STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355053	A. BUILDING _____ B. WING _____	05/09/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KNIFE RIVER CARE CENTER	118 22ND ST NE BEULAH, ND 58523

(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 05/06/13 and completed on 05/09/13, the sample included 4 residents for complete review, 10 residents for focused review, and 3 closed records for review. The sample included 4 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: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 05/17/12. Based on observation, review of facility procedure, and staff interview, the facility staff failed to provide care in a manner that maintained or enhanced each resident's dignity and individuality during 2 of 6 meal observations (noon meal on 05/07/13 and evening meal on 05/08/13) and an observation of personal care with 1 of 14 sampled residents (Resident #1). Scraping and re-feeding food from residents' faces and failing to knock during personal cares may negatively affect residents' quality of life. Findings include: Review of the facility procedure, "Feeding the Resident," occurred on 05/09/13. This procedure,	F 241	**Plan of Correction F241** 1. NA 2. Knife River Care Center strives to maintain or enhance each resident's dignity and respect in full recognition of individuality. The potential may always exist where staff divert from providing the level of dignity and respect expected of each employee. 3. Education regarding providing dignity and respect to all residents residing at Knife River Care Center specific to knocking before entering resident room and proper cleaning of resident's face during meal times was discussed at CNA meeting held on 5/16/13. See exhibits # F241-1 & # F241-2. The current policy and procedure for Feeding the Resident	06/13/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	ADMINISTRATOR	06-24-13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 241	Continued From page 1 dated 06/23/12, stated "Objective: 1. To assist the resident with feeding as is necessary. . . . Procedure: . . . 15. During the meal, wipe the resident's mouth with clean item such as cloth or paper napkin. . . ." Observation in the Golden Grain household dining room identified the following: *05/07/13, 11:55 a.m. - Resident #20 - seated in a wheelchair at the dining room table fed by a certified nursing assistant (CNA) (#10). The CNA (#10) repeatedly fed the resident meal items with a spoon, scraped food material from the resident's face, and re-fed the food to the resident. Resident #21 - seated in a wheelchair at the dining room table fed by a CNA (#10). The CNA (#10) repeatedly fed the resident meal items with a spoon, scraped food material from the resident's face, and re-fed the food to the resident. *05/08/13, 5:45 p.m. - Resident #20 - seated in a wheelchair at the dining room table fed by a CNA (#7). The CNA (#7) repeatedly fed the resident meal items with a spoon, scraped food material from the resident's face, and re-fed the food to the resident. Resident #21 - seated in a wheelchair at the dining room table fed by a CNA (#7). The CNA (#7) repeatedly fed the resident meal items with a spoon, scraped food material from the resident's face, and re-fed the food to the resident. During interview, on 05/09/13 at 10:45 a.m., a supervisory nursing staff member (#13) stated her expectation was that facility staff would use napkins to wipe residents' faces during meals.	F 241	has been reviewed and a policy on Maintaining Resident Dignity will be developed for staff review. See exhibits # F241-3 & # F241-4. 4. Feeding the Resident policy and procedure and Maintaining Resident Dignity policy will be reviewed at the scheduled Nurse and CNA meeting on 6/13/13 and Maintaining Resident Dignity policy will be reviewed at the All staff meeting scheduled on 6/19/13. 5. The QA tool Feeding the Resident and Resident Personal Privacy and Confidentiality will be completed by DON, Nurse Managers, Charge Nurses, CMA's, and CNA's bi-monthly for three months then monthly for three months, then quarterly thereafter. See exhibits # F241-5 & # F241-6. Results of QA will be reviewed at the quarterly Quality Assurance meeting scheduled for August 8, 2013 and quarterly thereafter.	

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F 241	Continued From page 2 - Observation on 05/07/13 at 9:34 a.m. showed a CNA (#17) assisted Resident #1 with incontinence cares as the resident lay in bed. During the observation, an unidentified staff member opened the door and immediately entered the room. The staff member stated, "Oh. Sorry," set a water pitcher on the dresser, and left the room. The staff member failed to knock and wait for a response before entering the room.	F 241		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of professional reference, review of facility procedure, and staff interview, the facility failed to provide the necessary care and services for 1 of 1 sampled resident (Resident #4) with physician orders to maintain the head of the bed at a 45 degree angle at all times. Failure to maintain the head of Resident #4's bed at 45 degrees at all times placed her at risk for aspiration pneumonia. Findings include: Review of the National Institutes of Health (NIH) and the United States National Library of Medicine internet site, nih.gov, Medline Plus,	F 309	**Plan of Correction F309** 1. Primary Physician examined Resident # 4 on rounds on 5/15/13. Progress notes from that visit state "It is not going to hurt her to have it elevated (referring to head of bed) , but it is probably not mandatory that she elevate this." (See Exhibit #F309-1). The order for Resident # 4 to "Keep HOB up at a 45 degree angle at all times" was discontinued on 5/16/13. 2. KRCC will identify other residents for high risk of aspiration utilizing the Aspiration Risk Assessment Tool. (See Exhibit #F309-2) 3. Residents will be assessed for high risk of aspiration on admission, with a significant change/change of condition and monthly utilizing the Aspiration Risk Assessment Tool. If the resident is found to be at high	06/13/13

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F 309	Continued From page 3 occurred on 05/09/13. This internet site stated "Esophageal stricture . . . Treatment, Dilation (stretching) of the esophagus is the preferred treatment. . . . Possible Complications . . . There is also an increased risk (with regurgitation) of having food, fluid, or vomit enter the lungs and cause choking or aspiration pneumonia. . . ." Review of the facility procedure, "Feeding The Resident," occurred on 05/09/13. This procedure, dated 06/23/12, stated "Objective: 1. To assist the resident with feeding as is necessary. 2. To assist the resident with meeting his/her nutritional needs. . . . Procedure: . . . 4. . . . Need to have head of bed elevate [sic] to fowler [sic] position [45 to 60 degrees] or be sitting up to make swallowing easier and reduce the risk of aspiration and choking. . . ." Review of Resident #4's medical record occurred on May 06-09, 2013. The facility admitted the resident in March 2006. Current diagnoses include esophageal stricture, upper respiratory infection (January 2013), and dysphagia. The resident's annual Minimum Data Set (MDS), dated 03/17/13, identified the resident usually makes herself understood and understands others, required extensive assistance of one person for bed mobility and transfers, and did not have a swallowing disorder. Resident #4's current care plan, dated 03/25/13, stated ". . . have problems with a recurrent esophageal stricture and have had it dilated to help prevent me from vomiting after meals. My last dilation was on 02/26/13. . . . I do accept fluids and cream of rice cereal at my meal times. . . . I should not eat about 3 hours before I go to	F 309	risk, the Nurse will implement the Aspiration Precautions Protocol (See Exhibit # F309-3). Nursing staff will be educated on aspiration precautions. Nursing staff will continue to assess the high risk residents based on the Aspiration Precautions Protocol and document monthly in Nurses Notes. 4. Nursing Staff will be educated on use of the Aspiration Risk Assessment Tool and Aspiration Precautions Protocol at the June 13, 2013 C.N.A and Nursing Meeting. 5. A Quality Assurance tool on Aspiration Precautions has been developed and will be completed by Nursing Staff monthly x three months, then quarterly. (See Exhibit # F309-4). Results will be reported at each quarterly QA meeting. The next QA meeting is scheduled for August, 2013.	

