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	355031	A. BUILDING _____ B. WING _____	05/09/2023

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F 000	INITIAL COMMENTS The standard Medicare/recertification survey started on 05/07/23 and concluded on 05/09/23.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.	F 550		6/13/23

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

Electronically Signed | 06/08/2023

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F 550	Continued From page 1 §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and resident and staff interview, the facility failed to provide dignity for 1 of 1 sampled resident (Resident #21). Failure to address the resident with the name of the resident's choice does not preserve the resident's personal dignity or enhance the quality of life and places the resident at risk for anger, anxiety, lack of self-esteem, and other forms of emotional distress. Findings include: Review of the facility policy titled "Resident Rights" occurred on 05/08/23. This policy, revised in September 2022, stated, ". . .Do not use nicknames when addressing or referring to a resident, unless the resident asks that you do. . . . other such names . . . shows disrespect for the resident. During an observation of cares on 05/07/23 at 2:11 p.m., a registered nurse (#3) referred to and called Resident #21 "Bud" multiple times. During an interview on 05/07/23 at 4:41 p.m., Resident #21 stated he did not like to be called "Bud" because that is not his name.	F 550	1. Resident Rights Policy (revised in September 2022) was reviewed with staff member that called Resident #21 Bud on 5/8/2023. One on one education form completed with staff member and Director of Nursing on 5/8/2023. 2. Residents in the facility are potentially at risk to be affected by this allege of practice. 3. Director of Nursing or designee will educate facility licensed and non-licensed staff on Resident Rights at Staff Meeting scheduled June 6, 2023, to include the use of nicknames when addressing or referring to a resident, unless the resident asks that you do. Those not in attendance must sign off education prior to next worked shift. 4. Social Worker or designee will audit through interview or direct observation of interactions with staff and Resident name preference starting 6/8/23. Audits will include Resident #21 and four other residents and to be completed 3 times weekly x 4, then once weekly x 4, then monthly x 3. Audit results will be submitted to QAPI Committee for review and further recommendations if indicated.	

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F 550	Continued From page 2 During an interview on 05/09/23 at 10:45 a.m., when asked questions pertaining to dignity, two administrative staff members (#1 and #2) stated they expected staff to follow policy and resident's rights, and address residents as they wish to be addressed.	F 550		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the	F 583		6/13/23

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F 583	Continued From page 3 Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and resident and staff interview, the facility failed to provide personal privacy for 1 of 5 sampled residents (Resident #26) observed during a glucometer check and insulin administration, and 1 of 12 sampled residents (Resident #335) observed during personal cares. Failure to provide privacy in a manner/environment that maintains bodily privacy does not preserve the resident's right to privacy or enhance their quality of life. Findings include: BLOOD GLUCOSE MONITORING AND INSULIN ADMINISTRATION Review of the facility policy titled "Blood Glucose Monitoring" occurred on 05/08/23. This policy, revised 08/05/22, stated, ". . . Provide Privacy. . . ." Review of facility policy titled "Insulin Administration - Pen" occurred on 05/08/23. This policy, revised October 2022, stated, "Provide for resident privacy. . . ." Review of facility policy titled "Resident Rights" occurred on 05/08/23. This policy, revised July 2022, stated, ". . . The resident has the right to personal privacy . . . When providing cares, always provide privacy . . ."	F 583	F583 - Insulin 1. Blood Glucose Monitoring Policy was reviewed with staff member that performed blood sugar check on Resident #26□s finger and then pulled the resident□s shirt up exposing their abdomen and administering the insulin on 5/7/2023. One on one education form completed with staff member and Director of Nursing on 5/7/2023. 2. Diabetic residents in facility are potentially at risk to be affected by this deficiency. 3. Administrator or designee will educate nurses on Blood Glucose Monitoring, Medication Administration Policy, and Resident Rights at the Staff Meeting scheduled June 6, 2023. Those not in attendance must sign off education prior to next worked shift. 4. Director of Nursing or Designee will audit blood glucose monitoring and insulin administration starting 6/8/23. Audits will include Resident #26 and four other residents while being completed 3 times weekly x 4, then once weekly x 4, then monthly x 3. Audit results will be submitted to QAPI Committee for review and further recommendations if indicated. F583 □ Toileting	

