STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355106	A. BUILDING _____ B. WING _____	C 07/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH CONTINUING CARE CENTER OFF COLLINS	201 14TH ST NW MANDAN, ND 58554

(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 unannounced complaint survey conducted on July 19-20, 2016, the sample included three residents and one closed record for focused review. The complaint issues regarding failing to assess a resident following a change in condition, failing to notify family of a resident's change in condition, and failing to provide proper incontinence cares could not be substantiated.	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: Based on observation, review of the facility's policy/procedure, and staff interview, the facility failed to provide care for 2 of 3 sampled residents (Resident #1 and #2) in a manner and environment that maintained, enhanced, and respected each resident's dignity and individuality. Failure to knock on doors/wait for a reply before entering a resident's room and failure to provide privacy during pressure ulcer/incontinence cares does not promote residents' dignity or enhance their quality of life. Findings include: Review of the facility's "Dignity" policy occurred on 07/20/16. This policy, revised 01/20/16, stated, ". . . Maintaining a resident's dignity	F 241	F-241: Dignity and Respect of Individuality It is the intent of this facility to promote care for residents in a manner that maintains or enhances each resident's dignity and respect as evidenced by the following: The Dignity P & P was reviewed and remains in place without changes. Emphasis will be placed on adhering to the established policy addressing dignity and privacy. On 7/21/2016 training was provided for staff #2, #3, #4, #5 & #6 in regards to the	8/23/16

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

Electronically Signed | 07/29/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 241	Continued From page 1 includes . . . Respecting resident's private space and property . . . knocking on doors and requesting permission to enter . . ." - Observation on 07/19/16 at 4:45 p.m. showed Resident #2 lying in bed, exposed from the waist down, as a nurse (#1) and two certified nursing assistants (CNAs) (#2 and #3) provided incontinence cares. An unidentified CNA knocked on Resident #2's door and entered her room without announcing herself even though all three staff members called out "Cares (indicating staff are in the process of providing cares and the person who is knocking should wait for permission to enter)." A few minutes later, a second unidentified CNA knocked on Resident #2's door and entered her room without announcing herself even though all three staff members called out "Cares." The CNA then exited the room in search of clean linens. Upon her return, she entered Resident #2's roomwithout knocking and/or waiting for permission. - Observation on 07/20/16 at 10:02 a.m. showed Resident #3 lying in bed as a nurse practioner (#4), a nurse (#5), and a CNA (#6) provided pressure ulcer cares. An unidentified nurse knocked on Resident #3's door and entered her room without announcing herself even though two of the staff members called out "Cares." During an interview on the afternoon of 07/21/16, an administrative nurse (#7) stated she expected facility staff to knock and wait for permission before entering a resident's room.	F 241	Dignity P & P and how to best protect a resident while providing cares in the event someone enters a resident's room or private space. Advised to use the words "Cares" and allow entry when the resident has been covered to preserve the resident's dignity. Education was held for all nursing staff members on 7-28-16 at which time the importance of resident privacy especially during the delivery of personal cares will be emphasized along with the Dignity P & P. Staff members are expected to knock, pause, and announce themselves prior to entering a resident room to allow the resident or others the opportunity to respond before staff enter the area. It is expected that residents are appropriately covered at all times when other individuals enter or leave a room. Residents requiring assistance with incontinence care while in bed and/or pressure ulcer care have been identified. The QI Coordinator and/or her designee will monitor 5-10 care encounters weekly X4 beginning the week of 8-1-16 and then monthly X2 to ensure that privacy and dignity are maintained. Care delivery for Resident #1 & #2 was monitored the week of 8-1-2016 at which time the facility focus on providing cares with dignity was addressed with the resident and staff members. Results of the QI monitoring will reviewed by the QI Coordinator as part of the	

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F 241	Continued From page 2	F 241	monthly facility QI Meetings and then summarized at the Quarterly QI Meeting with the Medical Director in attendance. The need for further monitoring will be determined based upon these results. Date Certain: 8-24-2016	