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F 309	Continued From page 4 bed due to my esophageal reflux disease/guidelines. . . ." Resident #4's physician orders, dated 02/26/13, following the dilation referenced in the resident's care plan, included ". . . Do Not [Eat] 3 Hours Prior To Bedtime, Aspiration Precautions, Keep HOB [head of bed] Up @ [at] A 45 Degree Angle @ All Times . . ." Resident #4's physician orders, originally ordered on 06/30/08 and renewed on 03/20/13, included "Keep HOB up @ 45 degree angle @ all times." Resident #4's care plan failed to identify the aspiration precautions and failed to include keeping the head of the bed at a 45 degree angle at all times. Observation identified Resident #4 sleeping supine or right side lying in bed with the HOB elevated approximately 15 to 20 degrees, at 7:30 a.m. on 05/07/13, 05/08/13, and 05/09/13. On 05/07/13, the resident remained supine until 9:55 a.m. when a certified nursing assistant (CNA) (#12) assisted her to the toilet with a sit to stand lift. It is unknown how long Resident #4 remained with the HOB below 45 degrees before 7:30 a.m. on each of these days. During interview, on 05/09/13 at 10:45 a.m., a supervisory nursing staff member (#13) confirmed the physician orders to keep Resident #4's head of bed at 45 degrees at all times and identified this as an aspiration precaution. This staff member also reported Resident #4 refuses to keep the head of the bed elevated at 45 degrees. Staff member (#13) did not provide requested documentation of this refusal. Resident #4's physician orders since 2008	F 309		

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F 309	Continued From page 5 include keeping the head of her bed at 45 degrees at all times. Physician orders after the esophageal dilation for treatment of her esophageal stricture include the same orders as an aspiration precaution. Facility staff failed to include these approaches in Resident #4's care plan and failed to implement these approaches. These failures placed Resident #4 at increased risk of aspiration and pneumonia.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 05/17/12. Based on observation, record review, review of facility policy and procedure, and staff interview, the facility failed to provide the necessary services to maintain good nutrition and personal hygiene for 2 of 12 sampled residents requiring assistance with eating (Resident #13) and toileting (Resident #4). Failure to provide repositioning, assistive devices, a supplement, and assistance at meals limited Resident #4's ability to maintain good nutrition. Failure to provide toileting assistance may have contributed to Resident #4's incontinence, failed to maintain good personal hygiene, and placed the resident at risk of skin breakdown.	F 312	**Plan of Correction F312** 1. Resident #13 was evaluated by COTA and adaptive deep dish was removed on 5/15/13, resident #13 is care planned to be assisted with all meals. The Harvest Lane Meal Plan form will note the appropriate staff assigned to assist resident #13 at each meal. Charge Nurse will monitor offering and acceptance of afternoon supplement and will document in Treatment Administration Record (TAR). Resident #4 had care plan and daily care guide updated to indicate offer routine toileting every 2-3 hours as resident allows. A Bowel and Bladder Patterning worksheet has been implemented for resident #4. 2. All residents will have a Physical Functioning Evaluation/Screening and Urinary Incontinence Management Evaluation completed on admission, quarterly and with a change in condition to identify	06/13/13

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F 312	Continued From page 6 Findings include: Review of the facility procedure, "Feeding The Resident," occurred on 05/09/13. This procedure, dated 06/23/12, stated "Objective: 1. To assist the resident with feeding as is necessary. 2. To assist the resident with meeting his/her nutritional needs. . . . Procedure: . . . 10. Encourage the resident to feed him/herself if he can. . . . Plate Guard, This device blocks food from spilling off the plate. Attach the guard to the side of the plate opposite the hand the resident uses to feed him/herself. . . . When the resident tires, feed him/her the rest of the meal. . . ." Review of the facility procedure, "Positioning The Resident In A Wheelchair," occurred on 05/09/13. This undated procedure, stated "Objective: 1. To keep the resident comfortable when sitting in wheelchair for prolonged periods of time. 2. To prevent skin breakdown. . . . Repositioning in the Wheelchair: 1. If the resident begins to slump in chair the resident may need to be repositioned. . . ." - Observation in the Golden Grain household dining room, on 05/07/13 at 11:55 a.m., identified Resident #13 seated in a wheelchair at the dining room table. Three certified nursing assistants (CNAs) (#10), (#11), and (#12) sat at the table assisting other residents. Resident #13 leaned to the right against the right arm rest of wheelchair, her trunk at approximately a 30 degree angle to the right, and, at times, her right arm dangling down towards the floor. A partially consumed meal of fish and green beans	F 312	residents who have the potential to be affected. 3. Education regarding timeliness and necessity of adhering to toileting plans & toileting schedules, positioning of residents, assisting residents at meal times and with afternoon and evening snacks was discussed at CNA meeting held on 5/16/13. See exhibits # F241-1 & # F241-2. The day Charge Nurse will assign appropriate staff to assist the specific residents at each meal utilizing "Meal Plan" assignment form. Charge Nurse will monitor offering and document acceptance of afternoon and evening supplements for those residents noted in (TAR). The Urinary Incontinence Management Evaluation will be completed on admission, quarterly and with a change in condition to identify residents for bladder training/toileting/adult briefs. Resident's on routine toileting and individualized toileting schedules will have their daily care guide and care plan updated to reflect the toileting plan which meets the resident need. The current policy and procedure for Feeding the Resident, Positioning and Repositioning the resident in a wheelchair will be reviewed and the	

