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 _____	C 05/24/2021

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

(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 and complaint survey started on 05/16/21 and concluded 05/24/21.	F 000		
F 550 SS=E	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	F 550		6/30/21

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

Electronically Signed | 06/25/2021

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F 550	Continued From page 1 from the facility. §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 document, and staff interview, the facility failed to provide care in a manner that enhanced or maintained residents' dignity for 3 of 19 sampled residents (Resident #27, #29, and #37) and 1 supplemental resident (Resident B). Failure to ensure residents' privacy while providing personal cares (Resident #27 and #29) and failure to knock on residents' doors/announce themselves prior to entering (Resident #29, #37, and Resident B) does not enhance their quality of life, does not respect their privacy or personal space, may place them at risk for embarrassment and/or emotional harm, and is a violation of residents' rights. Findings include: Review of the facility document "Our Guiding Principles" occurred on 05/19/21. The document stated, "Respect and Dignity - We will respect and protect the dignity of our residents, patients . . ." - During an interview on 05/16/21 at 1:25 p.m., an anonymous resident (Resident B) reported staff do not knock prior to entering his/her room and stated, "This is my home and I wouldn't just	F 550	F 550 E It is the policy of the facility to provide care in a manner that enhances or maintains residents dignity. 1) Certified Nursing Assistants and Therapy staff have been educated by Director of Nursing or designee on Residents rights starting 6/15/21 including knocking on residents doors and allowing time prior to entering room, on ensuring curtains, doors and privacy curtains are pulled shut during cares and treatments. 2) In-house facility residents have potential to be affected by alleged practice. 3) Facility staff licensed and unlicensed were educated by Director of Nursing or designee on Residents Rights starting 6/15/21 including knocking on residents doors and allowing time prior to entering room, on ensuring curtains, doors and privacy curtains are pulled shut during cares and treatments. 4) Audits will be completed 3 per week by Director of Nursing or designee on privacy and ensuring staff knocking on doors prior to entering a resident room	

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F 550	Continued From page 2 walk into their home without knocking." - Observation on 05/17/21 at 9:15 a.m. showed a certified nursing assistant (CNA) (#13) entered Resident #37's room without knocking on the door. - Observation on 05/17/21 at 2:04 p.m. showed a physical therapist (PT) (#3) walked Resident #27 to his room and untied facility gown exposed his back side and sagging brief. The PT continued to work with Resident #27 in his room with his back side exposed to the hallway while another resident in the hallway watched. The PT failed to pull the privacy curtain and/or close resident's door. - Observation in 05/17/21 at 5:14 p.m. showed two CNAs (#11 and #12) assisted Resident #29 to the bathroom. While the resident was in the bathroom and seated on the toilet, another CNA (#9) entered the resident's room without knocking on the door. - Observation on 05/18/21 at 11:49 a.m. showed a CNA (#8) assisted Resident #29 to the bed and changed her incontinent product. The CNA failed to pull the privacy curtain between Resident #29 and the roommate. The roommate watched the CNA check and change Resident #29. During an interview on 05/19/21 at 12:20 p.m., a supervisory staff member (#7) agreed staff are expected to knock on doors prior to entering the residents' rooms and close the privacy curtain between roommates during personal cares.	F 550	and allowing time for resident to answer prior to entering and ensuring doors shut to rooms and curtains pulled during cares. Audits will be completed for 12 weeks or until substantial compliance is maintained. Results of audits will be brought to QAPI for review and recommendations.	
F 558 SS=D	Reasonable Accommodations Needs/Preferences	F 558		6/30/21

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F 558	Continued From page 3 CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and family interview, the facility failed to provide reasonable accommodation of needs for 1 of 11 sampled residents (Resident #17) who required staff assistance to reach commonly used items such as call light, trash can, remote control, clip board, and writing utensil. Failure to consistently place items near Resident #17 while in bed may result in an inability to call for help and/or increase the resident's risk for falls. Findings include: Review of Resident #17's medical record occurred on all days of survey. Resident #17's current care plan stated, "Minimize risk for injury r/t falls. . . . Ensure trash can is next to resident's bed within easy reach. . . . Have commonly used items within easy reach. Remote control, glasses, box of Kleenex, clip board and something to write with. . . ." The following observations showed Resident #17 in bed without call light in reach, no glasses visible, remote control and Kleenex box across the room on television tray, trash can at the end of the bed, and no clipboard in room on: * 05/17/21 at 9:23 a.m.	F 558	F 558- D It is the policy of facility to provide reasonable accommodations of resident needs and preferences except when to do so would endanger the health and safety of the resident or other residents. 1) Resident #17 was educated on call light and how to use by Director of Nursing or designee on 6/24/21 and the care plan for Resident #17 was also reviewed and updated to ensure staff keep glasses and other frequently used items within resident reach on 6/22/21. 2) In-house facility residents have the ability to be affected by alleged practice. 3) Facility Nursing Staff, Therapy and Interdisciplinary Team were educated by Director of Nursing or Designee on prior to leaving room ensuring residents have call light within reach and other frequently used items, such as tissues, glasses, reachers, etc. This education started on 6/14/21. 4) Audits will be completed by Executive Director or designee 3 per week for 12 weeks or until substantial compliance is maintained. Results of audits will be	

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F 558	Continued From page 4 * 05/17/21 at 11:29 a.m. * 5/17/21 at 1:42 p.m. * 5/17/21 at 2:21 p.m. * 5/17/21 at 2:51 p.m. * 5/17/21 at 4:13 p.m. * 5/18/21 at 7:54 a.m. * 5/18/21 at 5:22 p.m. During a family interview on 05/17/21 at 5:23 p.m., observation showed the family member placed the call light in Resident #17's hand, encouraged the resident to use, and the resident pushed the call light. A family member stated Resident #17 is able to use the call light, however staff consistently failed to place it within reach. Failure of the facility to make reasonable accommodations and assist residents in maintaining their highest level of functioning may result in injuries related to falls.	F 558	brought to QAPI for review and recommendations.	
F 577 SS=C	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility.	F 577		6/30/21

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F 577	Continued From page 5 (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation, resident council interview, and staff interview, the facility failed to post the results of the most recent Federal and/or State surveys in a place readily accessible to residents, family members, and/or legal representatives on 4 of 4 days of survey (May 16-19, 2021). Failure to post or make available the Health and Life Safety Code survey results for the prior three years is an infringement of the residents' rights. Findings include: Observations throughout the facility May 16-19, 2021 found no survey results posted in a readily accessible, prominent location for residents or others to view. During the group interview on 05/17/21 at 3:32 p.m., when asked if the Federal and/or State survey results were placed in a readily accessible location where residents, family members, and/or legal representatives wishing to examine them did not have to ask to see them, seven residents	F 577	F 557 C It is the policy of facility to post the survey results of the most recent Federal and/or State surveys in a place readily accessible to residents, family members, and/or legal representatives. 1) The State Health Department Survey results are now located in a specified location. Each existing resident/representative will be educated utilizing a letter to the resident and/or representative to the precise location of the result and how to obtain survey results for the past 3 years. 2) Residents have the potential to be impacted. On 6/1/21 a Resident Council Meeting was conducted; facility residents were educated on location of survey results binder by Executive Director or designee. An audit was completed by Executive Director or designee on 6/24/21 on ensuring signs defining where results are located are available in facility at height residents can see and read. As	

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F 577	Continued From page 6 (Resident, D, F, G, H, I, J, and K), identified by the facility as interviewable, responded, "No." During an interview on 05/19/21 at 2:45 p.m., when asked where Federal and/or State survey results were placed in a readily accessible location where residents, family members, and/or legal representatives wishing to examine them did not have to ask to see them, an administrative nurse (#6) stated she had a copy in her desk drawer but was unaware of the requirement. During an interview on 05/19/21 at 2:48 p.m., an administrative manager (#7) stated results of the surveys are normally on the table outside of the office by the elevator.	F 577	part of the admission process, each new admit/representative will be provided documentation with the precise location of the binder and the survey binder□s intended purpose. 3) Facility staff were educated by Executive Director or designee on location of survey results binder starting 6/25/21 for staff to assist resident to area as needed. 4) Audits will be completed by Executive Director or designee, audits will be completed 3 per week for 12 weeks or until substantial compliance is maintained. Audits will include ensuring binder up to date and available and will also include a resident or family/responsible party interview to verify location of results known if wanted. 5) The date of compliance, June 30th, 20121	
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).	F 578		6/30/21

