STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355092	A. BUILDING _____ B. WING _____	03/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILL TOP HOME OF COMFORT INC	95 HILL TOP DR KILLDEER, ND 58640

(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 03/01/21 and concluded on 03/04/21.	F 000		
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 follow professional standards of practice for 2 of 2 sampled residents (Resident #47 and #50) with skin wounds. Failure to follow physician's orders, and failure to complete weekly documentation regarding wound measurements may result in worsening skin wounds and delayed treatment changes as needed. Findings include: Review of the facility policy titled, "Documentation of Wound Treatments" occurred on 03/04/21. This policy, reviewed/revised February 2020, stated, "Policy: The purpose of this guideline is to provide a consistent process for accurate and complete wound treatment documentation. . . . The facility must maintain clinical records on each resident in accordance with professional standards and practices that are: Complete, Accurately documented . . . Treatment Documentation Guidelines: Type of wound (pressure injury, surgical, etc.), Stage if	F 658	1. Res # 47 has expired. Res #50 skin tear to shin healed. 2. Facility has determined that all residents have the potential to be affected. 3. Education will be completed with nurses at CN Meeting on 03/29/2021 regarding skin assessments and appropriate documentation of skin assessment and all skin concerns. Will review procedures of documentation of abnormal skin findings into Matrix including an assessment with wound measurements. Education of new implementation Matrix Wound Management documentation system. Education will be conducted with return demonstration of wound assessment and measurement. Review updated facility Skin Assessment Policy and Documentation of Wound Treatments policy at charge nurse meeting.	4/6/21

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

Electronically Signed | 03/29/2021

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F 658	Continued From page 1 pressure injury . . . or wound depth if non-pressure . . . Measurements: height, width, depth, undermining, tunneling. Description of wound characteristics: Color of the wound bed, type of tissue in the wound bed (i.e. granulation), Temperature of the peri -wound (warm, inflamed, macerated), Drainage/Exudate, Odor, Pain. . . . Frequency of Wound Documentation: Weekly. PRN (as needed) with any resident change in condition or change in wound status." - Review of Resident #47's medical record occurred on all days of the survey and included diagnoses of Type 2 Diabetes mellitus and dehydration. A significant change Minimum Data Set (MDS) dated 01/29/21, identified the "application of a nonsurgical dressing other than to feet." Resident #47's current treatment administration record (TAR) showed "Change dressing to left shin wound: apply dry dressing to area daily." Resident #47's current care plan stated, ". . . I am at risk for potential skin integrity impairment due to aging, health problems, and limited mobility. Goal: My skin will remain intact through the next review. . . ." Review of Resident #47's progress notes from 12/28/20 - 03/03/21 identified the following: * 12/28/20 at 9:14 a.m.: "Call placed to [physician] in regards to left shin wound not improving, orders received to send to ER [emergency room] for wound evaluation." * 01/28/21 at 2:51 p.m.: "With open area on left shin, with whitish tissue covering the wound, small amount of brownish discharges [sic] noted, non-foul smelling." * 02/01/21 at 7:24 a.m.: "Weekly skin assessment. Open area noted on left shin, with	F 658	4. The nurse management team will audit 12 residents skin assessments q week x 4 weeks; then 12 residents q 2 weeks x one month; then monthly x 4 months to ensure appropriate skin assessments are documented and completed. Audits will be reviewed by the QAPI nurse and quality assurance committee until such time consistent substantial compliance has been achieved as determined by the committee. 5. Corrective action completion date 04/06/2021	

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F 658	Continued From page 2 tissue covering the wound, small amount of brownish discharges [sic] noted, non-foul smelling." * 02/08/21 at 6:51 a.m.: "Weekly skin assessment. Continuous [sic] to have open area to left shin with small amount of brownish discharges [sic] noted, non-foul smelling" * 02/15/21 at 5:29 a.m.: "Weekly skin Assessment. Continuous [sic] to have ope [sic] area on left shin with small amount of brownish discharges [sic] noted, non-foul smelling" T * 03/01/21 at 7:47 a.m.: "Skin Assessment. Continuous [sic] to have open area on left shin with yellowish tissue covering the wound bed with small amount of brownish discharges [sic] noted." The facility failed to provide documentation of weekly wound assessments including wound measurements. - Review of Resident #50 medical record occurred on all days of survey. A quarterly MDS dated 01/26/21 identified "application of nonsurgical dressing other than to feet". An Event, dated 12/26/20, stated, ". . . Wound measuring 9 cm x 6 cm noted to left lower leg (shin). Type of Injury: Laceration. Deep . . . " Resident #50's current TAR identified "Clean wound to left lower leg with normal saline. Apply wet to dry dressing . Cover gently with ACE wrap. On in AM [morning]. Off in PM [evening]. The current care plan stated, ". . . I am at risk for skin breakdown related to incontinence and fragile skin. Goal: My skin will remain intact through the next review. . . ." Review of resident #50's progress notes	F 658		

