STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355114	A. BUILDING _____ B. WING _____	04/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH DAKOTA VETERANS HOME	1600 VETERANS DRIVE LISBON, ND 58054

(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 04/04/22 and concluded 04/07/22.	F 000		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and review of the Long-Term Care Facility Assessment Instrument (RAI) 3.0 User's Manual, the facility failed to complete a significant change in status assessment (SCSA) for 1 of 12 sampled residents (Resident #21). Failure to identify the need for and complete a SCSA may limit the facility's ability to accurately assess the resident's status and develop an appropriate care plan. Findings include: The Long-Term Care Facility RAI 3.0 User's Manual (Version 1.15), dated October 2019, page 2-22 stated, ". . . A 'significant change' is a major decline or improvement in a resident's	F 637		5/15/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 04/25/2022

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F 637	Continued From page 1	F 637		

status that: 1. Will not normally resolve itself without staff intervention . . . 2. Impacts more than one area of the resident's health status; and 3. Requires interdisciplinary review and/or revision of the care plan. . . ." and page 2-25 stated, "A SCSA is appropriate if there are either two or more areas of decline or two or more areas of improvement. . . . This may include two changes within a particular domain (e.g., [for example] two areas of ADL [Activities of Daily Living] decline or improvement mobility, transfers, walking in corridor and toileting."

Review of Resident #21's medical record occurred on all days of survey. The admission Minimum Data Set (MDS), dated 11/09/21, identified independent with bed mobility, locomotion on and off the unit, and toilet use, independent with set up assist for transfers, supervision with limited assist for walking in room, dressing, and personal hygiene, independent walking in the corridor occurred 1-2 times, and weighed 236 pounds.

The quarterly MDS, dated 02/22/22, identified Resident #21 required extensive assist of two persons for bed mobility, transfers, and toileting, extensive assist of one person for dressing and personal hygiene, dependent on one person for locomotion on/off the unit, the resident did not walk in room or corridor, and weighed 222 pounds (a significant weight loss).

The record lacked evidence the staff identified and/or completed a SCSA following Resident #21's decline in health status.

During an interview on 04/06/22 at 10:55 a.m., an

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F 637	Continued From page 2 administrative staff (#3) was not able to show why the facility failed to complete a SCSA and agreed they should have.	F 637		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review, review of the North Dakota Provider Manual Preadmission Screening and Resident Review (PASARR) and Level of Care Screening Procedures for Long Term Care Services, and staff interview, the facility failed to complete a status change assessment for 1 of 1 sampled residents (Resident #39) reviewed for PASARR. Failure to complete a change in status assessment with a newly diagnosed mental illness may result in the delivery of care and services that are inconsistent with the resident's	F 644		4/30/22

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F 644	Continued From page 3 needs. Findings include: The North Dakota PASARR Provider Manual states, ". . . Change in Status Process . . . Whenever the following events occur, nursing facility staff must contact Ascend to update the Level I screen for determination of whether a first time or updated Level II evaluation must be performed. These situations suggest that a significant change in status has occurred: . . . If an individual with MI, ID, and/or RC (mental illness, intellectual disability, and conditions related to intellectual disability [referred to in regulatory language as related conditions or RC]) was not identified at the Level I screen process, and that condition later emerged or was discovered. . . ." Review of Resident #39's medical record occurred on all days of survey. A Level 1 PASARR, dated 08/08/19, identified a diagnosis of major depressive disorder. A psychology clinician's note, dated 02/30/20, included a new diagnosis of post traumatic stress disorder (PTSD). The record lacked evidence of an updated PASARR which included the diagnosis of PTSD. During an interview on 04/07/22 at 10:02 a.m., a social services staff member (#1) confirmed the facility should have submitted a new Level 1 when Resident #39 was diagnosed with PTSD and stated, "We really don't have a process in place to notify myself when a resident receives a new diagnosis."	F 644		
F 880	Infection Prevention & Control	F 880		4/30/22

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F 880 SS=D	Continued From page 4 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; (iii) Standard and transmission-based precautions to be followed to prevent spread of	F 880		

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F 880	Continued From page 5 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, review of facility policy and staff interview, the facility failed to follow infection control practices for 2 of 7 sampled residents (Resident #24 and #39) observed during toileting cares. Failure to follow infection control practices related to hand hygiene has the potential to transmit infections to other residents,	F 880	1. Corrective Action The facility will immediately implement an appropriate infection prevention and intervention plan consistent with the requirements of §483.80 for the affected resident(s)/neighborhood(s) identified in the deficiency.	

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F 880	Continued From page 6 staff, and visitors. Findings include: Review of the facility policy titled "HAND WASHING & HAND HYGIENE" occurred on 04/07/22. This policy, revised August 2006, stated, ". . . Handwashing is the single most important means of preventing the spread of infections . . . The following is a list of some situations that require hand hygiene: . . . Before and after assisting a resident with toileting . . ." Observation on 04/05/22 at 8:43 a.m. showed a certified nursing assistant (CNA) (#5) assisted Resident #39 to the bathroom, donned gloves, and performed perineal cares. Using the same gloves, the CNA applied a protective ointment to the resident's perineal area and removed the gloves. Without performing hand hygiene, the CNA removed the resident's hearing aid from the drawer, assisted the resident with putting in the hearing aid, opened the curtains, and made the bed. The CNA exited the room with the garbage bag in her hand, threw it away in the soiled utility room and washed her hands at the sink in the hallway. The CNA (#5) failed to perform hand hygiene after removing her gloves and before completing other tasks. Observation on 04/05/22 at 9:54 a.m. showed a CNA (#4) assisted Resident #24 to the bathroom, donned gloves, performed perineal cares after the resident had a bowel movement, and removed the gloves. Without performing hand hygiene, the CNA applied toothpaste to the resident's toothbrush, handed the toothbrush to the resident for her to brush her teeth, and	F 880	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) Ensure staff perform hand hygiene when removing gloves, after perineal cares, after toileting, and before exiting a resident's room in accordance with CDC guidelines. 2. Identification of Others The IP and DON, in conjunction with the applicable the interdisciplinary team (IDT) members, will review current 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 04/30/2022 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 complete hand hygiene in accordance with CDC guidelines. (2) The DON, IP or suitable designee will ensure the following: a. All staff will receive education on	

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F 880	Continued From page 7 combed the resident's hair. The CNA then donned new gloves, emptied the garbage, doffed her gloves, and used hand sanitizer. The CNA (#4) failed to perform hand hygiene after removing her gloves and before completing other tasks. During an interview on 04/07/22 at 9:45 a.m., an administrative nurse (#2) confirmed she expected staff to follow the facility policy regarding performing hand hygiene.	F 880	proper hand hygiene after perineal care, after toileting, and after removing gloves and before exiting a resident's room. 4. Monitoring Weekly for no less than 12 weeks, the DON, IP, or a designee will conduct on-going monitoring to ensure, via observation, the approaches to correct deficient practice related to infection control and prevention are consistently implemented and effective. Such monitoring will include: (1) Observations of certified nursing staff to ensure performance of proper hand hygiene, when indicated, in the course of their routine duties. Observations will be made across all shifts and neighborhoods/units. Observations of noncompliance with the above will result in ad hoc education for the involved staff. Such education will be documented on monitoring forms. After twelve weeks of monitoring, provided that such monitoring demonstrates expectations are 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	

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F 880	Continued From page 8	F 880	committee and medical director. 5. Correction Date 04/30/2022	