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 _____	08/25/2016

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

(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 For the standard Medicare/Medicaid recertification survey, started on 08/22/16 and completed on 08/25/16, the sample included 4 residents for complete review, 11 residents for focused review, and 3 closed records for review. The sample included 2 additional residents to verify specific concerns during the survey.	F 000		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide cares for 2 of 9 sampled residents (Resident #6 and #7) in a manner and environment that maintained, enhanced, and respected each resident's dignity and self worth. Failure to knock on the door and wait for a reply before entering a resident's room (Resident #6 and #7), to provide privacy during toileting (Resident #7), and to speak to or about a resident (Resident #7) in a dignified manner did not preserve or promote the resident's dignity or enhance their quality of life, and placed the residents at risk of embarrassment or emotional harm. Findings include: Review of the an untitled policy occurred on	F 241	The CNAs involved with the care of resident #6 and #7 were immediately in-serviced on the proper procedures for maintaining resident dignity during cares. The facility has determined that all residents needing assistance for ADL's have the potential to be affected. All CNA's involved in providing ADL assistance to residents will be in-serviced on the proper procedure for assisting residents in a manner and environment that maintain, enhance, and respect each resident's dignity and self worth on September 13th, 2016. A "Validation Checklist" will be completed for each individual whose duties include assisting resident's with ADL's to determine if he/she was performing the procedure correctly by September 29th, 2016.	9/29/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/15/2016

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F 241	Continued From page 1 08/25/16. This undated policy stated, "POLICY: To provide peri [perineal] cares after each incontinent episode . . . PREPARE RESIDENT: Close the door and pull curtains as necessary for privacy . . ." - Review of Resident #7's medical record occurred on all days of survey. The quarterly Minimum Data Set (MDS), dated 08/13/16, indicated moderately impaired cognition and usually understands others. Observation on 08/23/16 at 12:20 p.m. showed a certified nursing assistant (CNA) (#7) provided Resident #7's toileting cares. Observation showed Resident #7 and the CNA (#7) in the bathroom with the door open when an unidentified staff member entered the room without knocking, announcing herself or requesting permission prior to entering the room. Observation on 08/23/16 at 3:25 p.m. showed a CNA (#10) provided Resident #7's toileting cares. Observation showed Resident #7 and the CNA (#10) in the bathroom with the door open when an unidentified CNA knocked on the door and looked in the room without waiting for a response and/or permission to enter the room. The unidentified CNA saw Resident #7 sitting on the toilet and stated, "Oh," and shut the door. Resident #7 stated, "It's not very nice when someone says they will come back and help you get to the toilet and then they don't come back." The CNA (#10) asked the resident who she was referring to. Then Resident #7 stated, "I don't remember." The CNA (#7) stated to the surveyor in front of Resident #7, "She [Resident #7] is really confused."	F 241	Findings will be reviewed with each individual and corrective action will be provided as needed. The Director of Nursing (DON), or designee, will conduct weekly random observations of staff during cares for the first month, then monthly for the next (3) months to ensure staff are promoting and maintaining resident dignity during cares in accordance with our facility's practice guidelines and regulatory requirements. Observation reports and validation checklists will be reviewed by the Quality Assurance Committee monthly until such time consistent substantial compliance has been achieved as determined by the committee. The Social Workers will review the results of QA/observation reports and any corrective measures taken with the Resident Council during their monthly meetings for comments and suggestions.	

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F 241	Continued From page 2 Observation on 08/24/16, at 9:05 a.m., showed the CNA (#13) dressed Resident #7 in bed (leaving her pants below her knees) and transferred her to the bathroom with the mechanical stand lift, exposing the resident from the waist down. The CNA (#13) lowered the Resident #7 onto the toilet and left the room with the bathroom door open and the door to Resident #7's room open. The CNA (#13) left and reentered the room two more times without closing the doors. The CNA (#13) failed to close the doors which allowed the Resident #7 to be seen from the hallway. - Observation on 08/24/16 at 7:54 a.m. showed two certified nursing assistants (CNAs) (#1 and #3) assisted Resident #6 with morning cares as the resident lie in bed. A CNA (#2) opened the door without knocking/announcing herself and walked into the room. During an interview on 08/25/16 at 11:15 a.m., a nurse manager (#12) agreed staff should knock and wait for a response before entering resident rooms and that she expected staff to close doors during cares.	F 241		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by:	F 281		9/29/16