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F 658	Continued From page 3 12/18/20- 02/27/01 identified the following: * 01/01/21 at 10:04 p.m.: "Weekly skin assessment. Resident continues to have abrasion to left shin. . . . No bleeding or drainage noted form scab or abrasion to shin. Denies pain. . . . " * 01/07/21 a 6 8:25 p.m.: ". . . Dressing change to left lower leg done. Does look more red around edges of wound this evening. Denies pain in area." * 01/15/21 at 10:06 p.m.: "Weekly skin assessment. Resident continues to have abrasion to left shin, has no bleeding or drainage noted. . . ." * 02/19/21 at 10:31 p.m.: "Weekly skin Assessment. . . . 0.5 cm open area on left shin, area is moist, with white tissue covering the wound bed, slight redness noted on the surrounding area. Area left open to air. . . ." * 02/27/21 at 03:01 a.m.: "Skin Assessment: . . . Wound to left leg is healing good, slightly red due to granulation, no open area noted, left open to air. . . ." The facility failed to provide documentation of weekly wound assessments including wound measurements. During an interview on 03/03/21 at 3:00 p.m., an administrative nurse (#6) clarified the facility nursing staff should document on all skin concerns as per facility policy.	F 658		
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	F 686		4/6/21

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F 686	Continued From page 4 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: Based on record review, review of facility policy, and staff interview, the facility failed to ensure staff provided appropriate/timely treatment and services to monitor/prevent the possible deterioration/healing of pressure ulcers for 3 of 3 sampled residents (Resident #2, #42, and #47) with pressure ulcers. Failure to identify and consistently monitor/assess may have resulted in delayed identification and treatment of the residents' pressure ulcers. Findings include: Review of the facility policy titled "Wound Treatment Guidelines" occurred on 03/04/21. This policy, dated October 2019, stated, ". . . Wound treatments will be provided in accordance with physician orders, including the cleansing method, type of dressing, and frequency of dressing change. . . . In the absence of treatment orders, the licensed nurse will notify physician to obtain treatment orders. . . . 6. Treatments will be documented on the Treatment Administration Record [TAR] 7. The effectiveness of treatments will be monitored through ongoing assessment of	F 686	1. Res # 47 has expired. On 03/23/2021 Director of Nursing conducted a pressure injury assessment (Braden Scale Risk Assessment) on resident #2 and #42. Skin assessment was completed on resident #2 on 03/22/2021 and during skin assessment on Resident #2 the wound was measured, treatment administered as ordered and documentation completed. Resident #42 skin assessment was attempted on 03/22/2021 and 03/23/2021. Both days resident # 42 refused to allow nurse to complete measurements on wound after several attempts. Resident # 42 skin assessment was completed during transfer only as resident #42 refused to lay down in bed to have skin assessment completed and measurements taken. Nurse was able to visually see skin and change dressing during assessment. 2. All residents with risk for skin breakdown could be affected by this deficient practice.	