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F 578	Continued From page 7 (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review, policy review, and staff interview, the facility failed to ensure staff documented the resident's right to request, refuse, and/or discontinue treatment for 2 of 19 sampled residents (Resident #7 and #349) reviewed for advanced directives. Failure to ensure documentation of code status for each resident accurately reflected the resident/resident representative wishes has the potential to result in lack of or unwanted treatment.	F 578	F 578 It is the policy of facility to ensure staff document the residents right to request, refuse, and/or discontinue treatment. 1) Resident #7 was discharged home from facility on 5/22/21 and Resident #349 was discharged from facility on 6/15/21. 2) In facility residents have ability to be affected by alleged practice 3) By 6/22/21 an audit of in-house	

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F 578	Continued From page 8 Findings include: Review of the facility policy titled "Living Will/Advance Directives/Life-Sustaining Treatment Orders" occurred on 05/18/21. This policy, dated 06/01/17, stated, ". . . POLST (Physician Orders for Life-Sustaining Treatment) is a set of medical orders that are developed and documented following a resident's (or the resident's designated decision-maker) conversation with his/her physician. . . . Together the physician and resident (or resident's designated decision-maker) make an informed decision about life-sustaining treatment. . . ." - Review of Resident #349's medical record occurred on all days of survey. The physician's order identified "Full Code." The POLST form, signed and dated by the resident on 05/16/21, identified "DNR" (Do Not Resuscitate). The POLST form did not contain a physician signature. During an interview on 05/18/21 at 11:08 a.m., an administrative nurse (#1) stated the POLST form is completed and signed by the resident or his/her representative, then sent to the provider for signature. The administrative nurse (#1) stated the Electronic Medical Record (EMR) system defaults to full code until another status is entered. - Review of Resident #7's medical record occurred on all days of survey. The admission Minimum Data Set (MDS), dated 02/25/21, identified cognitively intact. A physician's order, dated 02/19/21, stated, "DNR." The resident's POLST form, dated 03/22/21, included a	F 578	residents was completed by Director of Nursing or designee verifying that POLST on file matches facility electronic charting designation. In-house residents that do not have current POLST on file or Advanced Directives will meet with Social Worker or designee and education on Advanced Directives provided. 4) Facility Nursing staff were educated by Director of Nursing or designee starting 6/23/21 on Advanced Directives and ensuring orders remain current and are updated with changes as they occur. 5) Random audits will be completed by Director of Nursing or designee 3 times per week for 12 weeks or until substantial compliance maintained. Audit will include ensuring Advanced Directive available in chart and they match facility electronic charting. Results of audits will be brought to QAPI for review and recommendation.	

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F 578	Continued From page 9 checkmark in the boxes for "CPR/Attempt Resuscitation," "Full Treatment," and "No artificial nutrition by tube." During an interview on 05/19/21 at 3:27 p.m., a nurse supervisor (#2) verified the order conflicted with the POLST form's information. The facility failed to ensure the POLST forms were signed by the physician and the orders accurately reflected resident/representative code status wishes.	F 578		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2)	F 580		6/30/21

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F 580	Continued From page 10 is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on information provided by the complainant, record review, review of the facility's policy, and staff interview, the facility failed to notify the physician and resident representative for 2 of 9 sampled residents (Resident #17 and #36) and 1 closed record (Resident #94) who experienced a change in condition and/or fall. Failure to notify the physician and resident representative of a change in condition and/or fall limits their ability to make informed decisions regarding medical care.	F 580	F 580 If is the policy of facility to notify physician and resident representative of a resident who experienced a change in condition. 1) Resident #94 was discharged from facility on 4/15/21. Resident#17 and #36 are currently residents in facility. Responsible Party for Resident #17 and #36 was contacted By Director of Nursing or designee by 6/24/21 and identified incidents were reviewed and any questions were answered. Resident	

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F 580	Continued From page 11 Findings include: Review of the facility policy titled "CHANGE OF CONDITION OF THE RESIDENT (OBSERVING RECORD AND REPORTING)" occurred on 05/19/21. This policy, dated December 2016, stated, ". . . When a resident presents with a possible change of condition, after a fall*[sic] or other possible injury, trauma, noted changes in mental or physical functioning . . . Notification of practitioner - include date, time, what was conveyed, any comments received (each time notified) . . . Notification of responsible party - include date, time, what was conveyed, any comments received (each time notified) . . ." Information received from the complainant indicated the facility staff failed to notify the resident's representative of a change in the resident's condition. - Review of Resident #17's medical record occurred on all days of survey. The progress notes identified the following: * 07/05/20 at 2:00 a.m., "Resident was found lying on the floor . . . [name of Doctor] notified through the fax, family to be notified this morning." The facility failed to provide additional documentation indicating notification to the family. * 07/15/20 at 3:11 p.m., "Wife, [name of wife] notified of witnessed fall . . . ." The facility failed to notify the physician. * 08/04/20 at 9:45 p.m., " . . . found [name of resident] lying on the fall mat . . . ." The facility failed to notify the physician or the family. * 09/09/20 at 2:00 p.m., " . . . noted on his floor	F 580	#17□s primary care physician was contacted By Director of Nursing or designee by 6/24/21 and physician was notified of incidents and plan of care was reviewed. 2) In-house facility residents have the ability to be affected by the alleged practice. 3) Facility Licensed Nursing staff was educated by Director of Nursing or designee on Change in Condition starting 6/24/21. Education includes ensuring timely notification to responsible party and physician and ensuring notification is documented. 4) Charting review is being completed with Morning clinical meeting by Director of Nursing or designee. Review will include verification of notification. Audits will be completed 5 per week by Director of Nursing or designee of a change of condition, audit will include ensuring proper notification and charting of notification. Audits will be completed for 12 weeks or until substantial compliance is maintained and results of audits will be brought to QAPI for review and recommendation.	

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	355031	A. BUILDING _____ B. WING _____	C 05/24/2021

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F 580	Continued From page 12	F 580		

mat . . . " The facility failed to notify the physician or the family.
* 11/12/20 at 3:00 p.m., " . . . had a supervised fall from his wheelchair. . . ." The facility failed to notify the physician or the family.
* 12/09/20 at 4:55 p.m., "Nurse . . . saw him sitting at his bed side. . . . He was lifted back to his bed. . . ." The facility failed to notify the physician.
* 03/12/21 at 8:00 p.m., "Resident was found . . . next to bed on floor . . . . Will have family updated in morning. Will let MD [Medical Doctor] know as well." The facility failed to notify the physician and the family.

The medical record lacked evidence staff notified the resident representative and/or physician of Resident #17's falls.

- Review of Resident #36's medical record occurred on all days of survey and identified a transfer to the emergency room (ER) on 04/23/21. The medical record lacked evidence the staff notified the resident representative of the change of condition and transfer to the ER.

- Review of Resident #94's medical record occurred on 05/18/21 and identified transfers to the ER on 04/10/21 and 04/15/21. The medical record lacked evidence staff notified the resident representative of the change of condition and trasnfer to the ER on both occasions.

During an interview on 05/18/21 at 3:50 p.m., an administrative staff member (#2) confirmed staff failed to notify the resident representative of change of conditions and transfers to the ER for Resident #36 and #94.