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F 312	Continued From page 7 remained on a plate in front of the resident. The plate lacked a plate guard. Resident #13 periodically attempted to scoop the remainder of her fish or beans onto a spoon with her right hand and used her left hand to try to push the meal items onto the spoon, with success about half the time. Resident #13 brought the empty spoon to her mouth, realized it was empty, waited a minute or two and then tried again. At 12:05 p.m., a licensed nurse (#14) sat next to Resident #13 and assisted her to finish her meal items. The CNAs (#10), (#11), and (#12) failed to offer to assist Resident #13 with her meal items. The staff members (#10), (#11), (#12), and (#14) failed to provide Resident #13 a plate guard and failed to offer or attempt to reposition Resident #13 in her wheelchair. Observation, on 05/08/13 at 4:20 p.m., identified a CNA (#7) assisted Resident #13 from her bed to toilet in the bathroom and then into the wheelchair. Observation identified a covered glass labeled "4 ounce Mighty Shake" with a straw on the resident's bedside stand next to the resident's eyeglasses. Following toileting, the CNA (#7) obtained the resident's eyeglasses, placed them on her face and wheeled her to the lounge. The CNA (#7) failed to offer Resident #13 the Mighty Shake or any other fluid during this episode of care. Review of Resident #13's medical record occurred on May 08-09, 2013. The facility admitted the resident in October 2011. Current diagnoses include malaise/fatigue, macular degeneration, esophageal reflux, and dementia. The quarterly Minimum Data Set (MDS), dated	F 312	Incontinence Management Policy was revised. See exhibits # F312-1, # F312-2 & # F312-3. 4. Feeding the Resident, Positioning and Repositioning the resident in a wheelchair policy and procedure and Incontinence Management policy will be reviewed at the scheduled Nurse and CNA meeting on 6/13/13. 5. The QA tools for Feeding the Resident, Incontinence Management and Positioning Quality will be completed by DON, Nurse Managers, Charge Nurses, CMA's, and CNA's monthly for six months, then quarterly thereafter. See Exhibit # F312-4, # F312-5, & # F312-6. Results of QA will be reviewed at the quarterly Quality Assurance meeting scheduled for August 8, 2013 and quarterly thereafter.	

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01/26/13, identified the resident usually understood others and made herself understood, was severely cognitively impaired, required extensive assistance of one person for bed mobility, transfers, and eating.

Resident #13's Interdisciplinary Progress Notes, dated 03/12/13 at 11:00 p.m., stated "Weekly Summary: . . . severely impaired cognition. Staff anticipates all needs. . . . Is a feeder for meals. . . . doesn't know which end of eating utensil to use. . . ."

Resident #13's Physical Functioning Screen, dated 05/01/13, stated ". . . declining cognition and ability to reposition self in w/c [wheelchair] or bed."

Resident #13's current care plan, dated 05/06/13, stated ". . . I use a deep dish . . . to aid in self feeding. I need more assistance with eating . . . I need supervision and @ [at] times assistance at my meals and should not have my food served before I have supervision/assistance available. . . ."

A supervisory nursing staff member (#13), during interview on 05/09/13 at 10:45 a.m., failed to provide additional information regarding assistance at meals, repositioning, and offering the supplement.

- Observation, on 05/07/13 at 4:00 p.m., identified two CNAs (#15) and (#16) assisted Resident #4 from her wheelchair to the bathroom for toileting using a sit to stand lift. The CNA (#15) reported Resident #4 requested the staff change her slacks because they were "icky." Following

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toileting, the CNA (#15) reported Resident #4 had been incontinent in her brief and soiled her slacks. This CNA also reported the resident did not have a bowel movement or void on the toilet. The staff members provided perineal care, changed the resident's brief and slacks, and returned her to the wheelchair with the sit to stand lift.

Observation, on 05/07/13 at 1:45 p.m., showed Resident #4 in the Coffee Shop; and, at 2:15 p.m., 3:00 p.m., and 4:00 p.m. showed her in her room. Observation failed to identify staff offering or attempting to toilet Resident #4 prior to 4:00 p.m.

Review of Resident #4's medical record occurred on May 06-09, 2013. The facility admitted the resident in March 2006. Current diagnoses include depression, delusions, and bipolar disorder. The resident's annual MDS, dated 03/17/13, identified the resident usually made herself understood and understood others, required extensive assistance of two or more persons for toileting, was frequently incontinent of bowel and bladder, and was not on a bowel or bladder training program.

Resident #4's Urinary Incontinence Care Area Assessment, dated 03/22/13, stated ". . . frequently incontinent of bowel and bladder. . . . at risk for skin breakdown . . ." Resident #4's Wound/Skin Healing Record, dated 10/03/12, stated "Healed" left and right buttocks ulcers identified as "Stage II" on 09/12/12 and 09/26/12.

Resident #4's current care plan, dated 03/25/13, stated ". . . I am frequently incontinent of bowel

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F 312	Continued From page 10 and bladder. . . . help me to the toilet on a routine basis. . . . I have a history of open areas to both buttocks. . . ." During interview with a supervisory nursing staff member (#13), on 05/09/13 at 10:45 a.m., this staff member reported the facility lacked a policy and her expectation of Resident #4's "routine" toileting was "every three to four hours." Following this interview, this staff member (#13) reported facility staff toileted Resident #4 at 12:30 p.m. During interview, on 05/09/13 at 1:55 p.m., an administrative nursing staff member (#1) reported her expectation of "routine" toileting was "every two to three hours." Resident #4 has a history of skin breakdown on her buttocks and is frequently incontinent. Facility staff care planned her toileting schedule as "routine," which the facility failed to define consistently. The resident's interval of three and one half hours between toileting, per staff report, may have contributed to Resident #4's incontinence and placed the resident at risk of skin breakdown.	F 312		
F 327 SS=G	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, review of professional reference, and staff	F 327	**Plan of Correction F-327** 1. For Resident #3 a record of meal fluid intake and between meal fluid intake will be monitored by dietary/nursing. An Acute Focus Care Plan was initiated for the charge nurses to complete a hydration assessment on said resident every shift for one month. The resident's afternoon supplement	06/13/13

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	355053	A. BUILDING _____ B. WING _____	05/09/2013