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F 583	Continued From page 4 Observations on 05/07/23 at 12:10 p.m. showed a nurse (#3) performed a blood sugar check on Resident #26 ' s finger and then pulled the resident's shirt up exposing their abdomen and administered the inulin. This occurred during the noon meal with other residents and staff present in the dining room. During an interview on 05/09/23 at 10:45 a.m., two administrative staff members (#1 and #2) stated they expected staff to follow facility policies and resident rights. TOILETING Observation on 05/07/23 at 4:00 p.m. showed a certified nurse aide (CNA) (#6) ambulated Resident #335 to the bathroom. The CNA donned gloves and without closing the bathroom door lowered the resident's pants and assisted her to sit on the toilet. The resident's roommate was laying on her bed with a direct view into the bathroom. During an interview on 05/08/23 at 8:10 a.m., Resident #335 stated. "Often they [staff] sit me on the toilet without shutting the door. Once I'm sitting, I can't stand up to close it. There have been times when my roommate will have to tell staff to shut the door." During an interview on 05/10/23 at 2:35 p.m., an administrative staff member (#1) agreed she expected staff to provide privacy during toileting.	F 583	1. Resident #335□s dignity will be remained by providing privacy while using the toilet. 2. Residents privacy in the facility can potentially be at risk by the allege of practice. 3. Administrator or designee will educate facility licensed and non-licensed staff on the Resident Rights Policy at the Staff Meeting scheduled on June 6, 2023. Those not in attendance must sign off education prior to next worked shift. 4. Director of Nursing or Designee will audit Resident toileting including Resident #335 and four other Residents starting 6/8/23. Audits will be completed 3 times weekly x 4, then once weekly x 4, then monthly x 3. Audit results will be submitted to QAPI Committee for review and further recommendations if indicated.	
F 684 SS=D	Quality of Care CFR(s): 483.25	F 684		6/13/23

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F 684	Continued From page 5 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident and staff interview, the facility failed to ensure appropriate care and services for 1 of 5 sampled resident (Resident #335) reviewed for edema (fluid retention). Failure to ensure timely and consistent implementation of support stockings may result in worsening edema. Findings include: Review of Resident #335's medical record occurred on all days of survey and identified diagnoses of transient ischemic attacks (small strokes), cerebral infarction (stroke), and hypertension. A physician's order, dated 05/01/23, stated, "Apply ted hose [support stockings to control edema] to BLE [bilateral lower extremities]-on am [morning], remove at hs [hour of sleep] every morning and at bedtime for edema." Resident #335's current care plan stated ". . . . Edema/excess fluid volume as evidenced edema bilateral lower extremities . . . compression stockings . . . on/am, off/hs . . ." A progress note, dated 05/03/23 at 11:59 p.m., stated, ". . . Resdient [sic] has some swelling to lower	F 684	1. Resident #335 did not exhibit further worsening edema with this alleged practice. 2. Residents who utilize ted hose can potentially be at risk by the affected deficiency. 3. Administrator or designee will educate nurses on the Charting and Documentation policy as well as Resident Rights policy at the Staff Meeting scheduled on June 6th, 2023. Those not in attendance must sign off education prior to next worked shift. 4. Director of Nursing or Designee will audit Resident ted hose validation and documentation for Resident #335 and four other Residents starting 6/8/23. Audits will be completed 3 times weekly x 4, then once weekly x 4, then monthly x 3. Audit results will be submitted to QAPI Committee for review and further recommendations if indicated.	

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F 684	Continued From page 6	F 684		

extremity edema/order for Ted Hose in place. . . ."
A daily skilled note, dated 05/06/23 at 11:59 p.m., stated, ". . . Late Entry . . . Edema present: Yes, . . . Bilateral lower extremities. . . ."

Observation and interview on 05/07/23 at 01:54 p.m. showed Resident #335 lying in bed with her feet elevated on a pillow with visible edema to both lower legs and no support stockings present. The resident stated, "I've had trouble with edema and have worn ted socks since I was 36 years old, but I couldn't put them on now and they haven't said anything [about getting them]."

Observation on 05/07/23 at 4:00 p.m., showed staff assisted the resident to the bathroom and she did not have support stockings on.

Observation on 05/08/23 at 9:00 a.m. showed Resident #335 in bed with no support stockings on lower legs.

During an interview on 05/09/23 at 1:52 p.m., Resident #335 stated, "This morning they [staff] put these on [mesh stockinette's] [a gauze like product used for skin protection or to keep a bandage in place, it does not have compression for edema]. I don't know why, they aren't ted stockings." The resident has visible edema present to both lower legs.