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F 281	Continued From page 3 Based on observation, record review, policy review, professional reference, and staff interview, facility staff failed to follow professional standards of practice for 1 of 4 nurses (#8) observed administering medications. Failure to administer medications and document administration immediately after preparation placed residents at risk of receiving another residents' medications. Findings include: The Geriatric Medication Handbook, 7th ed., American Society of Consultant Pharmacists, page 148, stated, "Medications should be prepared for the resident immediately before administration; medications should never be prepared in advance for multiple residents . . ." Review of the facility policy "Medication Documentation and Order Changes" occurred on 08/25/16. The procedure, dated May 1992, stated, ". . . 1. All medications given to be signed off on medication sheet immediately after administration. . . ." Review of the facility policy "Subcutaneous Injection" occurred on 08/25/16. The policy, dated April 2003, stated, ". . . PROCEDURE: . . . Draw [prepare] ordered amount of insulin . . . 5. Verify dose and medication with Medication Administration Record [MAR]. 6. Identify resident . . . 15. Document on MAR initials and site of injection for medication timed entry." Review of the facility policy "Medications, Administration of" occurred on 08/25/16. The	F 281	The nurse identified (#8) was immediately in-serviced on the facility's policy Administration of Medication along with an evaluation of her skills on 9-1-16 for resident #19 and #20. The facility has determined that all residents receiving medications could potentially be affected. All licensed nursing staff will be in-serviced on the facility's policy Administration of medications on September 15th, 2016. A validation Checklist will be completed for each nurse by September 29th to determine if the nurse is performing the procedure correctly. Findings will be reviewed with each nurse. Corrective action will be provided as necessary. The Director of Nursing (DON), or designee, will conduct random observations of nursing staff performing medication passes for six consecutive weeks to ensure nurses are performing the procedure in accordance with our facility's Practice Guidelines and the resident's physician order and care plan. Validation checklists will be reviewed by the Quality Assurance Committee until such time consistent substantial compliance has been achieved.	

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F 281	Continued From page 4 procedure, date January 1997, stated, ". . . Sign off for medications on MAR after resident has taken them. . . ." - During observation on 08/23/16 at 7:56 a.m., Resident #19 presented to the medication cart for her medications. The nurse (#8) removed a medication cup from a drawer in the medication cart with the resident's thyroid replacement pill mixed in applesauce and administered the medication via a spoon. The nurse stated "a lot of the time she refuses her medications." The medication administration record (MAR) showed the nurse signed off the medication prior to giving to the resident. - During observation on 08/23/16 at 8:40 a.m., Resident #20 presented to the medication cart for her insulin. The nurse (#8) removed an insulin pen from a drawer inside the cart. Observation showed the insulin pen primed with 24 units of Novolog (fast acting insulin) insulin. Upon surveyor request, the nurse attempted to find the medication order on the electronic MAR, but was unable. The nurse (#8) identified this was because she already documented the medication as given and added, "they [direct care staff] rush them [residents] right by." During interview on 08/23/16 at 4:00 p.m., a supervisory nursing staff member (#11) agreed nurses should not prepare medications for administration until the resident is present, and agreed staff should not sign off medication prior to administration.	F 281		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323		9/29/16