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F 585 SS=E	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone	F 585		6/30/21

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number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement

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F 585	Continued From page 15 as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on observation, the resident council interview, review of facility policy, and staff and family interviews, the facility failed to ensure 7 of 7 residents (Resident D, F, G, H, I, J, and K) attending the Resident Council interview obtained accurate information on the grievance process. Failure to implement the grievance policy inhibited residents' right to file and ensure prompt resolution of all grievances. Findings include: Review of facility policy "GRIEVANCE POLICY AND PROCEDURE" occurred on 05/18/21. This policy, dated 02/24/18, stated, "The facility will seek to resolve concerns, complaints or grievances and provide residents, responsible parties, staff and others feedback and resolution in a timely manner. . . . Concern forms will be made available . . . Residents, Residents'	F 585	F 585 It is the facility policy to ensure residents have the right to voice grievances to the facility or other agency or entity that hears grievances with discrimination or reprisal and without fear or discrimination and reprisal. 1) Facility in-house residents have the ability to be affected by alleged practice. 2) Interdisciplinary team was educated by Director of Clinical Services or designee on Grievance Process starting 6/23/21. 3) A Resident Council meeting was conducted by 6/1/21. Grievance Process was reviewed with residents including how to file a grievance. Each new admit/representative and existing	

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F 585	Continued From page 16 families . . . will be in-serviced [sic] on the Grievance procedure, how to initiate a grievance, who the Grievance Officer is . . . Residents will be in-serviced through Resident Council Meetings and admission . . . A copy of the initiated concern form will be placed in the Grievance Notebook . . . The Department Head that is assigned the concern form . . . provide a resolution to the issue within 72 hours . . . Once resolution of grievance is achieved, Grievance Officer will ensure that follow up with the concerned party, . . . and document of the concerned party's response . . . In addition, the Grievance Officer will receive a copy of the resident council meeting minutes . . . ensure that for any expressed concerns a grievance is initiated and addressed through the grievance process. . . . A Monthly Grievance Log will be completed . . . Additionally, the Monthly Grievance Logs will be submitted to the monthly QA/ PI (Quality Assurance/Performance Improvement) meeting for review and recommendation. . . . The Grievance Officer will maintain the Grievance Log monthly. At the end of each year, the Grievance Log with investigative summaries . . . maintained for 3 years to demonstrated resolution of complaints and grievances." Observations throughout the facility on May 16-19, 2021 found no grievance/concern forms available. During the resident council interview on 05/17/21 at 3:32 p.m., Residents D, F, G, H, I, J, and K, indicated no knowledge of the facility's Grievance Officer or how to locate or complete a grievance form. Resident F stated the administrative staff	F 585	residents and/or representative will be provided documentation and/or notification regarding the facility's grievance policy and process. 4) Facility staff were educated by Executive Director or Designee on Grievance Process including how to file a concern on behalf of resident or family member. Education was started on 6/14/21. 5) Audits will be completed by Executive Director or designee on Grievance Process including timely follow up with person filing grievance and ensuring documentation of grievances. Audits will be completed 3 per week for 12 weeks or until substantial compliance is maintained. Results of Audits will be brought to QAPI for review and recommendation.	

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F 585	Continued From page 17 had been told about his/her concerns but issues "are not addressed." During a family interview on the afternoon of 05/17/21, a family member (#3) stated, "I have reported concerns to administrative staff and nothing has ever been done about them." During an interview on 05/18/21 at 5:06 p.m., when asked how the facility handles concerns from a family or resident, an administrative manager (#7) verified the family/resident communicated verbally and without written documentation. An administrative nurse (#6) verified the facility should document concerns/grievances and has no plan currently in place. He/she agreed the facility failed to have a plan in place for the documentation of concerns/grievances. During an interview on 05/19/21 at 12:55 p.m., an administrative activity staff (#20) verified when meetings were held the facility failed to document in order to follow up on any concerns. The facility failed to implement the facility grievance policy, instruct residents on how to file a grievance, and identify the name and contact information of the Grievance Official violated Residents' Rights.	F 585		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the	F 625		6/30/21

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F 625	Continued From page 18 nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to provide a bed hold notice upon transfer to the hospital for 3 of 7 sampled residents (Resident #13, #29, and #36). Failure to provide a bed hold notice does not allow residents or their legal representatives to make informed choices regarding their readmission rights. Findings include: Review of the facility policy titled "Bed-Hold Policy" occurred on 05/18/21. This policy, dated	F 625	F625 It is the policy of the facility that at the time of transfer to provide the resident and resident representative written notice which specifies the duration of the bed-hold 1) Resident #13 was discharged on 6/13/21. Resident #29 was re-admitted to the facility on 4/1/21 to the same room and bed as prior to transfer. Resident #36 was re-admitted to the facility on 4/27/21 to the same room and bed as prior to transfer.	

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F 625	Continued From page 19 06/12/18, stated, ". . . The facility will notify the resident at the time of admission and again prior to a hospital transfer or therapeutic leave of its bed-hold and return policies. . . . In cases of emergency transfer, notice at the time of transfer means that the resident, family or representative is provided with written notification within twenty-four (24) hours of the transfer. . . ." - Review of Resident #13's medical record occurred on all days of survey and identified a transfer to the hospital on 03/01/21. The record lacked evidence the facility notified the resident and/or the family/legal representative. - Review of Resident #29's medical record occurred on all days of survey and identified a transfer to the hospital on 03/30/21. The record lacked evidence the facility notified the resident and/or the family/legal representative. - Review of Resident #36's medical record occurred on all days of survey and identified a transfer to the hospital on 04/23/21. The record lacked evidence the facility notified the resident and/or the family/legal representative. During an interview on 05/18/21 at 3:50 p.m., an administrative staff member (#2) confirmed the facility failed to provide the bed hold notices.	F 625	2) Facility in-house residents are at risk of the alleged practice. 3) Facility nurses and interdisciplinary team members will be educated by Executive Director on the bed-hold process starting on 6/23/21. Bed-hold forms will be reviewed with the resident or resident representative at the time of transfer. 4) Audits will be completed on resident transfers to the hospital or therapeutic leave. Audits will be completed 3 times weekly for 12 weeks or until substantial compliance is maintained. Results of audits will be reviewed by the QAPI committee for recommendations.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by:	F 641		6/30/21

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F 641	Continued From page 20 THIS IS A REPEAT DEFICIENCY FROM THE STANDARD SURVEY CONDUCTED ON 10/21/19 Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.16), and staff interview, the facility failed to ensure the Minimum Data Set (MDS) accurately reflected the resident's status for 1 of 19 sampled residents (Resident #37). Failure to accurately complete the MDS does not allow each resident's assessment to reflect their current status/needs, and has the potential to affect the accurate development of a comprehensive care plan and the care provided to the residents. Findings include: The Long-Term Care Facility RAI Manual, revised October 2019, pages M-35 states, ". . . M1200C Turning/Repositioning Program. The turning/repositioning program is specific as to the approaches for changing the resident's position and realigning the body. The program should specify the intervention [example given], reposition on side, pillows between knees) and frequency (e.g., every 2 hours). Progress notes, assessments, and other documentation (as dictated by facility policy) should support that the turning/repositioning program is monitored and reassessed to determine the effectiveness of the intervention. . . . " Review of Resident #37's medical record occurred on all days of survey. Diagnoses included multiple sclerosis. A quarterly MDS, dated 04/13/21, identified Section M0300B coded	F 641	F 641 It is the policy of facility to ensure the Minimum Data Set (MDS) accurately reflects the resident status. 1) Resident #37 with MDS dated 4/13/21 corrected for section M on turning and repositioning due to coding and was submitted on 6/24/21 by Resident Care Management Director. 2) Facility in-house residents have the ability to be at risk of the alleged practice. Review of most recent MDS section M related to turning and repositioning programming was completed by Resident Care Management Director or designee to verify if corrections were needed and any identified issues corrected and submitted on 6/25/21. 3) Resident Care Management Director, responsible for completing and submitting section M,was educated by Director of Clinical Reimbursement on 6/23/21 on Section M of MDS including turning and repositioning program. 4) Audit will be completed of 3 MDS submitted per week to verify accurate coding of section M of the MDS related to turning and repositioning. Audits will be completed by Resident Assessment Coordinator or designee and will be completed for 12 weeks or until substantial compliance is maintained. Results of MDS will be brought to QAPI for review and recommendations.	

