| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| NORTH DAKOTA VETERANS HOME | 1600 VETERANS DRIVE LISBON, ND 58054 |

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| F 000 | INITIAL COMMENTS<br><br>The standard Medicare/Medicaid recertification survey started on 07/24/23 and concluded 07/27/23. The extended survey started and concluded on 08/02/23. | F 000 | | |
| F 554 SS=D | Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7)<br><br>§483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, review of facility policy, and staff interview, the facility failed to ensure the interdisciplinary team assessed the appropriateness to self-administer medications (SAM) for 1 of 2 sampled residents (Resident #51) with medications observed in the resident's room. Failure to determine whether SAM is a safe practice has the potential to limit a resident's right to SAM or result in a medication error and/or harm to a resident.<br><br>Findings include:<br><br>Review of the facility policy titled "Self-Administration of Medications" occurred on 07/27/23. This policy, reviewed/revised 03/04/16, stated, ". . . To initiate and continue self-administration, the resident must meet all of the criteria for safe administration. . . . Brief Interview for Mental Status [BIMS] Score >=13 [greater than/equal to]. . . . If the resident wishes to self-administer medication, the following steps will be taken for the initiation and monitoring of self-administration. . . . Brief Interview for Mental | F 554 | | 10/16/23 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 09/06/2023

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| F 554 | Continued From page 1<br>Status will be conducted with the resident. . . . Specific orders from the attending physician will be obtained to include: a) name of the medication/treatment b) dosages, route, frequency c) that the medication/treatment is to be self-administered. . . . Any medication a resident should purchase on their own, needs to be reviewed by a nurse prior to use. . . ."<br><br>Observation on the afternoon of 07/26/23 showed bottles of Super Silver dietary supplement and Protocel (dietary supplement) in Resident #51's bathroom.<br><br>Review of Resident #51's medical record occurred on all days of survey. A Minimum Data Set (MDS), dated 06/21/23, identified moderate cognitive impairment. The resident's care plan stated, ". . . Resident chooses to take several supplements, per self. These are purchased per self. . . ." The record lacked physician orders for the dietary supplements and a SAM assessment indicating Resident #51 can safely self-administer medications.<br><br>During an interview on 07/26/23 at 5:18 p.m., an administrative nurse (#3) confirmed staff failed to complete the SAM assessment for Resident #51. | F 554 | | |
| F 641 SS=D | Accuracy of Assessments<br>CFR(s): 483.20(g)<br><br>§483.20(g) Accuracy of Assessments.<br>The assessment must accurately reflect the resident's status.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, review of the Long-Term Care Facility Resident | F 641 | | 10/16/23 |

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| F 641 | Continued From page 2<br>Assessment Instrument (RAI) 3.0 User's Manual (Version 1.17.1), and staff interview, the facility failed to ensure accurate coding of the Minimum Data Set (MDS) for 2 of 20 sampled residents (Resident #16 and #26). Failure to accurately complete the MDS does not allow each resident's assessment to reflect their current status/needs and may affect the accurate development of a comprehensive care plan and the care provided to the residents.<br><br>Findings include:<br><br>SECTION I: ACTIVE DIAGNOSES IN THE LAST 7 DAYS<br><br>The Long-Term Care Facility RAI User's Manual, revised October 2019, page I-8, stated, ". . . Item I2300 Urinary tract infection (UTI): The UTI has a look-back period of 30 days for active disease instead of 7 days. Code only if both of the following are met in the last 30 days: It was determined that the resident had a UTI using evidence-based criteria such as McGeer, NHSN, or Loeb in the last 30 days, AND A physician documented UTI diagnosis (or by a nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws) in the last 30 days. . . "<br><br>Review of Resident #16's medical record occurred on all days of survey. The annual Minimum Data Set (MDS), dated 05/21/23 identified under Section I: Active Diagnoses included a UTI within the last 30 days. Resident #16's medical record failed to identify a diagnosis of a UTI. | F 641 | | |

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| F 641 | Continued From page 3 | F 641 | | |

During an interview on 07/26/23 at 1:15 p.m., an administrative nurse (#1) confirmed that the facility incorrectly coded Resident #16's MDS for a diagnosis of a UTI.

SECTION P: PHYSICAL RESTRAINTS

The Long-Term Care Facility RAI User's Manual, revised October 2019, pages P-1 and P-5, stated, ". . . PHYSICAL RESTRAINTS: Any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body. . . Coding Instructions: . . . After determining whether or not an item . . . is a physical restraint and was used during the 7-day look-back period, code the frequency of use: Code 0, not used: if the item was not used during the 7-day look-back or it was used but did not meet the definition. . . Code 2, used daily: if the item met the definition and was used on a daily basis during the look-back period. . . "

- An observation on 07/25/23 at 8:38 a.m. showed Resident #26 without a restraint.