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F 327	Continued From page 11 interview, the facility failed to ensure adequate fluids to maintain an acceptable hydration status for 1 of 1 sampled resident (Resident #3) hospitalized with dehydration. Failure to ensure the availability and encourage the consumption of adequate fluid resulted in Resident #3's hospitalization for dehydration on two occasions, as well as prolonged and continued hypernatremia (high sodium levels). Findings include: Berman and Snyder, "Kozier & Erb's Fundamentals of Nursing: Concepts, Process, and Practice," 9th ed., Pearson Education, Inc., New Jersey, pages 1462-1464, states, ". . . Dehydration . . . occurs when water is lost from the body, leaving the client with excess sodium. . . . Older adults are at particular risk for dehydration because of decreased thirst sensation. . . . Hypernatremia is excess sodium in ECF (extracellular fluid), or a serum sodium of greater than 145 mEq/L (milliequivalents per liter). . . . Clients at highest risk for hypernatremia are . . . clients who are unable to request fluids such as infants or older adults with dementia . . ." Review of Resident #3's medical record occurred on all days of survey. Diagnoses included dementia and failure to thrive. The current Minimum Data Set (MDS), dated 03/30/13, identified severe cognitive impairment and extensive assistance from one person for eating. Current medications included Lasix (a diuretic) 20 milligrams (mg) three times per week. The record identified hospitalizations for hypernatremia from 12/18/12 to 01/01/13 and 01/29/13 to 02/08/13. Resident #3's current care plan stated, ". . . Offer	F 327	and amount accepted has been added to the medication administration record, thus being monitored closely by the charge nurse. A memo has been communicated (6/7/2013) to all staff that work on the resident's unit to offer fluids to the resident; with all resident cares, activities, meals, and between meals. The Dietician/MDS Coordinator will continue to complete a hydration assessment quarterly. Dietary is supplying the amount of fluid ounces for each meal recommended by the dietician. 2. All KRCC residents may have risk factors for dehydration and a Hydration Risk Evaluation (Exhibit # F327-1) will be completed on admission, weekly, and as needed. 3. A hydration risk evaluation will be completed by the charge nurse monthly on every resident; it will be signed off in the treatment administration record and interventions implemented. A nurses meeting will be held on Thursday, June 13th and this will be	

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F 327	Continued From page 12 fluids (encourage water) and encourage me to drink during the day. . . ." Hospital discharge notes stated the following: *01/01/13: ". . . The patient . . . had become unresponsive and feverish at the nursing home and was brought to the hospital for evaluation . . . Here he was found to be markedly hypernatremic, dehydrated, and had evidence of left lower lobe pneumonia. . . . His overall prognosis is not very good but he has survived this episode and will [sic] keep him comfortable, fed, and watered and he may survive for some time. . . ." *02/08/13: ". . . Patient . . . came in with Hypovolemic [low blood volume] hypernatremia and pneumonia. . . . switched to oral intake only and with concerted [sic] effort it was demonstrated he could maintain satisfactory serum sodium with oral intake of 1500 ml/day [milliliters per day]. He did not become edematous at this time. . . . not always simple/easy to get him to take them [medications] or take adequate oral sustenance. Serum sodium 167 at admit- 146 at discharge. . . . His chem 8 [lab test that measures electrolyte levels] will be followed weekly for the next 3 weeks. . . ." Resident #3's serum sodium levels were as follows: -01/08/13: 146 mEq/L -02/11/13: 144 mEq/L -02/18/13: 146 mEq/L -02/25/13: 151 mEq/L* -03/01/13: 146 mEq/L -03/08/13: 148 mEq/L -03/19/13: 146 mEq/L -03/26/13: 149 mEq/L, the physician wrote a	F 327	implemented on Friday, June 14th. The Current Resident Hydration and Prevention of Dehydration Policy is being reviewed and/or revised (Exhibit # F327-2). A CNA meeting was held on May 16, 2013 (Exhibit # F241-1) and education was provided that residents need sufficient fluids to maintain/promote hydration. Dietary staff are implementing a new labeling system for each beverage poured by dietary staff. The label indicates the resident's name, room number, type of beverage, date, meal time, and number of fluid ounces. It is then placed on the cover of the beverage. A dietary staff meeting will be held on Monday, June 17th and this will be implemented on Tuesday, June 18th. A dietary staff meeting was held on 5/29/2013 (See Exhibit F371-6) and education was provided regarding extra water being served and offered... Hydration education will be provided at the CNA/NURSE meeting on June 13, 2013. 4. All Staff will be encouraging and adequately supplying appropriate	

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F 327	Continued From page 13 response to this lab value: "Increase free water intake please." -04/02/13: 149 mEq/L -04/09/13: 152 mEq/L* -04/16/13: 152 mEq/L* -04/23/13: 152 mEq/L* * identifies critically high serum sodium levels as per clinic lab reports A physician's progress note stated the following: *04/09/13: ". . . It is a struggle to keep him hydrated enough to keep him from having pathologic elevations of his sodium. I have had to hospitalize him twice for IV [intravenous] fluids because of just the inability to get an oral intake adequate. . . . His sodium today is 152, that means that we need to work a little harder on getting some more water into him. I told him that I want him to drink a little more water and he says, 'I don't drink much water.' I asked if he would drink a little more and he said okay. . . . He is smiling today despite a 153 sodium; some patients aren't so intolerant of this that they become almost comatose at that level. . . . . We will continue to do as we are with a reminder to the staff to work extra hard on trying to get more water into him. . . ." A communication form (sent by facility staff to the physician), dated 04/12/13, stated, "Na [sodium] 152 - same as on Tuesday." The physician responded, "MORE WATER please. Repeat Chem 8 Tues." Additional physician's orders included: *04/09/13: "Encourage more water/juice intake" *02/27/13: "1500 cc/day [cubic centimeters per day] water - minimum" *02/21/13: ". . . supplement as needed to get	F 327	hydration for the resident effective immediately. 5. A Meal Time Fluid/Supplement/Adaptive Equipment QA Audit will be completed by Nurse Managers, Dietary Manager, Dietician, Director of Nursing, and/or Charge Nurses to assure the resident's menu card matches what fluids they are being served and that all fluids were offered at meal time (See Exhibit # 327-3). A Hydration QA will be completed to assure fluids are being offered and accepted with cares (See Exhibit # 327-4). The quality assurance studies will be completed on or before June 13, 2013; weekly for one month, bimonthly for two months, monthly for 6 months, then quarterly. Results will be reported at each Quality Assurance Meeting. The next Quality Assurance Meeting will take place August 8th, 2013.	

