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	355040	A. BUILDING _____ B. WING _____	08/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHER MEMORIAL HOME	750 MAIN ST E MAYVILLE, ND 58257

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F 000	INITIAL COMMENTS The standard Medicare/Medicaid recertification survey started on 08/29/22 and concluded 08/31/22.	F 000		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and review of facility policy, the facility failed to ensure staff followed professional standards of practice for 1 of 1 sampled resident (Resident #58) with a feeding tube. Failure to ensure residents received their complete dose of medication during administration may lead to reduced efficacy and adverse health effects. Findings include: Review of the facility policy titled, "Medication Administration" occurred on 08/31/22. This policy, revised/reviewed July 2018, stated, ". . . Prepare medication for administration, using these rules: Observe the Five Rights of Medication Administration . . . Right dosage. . . ." Review of Resident #58's medical record occurred on all days of survey. Diagnoses included epilepsy. A physician's order identified "oxcarbazepine (anti-seizure) tablet; 300 mg [milligram]; amt: [amount] 600 mg; gastric tube Twice A Day at 08:00 AM, 08:00 PM."	F 658	Plan of Correction F658 For resident #58 the PEG Tube Feeding and Medication Administration Procedure has been revised to include ensuring entire dose of medication is administered and medication residue is not left in med cup. No other residents receive medications per feeding tube, so no other residents have potential to be affected by this practice. Nursing staff will be educated regarding medication administration procedure per feeding tube and ensuring medication residue is not left in med cup after it is poured into the syringe at mandatory nursing staff meeting on September 21, 2022. Medication administration per feeding tube will be audited by QA nurse, Unit Managers and Nursing Supervisors 2 x per week for one month, 1 x per week for one month and 1 x per month for 4	10/5/22

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

Electronically Signed | 09/23/2022

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F 658	Continued From page 1 During an observation on 08/30/22 at 9:15 a.m., a facility nurse (#1) administered Resident #58's medication via the feeding tube. The nurse crushed and mixed all medications with water in separate labeled medication cups, and administered them one at a time with a 10 cubic centimeter (cc) water flush between each med. After the nurse finished administering the medication, the cup labeled "oxcarbazepine" contained a layer of medication that covered the bottom of the cup. The nurse failed to administer the complete dose of the medication.	F 658	months. Results will be reported to the QA nurse. If concerns are identified, immediate corrective action, such as education will be taken. The QA nurse will submit a report of the audit results to the QA committee at each scheduled meeting.	
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced	F 692		10/5/22

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F 692	Continued From page 2 by: Based on observation, record review, policy review, and staff interview, the facility failed to ensure acceptable parameters of nutritional status for 1 of 6 sampled residents (Resident #9) with weight loss. Failure to adequately monitor and evaluate weights, complete nutritional assessments, assess the effectiveness of existing interventions, and re-evaluate the need for updated or additional interventions may result in weight loss, inadequate nutrition, and/or delayed wound healing. Findings include: Review of the facility policy titled "Weight Loss Protocol" occurred on 08/30/22. This policy, dated June 2000, stated, ". . . residents with a 3# [pound] or greater weight change . . . will be monitored via weights, intakes, etc. . . . to determine if interventions are necessary to prevent further weight loss. . . . Changes to be documented in resident chart. . . ." Review of Resident #9's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease and Dementia. The quarterly Minimum Data Set (MDS), dated 06/10/22, identified a significant weight loss and not on a physician-prescribed weight loss program. The record lacked a nutritional assessment to address Resident #9's weight loss. Review of Resident #9's weights showed the following.	F 692	F692 □ For resident #9 and all other residents at Luther Memorial Home that receive supplements to increase nutritional intake and mitigate weight loss, C.N.A.s and Nursing staff will be educated on the process for documentation of nutritional supplements at the nurses mandatory meeting on September 21, 2022, and the C.N.A. mandatory meeting on September 27th, 2022. The dietician will add supplement intake to the point of care charting for C.N.A.s to document the percentage of intake of supplements. The dietician will enter a general order to go on the treatment administration record for the nurse to verify that the supplements were offered. There was a nutritional assessment documented in the resident's progress notes dated 6/8/22 that identifies the residents weight loss and states, "Have tried different supplements and she wouldn't take". Another nutritional assessment was documented on 9/9/22 that continues to identify weight loss and states "Intake is often dependent on mood" and "Will try scheduling supplements again to see if she is willing to accept now". Documentation of administration of all supplements will be audited 2 x per week for one month, 1 x per week for one month and 1 x per month for 4 months by the dietician. If concerns are identified corrective action will be taken. The dietician will submit audits to the QA	