Review of Resident #26's medical record occurred on all days of survey. The quarterly MDS, dated 06/08/23 identified "other" as the type of restraint used by the resident. Resident #26's medical record failed to identify the use of a restraint.

During an interview on 07/25/23 at 10:06 a.m., an administrative staff (#2) confirmed the facility incorrectly coded Resident #26's MDS for a

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| F 641 | Continued From page 4<br>restraint. | F 641 | | |
| F 657 SS=E | Care Plan Timing and Revision<br>CFR(s): 483.21(b)(2)(i)-(iii)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(2) A comprehensive care plan must be-<br>(i) Developed within 7 days after completion of the comprehensive assessment.<br>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--<br>(A) The attending physician.<br>(B) A registered nurse with responsibility for the resident.<br>(C) A nurse aide with responsibility for the resident.<br>(D) A member of food and nutrition services staff.<br>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.<br>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.<br>(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, review of facility policy, and staff interviews, the facility failed to review and revise comprehensive care plans to reflect the current status for 4 of 20 sampled residents (Residents #12, #15, #41, and #50). Failure to | F 657 | | 10/16/23 |

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| F 657 | Continued From page 5<br>review and revise the care plan limited the staffs' ability to communicate needs and ensure continuity of care.<br><br>Findings include:<br><br>Review of the facility policy titled "CARE PLAN, Baseline and Comprehensive" occurred on 07/27/23. This policy, dated 04/30/18, stated, ". . . Care plan will be updated with resident condition or per their choice. . . ."<br><br>- Review of Resident #12's medical record occurred on all days of survey and identified a diagnosis of post traumatic stress disorder (PTSD). The current care plan failed to reflect the clinically appropriate and person-centered interventions used to eliminate or mitigate re-traumatization.<br><br>During an interview on 07/27/23 at 10:25 a.m., an administrative nurse (#1) confirmed the current care plan failed to address Resident #12's emotional/psychosocial needs related to his identified PTSD triggers.<br><br>- Review of Resident #15's medical record occurred on all days of survey and identified a diagnosis of PTSD. The current care plan failed to reflect Resident #15's identified triggers and the clinically appropriate and person-centered interventions used to eliminate or mitigate re-traumatization.<br><br>During an interview on 07/25/23 at 2:49 p.m., a social services staff member (#4) confirmed the current care plan failed to identify Resident #15's triggers and/or address his | F 657 | | |

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| F 657 | Continued From page 6<br>emotional/psychosocial needs related to his PTSD.<br><br>- Review of Resident #41's medical record occurred on all days of survey and identified a diagnosis of PTSD. The current care plan failed to reflect Resident #41's identified triggers and the clinically appropriate and person-centered interventions used to eliminate or mitigate re-traumatization.<br><br>During an interview on 07/27/23 at 10:45 a.m., a social services staff member (#4) confirmed the current care plan failed to identify Resident #41's triggers and/or address his emotional/psychosocial needs related to his PTSD.<br><br>- Review of Resident #50's medical record occurred on all days of survey. An emergency department note, dated 06/13/23, stated, ". . . after having near syncopal episode . . . Need for IV Hydration Symptom Documentation: Dehydration . . ." The current care plan lacked goals and interventions to monitor Resident #50's fluid intake after the emergency room (ER) visit on 06/13/23.<br><br>During an interview on 07/26/23 at 5:07 p.m., an administrative nurse (#3) agreed a hydration observation should have been added to Resident #50's care plan after the ER visit. | F 657 | | |
| F 689 SS=K | Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains | F 689 | | 10/16/23 |

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| F 689 | Continued From page 7<br>as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, and staff interview, the facility failed to ensure an environment free of accident hazards for 4 of 4 coffee/hot water machines located in various areas within the facility (Town Hall, and Freedom Ridge, Honor Hill, and Peace Garden households). Failure to ensure appropriate coffee/water temperatures resulted in serving temperatures above the acceptable range and resulted in one resident acquiring burns to the left thigh, forearm, and hand, and may result in serious burns to other residents.<br><br>During the standard survey, the team determined an Immediate Jeopardy (IJ) situation existed on 07/27/23 at 3:07 p.m. The IJ resulted from temperature readings obtained from coffee/hot water machines, a lack of temperature monitoring by staff, and an injury to a resident. This finding placed residents in immediate danger due to hot temperatures and the potential for serious burns.<br><br>* 07/27/23 at 4:03 p.m., The survey team notified the administrator and director of nursing of the IJ and requested they develop a plan for removal of the immediate jeopardy.<br><br>* 07/27/23 at 4:46 p.m., The survey team reviewed and accepted the facility's removal plan for the IJ. | F 689 | | |