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F 641	Continued From page 21 for stage 2 pressure ulcer and M1200 coded for a turning/repositioning program. During an interview on 05/18/21 at 2:25 p.m., an administrative nurse (#6) verified the medical record lacked doucmentation of a turning/repositioning program for Resident #37.	F 641		
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 for Preadmission Screening and Resident Review (PASRR) 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 3 sampled residents	F 644	F644 It is the policy of the facility to coordinate assessments with the PASARR program and incorporate recommendations into the resident care plan. 1) Resident #17 had a PASARR level I completed and submitted to the State	6/30/21

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F 644	Continued From page 22 (Resident #17) with a newly diagnosed mental illness. Failure to complete a change in status assessment may result in the delivery of care and services inconsistent with the residents' needs. Findings include: The North Dakota PASRR Provider Manual, page 13, stated, ". . . 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 #17's medical record occurred on all days of survey. The initial PASRR, completed on 11/16/16, identified no Level II Condition and was appropriate for Long Term Care (LTC) placement. The medical record identified a new diagnosis of unspecified psychosis not due to a substance or known physiological condition on 06/18/18. The record lacked evidence of an updated Level I screening/change in status assessment since the additional diagnosis. During an interview on 05/18/21 at 2:02 p.m., two administrative nurses (#2 and #6) confirmed the	F 644	agency on 6/21/21. 2) Residents in-house with newly diagnosed mental health illness are at risk for the alleged practice. Facility residents reviewed for change of condition PASARR with newly diagnosed mental health illness on 6/22/21.Psychotropic medication changes will be reviewed by IDT at morning meetings, Social Worker or designee will update or complete PASARR forms and submit to State Agency as indicated. 3) Social Worker or designee will be educated by the Director of Nursing on the PASARR programs, including level one and level two screening and incorporating recommendations into the resident care plan by 6/30/21. 4) Audits will be completed by the Social Worker or designee on new diagnoses requiring PASARR screening 3 times weekly for 12 weeks or until compliance is maintained. Audits will be brought forward to the QAPI Committee for review and recommendation.	

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F 644	Continued From page 23 facility failed to submit a PASRR for Resident #17 due to the change in status.	F 644		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the	F 656		6/30/21

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F 656	Continued From page 24 community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident and staff interviews, the facility failed to develop a comprehensive care plan for 3 of 19 sampled residents (Resident #5, #13 and #39). Failure to develop a care plan that includes the care and services to be provided to the resident may negatively impact the resident's quality of life. Findings include: - Review of Resident #5's medical record occurred on all days of survey. A progress note, dated 03/15/21, stated, ". . . Call . . . with Aging Service to discuss discharge plan. . . . [Aging Service] . . . to assist with going home. Family meeting scheduled with all disciplines and resident for 3/24/21 to assist with finalizing planning." During an interview on 05/16/21 at 2:30 p.m., Resident #5 stated he/she expected to return home, however waiting for assistance to make home more handicap accessible. On the afternoon of 05/19/21, an administrative staff member (#2) stated facility staff met with family on 03/24/21 and failed to complete documentation regarding this meeting.	F 656	F656 D It is the policy of facility to develop a comprehensive care plan that includes the care and services to be provided to the resident. 1) Resident # 5 was discharged from facility on 6/1/21, Resident # 13 was discharged from facility on 6/16/21 and Resident #39 was discharged from facility on 6/15/21. 2) Facility in house residents have ability to be affected by alleged practice. Facility in house residents had care plan reviewed by Interdisciplinary Team starting 6/9/21. Any identified services provided to resident were reviewed and care plans were updated as appropriate. 3) Interdisciplinary Team and Administrative nurses were educated on need to care plan services provided to resident and discharge planning starting 6/9/21, this includes updating care plan as changes are made to plan of care. Facility licensed nursing staff was educated by Director of Nursing or designee on need to update care plan to accurately reflect services provided to residents.	

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F 656	Continued From page 25 The care plan failed to address the resident's and/or their representative's wishes regarding discharge planning. - Review of Resident #13's medical record occurred on all days of survey. The current physician orders stated, ". . . Oxygen 4 LPM [liters per minute]/NC [per nasal cannula] every shift [started 03/07/21] . . ." During an interview on 05/16/21 at 11:55 a.m., Resident #13 stated he/she is expecting to return home. Observation at this time showed the resident utilized oxygen. The care plan failed to address the resident's and/or their representative's wishes regarding discharge planning or the use of the oxygen. - Review of Resident #39's medical record occurred on all days of survey. Random observations on May 16-19, 2021 showed resident currently on contact precautions for a history of Methicillin-resistant Staphylococcus aureus (MRSA). The care plan failed to address Resident #39's contact precautions.	F 656	4) Audits will be completed by Director of Nursing or Designee of residents care plans. Audit will include review of care plan to ensure accurate reflection of services to resident. Audits will be completed 4 audits per week for 12 weeks or until substantial compliance is maintained. Results of Audits will be brought to QAPI for review and recommendations.	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to--	F 657		6/30/21

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F 657	Continued From page 26 (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (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. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE STANDARD SURVEY CONDUCTED ON 10/21/19 Based on record review and resident and staff interviews, the facility failed to ensure staff reviewed and revised comprehensive care plans to reflect the residents' current status for 2 of 19 sampled residents (Resident #7 and #13) reviewed. Failure to review and revise the care plans limited the staffs' ability to communicate needs and ensure continuity of care. Findings include: - Review of Resident #7's medical record	F 657	F657 D It is the policy of facility to ensure staff review and revise comprehensive care plans to reflect the residents current status. 1) Resident #7 was discharged from facility on 5/22/21. Resident #13 was discharged from facility on 6/16/21. 2) Facility in-house residents have ability to be affected by alleged practice. Facility in-house residents had care plan reviewed by Interdisciplinary Team starting 6/9/21. Any identified services provided to resident were reviewed and care plans were updated as appropriate. 3) Interdisciplinary Team and	

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F 657	Continued From page 27 occurred on all days of survey. The current care plan stated, ". . . At risk for falls . . . Provide assist to transfer and ambulate as needed . . ." During an interview on 05/16/21 at 12:20 p.m., Resident #7 stated she was bedbound, used a full-body lift to get up in the wheelchair, experienced dizziness when turned onto her left side, and complained of pain related to spasms, nerve issues, and headaches. During an interview on 05/18/21 at 1:57 p.m., a medication aide (MA) (#5) reported Resident #7 was unable to stand or walk, transferred with a full-body lift, rarely got up in wheelchair, and experienced dizziness when sitting up. Resident #7's care plan failed to include her inability to ambulate, pain, dizziness, and use of a full-body lift for transfers. - Review of Resident #13's medical record occurred on all days of survey. The current care plan stated, ". . . Resident has actual skin integrity break and/or pressure sore(s) - See wound assessment Surgical Wound left ankle . . ." During an interview on 05/16/21 at 11:55 a.m., Resident #13 stated he/she had a skin graft procedure on his left foot and has an open area to his/her buttock that staff provide treatment. Review of Resident #13's wound assessment, dated 05/13/21, identified a stage III pressure ulcer to right gluteal fold. Resident #13's care plan failed to include the	F 657	Administrative nurses were educated on need to care plan services provided to resident and discharge planning starting 6/9/21 this includes updating care plan as changes are made to plan of care. Facility licensed nursing staff was educated by Director of Nursing or designee on need to update care plan to accurately reflect services provided to residents. 4) Audits will be completed by Director of Nursing or Designee of residents care plans. Audit will include review of care plan to ensure accurate reflection of services to resident. Audits will be completed 4 audits per week for 12 weeks or until substantial compliance is maintained. Results of Audits will be brought to QAPI for review and recommendations.	