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F 327	Continued From page 14 1800 cc/day [cubic centimeters per day]." Dietary assessments showed the following: *02/20/13: ". . . Na [sodium] 146 [elevated] - encourage fluids . . . Avg [average] 930 cc/d . . ." *02/27/13: ". . . Phys. [physician] ordered 1500 cc/d [water] d/t [due to] [increased] Na Level - 151 on 2/25/13. . . . Avg 1050 cc/day . . . Plan: . . . Encourage [water] acceptance. . . ." *04/03/13: ". . . 2100 cc fluids/day offered @ meals . . . Avg 855 cc/d . . . 1500 cc/d Water - needs - encouraged . . . Plan: Encourage [water]/fluid acceptance as able . . ." *05/08/13: ". . . Encourage intake- 1500 cc/d Water minimum. . . . 2280 cc/d offered @ meals. . . . Avg [average] 880 cc/d . . . Plan: continue [with] current supplements. Continue to offer/enc. [encourage]/assist [with] fluid intake throughout the day. . . ." Observations and record review of Resident #3 throughout the survey showed the following: *05/06/13 at 2:49 p.m.: A certified nursing assistant (CNA) (#22) assisted Resident #3 out of bed. Observation showed his brief was dry. The CNA asked, "You want some water?" The resident shook his head "no," and the CNA brought him to the activity area. Observations until approximately 5:30 p.m. showed staff failed to offer/encourage additional fluids. *05/07/13: a note stated, "[Resident #3] did [not] void all [night] long." *05/07/13 at 7:53 a.m.: 4 ounces (oz) cranberry juice, 4 oz water, and 4 oz Mighty Shake served on Resident #3's breakfast tray. Staff failed to offer 8 oz of juice supplement (in addition to the cranberry juice), 8 oz of water, and 8 oz of Mighty Shake as identified on the resident's tray card (a	F 327		

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F 327	Continued From page 15 guide used by dietary staff which tells the amount of food and fluids served at each meal). CNA charting for this meal identified intakes of 6 oz juice supplement and 8 oz Mighty Shake supplement, although observation showed Resident #3 received 4 oz of cranberry juice, no additional juice supplement, and 4 oz of Mighty Shake. *05/07/13 at 8:25 a.m.: Resident #3 finished breakfast and sat in the dining room/activity area until 10:03 a.m. when a CNA (#17) assisted him to lie down. The CNA failed to offer fluids during this time. At 11:23 a.m., a CNA (#18) assisted Resident #3 to get up for lunch and failed to offer fluids with cares. *05/07/13 at 11:59 a.m.: 4 oz juice supplement and 4 oz water served on Resident #3's lunch tray. Staff failed to offer 8 oz of juice and 8 oz of water as identified on the tray card. CNA charting for this meal identified intakes of 6 oz juice supplement, although observation showed Resident #3 received 4 oz of juice. *05/07/13 at 1:30 p.m.: Resident #3 asleep in bed until 4:38 p.m. when two CNAs (#19 and #20) assisted him to the dining room. The CNAs failed to offer fluids during this time. *05/07/13 at approximately 5:20 p.m.: 4 oz water, 8 oz Mighty Shake, and 8 oz juice served on Resident #3's supper tray. Staff failed to offer 8 oz of water as identified on the resident's tray card. *The CNA flowsheet for 05/07/13 confirmed Resident #3 did not consume any fluids between meals. *05/08/13 at 7:40 a.m.: 4 oz water, 4 oz orange juice, and 8 oz Mighty Shake served on Resident #3's breakfast tray. Staff failed to offer 8 oz of juice supplement (in addition to the orange juice)	F 327		

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F 327	Continued From page 16	F 327		

and 8 oz of water as identified on the resident's tray card.
*05/08/13 at 12:26 p.m.: 4 oz water, 4 oz juice, and 8 oz Mighty Shake served on Resident #3's lunch tray. Staff failed to offer 8 oz of juice and 8 oz of water as identified on the resident's tray card. Observation also showed the lid covering the Mighty Shake remained untouched.
*05/08/13 at approximately 1:00 p.m.: A CNA (#17) assisted Resident #3 to lie down after lunch. The resident remained in bed until 3:56 p.m. when two CNAs (#10 and #19) assisted him to the activity area. At 5:30 p.m., staff assisted Resident #3 to the dining room for supper. Staff failed to offer fluids during this time.

Although the dietician expected staff to serve 2280 ml of fluid per day, observation showed staff did not serve Resident #3 the correct fluid amounts as listed on the tray card; therefore, it is difficult to determine how much fluid Resident #3 actually consumed and does not accurately reflect the resident's hydration status.

During an interview on 05/09/13 at 10:26 a.m., a supervisory nurse (#21) stated it is important for staff to offer fluids between meals and with cares, especially given Resident #3's critically high sodium levels.

Failure to ensure Resident #3 (who is dependent upon staff to meet his fluid needs) received adequate fluids with meals as recommended by the dietician and failure to offer/encourage fluids frequently as recommended by the physician resulted in insufficient fluid intake, prolonged and continued hypernatremia, and hospitalization for dehydration on two occasions.

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F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to properly store potentially hazardous food in a safe and sanitary manner and failed to ensure proper sanitation of a food prep area and meat slicer in 1 of 1 main kitchen. Failure to follow safe food sanitation practices has the potential to increase the risk of food borne illness and can affect residents who eat food prepared in the kitchen. Findings include: Observations in the main kitchen identified the following concerns: - 05/06/13 at 9:35 a.m. and on 05/08/13 at 10:05 a.m., a meat slicer stored under a plastic covering showed small dried on food particles on the equipment. During the observation on 05/08/13 when removing the plastic covering, small dried food particles fell onto the meat slicer and onto the floor and a dietary manager (#8) stated to leave the meat slicer uncovered so the staff could clean it. Later the dietary manager	F 371	**Plan of Correction F371** Paragraph 1 under Findings on page 25 In the spirit of cooperation and consistent with Knife River Care Center's historical and current commitment to quality care for the residents, the facility states: 1. 05/06/13 and 05/08/13: There were no Residents identified as being impacted 2. All residents could have been impacted by the use of the meat slicer as a result of it not being cleaned and sanitized. However, review of the menu for this time period indicates that the meat slicer was not used (Exhibit # F371-1), therefore, no residents were negatively impacted. 3. The policy for cleaning the meat slicer has been revised to include instructions to clean and sanitize the meat slicer after each use, to wipe off with sanitizer before use, and to clean and sanitize the meat slicer before use if it appears to have been left unclean. (see exhibit # F371-2) Dietary Staff received verbal instruction to clean the meat slicer both on 05/06/13 and 05/08/13 following state survey findings and	06/13/13