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| F 689 | Continued From page 8<br>The removal plan contained the following:<br>* Shut off all automatic coffee machines.<br>* Remove from households.<br>* Cooks will brew coffee, temp it to make sure it is below 150F and place it into a carafe.<br>* New machines will be obtained that operate at a safe temperature.<br><br>* 07/27/23 at 6:25 p.m., The team notified the administrator of the IJ removal.<br><br>* On 07/27/23, the survey team verified the implementation of the facility's removal plan and removed the IJ. The deficient practice remained at an "E" scope and severity following the removal of the immediate jeopardy.<br><br>Findings include:<br><br>Review of Resident #3's medical record occurred on all days of survey. The Minimum Data Set (MDS), dated 05/23/23, identified moderate cognitive impairments. The current care plan stated, ". . . [Resident #3] was deemed incompetent to make his own medical decisions. . . . Coffee burn to left anterior mid-thigh . . . Encourage resident to ask for assistance when wanting fresh coffee . . . Resident has history of frequent spilling of drinks. Resident does have shaker cups with lids. Resident should have lids on all drinks out of dining room area . . . [Resident #3] has been noted to get his own coffee at nights and burn himself with the hot liquids. At this time his household (Peace Garden) will be removing coffee from the machine and turning off the machine at night or shutting off the machine, the door between the households will be closed to deter him from going | F 689 | | |

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| F 689 | Continued From page 9 | F 689 | | |

to the other house to get coffee. Staff are to monitor him and make sure that coffee has ice added to help decrease the risk for burns. . . ."

A progress note, date 01/15/23 at 9:30 p.m., identified, "Resident sustained a coffee burn to L [left] anterior mid thigh discovered at 1925 [7:25 p.m.]. Noted full, uncovered cup of coffee he was carrying from kitchen, while propelling to living room in w/c [wheelchair]. Assisted to room, changed clothing, observed area to be 8 cm [centimeters] x 5 cm, oval shaped with medium pink coloring. No raised of [sic] blistering of skin at that time. Area is tender to touch, Some relief with cool, wet compress. . . . Renewed cool compress, observed site at 2130 [9:30 p.m.] to be reduced to area approx [approximately] 3 cm oval. Does appear to be starting to blister, will continue to monitor, renew cool pack through night as needed. Advised to please ask for assistance for hot beverages in the future." The record showed the coffee burn resulted in a blister that resolved 18 days later.

An incident report, dated 01/15/23, also identified, ". . . large, wet coffee stain on L thigh sweat pants. . . . 'I spilled really hot coffee on it and it hurts.' . . . Coffee burn to L anterior thigh. . . . Resident is independent to obtain own drinks as wishes. . . . Asked resident to request help and covered cup for coffee. . . . Education provided, but with resident unable to identify his limitations continues at risk for future incidents. Staff are reminded to assist resident with his drinks . . ."

A progress note, dated 02/23/23 at 8:32 p.m., identified, "Resident reported to staff that he

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| F 689 | Continued From page 10 | F 689 | | |

spilled hot coffee on his leg. On assessment, left upper thigh without redness or blistering. Skin cool to touch at this time, pants are damp. Full cup of coffee on end table next to him that was cool. Resident denies pain at this time. . . ." The record showed the coffee burn resulted in a 1 cm light red area that resolved four days later.

An incident report, dated 02/23/23, also identified, ". . . Resident in living room watching tv, states it [coffee] spilled during transfer . . . 'I can't learn.' . . . Educated Resident to allow staff to help him. . . . noted . . . spills occurring on PM and night shift. . . . Discussion held with dietary with plan of unplugging coffee machine after supper meal and replug in the morning prior to breakfast. Staff and residents have access to the coffee machine on honor during time of machine being unplugged. . . ."