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F 657	Continued From page 28 stage III pressure ulcer to the right gluteal fold.	F 657		
F 658 SS=E	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: THIS IS A REPEAT DEFICIENCY FROM THE STANDARD SURVEY CONDUCTED ON 10/21/19 Based on information provided by a complainant, observation, record review, policy review, and resident and staff interviews, the facility failed to follow professional standards of practice for 4 of 19 sampled residents (Resident #27, #36, #39, and #349) and 1 supplemental resident (Resident #4). Failure to follow up on the physician's recommendations regarding insulin dosage (Resident #349), follow/clarify physicians' orders (Resident #27, #36, and #39), and follow orders/policy regarding residents' weights (Resident #4 and #36) placed the residents at risk for adverse health effects. Findings include: Information received from the complainant indicated the facility staff failed to follow physician's orders in providing cares. BLOOD SUGAR LEVELS/INSULIN ORDERS - During an interview on 05/16/21 at 12:01 p.m.,	F 658	F 658 E It is the policy of facility that services provided or arranged by the facility as outlined by the comprehensive care plan, must meet professional standards of quality. 1) Resident #349 was discharged from facility on 6/15/21. Resident # 27 was discharged from facility on 6/10/21. Resident #39 had supplement order reviewed and updated by Registered Dietician on 6/21/21. Resident # 36 is refusing unaboot application, primary care physician was updated and orders were discontinued for unaboots, Resident #36 responsible party was updated and in agreement 6/17/21. Resident # 36 had weights reviewed by primary care physician on 6/25/21, and RD review weights on 6/21/21 any new recommendations were implemented 6/25/21 , and Responsible party updated 6/25/21. Resident # 4 had weights reviewed by Registered Dietician on 5/3/21, Primary Care physician was updated on weights on 5/3/21. Any new order recommendations received were	6/30/21

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F 658	Continued From page 29 Resident #349 stated her blood sugars have been elevated since her admission to the facility. The resident stated she was taking 100 units of Humulin R (regular insulin) three times a day before meals prior to admission but is currently only receiving 10 units three times a day. Review of Resident #349's medical record occurred on all days of survey. Diagnoses included diabetes mellitus. The current physician's orders identified Humulin R 20 units three times a day. Resident #349's progress notes identified the following: * 05/07/21 at 1:39 p.m.: "Resident saw on rounds today. Orders received . . . sliding scale Novolog (fast acting insulin) added . . ." * 05/07/21 at 6:01 p.m.: "[Name of pharmacy] called and they have a concern with the Novolog insulin order, as resident is already on a short acting insulin. She is on Humulin R 20 units with meals and rec'd [received] a new order for SS [sliding scale] Novolog insulin today from [provider name]. Will fax provider to clarify order." * 05/07/21 at 6:53 p.m.: "Spoke with [provider name], he called the facility, in regards to insulin order, he stated okay to hold it for the weekend, he will look into it on Monday." * 05/10/21 at 3:42 p.m.: "Response rec'd for this note, from provider. "We can hold off sliding scale Novolog until reevaluated next week." * 05/12/21 at 7:04 p.m.: "Late Entry: Resident BS [blood sugar] reading continues to read in the 300 [milligrams per deciliter], and sometimes 200. She stated "My insulin is reduced now, and I usually take 100u [units] with meals. That's why my readings has [sic] been high" I contacted	F 658	implemented and Responsible party was updated on weights and changes on 6/25/21. 2) Facility in-house residents receiving medications and having weights monitored by facility have ability to be affected by alleged practice. 3) Facility nursing staff and those administering medications to residents were educated by Director of Nursing or designee starting 6/24/21 on weight policy and following physician prescribed orders. If residents refusing prescribed treatments or orders then primary care physician is to be notified for possible treatment changes. 4) Audits will be completed of residents weights and EMAR/ETAR to verify weights and orders are being completed per policy and orders. Audits will be completed by Director of Nursing or designee and will be completed 4 per week for 12 weeks or until substantial compliance is maintained. Results of Audits will be brought to QAPI for review and recommendations.	

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[provider name] and reported her complains [sic]. He asked me to contact her endocrinologist in [city]. So I called [city] and got a hold on [sic] the nurse to FNP [Family Nurse Practitioner name]. She asked for her BS record and her MAR [medication administration record]. I faxed all document to [nurse] and hope to hear back from her, with insulin dosing change."
* 05/13/2021 at 12:39 a.m.: "Pt [patient] has been experiencing high CBG's [capillary blood glucose] since admission to facility. Pre admission MD [medical doctor] over seeing diabetic Monitoring and ordering has faxed pre admit to facility orders which consist of Humulin R U-500 of 100 units TID [three times a day] 30 minutes prior to meal. On admit to facility pt [patient] orders are Humulin R U-500 20 units. S/S on Hold as Per admit orders. Both pre orders, current orders, and CBG's since admit faxed to house MD for review. Via Phone From prior provider [provider name]."
* 05/17/2021 at 2:52 a.m.: ". . . Continue to wait for response on elevated CBG's and reinstating, pre admission insulin orders. Will pas [sic] on to day shift to call MD in AM [morning]"

The "Vitals: Blood Sugar" summary, dated May 6-19, 2021, identified the resident's blood sugars ranged in the 300's on 25 occasions and in the 400's on nine occasions.

It took the facility staff 13 days to followup with the MD on the elevated blood sugars for Resident #349.

During an interview on 05/18/21 at 8:03 a.m., Resident #349 stated her blood sugar was in the 300's this morning and she is concerned about

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her blood sugars running so high.

During an interview on 05/18/21 at 11:16 a.m., two administrative nurses (#1 and #2) confirmed followup on Resident #349's blood sugars and insulin dose should have been sooner.

On 05/19/21 at 12:30 p.m., Resident #349's MAR identified Humulin sliding scale restarted on 5/18/21. An administrative nurse (#1) failed to locate the provider's order for the Humulin insulin.

During an interview on 05/19/21 at 12:46 p.m., an administrative nurse (#2) stated a facility provider called her back last night with the order to restart the Humulin sliding scale but the nurse (#2) failed to document the phone order.

Failure to follow up on Resident #349's elevated blood sugars and insulin dose in a timely manner and document physician's orders placed the resident at increased risk for further medical concerns.

PHYSICIAN ORDERS

- Review of Resident #36's medical record occurred on all days of survey and included a diagnosis of edema and dementia. A current physician's order, dated 09/09/20, stated, ". . . Please place on both legs from tip of toes to knee: UNA [sic] boots [medicated wraps to reduce swelling and/or assist with healing wounds] to BLE [bilateral lower extremities] change after shower on Monday and Thursday to help with edema and keep [Resident #36's name] from tearing legs reopen. . . ."

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F 658	Continued From page 32 Random observations on all days of survey showed Resident #36 without UNNA boots to bilateral lower extremities. During an interview on 05/19/21 at 10:16 a.m., a staff nurse (#15) agreed the facility failed to follow physician's orders for Resident #36's UNNA boots. - Review of Resident #27's medical record occurred on all days of survey. A physician order, dated 04/01/21, stated, "Edema to BLE management: Cleanse BLE with wound cleanser, apply vasoline impregnated gauze to any open areas, wrap with kerlex [Kerlix gauze] and wrap with ACE [a proprietary elastic bandage] wraps once daily and as needed." Random observations on all days of survey showed Resident #27 without ACE wraps to both lower legs per physician's order. Review of the May 2021 Treatment Administration Record (TAR) showed staff failed to apply ACE wraps on 7 of 19 days. - Review of the facility policy titled "Receiving and Recording Medication Orders" occurred on 05/19/21. This policy, dated 06/01/17, stated, "Purpose: Establish uniform guidelines in the receiving and recording of medication orders . . . Procedure: . . . 7. When recording orders for commercial dietary supplements, specify the type, amount and frequency (e.g. [such as], Ensure 3 oz. [ounces] tid between meals.). . . ." Review of Resident #39's medical record	F 658		

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occurred on 05/19/21. Diagnoses included multiple pressure ulcers and obesity. The current care plan stated, "At risk for nutritional status change r/t [related to] increased need for healing, small wt [weight] loss . . . Administer vitamin/mineral supplements as ordered Proheal [liquid protein supplement] TID . . ."

A physician's order per a dietician's recommendation, dated 01/30/21, stated, "Proheal 300 cal. [calories] 45 gm [grams] [protein] PO [orally] TID, three times a day for skin breakdown."

Observation on 05/19/21 at 8:19 a.m. showed a medication aide (MA) (#8) administered one ounce of Proheal supplement (100 calories and 15 grams protein per one ounce) to Resident #39. The medication aide failed to administer the three ounces (300 cal/45 gm) as ordered.

During an interview on 05/19/21 at 10:17 a.m., a MA (#8) verified the one ounce dose administered to Resident #39 and a staff nurse (#15) present at the time agreed with the one ounce dose.

During an interview on 05/19/21 at 10:30 a.m., an administrative nurse (#6) agreed the order "looks like each dose is for 45 grams." At 10:50 a.m., the nurse conferred with the dietician who wrote the order and who clarified the total daily dose was meant to be 45 grams (15 grams three times daily).

Facility staff failed to follow and/or clarify the physician's order for Resident #39.