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F 692	Continued From page 3 02/27/22 (122.5 lbs) 08/28/22 (110 lbs) (02/27/22 to 08/28/22 = 10.2% decrease in weight) The current care plan stated, "I will maintain weight above 115# thru [sic] next review. . . Resident would benefit from supplements but has been unwilling to take them." Observations of Resident #9 throughout the survey showed the resident ate independently, without supplements offered at meals. The record lacked evidence that high calorie foods were offered. During an interview on the morning of 08/31/22, an administrative nurse (#6) stated she expected staff to "implement supplements and monitor weights." The dietary manager (#7) stated Resident #9 "will not take supplements and only wants half portions." Both staff failed to explain the facility's system for identifying weight loss and implemention of interventions. The dietary manager (#7) failed to provide documentation of interventions regarding Resident #9's weight loss.	F 692	nurse and will report audit results to the QAPI committee at each scheduled meeting.	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals	F 761		10/5/22

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F 761	Continued From page 4 §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to ensure proper labeling of multi-dose insulin pens during 1 of 1 medication storage rooms (Unit B) observed. Failure to correctly label insulin pens increases the risk of residents receiving inaccurate doses of medications. Findings include: Kozier & Erb's "Fundamentals of Nursing, Concepts, Process and Practice," 11th Edition, 2021, Pearson, Boston, Massachusetts, page 840, states, ". . .The labeling of all medications, medication containers, and other solutions is a risk-reduction activity consistent with safe medication management. . ." Review of the facility policy titled "Process for Relabeling Medication Cards" occurred on 08/31/22. This policy, revised September 2018	F 761	F761 For resident #57 and all other residents that receive insulin pen prescriptions through the VA pharmacy the medication relabeling process has been updated after consulting with the consulting pharmacist and the ND Board of Pharmacy. Insulin pen prescriptions dispensed to residents at Luther Memorial Home from the VA will be sent to the local pharmacy, ensuring proper storage and handling for labeling of the individual pens per the ND Board of Pharmacy administrative guidelines for repackaging of prescriptions. Nurses will be educated on this process at mandatory meeting on September 21st, 2022. Labeling of insulin pens will be audited	

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F 761	Continued From page 5 stated, "Luther Memorial Home [Facility name] will ensure drugs and biologicals used withing the facility are labeled accurately and in accordance with currently accepted professional pharmacy requirements. . . ." " Review of facility policy titled "Medication Administration" occurred on 08/31/22. This policy, revised July 2018 stated, ". . . Never administer medication from an unlabeled supply. . ." - Observation during medication storage and labeling on Unit B for Resident #57 on 08/31/22 at 8:20 a.m., with a staff nurse (#8) identified the following: * A Levemir insulin pen was without a label or original container. * A Novolog insulin pen was without a label or original container. During an interview on 8/31/22 at 1:03 p.m., an administrative nurse (#6) confirmed the insulin pens lacked labeling and/or original container.	F 761	weekly X 2 months and monthly X 4 months by the medication nurse/C.M.A. and reported to the QA nurse. If concerns are identified, corrective action will be taken. The QA nurse will submit a report of the audit results to the QA committee at each scheduled meeting.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention	F 880		10/5/22

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F 880	Continued From page 6 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 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	F 880		

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F 880	Continued From page 7 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 1 of 9 sampled residents (Resident #23) and 1 supplemental resident (Resident #42) observed during perineal care. Failure to follow infection control practices related to hand hygiene has the potential to transmit infections to other residents, staff, and visitors. Findings include: Review of the facility policy titled "Hand Washing and Hand Hygiene" occurred on 08/31/22. This undated policy stated, ". . . To provide guidelines to employees for proper and appropriate hand washing techniques that will aid in the prevention or the transmission of infections. . . . When to wash hands with soap and water or alcohol based hand rubs: 1. Hand hygiene should be	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)/unit(s) identified in the deficiency. The infection preventionist (IP), director of nursing (DON), in conjunction with applicable interdisciplinary team (IDT) members, shall identify and implement a consistent system for ensuring a system for: (1) Ensuring staff perform hand hygiene or handwashing after removing gloves and during/after performing perineal care, in accordance with CDC guidelines. The DON, staff development coordinator	