A review of Resident #335's treatment administration record (TAR) from May 7-9, 2023, showed the following:
05/07/23 TED Hose initialed as applied in the morning and removed at bedtime. (Resident did not have TED hose on)
05/08/23 TED Hose initialed as refused in the

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F 684	Continued From page 7 morning but removed at bedtime. (Resident did not have TED hose on) 05/09/23 TED Hose initialed as applied in the morning. (Resident has stockinette's on) During an interview on 05/09/23 at 02:35 p.m., an administrative staff nurse (#1) agreed staff should apply TED hose as ordered and to document correctly.	F 684		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on record review, facility policy, and resident and staff interview, the facility failed to ensure 1 of 2 sampled residents (Resident #24) reviewed for restorative therapy received the services developed by the therapy staff. Failure	F 688	1.) The facilities procedure titled, Restorative Nursing Programs was reviewed and revised by the Quality Assurance Committee on 5/30/2023. Resident #24 began Physical Therapy on	6/13/23

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F 688	Continued From page 8 to consistently provide restorative nursing/therapy services may adversely affect the residents' abilities to maintain their range of motion (ROM), balance, strength, and mobility. Findings include: Review of facility policy titled "Prevention of Decline in Range of Motion" occurred on 05/09/23. This policy, revised 02/02/23, stated, ". . . The facility in collaboration with the medical director, director of nurses and as appropriate, physical/occupational consultant shall establish and utilize a systematic approach for prevention of decline in range of motion, including the assessment, appropriate care planning, and preventive care. . . . Preventive Care. Staff will be educated on basic, restorative nursing care that does not require the use of a qualified therapist or licensed nurse oversight. . . ." Review of Resident #24's medical record occurred on all days of survey. The current care plan stated, ". . . Impaired Functional mobility due to weakness, obesity, respiratory failure . . . Nursing will provide assistance as needed for transfers and ambulation. . . At risk for falls r/t [related to] medication, deconditioning/weakness . . . Follow Therapy recommendations for transfers, mobility, and ambulation . . ." Review of a physical therapy discharge note, dated 04/07/23, stated, ". . . Resident discharged from PT [physical therapy] on 4/7/23. Analysis of Functional Outcome/Clinical Impression states 'Overall, patient has made fair-good progress throughout PT. Because of patient progress and variable participation in PT, feel that she is	F 688	6/8/2023. 2.) Facility residents who discharge from Medicare or have a need to improve their abilities to the highest practicable level have the potential to be affected by the alleged practice. 3.) The facility Social Worker, Physical Therapy Assistant, MDS Nurse, Director of Nursing, Unit Manager, and Administrator were educated by the Administrator on 5/30/23 for the procedure titled, Restorative Nursing Programs. Facility nursing staff were educated by the Administrator or designee, starting 6/6/2023 on the policy titled, Restorative Nursing Programs. Registered Nurses and License Practical Nurses started two Relias courses on 5/23/23 1.) Foundation of Restorative Nursing and 2.) Restorative Nursing: Mobility for the Licensed Nurse. Certified Nursing Assistants starting 5/23/23 were education on three Relias courses 1.) Restorative Nursing: Foundation for CNAs 2.) Restorative Nursing: Mobility for CNA 3.) Restorative Nursing: Positioning and ROM for Nursing Assistants. Certified Nursing Assistants starting 6/6/23 performed return demonstration on range of motion, walking, and transfers to a nurse manager. Administrator or designee will educate nurses and aids on the policy Restorative Nursing Programs at the Staff Meeting scheduled on June 6th, 2023. Those not in attendance must sign off education prior to next worked shift. 4.) Audits will be conducted by the	

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F 688	Continued From page 9 appropriate to continue progression of LE [lower extremity] strengthening, core stability, and ambulation with RNP [restorative nursing program]. The patient is agreeable to this.' . . . Discharging to RNP (Supine [laying on back] LE strengthening HEP [home exercise program], sitting EOB [edge of bed], standing near EOB with FWW [front wheeled walker], sitting up in w/c [wheelchair] 30-60 mins [minutes]/day, and ambulate to bathroom with FWW. . . ." The record lacked documentation of a restorative nursing program. Observation of Resident #24 on all days of survey showed the resident in bed. During an interview on 05/08/23 at 4:23 p.m., an administrative nurse (#1) stated the facility does not have a current restorative program but are currently working on putting one in place. The medical record lacked evidence of restorative nursing provided to the resident for the dates of April 26-May 8, 2023.	F 688	Assistant Director of Nursing or designee on ensuring restorative nursing programs are being completed by the Certified Nursing Assistants based on the Residents restorative program. Audits of five Residents, including Resident #24, on a restorative program will begin 6/8/23. Audits will be completed 3 times weekly x 4, then once weekly x 4, then monthly x 3. Results of audits will be brought to QAPI for review and recommendation.	
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.	F 880		6/13/23

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F 880	Continued From page 10 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 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	F 880		