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F 658	Continued From page 34 WEIGHTS Review of the facility policy titled "WEIGHT ASSESSMENT AND INTERVENTION" occurred on 05/19/21. This undated policy stated, ". . . Team member will follow a consistent approach to weighing . . . Any weight change of five (5) pounds or more since the last weight assessment will be retaken for confirmation . . ." - Review of Resident #4's medical record occurred on 05/17/21. The physician's order stated, "Weekly weight every Thursday. Chart results under weight tab . . . (started 01/29/21)" Facility staff failed to complete Resident #4's weekly weights on 10 of 17 occassions in the last four months and failed to re-weigh the resident when a weight change of greater than five pounds occurred on 02/17/21 and 05/01/21. During an interview on 05/17/21 at 4:42 p.m., a registered dietitian (#14) stated staff failed to obtain weekly weights. - Review of Resident #36's medical record occurred on all days of survey. The record identified three occasions in the last six months the resident's weights differed more than five pounds from the previous weights. Facility staff failed to re-weigh the resident on 10/27/20, 04/09/21, and 05/04/21 as per facility policy. The facility failed to follow the physician's orders to obtain weekly weights for Resident #4 and failed to follow the facility's policy regarding re-weighing residents for Resident #4 and #36.	F 658		
F 660	Discharge Planning Process	F 660		6/30/21

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F 660 SS=E	Continued From page 35 CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in	F 660		

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F 660	Continued From page 36 returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. This REQUIREMENT is not met as evidenced by:	F 660		

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F 660	Continued From page 37 Based on information provided by the complainant, record review, and resident and staff interview, the facility failed to develop or implement a discharge plan for 2 of 2 sampled residents (Resident #5 and #13), 1 supplemental resident (Resident #25), and 1 closed record (Resident #95) identified by the facility as planning for discharge. Failure to assess and provide sufficient preparation for discharge has the potential to cause unnecessary/avoidable anxiety, prevent the resident from receiving necessary services, and cause unnecessary delays in the residents' discharge. Findings include: Information received from the complainant indicated facility staff failed to assist with discharge planning. - Review of Resident #5's medical record occurred on all days of survey. The admission Minimum Data Set (MDS), dated 11/23/20, identified active discharge plan in place for the resident to return to the community. A progress note, dated 03/15/21, stated, ". . . Call . . . with Aging Service to discuss discharge plan. . . . [Aging Service] . . . to assist with going home. Family meeting scheduled with all disciplines and resident for 3/24/21 to assist with finalizing planning." During an interview on 05/16/21 at 2:30 p.m., Resident #5 stated he/she is expected to return home, however waiting for assistance to make home more handicap accessible.	F 660	F 660 E It is the policy of facility to develop and implement discharge planning. 1) Resident #5 was discharged from facility on 6/1/21. Resident #13 was discharged from facility on 6/16/21. Resident #25 met with IDT on request to return home on 6/21/21, care plan was initiated based on Care Conference. Resident #95 discharged from facility on 4/16/21. 2) Facility in-house residents with wishes to return home or to alternate care setting have the ability be affected by alleged practice. 3) Interdisciplinary Team was educated by Director of Clinical Services on discussing wishes to return home with initial Care Conference and quarterly care conferences or as resident or responsible party voices wishes. Education includes need to document these wishes and to establish care plan with discharging information. Education was started on 6/23/21. 4) Audits will be completed by Social Worker or designee of discharge planning process and care plan. 3 audits will be completed per week for 12 weeks or until substantial compliance is maintained. Results of audits will be brought to QAPI for review and recommendations.	

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On the afternoon of 05/19/21, an administrative staff member (#2) stated facility staff met with family on 03/24/21 and failed to complete documentation regarding this meeting.

The medical record lacked evidence of a scheduled meeting, and the care plan failed to address the resident's and/or representative's wishes regarding discharge planning.

- Review of Resident #13's medical record occurred on all days of survey. The admission MDS, dated 12/24/20, identified active discharge plan in place for the resident to return to the community.

During an interview on 05/16/21 at 11:55 a.m., Resident #13 stated he/she is expected to return home.

The medical record lacked evidence of active discharge planning, and the care plan failed to address the resident's and/or representative's wishes regarding discharge planning.

- Review of Resident #25's medical record occurred May 16-17, 2021. The admission MDS, dated 03/31/21, identified active discharge plan in place for the resident to return to the community.

During an interview on 05/16/21 at 3:22 p.m., Resident #25 stated he/she wanted to go home.

The medical record lacked evidence of active discharge planning

- Review of Resident #95's medical record

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F 660	Continued From page 39 occurred on 05/19/21. The admission MDS, dated 04/14/21, identified active discharge plan in place for the resident to return to the community. A physical therapy (PT) discharge summary, dated 04/16/21, stated, ". . . Patient discharged to live alone in private residence . . . Transfer = modified independent . . . Discharge Recommendations: Home exercise program and Assistance with IADLS [sic] . . ." An occupational therapy (OT) discharge summary, dated 04/16/21, stated, ". . . Discharge Recommendations: Home exercise program . . ." A progress note, dated 4/16/21, stated, "Resident discharged to home today as she is back to baseline. She left facility with [family] and walking independently using her FWW [front wheeled walker] . . . Referral for Home Health Services to [name of service] per resident choice." The medical record lacked evidence the facility completed and submitted a "Home Health Service Referral" form per the resident's request. During an interview on 05/19/21 at 2:24 p.m., an administrative staff member (#2) confirmed the medical record lacked a completed "Home Health Service Referral" form.	F 660		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;	F 677		6/30/21

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F 677	Continued From page 40 This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE STANDARD SURVEY CONDUCTED ON 10/21/19 Based on information provided by the complainants, observation, record review, resident, staff, and family interviews, the facility failed to provide Activities of Daily Living (ADL) assistance to 9 of 15 sampled residents (Resident #7, #10, #17, #27, #29, #34, #36, #97, and Resident E), and 1 closed record (Resident #94) who required staff assistance for ADL's (toileting, bathing, nail care, and eating). Failure to provide appropriate assistance to residents who cannot independently complete ADLs may result in skin irritation, unkempt fingernails, decreased self-esteem, and weight loss. Failure to check and change/toilet may result in incontinence, odor, urinary tract infection, skin breakdown, and pain/discomfort. Findings include: Information received from the complainants indicated facility staff failed to assist with toileting and bathing. - Review of Resident #34's medical record occurred on all days of survey and included diagnoses of dementia, depression, and anxiety. The current care plan stated, ". . . Total assistance with toileting. . . . Set up assist with meals. . . ." The annual Minimum Data Set (MDS), dated 04/08/21, identified extensive assist of two for toileting and limited assistance of one for eating.	F 677	F 677 E It is the policy of facility that a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming and oral hygiene. 1) Resident # 27 was discharged from facility on 6/9/21. Resident # 7 discharged from facility on 5/22/21, and Resident # 94 discharged from facility on 4/15/21. Resident # 17, 36, 34, 29, 10, 97 had fingernails and toenails checked by nurse and trimmed as needed or appt set up for podiatry for treatment. Identified residents, had care plans reviewed by IDT team and care plans updated as needed. Facility uses agency staff and is hiring new full and part-time staff to fill open nursing staff positions. The orientation process has been reviewed and updated to include facility care processes, communication, and documentation. Staffing levels and schedules reviewed by IDT and adjusted daily, as needed based on census and acuity levels to maintain adequate staffing levels and monitor hours per patient day. Facility IDT will interview residents 5-7 days weekly regarding general care and responsiveness to call lights. Resident Council will include review of call light responsiveness. Negative responses on call wait times will be brought to morning meetings and reviewed by IDT.	