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F 880	Continued From page 8 performed . . . After contact with a resident's mucous membranes and body fluids or excretions. . . . After removing gloves . . . If moving from a contaminated body site to a clean body site during resident care. . . ." - Observation on 08/29/22 at 3:19 p.m. showed two certified nursing assistants (CNAs) (#4 and #5) transferred Resident #42 from the wheelchair to the bed. The CNAs performed hand hygiene, donned gloves, lowered the front of the resident's brief, performed perineal cares, and rolled the resident onto her left side. One CNA (#4) cleansed the rectal area of bowel movement (BM) with a disposable wipe. Without removing gloves, the CNA (#4) removed the soiled brief, placed a new brief under the resident, obtained a tube of barrier cream from the nightstand, and applied the cream to the resident's buttocks. The CNA (#4) then removed her gloves, adjusted the brief, and placed the the tube of barrier cream back into the resident's nightstand. The CNA (#4) failed to remove her soiled gloves and perform hand hygiene after cleansing the resident's rectal area and before touching other objects and/or applying barrier cream. - Observation on 08/30/22 at 10:38 a.m. showed two CNAs (#2 and #3) transferred Resident #23 from the wheelchair to the bed. The CNA's performed hand hygiene, donned gloves, lowered the front of the resident's brief, performed perineal cares, and rolled the resident onto his left side. One CNA (#2) cleansed the rectal area of BM with a disposable wipe and rolled the soiled brief under the resident. Without removing her gloves, the CNA (#2) obtained a tube of barrier cream from the windowsill and	F 880	(SDC), IP or designee, in conjunction with applicable IDT members, will: (1) Educate all staff on correctly completing hand hygiene after changing tasks, after removing gloves, and before touching items that potentially contaminate surfaces. To verify this/these staff understands hand hygiene and handwashing, this/these staff will perform a successful return demonstration of identifying the need and correct procedure for performing hand hygiene and handwashing. 2. Identification of Others The IP and DON, in conjunction with the applicable interdisciplinary team (IDT) members, will review current nursing facility guidelines for hand hygiene 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 10/05/2022 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 handwashing or hand hygiene in accordance with CDC guidelines. Information about root cause analysis can be found at	

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F 880	Continued From page 9 applied the cream to the residents buttocks. The CNA (#2) then placed the tube of cream back onto the windowsill, removed her gloves and held the resident's hand as he rolled onto his right side. The CNA (#2) failed to remove the soiled gloves and perform hand hygiene after cleansing the resident's rectal area and before touching other objects, applying barrier cream and/or holding the resident's hand. During an interview on 08/31/22 at 12:55 p.m., an administrative nurse (#6) confirmed she expects staff to follow the facility's policy regarding hand hygiene.	F 880	https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/GuidanceforRCA.pdf (2) The DON, SDC, IP or suitable designee will ensure the following: a. All staff will receive education in regard to keeping hands clean between tasks, and contacts with objects/persons that has the potential for cross contamination. This education will include the CDC's lesson on clean hands available at https://youtu.be/xmYMUly7qiE. (3) The facility leadership will contact the North Dakota Quality Improvement Organization (QIO), to inquire about the assistance and services available from the QIO in improving infection prevention and control within the facility through quality assurance process improvement (QAPI) methods. 4. Monitoring Weekly for no less than 12 weeks, the DON, IP, SDC or a designee will conduct on-going monitoring to ensure, via observation, the approaches to correct deficient practice related to infection control and prevention are consistently implemented and effective. Such monitoring will include: (1) Observations of all staff types to ensure performance of proper handwashing and hand hygiene, when indicated, in the course of their routine duties. Observations will be made across all	

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F 880	Continued From page 10	F 880	shifts and 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 committee and medical director. 5. Correction Date 10/05/2022	