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F 880	Continued From page 11 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 3 of 11 sampled residents (Resident #21, #185, and #235) observed during dressing changes and/or blood glucose monitoring. Failure to follow infection control practices for wound care (Resident #21) and blood glucose monitoring (Resident #185 and #235) has the potential for transmission of communicable diseases and infections to residents, staff, and visitors. Findings include: WOUND CARE Review of the facility policy "Clean Dressing Change" occurred on 05/08/23. This policy, dated 07/20/22, stated, ". . . 5. Set up clean field on the	F 880	F880 □ Wound Care 1. Resident #21 did not have negative outcomes from the alleged practice. 2. Resident□s who require dressing changes can be affected by the alleged practice. 3. Administrator or designee will educate nurses and aids on the policy Clean Dressing Change at the Staff Meeting scheduled on June 6th, 2023. Those not in attendance must sign off education prior to next worked shift. 4. Director of Nursing or Designee will audit five Resident dressing changes, including Resident #21, starting 6/8/23. Audits will be completed 3 times weekly x 4, then once weekly x 4, then monthly x 3. Audit results will be submitted to QAPI Committee for review and further	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355031	A. BUILDING _____ B. WING _____	05/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINOT HEALTH AND REHAB, LLC	600 S MAIN ST MINOT, ND 58701

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F 880	Continued From page 12 overbed table with needed supplies for wound cleansing and dressing application . . . a. If table is soiled, wipe clean. b. Place a disposable cloth or linen saver on the overbed table. . . . d. use no-touch techniques . . . (i.e. use tongue blade or applicator) . . . 15. . . . dress wound as ordered. . . . 16. . . . Mark with initials and date." - Observation on 05/07/23 at 2:11 p.m. showed a staff nurse (#3) completed a dressing change to Resident #21's groin area. The nurse placed the clean wound care supplies on the overbed table without first cleaning the table and placing a disposable cloth on the surface. With a gloved hand the nurse reached into his pocket and removed scissors and a sterile water ampule. After removing the supplies from his pocket the nurse then proceeded to pack the wound with Iodoform [type of gauze dressing] using a finger rather than a no-touch technique. Nurse (#3) failed to apply clean gloves and sanitize hands before applying the dressings to the wound. When finished with the procedure the nurse (#3) wiped off the overbed table with hand sanitizer. BLOOD GLUCOSE METERS Review of the facility policy "Blood Glucose Monitoring" occurred on 05/08/23. This revised policy, dated 08/05/22, stated, ". . . Procedure: . . . 8. Clean intended site with an alcohol pad and allow to dry completely do not wave hand to dry puncture site . . .11. Wipe away the first drop of blood using a gauze pad. . . . 18. Remove and discard gloves and perform hand hygiene, 19. Clean and disinfect glucometer as per manufacturer's instructions. . . ."	F 880	recommendations if indicated. F880 Glucose Monitors 1. Resident #235 did not have negative outcomes from the alleged practice. 2. Resident□s who use a glucometer can be affected by this practice. 3. Administrator or designee will educate nurses on the policy titled Blood Glucose Monitoring at the Staff Meeting scheduled on June 6th, 2023. Those not in attendance must sign off education prior to next worked shift. 4. Director of Nursing or Designee will audit blood glucose monitoring and glucometer cleaning for five residents starting 6/8/23. Resident #235 is unable to be audited as they have discharged from the facility. Audits will be completed 3 times weekly x 4, then once weekly x 4, then monthly x 3. Audit results will be submitted to QAPI Committee for review and further recommendations if indicated.	

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F 880	Continued From page 13 - Observation on 05/07/23 at 11:48 a.m., showed a staff nurse (#3) performed a blood glucose monitoring check on Resident #235, using the resident's individual blood glucose monitor. After cleansing the resident's finger with an alcohol pad, the staff nurse (#3) waved his hand to dry it failing to let the finger air dry, then punctured the finger and failed to wipe away the first drop of blood. After completing the task, the nurse (#3) dropped the monitor and disinfecting wipe into the garbage, then retrieved both items from the garbage, and proceeded to use the same wipe to disinfect the monitor. - Observation on 05/07/23 at 4:06 p.m., showed a staff nurse (#4) performed a blood glucose monitoring check on Resident #185, using the resident's individual blood glucose monitor. After completing the task, the nurse (#4) proceeded to apply hand sanitizer directly onto gloved hands and rubbed it onto the glucometer. Both nurses (#3 and #4) failed to disinfect the residents' individual glucose monitors per facility policy. During an interview on the afternoon of 05/09/23, two administrative staff members (#1 and #2) confirmed that they expected staff to follow facility policy and procedure.	F 880		