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F 323	Continued From page 5 The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 09/30/15. Based on observation, record review, facility policy review, and staff interview, the staff failed to ensure each resident received adequate supervision and assistive devices to prevent accidents for 2 of 4 sampled residents (Resident #7 and #9) observed during transfers using a sit-to-stand mechanical lift. Failure to utilize a sit-to-stand lift in an appropriate and safe manner, and provide supervision while seated without the lift in place, or while standing with the lift in place increased the risk for pain, falls, and injury. Findings include: Review of the facility policy titled "Sit/Stand Mechanical Lift" occurred on 08/25/16. This policy, dated November 2009, stated, " . . . A sit/stand mechanical lift provides a safe seat-to-seat transfer for the resident who has partial weight bearing capabilities in one or both legs. . . . Document the resident's physical and cognitive ability to actively participate throughout the transfer. . . . A resident should possess at	F 323	A memo was placed on 8-25-16 instructing all CNA's on the use of the sit to stand lift in an appropriate and safe manner. Resident #7 was evaluated on 9-13-2016 by PT and resident number 9 was evaluated by PT on 9-12-2016. Both residents were changed to a total body lift. The nurse management team along with the COTA reviewed all residents who are currently being transferred with the sit to stand mechanical lift and have been reassessed for appropriateness of the lifting device. The sit to stand mechanical lift policy has been reviewed. All licensed nursing staff and CNA's have been in-serviced on this policy on 9-13-16 and 9-15-16. Observation of transfers using the sit to stand lift will be completed by the nursing staff along with skills validation checklist by 9-29-16. A minimum observation of one staff per shift per unit will be completed 4 to 5 days per week until the majority of the staff have been observed. QA studies will be completed under the direction of the Director of Nursing or her designee until 100% compliance has been achieved for	

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F 323	Continued From page 6 least 30% [percent] to 60% weight-bearing status . . . Ability to hold on to the lift. . . Cooperation that is maintained throughout the transfer. . . .Transfer: . . . Adjust the foot board, if lift allows, allowing resident to reach the foot board comfortably . . ." - Review of Resident #7's medical record occurred on all days of survey. Diagnoses included dementia, osteoporosis, polyarthritis (arthritis that affects five or more joints), and history of a fall with fracture. The quarterly Minimum Data Set (MDS), dated 08/13/16, indicated extensive assist of one for transfers, and functional limitation/impairment on one side of upper extremities and both sides of lower extremities. Resident #7's "Fall Risk Assessment," dated 11/16/15, stated, ". . . Risk Assessment for Falls . . . H/O [history of] Falls . . . Visual/auditory impairments . . . Problems with mobility/gait . . . Dementia . . ." The resident's current care plan stated, ". . . Problem . . . Potential for falls related to h/o falls with fracture and anxiety . . . Approaches . . . Assist with stand aid lift and assist of 1 for all transfers . . ." Observation on 08/23/16 at 08:30 a.m. showed a certified nurse aide (CNA) (#7) prepared to transfer Resident #7 from her wheelchair to the toilet with a sit-to-stand mechanical lift. As the CNA (#7) raised the resident from the wheelchair to a semi-standing position, only the toes of Resident #7's right foot touched the foot board. The resident did not bear weight on either foot	F 323	two consecutive weeks. QA studies will then be completed monthly until compliance has been achieved for two consecutive months then quarterly for one year.	

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due to the position of her legs. The CNA failed to appropriately position the resident's legs and failed to remind her to place her feet flat on the foot board during the sit-to-stand lift transfers.

Observation on 08/23/16 at 12:20 p.m. showed a CNA (#7) prepared to transfer Resident #7 from the wheelchair to the toilet with a sit-to-stand mechanical lift. The CNA placed the lift sling around Resident #7. The resident's left knee bent inward, touching her right knee, and her left foot failed to reach the foot board. The CNA transferred the resident to the toilet with the sit-to-stand lift. Resident #7 yelled out, "Ouch, this hurts. It's pulling under my arms." After Resident #7 voided, the CNA raised her off the toilet with the lift and completed perineal cares. Only her toes touched the foot board which did not allow her to bear her own weight. The resident stated "Ouch Ouch, this hurts." The CNA stated, "It's ok, I got you." The sling pulled up under Resident #7's axilla, raising her shoulders to ear level, forcing her elbows outward and parallel to the floor. The resident's feet were not on the foot board, as both knees were bent. The CNA failed to appropriately position the resident's legs and failed to remind her to place her feet flat on the foot board during the sit-to-stand lift transfers.

