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 _____	C 11/02/2023

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 The standard Medicare/Medicaid recertification survey started on 10/30/23 and concluded 11/02/23.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the	F 578		11/21/23

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

Electronically Signed | 11/21/2023

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F 578	Continued From page 1 individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to ensure the resident's right to request, refuse, and/or discontinue treatment for 1 of 20 sampled residents (Resident #132) reviewed for advance directives. Failure to ensure the medical record accurately reflected the resident's code status limited the facility's ability to communicate to direct care staff and emergency personnel the resident's choice in the event of a medical emergency. Findings include: Review of the facility policy titled "Code Blue" occurred on 11/01/23. This policy, dated October 2013, stated, ". . . Code Level 1 residents are identified at LSH [Lutheran Sunset Home] by a red heart on the spine end of the paper medical record. . . ." Review of Resident #132's medical record occurred on all days of survey. The "ND POLST: Physician Orders for Life Sustaining Treatment," signed by Resident #132 on 10/23/23 and the physician on 10/25/23, indicated CPR (cardiopulmonary resuscitation)/Attempt Resuscitation.	F 578	The red heart, code level 1, communication was added to the spine of resident #132's chart on 10/31/2023. All resident records were reviewed on 11/20/2023. All code level 1 residents charts were identified with a red heart on the paper chart spine. The Social Services Admission Checklist was updated on 11/2/2023 to include a check line for the placement of the red heart on code level 1 residents. This task was added under the heading of required tasks on the day of admission. The Director of Resident Services/designee will monitor for compliance with all new admissions weekly x 8, monthly x 3, quarterly x 3. Results will be reported to the Quality Assurance Performance Improvement committee quarterly.	

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F 578	Continued From page 2 During an interview on 10/31/23 at 9:55 a.m., a licensed nurse (#4) stated full code residents have a red heart on the chart. Observation on 10/31/23 at 10:00 a.m. showed Resident #132's medical record lacked a red heart at the spine end of the chart. The licensed nurse (#4) confirmed the chart lacked the red heart. During an interview on 11/01/23 at 3:25 p.m., an administrative nurse (#1) stated she expected staff to place a red heart on the chart of a resident who elected full code/CPR as soon as the resident completed the form.	F 578		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the	F 657		11/21/23

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F 657	Continued From page 3 resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of a facility reported incident, review of facility policy, and staff interview, the facility failed to review and revise comprehensive care plans to reflect the residents' current status for 3 of 20 sampled residents (Resident #12, #30, and #50). Failure to review and revise the care plan limited staffs' ability to communicate needs and ensure continuity of care. Findings include: Review of the facility policy titled "Reviewing and Revising the Care Plan" occurred on 11/01/23. This policy, dated September 2022, stated, ". . . The purpose of this procedure is to provide a consistent process for reviewing and revising the care plan for those residents experiencing a status change. . . . The care plan will be updated with the new or modified interventions. . . ." - Review of Resident #12's medical record occurred on all days of survey. The facility reported incident (FRI) identified the resident displayed inappropriate physical behavior with a female resident on 10/26/23. The FRI also identified the facility updated Resident #12's care plan. Resident #12's medical record failed to	F 657	Resident #12's care plan was updated on 11/2/2023. The problem and interventions were expanded to include information related to the Facility reported incident. All resident records were reviewed on 11/17/2023. No other residents were found to have inappropriate behaviors with other residents. Licensed nurses were educated on care plan updates on 11/21/2023. The Director of Resident Services/designee will monitor to ensure care plan entries are present for residents who have exhibited inappropriate behaviors involving others weekly x 8, monthly x 3, quarterly x 3. All findings will be reported to the QA committee at the quarterly meetings. Resident #30's care plan was updated on 11/1/2023 to include the use of the pummel cushion to improve upright posture.	

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F 657	Continued From page 4 identify any information related to the incident that occurred on 10/26/23. Review of Resident #12's care plan, updated 10/17/23, stated, ". . . does make inappropriate comments towards female staff at times . . ." The care plan failed to identify any update regarding inappropriate physical behavior with female residents or any interventions. During an interview on 11/02/23 at 9:37 a.m., an administrative staff member (#1) confirmed she expected staff to update Resident #12's care plan with information to reflect behaviors of inappropriate touching with a female resident. - Review of Resident #30's medical record occurred on all days of survey. Diagnoses included Parkinson's disease and CVA (cerebral vascular accident). A restorative nursing note, dated 06/28/23, stated, ". . . Provided resident with a pommel anti trust (sic) wheelchair cushion to improve upright seated posture. . . ." Observation on all days of survey showed Resident #30's wheelchair with a pommel cushion in place. Resident #30's care plan lacked information related to the pommel cushion. During an interview on 11/01/23 at 1:43 p.m., an administrative nurse (#1) confirmed Resident #30's care plan lacked information related to the pommel cushion. - Review of Resident #50's medical record occurred on all days of survey. The medical	F 657	Chart review on 11/17/2023 completed on all residents who have a specialized positioning devices present. All were found to have specific devices mentioned on the plan of care. The restoravite nursing department manager was educated on the need to complete care plan updates and how to complete this task on 11/20/2023. The Director of Resident Services/designee will monitor to ensure care plan entries are present for residents who have specialized positioning devices newly put in place weekly x 8, monthly x 3, quarterly x 3. All findings will be reported to the QA committee at the quarterly meetings. Resident #50's care plan was updated on 11/2/2023 to include resident accepts the responsibility to self-administer medications. Chart review completed on 11/17/2023 Found care plan entries on all residents who have consented to complete self-administation of medications in some manner. All licensed nursing staff and medication techs were educated on policy and procedure on self-administration of medications on 11/21/2023. The Director of Resident	