Additional progress notes identified the following:
* 03/02/23 at 1:33 a.m., ". . . resident was attempting to clean something off of dining room floor. When this nurse offered to help, resident stated he had spilled 'hot, hot' coffee on his left forearm. Resident did have fresh cup of coffee sitting on counter near him and sleeve of shirt was wet. No redness or blistering noted to arm or hand. Resident was assisted to take his coffee to his recliner and was reminded he needed to call for help so that he didn't get burned. Resident stated 'I know. Seems like every week.' . . ."
* 04/23/23 at 10:33 p.m., "This nurse noted resident cleaning coffee off of floor. Nurse assisted resident with cleaning up coffee and asked if he had spilled any on himself. Resident stated 'yes, hot, hot'. When asked, resident stated he had spilled coffee on his left hand.

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| F 689 | Continued From page 11<br>Hand was dry and cool to touch. No redness or blistering noted. . . . Coffee machine locked and resident reminded to ask for staff assistance with coffee to prevent accidental burns. . . ." The record showed the coffee burn resulted in a pink area that resolved two days later.<br><br>An incident report, dated 04/23/23, also identified, ". . . resident indicated he had spilled coffee on his left hand. . . . Resident likes to maintain as much independence as possible and does not ask for assistance. . . . Coffee machine buttons locked at this time. . . . Discussion held with dietary on machine being turned off at end of cooks shift and turned back on when the cook arrives in the morning. Staff will be closing the door between honor and peace households to detour resident from coming to honor to fill his coffee mug during the night. . . ."<br><br>Temperature readings were obtained from various coffee/hot water machines on the afternoon of 07/27/23 and showed the following:<br>* Town Hall: 176.7 degrees Fahrenheit (F)<br>* Freedom: 173.2 degrees F<br>* Honor: 174.2 degrees F<br>* Peace Garden: 176.0 degrees F<br>Observation showed staff posted a fact sheet on each of the coffee/hot water machines informing the residents of the coffee/hot water temperatures and warning them these temperatures could cause 3rd degree burns.<br><br>During interviews on 07/27/23 at 2:15 p.m. and 2:31 p.m., an administrative nurse (#3) confirmed the facility failed to monitor the coffee/hot water temperatures resulting in injuries. | F 689 | | |
| F 742 | Treatment/Srvcs Mental/Psychoscial Concerns | F 742 | | 10/16/23 |

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| F 742 SS=D | Continued From page 12<br>CFR(s): 483.40(b)(1)<br><br>§483.40(b) Based on the comprehensive assessment of a resident, the facility must ensure that-<br>§483.40(b)(1)<br>A resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being;<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, review of facility policy, and staff interview, the facility failed to ensure 3 of 4 sampled residents (Resident #12, #15, and #41) diagnosed with post-traumatic stress disorder (PTSD) received appropriate treatment and services to meet their assessed needs. Failure to provide clinically appropriate, person-centered treatment and services may result in the residents' inability to attain their highest practicable mental and psychosocial well-being.<br><br>Findings include:<br><br>Review of the facility policy titled "Trauma Informed Care" occurred on 07/26/23. This policy, reviewed/revised 08/28/20, stated, ". . .The facility will account for residents' experiences, preferences, and cultural differences in order to eliminate or mitigate triggers that may cause re-traumatization . . . care plan will be updated to reflect known trauma, potential triggers, and interventions for | F 742 | | |

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| | 355114 | A. BUILDING _____ B. WING _____ | 08/02/2023 |

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| F 742 | Continued From page 13 | F 742 | | |

management."

- Review of Resident #12's medical record occurred on all days of survey. The annual Minimum Data Set (MDS), dated 06/06/23, identified a diagnosis of PTSD. Current medications included an antidepressant.

A trauma screening, dated 06/23/22, identified Resident #12 had "experiences that were frightening, horrible, and/or upsetting, [he had] tried hard not to think about it [the trauma] or went out of [his] way to avoid situations that reminded [him] of it, and felt numb or detached from others, activities, [and his] surroundings." Resident #12 "did not wish to talk about it [the trauma]." The screening indicated Resident #12 is triggered by "loud noises . . ."

Resident #12's current care plan failed to reflect the clinically appropriate and person-centered interventions addressing his known trigger (loud noises) and interventions used to eliminate or mitigate re-traumatization.

During an interview on 07/27/23 at 10:25 a.m., an administrative nurse (#1) confirmed the current care plan failed to address Resident #12's emotional/psychosocial needs related to his previously identified PTSD triggers.

- Review of Resident #15's medical record occurred on all days of survey. The quarterly MDS, dated 12/02/22, identified a diagnosis of PTSD. Current medications included an antidepressant and antipsychotics.