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F 686	Continued From page 5 the wound. . . ." Review of the facility policy titled "Documentation of Wound Treatments" occurred on 03/04/21. This policy, dated February 2020, stated, "The purpose of this guideline is to provide a consistent process for accurate and complete wound treatment documentation . . . 2. Type of wound (pressure injury, surgical, etc.) 2. Stage, if pressure injury (I, II, III, IV, unstageable) or wound depth, if non-pressure (partial or full thickness) 3. Measurements: height, width, depth, undermining, tunneling 4. Description of wound characteristics a. Color of wound bed b. Type of tissue in the wound bed (i.e. granulation) c. Temperature of the peri-wound (warm, inflamed, macerated) d. Drainage/Exudate e. Odor f. Pain 5. Current treatment 6. Weekly progress towards healing, effectiveness of current interventions 7. Any treatment for pain, if present 8. Modifications of interventions 9. Notifications to physician and/or responsible party regarding wound or treatment changes. Frequency of Wound Documentation: 1. Weekly 2. PRN [as needed] with any resident change in condition or change in wound status." -Review of Resident #2's medical record occurred on all days of the survey and included diagnoses of Type 2 Diabetes mellitus with stage 4 kidney disease and pressure ulcer of right heel, unstageable. Resident #2 current care plan stated, ". . . Pressure Ulcer. I am at risk for potential skin integrity impairment due to aging, health problems, and limited mobility. . . I currently have an unstageable pressure ulcer to right heel . . .	F 686	3. Pressure injury risk assessments (Braden Scale Risk Assessment) will be completed on all residents. Skin assessments will be completed on a weekly basis for all residents. For those residents at risk, care plans will be reviewed to ensure appropriate interventions are in place. The facility policy regarding Pressure Injury Risk Assessment was reviewed and updated to include pressure injury risk assessments (Braden Scale Risk Assessment) to be completed on admission, readmissions, quarterly and PRN. All Nursing staff will be in-serviced by nurse management team on the revised policy for Pressure Injury Prevention, adequate assessment and documentation of skin assessments and timely reporting of skin concerns at Charge Nurse Meeting on 03/29/2021. 4. The nurse management team will audit 12 residents skin assessments to ensure appropriate documentation and interventions are in place q week x 4 weeks; then 12 residents q 2 weeks x one month; then monthly x 4 months to ensure appropriate skin assessments are documented and completed. Audits will be reviewed by the QAPI nurse and quality assurance committee until such time consistent substantial compliance has been achieved as determined by the committee. 5. Corrective action completion date	

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F 686	Continued From page 6 upon return (10/29/2020 . . . stage 2 on admission) . . . 12/04/2020 unstageable/Diabetic ulcer . . . Goal: My skin will remain intact through next review . . . Approach: Heel protection/Blue boots 24/7 . . . assist me to avoid skin to skin contact as possible . . . complete skin assessment of my body weekly and as needed if I have an area of concern. See [EMR] and Progress notes for updates . . ." Resident #2's physician orders and current TAR identified the following: -"Resident to wear heel protector to both heels 24/7. Special instructions: for unstageable decubitus right heel ulceration. Every shift 7:00 a.m. - 3:00 p.m., 3:00 p.m. - 11:00 p.m., 11:00 p.m. - 7:00 a.m. RIGHT HEEL: cleanse open area; apply Collagenase, and change dressing DAILY. Special instructions treatment to right heel DAILY. Once a Day. 7:00 a.m. - 3:00 p.m. . . . ULCER: Weekly Ulcer Report (Document measurements, color of wound bed, drainage amount and color, odor, tunneling and surrounding tissue. Describe progress and effectiveness of treatment) Once a day on Thursday evenings . . ." Review of Resident #2's progress notes showed the following: -11/05/20 at 9:41 p.m.: Weekly skin assessment failed to assess/measure right heel wound. -11/12/20 at 9:11 a.m.: Weekly skin assessment failed to assess/measure right heel wound. -11/19/20 at 10:53 p.m.: Weekly skin assessment failed to assess/measure right heel wound. -11/26/20 at 10:23 p.m.: "MDS Charting/skin assessment: right heel is black in color. . ." The facility failed to measure right heel wound.	F 686	04/06/2021	

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F 686	Continued From page 7 -12/03/2020 at 9:39 p.m.: "Weekly skin assessment . . . wound to right heal is covered with black eschar. . ." The facility failed to assess right heel wound. -02/11/21 at 10:40 p.m.: Weekly skin assessment failed to assess/measure right heal wound. The facility failed to follow physician orders for weekly or PRN skin assessments and provide consistent documentation of Resident #2's wounds and follow facility policy, which may have resulted in delayed identification and treatment of the resident's pressure ulcers. - Review of Resident #42's medical record occurred on all days of survey and included diagnoses of left femur fracture and Type 2 Diabetes mellitus. The significant change Minimum Data Set (MDS), dated 01/13/21, identified one stage 2 pressure ulcer present on admission/reentry, extensive assist of two staff for bed mobility, transfer, toileting, and dressing, and high cognitive function. The current care plan, updated 02/08/21, stated, ". . . I currently have open areas to coccyx present upon return. I frequently refuse to allow staff to treat. I also refuse to lay down in bed . . . I desire my wounds to exhibit signs of healing evidenced by decrease in size, improved appearance, and be free from signs & symptoms of infection by next review date." Resident #42's current physician's orders identified the following: - "Rash/Lesion: Daily monitoring, Mepilex to right upper buttocks daily til (sic) healed. Special Instructions: THREE OPEN AREAS TO	F 686		