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F 371	Continued From page 18 provided a note stating "the meat slicer is to be cleaned after each use." - 05/08/13 at 10:05 a.m. a dietary staff member (#9) stood at a food preparation sink/counter washing lettuce. Two to three feet above the counter a shelf extended approximately one foot out of the wall and the shelf ran the length of the counter and sink food preparation area. Dried food particles were observed on the underside of the shelf. When asked if staff cleaned the underside of the shelf, a dietary manager (#8) stated the area "desperately needed to be [cleaned]," and the dietary employee working in the area (#9) stated she had not cleaned the area prior to starting food preparation. Both staff were not aware the last time staff had cleaned the area. - 05/08/13 at 10:20 a.m., the walk-in cooler contained the following raw meats ready for use and stored past the seven day maximum holding guidelines: * A resealed, partially used ten pound package of hamburger, dated 04/30/13 (nine days in cooler). This hamburger contained a second date of 05/07/13 when staff opened and used the hamburger (used on day eight) * One sealed, ten pound hamburger, dated 04/30/13, currently on day nine * six sealed, ten pound packages of hamburger, dated 05/01/13, currently on day eight * two sealed boxes of raw bacon, dated 04/30/13, currently on day nine The meat products failed to identify a thaw date or a manufacturer's use by date on the packaging.	F 371	an in-service regarding the cleaning of the meat slicer was given on May 29, 2013 (see exhibit # F371-3). 4. The Quality Assurance Director or designee will be responsible to monitor for compliance of Cleaning, Sanitizing of the Meat Slicer. Sanitation Audit/QA Tool has been developed to monitor the cleaning of the meat slicer, food contact surfaces and Food Safety /Storage (see exhibit # F371-4) and will be implemented and will be completed for the months of July, August and September, then quarterly thereafter, or as necessary. The deficiency cited in F-tag 371 was corrected as noted above and ongoing correction will be made as noted in #'s 1, 3, and 4 above. 5. Results of the findings will be discussed with the Dietary Manager or designee and reported at the next scheduled Quarterly Quality Assurance Meeting on August 8, 2013. Dietary Plan of Correction for F-tag 371 2013 (cont.) on Paragraph 2 under Finding on page 25	

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F 371	Continued From page 18 provided a note stating "the meat slicer is to be cleaned after each use." - 05/08/13 at 10:05 a.m. a dietary staff member (#9) stood at a food preparation sink/counter washing lettuce. Two to three feet above the counter a shelf extended approximately one foot out of the wall and the shelf ran the length of the counter and sink food preparation area. Dried food particles were observed on the underside of the shelf. When asked if staff cleaned the underside of the shelf, a dietary manager (#8) stated the area "desperately needed to be [cleaned]," and the dietary employee working in the area (#9) stated she had not cleaned the area prior to starting food preparation. Both staff were not aware the last time staff had cleaned the area. - 05/08/13 at 10:20 a.m., the walk-in cooler contained the following raw meats ready for use and stored past the seven day maximum holding guidelines: * A resealed, partially used ten pound package of hamburger, dated 04/30/13 (nine days in cooler). This hamburger contained a second date of 05/07/13 when staff opened and used the hamburger (used on day eight) * One sealed, ten pound hamburger, dated 04/30/13, currently on day nine * six sealed, ten pound packages of hamburger, dated 05/01/13, currently on day eight * two sealed boxes of raw bacon, dated 04/30/13, currently on day nine The meat products failed to identify a thaw date or a manufacturer's use by date on the packaging.	F 371	1. 05/08/13: There were no Residents identified as being impacted. 2. All residents could have been impacted by a result of the underneath part of the shelf not being cleaned and sanitized. However, Dietary Manager immediately instructed staff to clean the shelf once the surveyor pointed it out. 3. The policy for cleaning and sanitizing the Counter Spaces and Shelving has been revised to include underneath areas, legs, sides and tops and has been implemented. (see exhibit # F371-5). Dietary Staff received verbal instruction 05/08/13 following state survey findings and an in-service regarding the cleaning of Counter Spaces and Shelving was given on May 29, 2013. (see exhibit # F371-3) 4. The Quality Assurance Director or designee will be responsible to monitor for compliance of Cleaning and Sanitizing of Counters/Shelving. Sanitation Audit/QA Tool has been developed to monitor the cleaning of the meat slicer, food	

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provided a note stating "the meat slicer is to be cleaned after each use."

- 05/08/13 at 10:05 a.m. a dietary staff member (#9) stood at a food preparation sink/counter washing lettuce. Two to three feet above the counter a shelf extended approximately one foot out of the wall and the shelf ran the length of the counter and sink food preparation area. Dried food particles were observed on the underside of the shelf. When asked if staff cleaned the underside of the shelf, a dietary manager (#8) stated the area "desperately needed to be [cleaned]," and the dietary employee working in the area (#9) stated she had not cleaned the area prior to starting food preparation. Both staff were not aware the last time staff had cleaned the area.

- 05/08/13 at 10:20 a.m., the walk-in cooler contained the following raw meats ready for use and stored past the seven day maximum holding guidelines:
* A resealed, partially used ten pound package of hamburger, dated 04/30/13 (nine days in cooler). This hamburger contained a second date of 05/07/13 when staff opened and used the hamburger (used on day eight)
* One sealed, ten pound hamburger, dated 04/30/13, currently on day nine
* six sealed, ten pound packages of hamburger, dated 05/01/13, currently on day eight
* two sealed boxes of raw bacon, dated 04/30/13, currently on day nine

The meat products failed to identify a thaw date or a manufacturer's use by date on the packaging.

F 371 contact surfaces and Food Safety /Storage (see exhibit # F371-4) and will be implemented and will be completed for the months of July, August and September, then quarterly thereafter, or as necessary.

The deficiency cited in F-tag 371 was corrected as noted above and ongoing correction will be made as noted in #'s 1, 3, and 4 above.

5. Results of the findings will be discussed with the Dietary Manager or designee and reported at the next scheduled Quarterly Quality Assurance Meeting on August 8, 2013.

Dietary Plan of Correction for F-tag 371 2013 (cont.) Paragraph 4 on page 25 and Paragraphs 1, 2 and 3 on page 26 under Findings

1. 05/08/13: There were no Residents identified as being impacted.