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F 657	Continued From page 5 record showed Resident #50 signed a "Self-Administration of Medication Consent and Waiver Form" on 04/20/22. This form stated, "I assume the responsibility of taking my medications without direct observation. I do not wish to store medications in my room. By assuming this responsibility I agree to comply with the facilities policies and procedures for medication self -administration. I further understand that failure to comply with facility policy may result in the rescinding of my right to administer my medications". Resident #50's care plan lacked problem, goals, and interventions related to self-administration of medications. During an interview on 11/02/23 at 10:50 a.m., an administrative nurse (#1) stated she expected staff to include self-administration of medications on the care plan.	F 657	Services/designee will monitor to ensure care plan entries are present for residents who have consented to self-administration of medications, weekly x 8, monthly x 3, quarterly x 3. Results will be reported to the Quality Assurance Performance Improvement committee quarterly.	
F 812 SS=E	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	F 812		11/21/23

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F 812	Continued From page 6 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, facility documentation, and staff interview, the facility failed to serve, prepare, and store food in a safe and sanitary manner for 1 of 1 kitchen. Failure to discard spoiled food and protect dishware from contamination has the potential to result in foodborne illness to residents, staff, and visitors. Findings include: Observation of the main kitchen and walk-in cooler occurred on 10/30/23 at 12:40 p.m. and showed the following: * Two unopened containers of strawberries, with visible mold present. * One unopened container of cherry tomatoes, shriveled and covered with dark spots. * One open, undated bag of shredded lettuce, with visible browning present. * A tabletop fan visibly soiled with dust blowing in the direction of clean dishes. Review of the facility document titled "Food Rotation Chart" occurred on 11/02/23. This undated document listed various fruits and vegetables with guidance for their optimal length of storage as follows: * Tomatoes - Use by date; assess quality * Lettuce-shredded - Use by date; assess quality * Strawberries-5 days; assess quality	F 812	The fan was removed from service on 10/30/2023. The affected produce was removed and disposed of on 10/30/2023. All dietary staff will be inserviced on policies and procedures related to spoiled food and protecting dishware from comtamination on 11/21/2023 & 11/22/2023. All perishable items will be inspected upon delivery. Any items with visible signs of damage/spoilage will be rejected. The cook will be assigned the daily task of observing perishable items in the cooler and disposing of any items with visible signs of damage/spoilage. A sign off sheet has been created for this purpose. The Director of Nutrition/designee will monitor for compliance for perishable items in the cooler weekly x 8, monthly x 3, quarterly x 3. Results will be reported to the Quality Assurance Performance Improvement committee quarterly.	

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F 812	Continued From page 7 A fan cleaning schedule provided by maintenance showed a kitchen fan initialed as cleaned on September 14, 2023. During an interview on 11/02/23 at 10:15 a.m., two dietary administrative staff (#2 and #3) stated they expected all kitchen staff to monitor the walk in cooler and discard spoiled food. A dietary administrative staff (#3) stated it is the maintenance department's responsibility to clean fans monthly and staff should not direct fans toward dishes or food preparation areas.	F 812		
F 868 SS=D	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c) §483.75(g) Quality assessment and assurance. §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (iv) The infection preventionist. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (i) Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI	F 868		11/29/23

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F 868	Continued From page 8 program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects required under the QAPI program, are necessary. §483.80(c) Infection preventionist participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is not met as evidenced by: Based on review of Quality Assurance and Performance Improvement (QAPI) meeting minutes, facility policy, and staff interview, the facility failed to ensure participation by the medical director for 2 of 4 quarterly meetings (February 16, 2023 and August 17, 2023) reviewed. Failure to ensure the medical director participates in the facility's Quality Assurance activities deprived the committee of the physician's unique contributions for analyzing and correcting problems with identified resident care areas. Findings include: Review of the facility policy titled "Quality Assurance and Performance Improvement Program" occurred on 11/02/23. This undated policy, stated, ". . . Framework: The administrator, the director of resident services, infection control & [and] prevention officer, medical director . . . will provide QAPI leadership by being on the QAA [quality assurance and	F 868	The medical director was notified via phone on 11/6/2023 at 1:10pm of the non-compliance. The Medical Director Job Description was updated on 11/17/2023 to reflect the Medical Director is required to participate in quarterly QA meetings. The Medical Director has the option of attending in person, by phone or other electronic means, or designating another licensed physician to attend in his/her place. The Director of Resident Services/designee will monitor the minutes of the QA meeting quarterly to ensure medical director/designee participation.	

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F 868	Continued From page 9 assessment] committee. The QAA committee will meet quarterly. . . ." Review of QAPI meeting minutes occurred on 11/02/23 and identified the QAPI committee met on a quarterly basis between November 2022-August 2023. The QAPI meeting minutes identified the medical director failed to attend the meetings on February 16, 2023 and August 17, 2023. During an interview on 11/023 23 at 10:23 a.m., an administrative staff member (#1) confirmed the Medical Director failed to attend the QAPI meetings held February 16, 2023 and August 17, 2023.	F 868		