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F 686	Continued From page 8 GLUTEAL AREA: Cleanse with soap and warm water, barrier cream, and dressing Twice A Day 07:00 AM - 03:00 PM, 03:00 PM - 11:00 PM. Start date: 2-8-21" - "Weekly skin assessment completed Once A Day on Mon [Monday] 07:00 AM - 03:00 PM Start date: 12-1-2019" Review of the progress notes showed the following: - 12/28/19 - ".25 cm [centimeter] R [right] buttock. Mepilex per T.O. [telephone order] til (sic) healed." (no follow-up documentation on this area noted) - 01/06/21 - Assessment after returning from the hospital. ". . . Has open area (approx [approximately] 1cm) on left buttock near coccyx. After cleansing Mepilex applied. . . ." - 01/11/21 - ". . . meplix [Mepilex] placed to coccyx area, area remains 0.5 cm open with no drainage to site nor discoloration. No other bruising, ST's [skin tears], rashes nor lacerations noted throughout the body. . . ." - 01/24/21 - Left superficial area to buttock. - 01/25/21 - Weekly skin assessment. Right buttock open area .5 cm and left buttock with shearing - 02/08/21 - From top of coccyx and downward assessment. First area: 1.6 cm x 1.6 cm open on right gluteal cheek. Second area: 1.4 cm x 3 cm. Third area .5 cm x .5 cm left lower coccyx area. The progress notes failed to follow physician orders for weekly or PRN skin assessments and follow facility policy to identify the type of wound, the Stage or wound depth, color, temperature, drainage, odor, pain or pain treatment, dressing/treatment type, treatment	F 686		

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F 686	Continued From page 9 effectiveness/modification, or physician notification for treatment update/changes on a consistent basis. During an interview on 03/03/21 at 3:45 p.m., an administrative nurse (#1) agreed the facility failed to follow physician orders and facility policy to assess/monitor the resident's wounds on a consistent basis. The nurse (#1) identified the wound as a Stage II pressure ulcer on the MDS, dated 01/13/21, by reading the progress notes/medical record but agreed the nursing staff failed to identify wound type or stage the wounds in the documentation. - Review of Resident #47's medical record occurred on all days of the survey and included diagnoses of Type 2 Diabetes mellitus and dehydration. Resident #47's current care plan, stated, ". . . Pressure Ulcer. I am at risk for potential skin integrity impairment due to aging, health problems, and limited mobility. . . Goal: My skin will remain intact through the next review. . . Approach: Please place blue boots at all times. No shoes. Monitor left heel daily and notify MD [medical doctor] and family if worsens. . . Complete skin assessment of my body weekly and as needed if I have any area of concern. See Event and Progress notes for updates. . . ." Resident #47's physician orders and current TAR identified the following: - "Apply Mepilex dressing to blister to left heel every 3 days until healed. Once A Day Every 3 Days 11:00 p.m. - 7:00 a.m., dated 02/27/20." - "Weekly skin assessment completed. Special	F 686		

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F 686	Continued From page 10	F 686		

Instructions: Do on Monday morning bath days. Once a day on Sunday 11:00 p.m. - 7:00 a.m., dated 02/27/20."
- "OPEN AREA TO LEFT HEEL: Cleanse wound with wound cleanser spray, apply MEDIHONEY and MEPILEX dressing, once a day 11:00 p.m. - 7:00 a.m., dated 02/23/21."
- "Contact precautions for draining wound, every shift 7:00 a.m. - 3:00 p.m., 3:00 p.m. - 11:00 p.m., and 11:00 p.m. - 7:00 a.m., dated 02/24/21."