2. All residents could have been impacted by using meat products that were out dated. The Dietary Manager immediately instructed staff to not to use the meats dated 04/30/13 and 05/01/13 and the

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F 371	Continued From page 18	F 371		

provided a note stating "the meat slicer is to be cleaned after each use."

- 05/08/13 at 10:05 a.m. a dietary staff member (#9) stood at a food preparation sink/counter washing lettuce. Two to three feet above the counter a shelf extended approximately one foot out of the wall and the shelf ran the length of the counter and sink food preparation area. Dried food particles were observed on the underside of the shelf. When asked if staff cleaned the underside of the shelf, a dietary manager (#8) stated the area "desperately needed to be [cleaned]," and the dietary employee working in the area (#9) stated she had not cleaned the area prior to starting food preparation. Both staff were not aware the last time staff had cleaned the area.

- 05/08/13 at 10:20 a.m., the walk-in cooler contained the following raw meats ready for use and stored past the seven day maximum holding guidelines:
* A resealed, partially used ten pound package of hamburger, dated 04/30/13 (nine days in cooler). This hamburger contained a second date of 05/07/13 when staff opened and used the hamburger (used on day eight)
* One sealed, ten pound hamburger, dated 04/30/13, currently on day nine
* six sealed, ten pound packages of hamburger, dated 05/01/13, currently on day eight
* two sealed boxes of raw bacon, dated 04/30/13, currently on day nine

The meat products failed to identify a thaw date or a manufacturer's use by date on the packaging.

meats were placed all on one cart with a note for disposal. Although, the Dietary Manager stated that they would cook some of the meat dated 05/01/13 on 05/08/13, this did not happen and the meat dated 04/30/13 and 05/01/13 was discarded on 05/08/13.

3. The policy for keeping meats for 7 days in the refrigerator came from the North Dakota Department of Health Food Code (see exhibit # F371-6). The Dietary Manager does not excuse the fact that the meat dated 04/30/13 should have been disposed of by the time of the survey, the Dietary Manager was not counting 05/01/13 as day number one for the 7 days., therefore thinking that the meat dated could be cooked or frozen up through the end of the day on 05/08/13.

Surveyor recommended at the time of survey that we use the USDA/FDA guidelines. KRRC will follow Surveyor recommendation to use USDA/FDA guidelines and has posted a chart in the main kitchen on 05/10/13(see exhibit # F371-7).

Dietary Policy and Procedure Manual page 3-17 and 3-18 "Food

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The meat products failed to identify a thaw date or a manufacturer's use by date on the packaging.

Storage" has been revised and implemented to include the use of USDA/FDA Guidelines refrigerator/freezer food storage. (See Exhibit # F371-8)

Dietary Staff received verbal instruction on time storage of meat on 05/08/13 following state survey findings and an in-service regarding the same on was given on May 29, 2013. (see exhibit # F371-3)

4. The Quality Assurance Director or designee will be responsible to monitor for compliance of Food Safety//Storage. An Audit/QA Tool has been developed to monitor the cleaning of the meat slicer, food contact surfaces and Food Safety /Storage (see exhibit # F371-4) and will be implemented and will be completed for the months of July, August and September, then quarterly thereafter, or as necessary.

The deficiency cited in F-tag 371 was corrected as noted above and ongoing correction will be made as noted in #'s 1, 3, and 4 above.

5. Results of the findings will be discussed with the Dietary Manager or designee and reported at the next scheduled Quarterly Quality

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F 371	Continued From page 19 During an interview in the morning of 05/08/13, a dietary manager (#8) stated the facility lacked a specific facility policy on meat storage and the facility expectations would be to store the meat for a maximum of seven days as per the North Dakota food code guidelines.	F 371	Assurance Meeting on August 8, 2013.	
F 373 SS=D	483.35(h) FEEDING ASST - TRAINING/SUPERVISION/RESIDENT A facility may use a paid feeding assistant, as defined in §488.301 of this chapter, if the feeding assistant has successfully completed a State-approved training course that meets the requirements of §483.160 before feeding residents; and the use of feeding assistants is consistent with State law. A feeding assistant must work under the supervision of a registered nurse (RN) or licensed practical nurse (LPN). In an emergency, a feeding assistant must call a supervisory nurse for help on the resident call system. A facility must ensure that a feeding assistant feeds only residents who have no complicated feeding problems. Complicated feeding problems include, but are not limited to, difficulty swallowing, recurrent lung aspirations, and tube or parenteral/IV feedings. The facility must base resident selection on the charge nurse's assessment and the resident's latest assessment and plan of care.	F 373	**Plan of Correction F373** 1. No residents were affected – NA 2. Residents meeting the criteria to be assisted by a paid feeding assistant have the potential to be affected. 3. Staff hired into a PFA position will have completed the required PFA training class and certification. Staff re-hired into the PFA position will complete an orientation and a competency evaluation within 30 days of hire date. A new competency form has been established, see attachment # F373-1 Policy on orientation process 4. Nurse Managers, PFA Instructor and Human Resources Director	06/13/13

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F 373	Continued From page 20 NOTE: One of the specific features of the regulatory requirement for this tag is that paid feeding assistants must complete a training program with the following minimum content as specified at §483.160: o A State-approved training course for paid feeding assistants must include, at a minimum, 8 hours of training in the following: Feeding techniques. Assistance with feeding and hydration. Communication and interpersonal skills. Appropriate responses to resident behavior. Safety and emergency procedures, including the Heimlich maneuver. Infection control. Resident rights. Recognizing changes in residents that are inconsistent with their normal behavior and the importance of reporting those changes to the supervisory nurse. A facility must maintain a record of all individuals used by the facility as feeding assistants, who have successfully completed the training course for paid feeding assistants. This REQUIREMENT is not met as evidenced by: Based on employee record review, and staff interview, the facility failed to provide evidence of annual competency for 1 of 2 Paid Feeding Assistants (PFAs) (#2). Failure to ensure a PFA remains competent with feeding techniques has the potential to place residents at risk for choking and aspiration while being assisted by a PFA.	F 373	have been informed of the PFA orientation competency form. The use of the form is effective immediately; June 5, 2013. 5. A quality assurance study will be completed by Nurse Managers, HR Director, and Scheduler to assure the PFA orientation/competency form is being completed (See Exhibit # F373-2). The quality assurance study will be completed on or before June 13, 2013; monthly for three months, then quarterly. Results will be reported at each Quality Assurance Meeting. The next Quality Assurance Meeting will take place August 2013.	