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F 677	Continued From page 41 Observation on 05/17/21 at 8:44 a.m. showed Resident #34 seated in her wheelchair with the breakfast tray in front of her while eating the hot cereal with her fingers. Observation showed the milk carton opened but not poured on her cereal, sugar packets unopened, and the silverware located behind the plate out of sight of the resident. The facility staff failed to set up Resident #34's breakfast tray as stated in her care plan. Observation on 05/17/21 at 4:02 p.m. showed two certified nursing assistants (CNA) (#4 and #5) completed check and change for Resident #34 while lying in bed. The resident's incontinent product visibly soaked with urine and a small amount of soft stool. The CNAs completed perineal care with noted dry stool on the resident's buttocks and coccyx. The CNA (#4) stated they laid Resident #34 down about 10 minutes ago and did not complete incontinent cares at that time. Review of CNA task charting identified staff last toileted the resident at 10:58 a.m., five hours ago. - A family member (#1) complained staff failed to provide their relative (Resident E) a bath for eight days and the resident's hair and teeth looked uncared for. The family member believed staff failed to assist the resident with oral cares. - Review of Resident #7's medical record occurred on all days of survey. The current care plan stated, ". . . Has alteration in skin integrity related to: MASD [moisture-associated skin damage] -under breasts, folds, back-abdomen, groin. impaired mobility . . . Observe skin	F 677	2) Facility in-house residents have the ability to be affected by alleged practice. Care plan and C.N.A. Kardex will be updated with cares and level of assist needed related to tray set-up and/or eating, bathing, nailcare, oral care, transfers, and toileting for facility residents. Documentation of bathing and ADL care delivered will be reviewed weekly for discrepancies or missed documentation. Baseline care plan will indicate level of care for ADLs upon admission for new residents. 3) Facility nursing staff were educated by Director of nursing or designee starting 6/14/21 on need to review and follow residents established care plans/Kardex related to nailcare, bathing, toileting, tray set-up/eating, and oral care. Refusals of cares or difficulty completing cares need to be reported to nurse so alternate arrangements can be made to have cares completed. 4) Audits will be completed 5 times per week to ensure cares reflected on care plan are cares completed with resident. Audits will also include review of point of care charting, including shower schedules, visual check of resident and interview to ensure nails clean and neat, oral care completed, hair brushed and repositioning and toileting completed per established plan of care. Audits will be completed by Director of Nursing or designee and audits will be completed for 12 weeks or until substantial compliance	

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F 677	Continued From page 42 condition with ADL care daily . . . keep skin clean and dry . . ." The admission MDS, dated 02/25/21, indicated intact cognition, extensive assistance of two people for transfers and toileting, bathing did not occur, and always incontinent of bowel. The current facility bath schedule identified Resident #7's baths scheduled on Sunday and Wednesday evening shifts. During an interview on 05/16/21 at 12:20 p.m., Resident #7 stated the facility scheduled her baths on Sunday and Wednesday evenings, and the facility had no bath aides. The resident stated, "The CNAs have to do four to seven baths a shift, based on what they tell me. They give baths if they want to. . . . one CNA was unaware Wednesday was her bath night. I sat in my BM [bowel movement] for hours before." Review of the CNA tasks documentation from March 21 to May 15, 2021 showed staff provided Resident #7 bathing assistance on March 21, 31, April 4, 14, 21, 25, 28, May 5 and 12. Staff failed to provide a bath for 10 days on several occasions and a second weekly bath during seven of the past eight weeks. - Review of Resident #10's medical record occurred on all days of survey. The current care plan stated, "ADL self-care deficit related to: disease process . . . Assist with daily hygiene, grooming, . . . as needed. . . ." Observation on 05/16/21 at 4:03 p.m. and random observations throughout the survey showed Resident #10's fingernails unkept. The	F 677	is maintained. Results of audits will be brought to QAPI for review and recommendation.	

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nails appeared thick, long, discolored, several nails with jagged edges, and the thumb nails especially thickened with part of the right nail broken off. The resident stated a CNA provided nailcare about a month ago and filed the resident's nails versus clipping them.

During an interview on 05/18/21 at 2:25 p.m., a nurse administrator (#6) stated staff checked residents' nails on shower days and clipped as needed.

- Random observations of Resident #97 on all days of survey showed a sling to her right arm. An observation on 05/18/21 at 08:05 a.m. showed the resident seated in her wheelchair and her hair appeared disheveled.

Review of Resident #97's medical record occurred on 05/17/21. Diagnoses included fracture of right femur neck and right shoulder, dementia, muscle weakness, cognitive communication deficit, and pain. The current care plan identified staff assistance required for bathing, bladder continence and incontinence, and bowel incontinence. The care plan failed to include assistance needed for oral care. The current facility bath schedule identified Resident #97's baths scheduled on Tuesdays and Saturdays.

Review of the CNA task documentation from May 7-17, 2021 showed staff failed to provide oral cares on 2 of the 11 days and failed to bathe Resident #97 on the scheduled day of May 15.

- Review of Resident #94's medical record

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occurred on 05/18/21. The current care plan identified bathing two times per week.

The admission MDS, dated 04/05/21, indicated Resident #94 required extensive assistance of two people for transfers and toileting, and bathing did not occur.

The medical record lacked evidence a bath was provided during Resident #94's stay (17 days) at the nursing home.

- Review of Resident #29's medical record occurred on all days of survey. The current care plan stated, "ADL self-care deficit as evidenced by requires assistance related to femur fracture and physical limitations . . . Assist with daily hygiene, grooming . . ." The quarterly MDS, dated 05/03/21, identified extensive assist with toileting, transfers, and bed mobility with two or more persons, occasionally incontinent of bowel, and frequently incontinent of bladder.

Observations on 05/17/21 showed the following:
* 1:02 p.m., Resident #29 in the wheelchair on her way to play bingo.
* 3:43 p.m., An unidentified CNA assisted Resident #29 to her room and failed to offer toileting.
* 4:58 p.m., Two CNAs (#9 and #11) assisted Resident #29 to the toilet. The resident's pants, shirt, and the wheelchair cushion were urine soaked. After incontinence cares were completed the two CNAs (#9 and #11) transferred the resident back on the wet/saturated wheelchair cushion. When asked if the two CNAs (#9 and #11) noticed the wet wheelchair cushion they replied "no." The surveyor then asked the two

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CNAs to stand the resident up to show pants again saturated with urine from the wet wheelchair cushion.

Observations on 05/18/21 showed the following:
* 10:10 a.m., an unidentified CNA assisted Resident #29 to the bed and failed to offer toilet or complete a check and change.
* 11:49 a.m., a CNA (#7) completed a check and change and assisted her to the wheelchair.

Failure to assist Resident #29 with toileting resulted in incontinence and sitting in clothing saturated in urine.

- Review of Resident #36's medical record occurred on all days of survey and included a diagnosis of dementia. The current care plan stated, "ADL self-care deficit as evidenced by: disease process . . . Assist with daily hygiene, grooming, . . . as needed. . . ." An annual MDS, dated 04/08/21, identified extensive assist with toileting, transfers, and bed mobility with two or more persons, and always incontinent of bowel and bladder.

Resident #36's skin assessments identified the following:
* 05/09/21- ". . . Redness noted to buttocks, barrier cream applied. . ."
* 04/28/21- ". . . Reddened areas under both breast and groin area. . ."

Observation on 05/16/21 at 3:21 p.m. and random observations on all days of the survey showed Resident #36's toenails unkept. The nails appeared thick, long, discolored, and several nails with jagged edges.

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F 677	Continued From page 46 Observation on 05/16/21 showed from 12:44 p.m. to 5:50 p.m. Resident #36 seated in a Broda chair (adjustable positioning wheelchair) in the commons area. Staff failed to toilet the resident for 5 hours. Observation on 05/17/21 from 9:27 a.m. to 12:35 p.m. and from 1:07 p.m. to 4:53 p.m. showed staff failed to toilet Resident #36. Observations on 05/18/21 from 8:53 a.m. to 12:12 p.m. showed staff failed to toilet Resident #36. The facility staff failed to trim Resident #36's toenails and failed to change/toilet for several hours at a time. - Review of Resident #17's medical record occurred on all days of survey. A quarterly MDS, dated 03/13/21, stated, total dependence for toileting with two or more persons. The current care plan, stated, ". . . Toileting every 3 hours during AM (morning) and PM (afternoon) shift. Toileting on night shift with rounds and PRN (as needed) . . ." Observations on 05/17/21 showed staff failed to toilet Resident #17 as care planned. A nursing progress note dated 05/9/21 at 5:30 p.m., stated, "Incontinence associated dermatitis to groin and buttocks found upon skin assessment." Review of the CNA toileting tasks documentation from May 4 to May 17, 2021 identified staff failed to provide toileting as the care plan indicated for	F 677		