Review of Resident #47's progress notes showed the following:
- 12/28/20 at 7:01 a.m.: "Weekly skin assessment . . . Bilateral heels are dry and intact; with 1 cm elevated lesion on left heel, denies pain. Applied Mepilex for protection. . . ."
- 01/04/21 at 6:24 a.m.: The weekly skin assessment failed to assess heel wound.
- 01/18/21 at 7:29 a.m.: The weekly skin assessment failed to assess heel wound.
- 01/28/21 at 2:51 p.m.: ". . .With 0.5 cm open area on left heel and raised lesion on left lateral side of the heel, area is covered with mepilex."
- 02/01/21 at 7:24 a.m.: "Weekly skin assessment . . . Open area on left heel and raised lesion on left lateral side of the heel, covered with mepilex . . ."
- 02/08/21 at 6:51 a.m.: "Weekly skin assessment . . . Open area on left heel and raised lesion on left lateral side of the heel, Mepilex applied . . ."
- 02/15/21 at 5:29 a.m.: "Weekly skin Assessment . . . Open area on left heel and raised lesion on left lateral side of the heel, Mepilex applied . . ."
- 02/21/21 at 7:21 a.m.: ". . .With 4 x 3 cm open area on left heel, with black eschar, whitish tissue in some area, macerated with foul-smelling

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F 686	Continued From page 11 brownish discharges [sic]. . ." - 02/22/21 at 6:34 a.m.: "Weekly Skin Assessment. With 4 x 3 cm open area on left heel, with black eschar, macerated with foul-smelling. Mepilex applied . . ." - 02/24/21 at 4:53 a.m.: "Wound dressing done to open are [sic] to left heel as ordered. Area noted with black eschar, dry and non-foul smelling. Complained tolerable pain during dressing change." - 02/25/21 at 4:47 a.m.: ". . . An open ulcer remains (approx. 5 cm width x 5 cm length) on the L [left] -heel. Perimeter of wound is macerated w/dk [white/dark] pink tissue. Interior of wound has combination of white/dk. brown flesh. No odor detected." - 02/28/21 at 7:19 a.m.: (Recorded as Late Entry on 03/01/21 2:22 PM) ". . . Left heel wound appears macerated, moist, with black eschar, whitish and red tissues noted on the wound bed, non-foul smelling . . ." - 03/01/21 at 7:47 a.m.: "Weekly Skin Assessment . . . Continuous [sic] to have 4 x 3 cm open area on left heel, with black eschar, dry and no discharges [sic] and non-odorous . . ." The facility failed to provide consistent monitoring of Resident #42 and Resident 47's wounds, including staging and measuring of the area which limited the facility's ability to identify the type of wound, treatment effectiveness, and if the wound was healing or worsening for physician follow-up and orders for proper treatment.	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that -	F 689		4/6/21

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F 689	Continued From page 12 §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure residents had a safe environment free from hazards and prevent accidents for 3 of 3 dryers during a tour of the laundry room. Failure to monitor and clean the buildup of lint in the dryers may create a hazard which poses a potential risk to the residents. During a tour of the laundry room on 03/04/21 at 9:11 a.m., observation showed three large dryers with lint collected on the lint screens. Each lint screen showed approximately two inches or more of lint buildup on the screens with the lint sagging and hanging down into the collection area. During an interview on 03/04/21 at 9:11 a.m., when asked questions regarding policy and cleaning schedule, an administrative staff (#11) stated he is not aware of a policy, daily or weekly log documentation of cleaning of the lint screens and assumed staff cleaned on a regular basis. During an interview on 03/04/21 at 9:15 a.m. two administrative staff members (#11 and #12) agreed of a need to have a policy addressing the cleaning and maintenance of the dryer lint screens.	F 689	1. The administrator and maintenance supervisor met with the laundry staff on 03/04/2021. All 3 dryer vents were cleaned of buildup of lint and assessed for any possible hazard. Any area of concern was corrected at that time. 2. All residents are believed to have the potential to be affected. The maintenance staff and administrator reviewed all dryers in the building. Any areas of concern were corrected immediately. All dryer lent screens are free of lint build up at this time. 3. The administrator and/or maintenance supervisor educated and instructed all laundry and maintenance staff that dryer lint screens need to be cleaned every day that dryers are in use. Laundry staff will sign a daily log sheet to ensure dryer lint screen are cleaned daily. Laundry staff will be in-serviced on the policy and procedure on the accident and supervision policy on 03/29/2021. 4. Maintenance/laundry supervisor will conduct routine dryer lint screen checks bi-weekly x 4-week, weekly x 4 weeks and monthly x 3.	