A psychiatry provider note, dated 06/02/23,

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| F 742 | Continued From page 14<br>identified PTSD symptoms including nightmares, flashbacks, startle response, and intrusive thought/memories . . . significant panic attacks when these occur, which is disabling . . ."<br><br>The current care plan failed to address Resident #15's emotional/psychosocial needs related to his trauma/PTSD diagnosis and failed to include clinically appropriate and person-centered interventions used to avoid re-traumatization.<br><br>During an interview on 07/25/23 at 2:49 p.m., an administrative nurse (#4) agreed, "the current LTC [Long Term Care] trauma/PTSD assessment and care plan lacked known trauma, potential triggers, and interventions."<br><br>- Review of Resident #41's medical record occurred on all days of survey. The quarterly MDS, dated 04/13/23, identified a diagnosis of PTSD. Current medications included an antidepressant.<br><br>A trauma screening, dated 06/30/22, identified Resident #41 had "experiences that were frightening, horrible, and/or upsetting," and indicated he "previously saw psychiatry through [a veteran's affairs facility]. He is open to this again related to high PAQ-9 [a depression scale] score. As well as referral to psychologist/therapist." The screening failed to identify Resident #41's expressions or indications of distress, identified triggers that may cause re-traumatization, and/or preferences.<br><br>The current care plan failed to reflect Resident #41's identified triggers and the clinically appropriate and person-centered interventions | F 742 | | |

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| F 742 | Continued From page 15<br>used to eliminate or mitigate re-traumatization.<br><br>During an interview on 07/27/23 at 10:45 a.m., a social services staff member (#4) confirmed the current care plan failed to identify Resident #41's triggers and/or address his emotional/psychosocial needs related to his PTSD. | F 742 | | |
| F 812 SS=E | Food Procurement,Store/Prepare/Serve-Sanitary<br>CFR(s): 483.60(i)(1)(2)<br><br>§483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br>(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.<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, review of manufacture instructions, review of facility policy, review of facility sanitizer logs, and staff interview, the facility failed to prepare and serve food under sanitary conditions in 1 of 1 kitchen (main | F 812 | | 10/16/23 |

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| F 812 | Continued From page 16<br>kitchen) and 2 of 2 kitchenettes (Courage/Freedom and Honor/Peace). Failure to monitor the concentration of the quaternary solution may result in unsafe preparation of food and foodborne illness.<br><br>Findings include:<br><br>Review of the manufacturer instructions for Smart Power Sink and Surface Cleaner Sanitizer posted above the kitchen dishwasher sinks occurred on 07/27/23 at 2:03 p.m., stated, "EPA-registered cleaner sanitizer for pre-cleaned use on hard, non-porous food prep surfaces and wares, kills foodborne organisms . . . it is a no-rinse sanitizer that is effective across a dilution range of 0.27 to 0.55 oz.[ounce] per gallon of water. Sanitization Range Testing: Testing solution should be at or above room temperature: 65F [Fahrenheit]. Withdraw a test strip from the canister. Dip test strip for 5 seconds in test solution. Shake off excess solution. Compare colors after 10 seconds with colors on the test strip canister to determine concentration (oz/gal) [ounces/gallon] . . . . Testing solution should be between 272-700 ppm [parts per million] DDBSA [dodecylbenzene sulfonic acid] . . ."<br><br>Review of the facility policy "Dietary Services Sink & Surface Sanitizer" occurred on 07/27/23. This policy dated 03/01/22 stated, " . . . Fill spray bottles with sanitizer, change out as needed per concentration level. . . Monitor the strength of the sanitizer and document every week. . . Report any problems with the machine or the strength of the chemical to the CDM [certified dietary manager] . . ." | F 812 | | |

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| F 812 | Continued From page 17<br><br>Review of the facility high temp dishwasher and sanitizer logs stated, " . . . Sanitizer should be 272-700 ppm . . . if not proper strength notify supervisor. Test Weekly."<br><br>Observation of the kitchenettes occurred on 07/27/23 at 9:05 a.m. with dietary manager (#5) and showed a dietary staff member tested the concentration of the sanitizer buckets that identified the following:<br>* Courage/Freedom kitchenette: 848 (high)<br>* Honor/Peace kitchenette: 848 (high)<br><br>Observation of the main kitchen occurred on 07/27/23 at 9:35 a.m. with dietary manager (#5) and showed a dietary staff member tested the concentration of a sanitizer bottle and identified a concentration of 848 (high).<br><br>Interview with a dietary manager (#5) on 07/27/23 at 10:00 a.m. confirmed that the testing solution was not within the acceptable range. | F 812 | | |