Observation on 08/23/16 at 3:25 p.m. showed a CNA (#10) prepared to transfer Resident #7 from the toilet to her wheelchair with the sit-to-stand mechanical lift. The CNA raised the resident off the toilet using the sit-to-stand lift. The resident's knees rubbed together against the leg pad and the left leg pulled up so her foot did not touch the foot board. Resident #7 stated "Ouch, ouch,

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ouch, my knees, they always get it." The CNA attempted two more times to reposition the resident's legs. The CNA lowered the resident to the toilet and readjusted her legs. As the CNA transferred the resident out of the bathroom the resident's right elbow hit the bathroom door and she yelled, "Ouch." During the transfer to her wheelchair, the sling pulled up under her axilla, raising her shoulders to ear level, forcing her elbows outward and parallel to the floor. The resident's feet were not on the foot board as both knees were bent. Resident #7 yelled, "That doesn't feel very good in my chest." The CNA (#10) failed to ensure proper arm and foot placement in the sit-to-stand lift causing discomfort to Resident #7 and increased the risk of falls and/or injury.

Observation on 08/24/16 at 9:05 a.m. showed the CNA (#13) prepared to transfer Resident #7 from the bed to the toilet using the sit-to-stand mechanical lift. With the bed elevated, the CNA sat the resident on the edge of the bed. Her feet failed to touch the floor. The CNA instructed the resident to hold the side rail with her right hand, walked to the other side of the room to get the sit-to-stand lift, and left the resident supporting herself on the bed with one hand. The resident leaned backwards and stated, "I can't hang on by myself." The CNA stated, "You're ok honey." The CNA returned to the bedside, attached the sling loosely around resident's waist and lowered the bed. The CNA failed to tighten the sling as she raised the lift. The resident stated, "I'm slipping. I can't hold onto this. It takes my breath away." The CNA transferred the resident into the bathroom and lowered her to the toilet. After Resident #7 voided, the CNA raised her to a

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standing position using the sit-to-stand lift. The CNA exited the bathroom and left the resident attached to the lift in front of the toilet. The CNA returned with needed supplies and provided Resident #7's perineal cares, adjusted her clothing, and transferred her back to her wheelchair. The CNA (#13) failed to tighten the sling around the resident's waist, provide adequate supervision for safety while Resident #7 sat on the bed, and ensure she was in a safe position in the bathroom when leaving the room.

During an interview on the morning of 08/25/16, a nurse manager (#12) confirmed staff should lower a resident back on the toilet before leaving the bathroom to get additional supplies.

- Review of Resident #9's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease, weakness, osteoporosis, and history of right wrist fracture. The current care plan stated, "Problem: Self care deficit . . . TRANSFERS/MOBILITY: . . . Standaid [mechanical] lift transfer with assist of 1. . . ."

On 08/23/16 at 8:45 a.m., observation showed a CNA (#6) lifted Resident #9 from the toilet with a mechanical sit-to-stand lift, provided perineal cares, performed hand hygiene, placed a new brief, adjusted her clothes, and transferred the resident to her wheelchair. Resident #9 was in the same position of half way between sitting and standing throughout the transfer and cares, even with the CNA encouraging the resident to "stand taller."

On 08/24/16 at 10:10 a.m., observation showed a CNA (#7) transferred Resident #9 with a

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F 323	Continued From page 10 sit-to-stand lift from her wheelchair to the toilet. After Resident #9 voided, the CNA (#7) engaged the lift to raise her from the toilet, provided perineal cares, performed hand hygiene, adjusted her brief and clothes, and transferred the resident to her wheelchair. Resident #9 remained in a sitting position throughout the transfer and cares, and her arms bent upward with her elbows pointed outward, parallel to the floor, even with the CNA's instruction to "stand up more." The facility failed to ensure Resident #9 had sufficient leg and arm strength to transfer safely with the mechanical stand lift. During an interview on 08/25/16 at 8:40 a.m., a restorative nursing manager (#9) stated concerns with a resident's ability to use a lift safely included trouble standing or keeping their arms down. The manager stated residents should be able to bear 30-60 percent of their weight.	F 323		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and	F 441		9/29/16

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F 441	Continued From page 11 (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 09/30/15. Based on observation, record review, facility policy review, and staff interview, the facility failed to ensure staff followed infection control practices for 2 of 8 sampled residents (Resident #5 and #7) observed during personal cares. Failure to follow infection control practice related to hand hygiene has the potential to spread infection within the facility.	F 441	The certified nursing assistants who were providing care for residents #5 and #7 were immediately in-serviced on proper hand washing procedures and the facilities Hand Hygiene policy. The facility has determined that all residents have the potential to be affected. All CNA's will be in-serviced on the facility's policy for hand washing on 9-13-2016. In-service training includes observations of personnel performing hand washing procedures according to facility policy and a skills	