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F 689	Continued From page 13	F 689	Audited records will be reviewed by the QAPI Committee at quarterly meetings until such time consistent substantial compliance has been achieved as determined by the QAPI Committee. 5.Corrective Action Completion date 04/06/2021.	
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to provide respiratory care consistent with physician's orders for 1 of 4 sampled residents (Resident #47) with oxygen orders. Failure to provide oxygen as ordered has the potential for residents to experience complications related to inadequate/excessive oxygen saturation levels. Findings include: Review of Resident #47's medical record occurred on all days of survey. A physician's order, dated 07/06/20, stated "Oxygen at 2LPM [liter(s) per minute] at night."	F 695	1. Nurse manager immediately called MD on 3/3/2021 and received orders for resident #47 to have O2 @2L via NC to maintain saturations greater then 90%. The physician□s order was changed to reflect the current plan of treatment. Resident #47 has since expired. 2. The facility has determined that all residents receiving oxygen have the potential to be affected. 3. An in-service education program will be conducted by the Nursing	4/6/21

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F 695	Continued From page 14 Observations of Resident #47 on 03/01/21 at 9:30 a.m. and 2:22 p.m., 03/02/21 at 7:50 a.m. and 2:04 p.m., 03/03/21 at 9:51 a.m., and 03/04/21 at 7:43 a.m. showed the resident wore a nasal cannula attached to an oxygen concentrator set at 2 LPM. These observations showed facility staff failed to follow the physician order. During an interview on 03/01/21 at 2:22 p.m., a certified nurse aide (#2) stated Resident #47 received comfort cares and wore oxygen all the time. During an interview on 03/03/21 at 3:45 p.m., an administrative nurse (#1) stated staff failed to clarify physician orders for the current oxygen use. The facility failed to follow the physician orders for Resident #47.	F 695	Management team with staff nurses on 3/29/2021 addressing the facility policy regarding the proper usage of oxygen and following the current orders in place. 4. The nursing management team will review each resident with oxygen to assure the current physician□s order reflect current oxygen usage. The Nursing Management team, will complete audits on 6 residents currently using oxygen weekly x 4 weeks, every 2 weeks x1 month then monthly x 4 months to ensure that current physician□s order reflect current oxygen usage. Audits will also assure that care plans remain updated to reflect current orders. Audited records will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee. 5. Corrective action completion date: 4/6/2021	
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals	F 761		4/6/21

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F 761	Continued From page 15 §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure staff discarded expired medications and laboratory supplies for 4 of 5 storage areas (Meadow Lane and Carus Court medication carts, a medication room, and a laboratory tray) observed. Failure to discard expired medications, vacutainers (blood specimen collection tubes), and other resident medical supplies increased the risk of residents receiving outdated medications with reduced efficacy and/or staff utilizing outdated laboratory and medical supplies. Findings include: - Observation of the Meadow Lane medication cart on 03/02/21 at 12:10 p.m. with a medication assistant (MA) (#3) identified a tube of Clotrimazole-Betamethasone-Dipropionate 1% ointment expired on 09/27/20. The MA (#3)	F 761	1. Nurse management cleaned out all medications carts as well as the medication room, storage room for any expired medications or supplies and disposed of per facility policy. 2. The facility has determined that all residents have the potential to be affected. 3. The night nurse duty form has been updated and now includes checking the medication carts and storage rooms for expired medications and/or supplies weekly. An in-service education program will be conducted by the Nursing Management team with staff nurses and certified medication assistance(CMA) on 3/29/2021 addressing the proper disposal	

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F 761	Continued From page 16 stated, "Resident #26 is no longer on that medication." - Observation of the Carus Court medication cart on 03/02/21 at 12:40 p.m. with a staff nurse (#4) identified one Magellan 25G [gauge] x1" [one inch] safety needle expired on 03/2019. - Observation of the medication room on 03/02/21 at 1:00 p.m. with a staff nurse (#5) and MA (#3) identified the following expired medications and laboratory/medical supplies: *Four Vacutainer Safety-Lok infusion sets (23Gx3/4") expired 06/30/20 *Forty-five Alcohol Prep Pads with expiration dates of 06/2020, 06/2019, and 08/2020 *Three Bacitracin Zinc packets expired 01/2018 *One Smart Site Needle Free Valve expired 01/25/20 *Three green top vacutainers expired 05/31/20 *Five blue top vacutainers expired 11/30/19 and 12/31/19 *Two Yellow top vacutainers expired 12/31/20 *One Purple top vacutainer expired 09/30/20 *Three Red top vacutainers expired 08/31/20 *One bottle of Debrox ear drops expired 06/2019 *Two NG [nasogastic] Sample Kits expired 10/2019 and 01/2021 *Three Copan culture tubes expired 02/2020 *Thirty male sterile caps (sterile caps for intravenous tubing) expired 03/01/20 - Observation of a laboratory tray on 03/02/21 at 1:31 p.m. with an administrative nurse (#6) identified four blue top vacutainers expired 05/31/20. During interview on 03/02/21 at 1:31 p.m., an	F 761	of expired supplies and/or medications and the updated routine schedule for checking for expired medications/supplies. 4. Nurse managers or designee will inspect all medication carts and the medication rooms for expired medications/supplies weekly x 4 weeks, every 2 weeks x1 month then monthly x 4 months. Audited records will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee. 5. Corrective action completion date: 4/6/2021	

