Semi-critical items include but are not limited to the following: . . . Mechanical Lifts (Cavi wipes [ready to use cleaning/disinfecting product] to be used after use in resident rooms when returned to the storage area) . . ." - Observation on 05/04/21 at 08:32 a.m. showed the CNA (certified nurse aide) (#9) assisted Resident #45 to the toilet using a sit to stand mechanical lift, then to the tub chair the after toileting. The CNA (#9) failed to clean the mechanical lift, leaving the lift in the hallway outside the resident's door. - Observation on 05/04/21 at 09:27 a.m. showed two CNAs (#10 and #11) transferred Resident #55 from bed to the commode, and then to his/her wheelchair, using a full body lift. The CNA (#11) removed the lift from the room, without cleaning the lift. - Observation on 05/04/21 at 11:21 a.m. showed two CNAs (#2 and #3) transferred Resident #23 from the wheelchair to the commode with a Maxi Lift (full body mechanical lift). The CNA (#3) removed Resident #23's saturated brief and provided perineal care after the resident had a small amount of stool and voided in the commode. After applying a new brief, the CNAs (#2 and #3) transferred the resident back to the wheelchair with the Maxi Lift. The CNA (#3) removed her gloves, washed her hands, and moved the lift out of the room and into the hall. When asked if she will do anything further with the Maxi Lift in the hall, she stated she will bring it to the storage room. When asked if staff clean	F 880	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 06/05/2021 All facility staff were educated on Infection control practices in regards to mechanical lifts, eye protection, storage of surgical masks and N95 masks. A memo was posted in all departments on 5/6/2021 with in person education provided on the following dates: 5/6/2021, 5/11/2021, 5/12/2021, 5/13/2021, and 5/18/2021. 5/24/2021 Root cause analysis found lack of sanitation of lifts between use was related lack of convenient access to cleaning products. In addition to Cavi wipes being kept in the lift storage areas, the facility has purchased lockable accessory pouches to be attached to each lift to hold individual Sani-cloth wipes. . Policy for cleaning critical and non-critical equipment will be updated and added to general orientation for all new nursing department employees. Reminder cue cards will be affixed to the	

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F 880	Continued From page 9 the lifts after use, she stated "no, that is not something we usually do." - Observation on 05/04/21 at 1:30 p.m. showed two CNAs (#4 and #5) assisted Resident #7 on and off the commode using the sit to stand mechanical lift. After the transfer, the CNA (#5) failed to clean the mechanical lift before he/she entered another resident's room with the lift.	F 880	lifts. 5/24/2021 Root Cause analysis of storage of masks and cleaning of eye protection found to be lack of reminders when the situation arose for use. Cue cards have been made up to accompany isolation carts. All facility staff have been assigned a course in Healthcare Academy titled "COVID-19: PPE guidance use" to be completed no later than 6/4/2021. Information on personal protective equipment requirements, storage and infection control processes necessary will be added to the general orientation for all new employee's and an acknowledgement form will be utilized. The Director of Nursing/designee will complete audits on all units, across all shifts to ensure proper sanitation of mechanical lifts weekly x 12, then monthly x 3, then quarterly x 3. The findings of the audits will be shared with the QAPI committee quarterly. The Director of Nursing/designee will complete audits on storage of surgical masks and N95 masks.Audits will occur daily for the duration of Enhanced Droplet Precautions when initiated in the facility for a known or suspected COVID-19 case. The findings of the audits will be shared with the QAPI committee quarterly.	

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F 880	Continued From page 10	F 880	The Director of Nursing/designee will complete audits on sanitation of eye protection in regards to use in enhanced contact precaution rooms (known or suspected COVID-19 infections) daily for the duration of use when the occasion for this type of precaution arises. The findings of the audits will be shared with the QAPI committee quarterly.	