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LUTHERAN SUNSET HOME	333 EASTERN AVE GRAFTON, ND 58237

(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 441	Continued From page 12 Findings include: Review of the facility policy titled "Hand Hygiene" occurred on 08/25/16. This policy, revised 02/15/10, stated, "SUBJECT: Hand Hygiene, POLICY: Hand hygiene is considered the most important single procedure for preventing nosocomial [facility acquired] infections. All personnel are required to perform hand hygiene after each direct or indirect resident contact for which hand hygiene is indicated by accepted professional practice . . . Hand hygiene continues to be the primary means of preventing the transmission of infection. The following is a list of some situations that require hand hygiene: . . . Before and after resident contact . . . Before and after assisting a resident with personal care . . . Before and after assisting a resident with toileting . . . After removing gloves . . . SPECIAL CONSIDERATION: Barriers do not replace hand hygiene but should be used along with hand hygiene . . ." Review of an untitled policy occurred on 08/25/16. The undated policy, stated, POLICY: To provide peri cares after each incontinent episode . . . PROCEDURE: . . . Remove gloves. Wash hands . . . " - Review of Resident #7's medical record occurred on all days of survey. The quarterly Minimum Data Set (MDS), dated 08/13/16, indicated extensive assist of one for toileting and personal hygiene. Observation on 08/23/16 at 8:30 a.m., showed the CNA (#7) assisted Resident #7 with toileting cares. The CNA (#7) gloved, performed perineal	F 441	validation checklist will be completed. Findings are reviewed with all personnel. Corrective action is provided as needed. To ensure personnel are performing the procedure in accordance with our facility's Practice Guideline, random monitoring will occur under the direction of the DON or her designee each week for 6 weeks or until the majority of the CNA's have been observed. The plan of correction will be monitored at the monthly Quality Assurance meeting until such time consistent substantial compliance has been met.	

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 _____	08/25/2016

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F 441	Continued From page 13	F 441		

care, placed a new incontinence product, adjusted the resident's clothing, removed gloves, and transferred Resident #7 to her bed using a mechanical stand lift. The CNA removed Resident #7's shoes, placed Prevalon boots (heel protectors), positioned her on her left side, placed a wedge behind her back, and handed her the call light. The CNA (#7) failed to wash her hands following perineal care and prior to completing other tasks. The CNA (#7) failed to perform hand hygiene following perineal care and before exiting the resident's room.

Observation on 08/23/16 at 12:20 p.m., showed the CNA (#7) assisting Resident #7 with toileting cares. The CNA (#7) gloved, while Resident #7 stood with assistance of the mechanical stand lift, removed the soiled incontinence product, performed perineal cares, placed a new incontinence product, adjusted the resident's clothing, removed gloves, and transferred Resident #7 to her bed using the mechanical stand lift. The CNA (#7) positioned Resident (#7) on her right side, placed a wedge behind her back, removed her shoes, placed Prevalon boots, and handed her the call light. The CNA (#7) failed to wash her hands following perineal care and prior to completing other tasks. The CNA (#7) failed to perform hand hygiene following perineal care and before exiting the resident's room.

- Review of Resident #5's medical record occurred on all days of survey. The current MDS, dated 06/10/16, identified extensive assistance from staff for toileting and personal hygiene.

- Observation on 08/23/16 at 4:47 p.m. showed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 441	Continued From page 14 two CNAs (#4 and #5) checked and changed Resident #5's brief as she lie in bed. One CNA (#4) performed perineal care, removed her gloves, and placed a new brief on Resident #5. The same CNA assisted with the resident's pants, placed a Hoyer (a mechanical full body lift) sling under the resident, transferred her to a wheelchair, removed the sling, placed foot pedals on the resident's wheelchair, and combed the resident's hair before using hand sanitizer. The CNA failed to perform hand hygiene after performing perineal care and prior to completing other tasks. During an interview on the morning on 08/25/16, a nurse manager (#12) confirmed staff are expected to wash their hands after removing their gloves following perineal cares and prior to exiting the resident's room.	F 441		