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F 761	Continued From page 17 administrative nurse (#6) confirmed the above items had expired and staff needed to discard the items. During interview on 03/02/21 at 3:00 p.m. with an administrative nurse (#1) identified the facility had no policy/procedure for review and destruction of expired medications/medical supplies. The administrative nurse (#1) agreed all nurses are responsible to ensure expired medications and medical supplies are discarded.	F 761		
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 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 and staff interview, the facility failed to serve food under sanitary	F 812	1. The dishwasher has been cleaned of the all the corrosion areas by the dietary	4/6/21

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F 812	Continued From page 18 conditions and kitchen equipment kept clean in 1 of 1 kitchens used to prepare food and wash dishware. Failure to change gloves before touching ready-to-eat foods and to effectively clean kitchen equipment has the potential to result in foodborne illness to residents, staff, and visitors. Findings include: Observation during a kitchen tour on 03/04/21 at 7:38 a.m., showed several areas of corrosion on the edges of the dishwasher and a layer of corrosion particles and dirt on its top. Observation of the breakfast meal on 03/04/21 showed an unidentified kitchen staff member touched serving counters, meal tickets, and the handle on a steamer/oven to retrieve hot plates. Without changing gloves, he repeatedly reached into a container of toast and placed it onto resident meal trays. During an interview on 03/04/21 at 8:43 a.m., administrative staff members (#1, #6, and #9) agreed falling debris from the outside of the unclean dishwasher could fall onto/contaminate clean dishes and kitchen staff (#7) should have changed gloves and utilized a utensil to serve the toast. During an interview on 03/04/21 at 9:34 a.m., an administrative staff member (#8) stated he assumed the dishwasher servicing company was responsible for cleaning/descaling the outside of the dishwasher when they come.	F 812	manager. The dietary staff member involved was immediately educated on appropriate food handling for the serving line. 2. The facility has determined that all residents who consume food by mouth have the potential to be affected. 3. All dietary staff will be in-serviced on April 6, 2021 by the Registered Dietician on the facility□s policies and practice guideline for maintaining a sanitary tray line and daily cleaning of the dishwasher. A Daily Sign off Form was created for staff to sign off that the dishwasher will be wiped down morning and evening. 4. The Dietary Manager or designee will complete random audits on employees during tray line serving weekly x 4 weeks, every 2 weeks x1 month then monthly x 4 months to ensure staff performance is in accordance food safety requirements. The dietary manager or designee will also conduct audits on twice daily sign off of cleaning of the dishwasher weekly x 4 weeks, every 2 weeks x1 month then monthly x 4 months to ensure compliance. Audited records will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee. 5. Corrective action completion date:	

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F 812	Continued From page 19	F 812	04/06/2021	
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. §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;	F 880		4/6/21

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F 880	Continued From page 20 (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 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, record review, review of facility policy and procedure, and staff interview, the facility failed to follow infection control standards on 2 of 4 days (03/01/21 and 03/02/21) of survey. Failure of the facility to ensure	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	