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F 373	Continued From page 21 Findings include: On 05/07/13 at 10:40 a.m., review of a PFA's (#2) employee file identified the PFA worked for the facility until June of 2011, and then left the facility. The facility rehired the PFA (#2) in July 2012 and upon rehire, the facility failed to complete an annual competency or have the PFA retake the training course for the PFA position. During an interview on 05/08/13 at 5:25 p.m., an administrative nursing staff member (#1) stated the PFA worked from July of 2012 until last week (April 2013), and stated the facility was not able to locate evidence of PFA competency in her employee file since the completion of the initial PFA class in August 2010.	F 373		
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 (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program	F 441	**Plan of Correction F441** 1. Not applicable. 2. All residents within the facility may have the potential to be affected; especially those residents who are transferred with a mechanical lift, who are assisted with toileting or check/change of brief. 3. Nursing staff will adhere to the Equipment Cleaning Policy (See Exhibit # F441-1). On Friday, June 7th, the Equipment Cleaning policy was put into communication binders on each neighborhood and ward clerk office for staff review. Nurses were also instructed to pass this	06/13/13

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F 441	Continued From page 22 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 05/17/12. Based on observation and review of policy and procedure, the facility failed to follow proper infection control procedures for 2 of 2 sampled residents (Resident #1 and #9) observed during personal cares. Failure to follow infection control procedures related to hand hygiene and sanitizing of a stand lift increases the potential for the spread of infections to other residents. Findings include: Review of a memo titled "Disinfecting Wipes" regarding cleaning of lifts occurred on 05/09/13. This memo, dated 04/05/13, stated, " . . . There	F 441	information on during daily nursing report. Oxivir wipes were placed into cloth bags and tied onto each mechanical lift, vital sign cart and R.T. walker. The Oxivir wipes were also placed in neighborhood medication rooms and in the therapy department for easy access for staff. Staff will adhere to the Resident Handwashing Procedure & Resident Use of Alcohol-Based Hand Rub procedure (See Exhibits # F441-2 & # F441-3. 4. During the May 16, 2013 at the C.N.A meeting (See Exhibit # F241-2), staff was educated regarding handwashing and the need to clean the mechanical lifts between residents. Direct care staff will be educated on the above mentioned policies and procedures at the June 13, 2013 C.N.A and Nurses Meeting. 5. Quality assurance tools have been devised to randomly monitor staff as they are providing cares and assisting residents. A quality assurance tool has also been devised to monitor staff adherence to the Equipment Cleaning and Resident Handwashing (See Exhibits # F441-4 & # F441-5. Nursing, dietary, social service, housekeeping,	

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F 441	Continued From page 23 will be individual packages of disinfecting wipes available on all of the units in the ward clerk offices. Please keep a few in your scrub pockets so you can disinfect the lift (especially the handles) in between residents. This is an infection control issues and we are trying to prevent cross contamination. . . ." Observation on 05/06/13 at 4:13 p.m. showed two certified nurse aides (CNAs) (#6 and #7) assisted Resident #9 out of bed using a stand lift. Prior to the transfer, a CNA (#6) pulled back the blanket covering the resident and revealed the resident in bed with her left hand inside her brief. The CNAs assisted to the resident to use a stand lift without providing hand hygiene. The resident held onto the handles during the transfer from bed, into the bathroom, and again from the bathroom to her wheelchair. The CNA (#6) stored the lift, failing to sanitize the handles after use and staff failed to offer Resident #9 hand hygiene prior to being transported out of her room. - Observation on 05/07/13 at 11:02 a.m. showed a CNA (#18) assisted Resident #1 with incontinence cares as the resident lay in bed. The resident was incontinent of stool and urine. As the CNA removed the resident's soiled brief, Resident #1 scratched her buttocks and front perineal area. The CNA finished cares and brought the resident to the dining room for lunch. At 11:40 a.m., staff served Resident #1 her lunch tray, and the resident began feeding herself. The CNA failed to assist Resident #1 with handwashing after contact with her soiled perineal area.	F 441	maintenance and administrative staff will complete the quality assurance tools. The quality assurance tools will be completed on or before June 1^{3th}, 2013; weekly for one month, bi-monthly for two months, monthly for three month, then quarterly. Results of the QA will be reviewed at the quarterly Quality Assurance meeting scheduled for August 2013.	
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS	F 520	**Plan of Correction F520** As of 06/12/13 The Knife River Care Center has retained the services of a local physician to assume the role of	06/12/13

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F 520	Continued From page 24 A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on review of the facility's Quality Assessment and Assurance (QA) program and staff interview, the facility failed to ensure a physician actively participated as a member of the QA committee for 3 of 4 quarters (last two quarters in 2012 and first quarter in 2013). Failure to have a physician participate in the facility's quality assurance activities deprives the committee of the physician's unique contributions for analysis of quality concerns and assisting with	F 520	Medical Director. (See Exhibit F520-1) Dr. Garman from Coal Country Community Health Center has agreed to accept this position. All residents within the facility have the potential to be affected. Quarterly Quality Assurance meetings were held per regulation. If there were any concerns brought forward from the meeting they were brought to the attention of the residents' personal physician or the previous Medical Director during his rounds or by email. Good faith attempts by the committee had been made to identify and correct quality deficiencies from the previous year. Numerous QA studies were conducted throughout the year to improve the care for our residents. This deficiency will be corrected by the hiring of our new medical director The Administrator, DON and QA Coordinator will monitor the attendance of our medical director by assuring that meetings will be held timely and arranged considering the schedule of physician acting as our Medical Director. In contracting with our new Medical Director emphasize was placed on the	

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F 520	Continued From page 25 decision making based on identified concerns. Findings include: During an interview on 05/08/13 at 10:30 a.m., a managerial nurse (#4) identified the facility has a QA committee which meets quarterly. The staff member reported the committee consists of multiple disciplines including the medical director/physician. Review of the rosters from meetings held from May 2012 to February 2013, indicated the medical director last attended a QA meeting on 05/11/12. At 12:40 p.m., the nurse (#4) identified the designated physician receives email updates from the QA meetings but has not participated in the last three meetings. During an interview on 05/09/13 at 12:45 p.m. an administrative staff member (#5) stated the facility does discuss QA meetings issues with the medical director when he is available during his resident visits, but the facility fails to keep a record of the discussions or what input the physician gave in regards to QA.	F 520	importance of attendance at our QA meetings held Quarterly.	