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F 880	Continued From page 21 appropriate transmission based precautions were followed may result in resident and staff exposure to COVID-19 [a viral infection] or other healthcare-associated infections. Findings include: Review of the facility policy titled, "Nebulizer Treatments during covid-19 pandemic" occurred on 03/02/21. This policy, dated 09/18/20, stated, "1) Must be fit tested with n95 [sic] to administer neb [nebulizer]. . . . 4) If only set up and resident can turn on and off, the staff member can set up, close door and rotate sign and keep track of time to open door again. 5) Door must be kept closed for the period of the neb and 30 minutes after neb. Sign on door need [sic] to be rotated back so [sic] staff goes into room. . . ." Review of the facility policy titled, "Transmission-Based Precautions" occurred on 3/03/21. This policy, revised November 2020, stated, ". . . Place residents with suspected or confirmed infectious agents on isolation precautions empirically while awaiting confirmation . . . as recommended by the CDC [Center for Disease Control] . . . will be documented in the medical record . . . communicated through in house communication forms . . . signage. Review of the Centers for Disease Control and Prevention (CDC) guidance for PPE use, found at: https://www.cdc.gov, stated, ". . . Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, updated 02/23/21, stated	F 880	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 close resident room doors and use proper signage during all nebulizer treatments, in accordance with Centers for Disease Control and Prevention (CDC) guidelines. (2) Ensuring staff entering and exiting a room on droplet precautions donned, doffed disposed of personal protective equipment (PPE), in accordance with CDC guidelines. The DON, staff development coordinator (SDC), IP or designee, in conjunction with applicable IDT members, will: (1) Educate all staff to close resident doors and use proper signage during all nebulizer treatments. Charge Nurse/CMA meeting on 3/29/2021, CNA will be educated 4/6/2021. (2) Educate all staff on selecting, donning, doffing and disposing of PPE when entering a room on droplet precaution isolation/quarantine procedures. To verify each of these/this staff understands the procedure, then each will perform a successful return demonstration of selecting, donning, doffing and disposing of PPE for providing cares in a droplet precaution room.	

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F 880	Continued From page 22 . . . The PPE [personal protective equipment] recommended when caring for a patient with suspected or confirmed COVID-19 includes the following . . . Put on an N95 respirator . . . Put on eye protection . . . Put on clean, non-sterile gloves . . . Put on a clean isolation gown upon entry into the patient room . . . ." - Observation on 03/01/21 at 10:45 a.m., showed Resident #303 sitting at the bedside in the room with a nebulizer treatment in progress. The resident's door remained open with no nebulizer signage displayed. During an interview on 03/02/21 at 11:24 a.m., a medication aide (MA) (#3) stated, "Staff wear N95 masks, face shield, gown, and gloves in residents' rooms while a nebulizer treatment is in progress. The resident's door must have a nebulizer in progress sign and must remain closed for 30 minutes following the completion of the treatment." -Observation on 03/02/21 at 7:10 a.m., showed three separate "Enhanced Precautions" signs and an isolation cart outside of a resident room on enhanced precautions with the door wide open. At 7:11 a.m., a certified nursing assistant (CNA) (#10), wearing a surgical mask and face shield, entered the room, turned off the call light, moved the bedside table, touched blankets, socks, a dresser, chair and door. The CNA failed to hand sanitize and don appropriate PPE when entering and exiting the room. During an interview on 03/03/21 at 5:06 p.m., two administrative nurses (#1and #6) agreed the staff should follow facility policy and CDC guidelines	F 880	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 04/06/2021 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 all resident doors are closed during nebulizer treatments and ensure proper signage is in place, in accordance with CDC guidelines. b. Failure to select, don and utilize the necessary PPE for droplet precautions isolation/quarantine room access, in accordance with CDC guidelines. (2) The DON, SDC, IP or suitable designee will ensure the following: a. Educate all staff, on the importance of ensuring resident room doors remain closed and use proper signage during nebulizer treatments. Charge Nurse/CMA meeting on 3/29/2021, CNA will be educated 4/6/2021. b. Educate all staff who perform the daily COVID-19 staff and visitor	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355092	A. BUILDING _____ B. WING _____	03/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 23 and wear the appropriate PPE and close the residents door.	F 880	screenings on all changes and updates to the facility screening policy and procedures. (3) The facility leadership will contact the North Dakota Quality Improvement Organization (QIO), to inquire about the assistance and services available from the QIO in improving infection prevention and control within the facility through quality assurance process improvement (QAPI) methods. 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) Observe all staff to ensure resident room doors remain closed and proper signage is in place on all residents receiving nebulizer treatments. (2) Observations of all staff types to ensure correct selection, donning, use and doffing of PPE when entering and exiting droplet precaution isolation/quarantine rooms. 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.	

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F 880	Continued From page 24	F 880	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 04/06/2021	