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F 677	Continued From page 47 14 of 14 days reviewed resulting in incontinence associated dermatitis. - Review of Resident #27's medical record occurred on all days of survey. The current care plan identified bathing two times per week. The admission MDS, dated 04/02/21, identified required extensive assistance of two people for transfers and toileting and bathing did not occur. Review of the CNA tasks documentation from March 26 to May 15, 2021 identified staff failed to provide a bath and/or second weekly bath during six of the past seven weeks. The record showed Resident #27 received the first bath 19 days after admission.	F 677		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 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: 1. Based on record review, review of professional references, review of the facility's policy, observation, resident and staff interviews, the facility failed to ensure residents received treatment and services to maintain the highest practicable physical well-being for 1 of 3 sampled residents (Resident #5) on coumadin (an	F 684	F684 G It is the policy of facility to ensure residents receive treatment and care in accordance with professional standards of practice. Facility residents on anticoagulants had orders reviewed and verified for accuracy. Facility investigated	6/30/21

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F 684	Continued From page 48 anticoagulant medication). Failure to accurately transcribe a physician's order and monitor Resident #5 for side effects of anticoagulant use resulted in a critically high INR value (international normalized ratio, a test to ensure blood clots normally) which required Vitamin K treatment to reverse, as well as a hematoma and excessive bruising. Findings include: Berman, Snyder, and Frandsen's "Kozier & Erb's Fundamentals of Nursing: Concepts, Process, and Practice," 10th ed., Pearson Education, Inc., Massachusetts, page 68, stated, ". . . Carrying Out a Physician's Orders . . . If the order is neither ambiguous nor apparently erroneous, the nurse is responsible for carrying it out. . . . Question and record verbal orders to avoid miscommunications . . . In addition to recording the time, the date, the primary care provider's name, and the orders, the nurse documents the circumstances that occasioned the call to the primary provider, reads the orders back to the primary care provider confirmed the orders as the nurse read them back . . ." pg. 752, stated, ". . . nurses should question any order that appears unreasonable and refuse to give medication until the order is clarified . . ." Wolters Kluwer "Nursing 2017 Drug Handbook," 37th Edition, page 1512, stated, ". . . Warfarin . . . Usual maintenance dosage is 2 to 10 mg [milligrams] P.O. [by mouth] daily . . . Recommended INR range is usually 2 to 3 for most patients . . ." Review of the facility policy titled "RECEIVING	F 684	the incident on 4/19/21, implemented a new process involving fax communication with Anticoagulant Clinic that was initiated on 4/19/21, INR tracking calendar implemented and reviewed for accurate Coumadin orders, starting 6/11/21. IDT to review INR and Coumadin orders daily at morning meetings. Facility residents, using wheelchairs were visually assessed for posture and positioning by IDT, referrals to therapy for further assessments and/or evaluation of wheelchairs as indicated was completed by 6/25/21. Candidates for therapy referral related to wheelchairs positioning reviewed by IDT daily in morning meetings. 1) Resident #5 was discharged from facility on 6/1/21. Resident #27 was discharged from facility on 6/9/21. Resident #36 had wheelchair positioning screened by Therapy by 6/23/21 and based on recommendations care plan was updated. 2) Facility in-house residents with orders for anticoagulants and those receiving assistance with wheelchair positioning and treatments have potential to be affected by practice. 3) Interdisciplinary Team was educated by Director of Clinical Services starting on 6/23/21 need to review charting and verify treatments not completed, new skin conditions, treatments and anticoagulant orders are addressed and followed up on including investigations of incidents. Audit was completed by Director of Nursing or designee of anticoagulants	

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F 684	Continued From page 49 AND RECORDING MEDICATION ORDERS" occurred on 05/19/21. This policy, dated 06/01/17, stated, ". . . Supervision by a Physician . . . Orders will be written/signed and placed in chronological order in the medical record . . . Telephone or verbal orders must be countersigned by the physician within forty-eight (48) hours of receiving the order . . ." During an interview on 05/16/21 at 2:30 p.m. Resident #5 stated she was receiving double the amount of coumadin she normally received and developed a hematoma (collection of blood) on her right side. Resident #5 showed this surveyor her hematoma on right lower abdomen which had a light purplish color. The resident described the area as hard when touched. Review of the medical record for Resident #5 occurred on all days of surveyand included a diagnosis of atrial fibrillation. Resident #5's nurses' notes (NN) and physician orders (PO) identified the following: * (NN) 03/23/21 at 5:24 p.m. - "INR 2.2 . . . Received orders from [doctor's name]/INR Clinic to change Coumadin to 5 mg 5mg [sic] today then 7.5 mg daily. Recheck INR 3/29/2021." * An unsigned verbal (PO) 03/29/21 - "Coumadin Tablet (Warfarin Sodium) Give 7.5 mg by mouth in the evening for INR 2.3 . . ." * An unsigned verbal (PO) 04/05/21 - "Coumadin Tablet (Warfarin Sodium) Give 17 mg by mouth one time a day for anticoagulant therapy. INR today 2.6 . . ." * (NN) 04/15/21 at 1:52 p.m. - "Resident has some reddened area to her lower abdomen, site is used for insulin injections. Currently resident	F 684	requiring lab monitoring, doses and next lab date verified and are being reviewed daily in morning meeting to verify proper reporting and follow through. Facility Nursing staff was educated by Director of Nursing or designee on anticoagulant monitoring, and ensuring physician order for medications and treatments are completed per order. Therapy staff were educated on review of residents with care conference schedule to ensure residents proper w/c positioning and to evaluate if need for therapy to help maintain highest level of functioning. 4) Audits will be completed 5 days per week by Director of Nursing or designee of anticoagulants, w/c positioning and prescribed treatments. Any discrepancies will be brought to Interdisciplinary Team for review and further investigation or notification and further recommendations, including but not limited to physician notification, therapy screen etc. Audits will continue for 12 weeks and results of audits will be brought to QAPI for review and ongoing recommendations.	

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F 684	Continued From page 50	F 684		

hematoma is intact with no drainage . . . Per protocol we need to informed [sic] her primary care physician. Will continue to monitor."
* (NN) 04/19/21 at 11:20 a.m. - "Resident continues to have hematoma on R) [right] lower abdomen . . . Resident is on long term coumadin . . . Resident has large, hard area to R)abdomen warm to touch. This area is noted to have began on 4/15/22 [sic] after insulin injection. Provider was contacted. Resident INR 8.0 [critical level] per INR machine and venous INR will be drawn at this time . . . Phone call to MD [medical doctor], awaiting response . . ."

The venous INR collected on 04/19/21 at 11:28 a.m. showed a prothrombin time (PT) 162.6 seconds (high level) (reference range 9.4 - 12.5) and an INR 14.1 (critical level) (suggested therapeutic range 2.0 - 4.0).

A fax received from the physician, dated 04/19/21 at 2:06 p.m., stated, "Hold Warfarin till INR below 3 . . . Vitamin K 2.5 mg PO today . . . Daily INR x [times] 3 days & [and] fax results to Anticoagulant clinic daily . . ."

An assessment form from the Anticoagulation Clinic, dated 04/23/21, stated, ". . . I spoke with [doctor name] today and she confirmed that patient not have [sic] any medication changes from her appt [appointment]. [Doctor] noticed the MAR [medication administration record] read Warfarin 17 mg daily and that the patient received that dose x2 weeks . . ."

During an interview on the afternoon of 05/18/21, an administrative nurse (#2) confirmed staff failed to transcribe order correctly and gave 17 mg of

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F 684	Continued From page 51	F 684		

coumadin for two weeks instead of 7.5 mg. The facility failed to complete an investigation related to this medication error.

2. Based on observation, information received from a complainant, record review, and staff interview, the facility failed to provide care and services in a manner to maintain the highest practicable well-being for 2 of 19 sampled residents (Resident #27 and #36) observed. Failure to provide positioning devices in a Broda chair for Resident #36 and apply ACE wraps for Resident #27 placed the residents at risk for discomfort/pain, increased skin concerns, and infections.

Findings include:

Information received from the complainant indicated the facility staff failed to follow physician's orders for wound care.

- Review of Resident #27's medical record occurred on all days of survey. A physician order, dated 04/01/21, stated, "Edema to BLE [bilateral lower extremities] management: Cleanse BLE with wound cleanser, apply vasoline impregnated gauze to any open areas, wrap with kerlex [gauze] and wrap with ACE [a proprietary elastic bandage] wraps once daily and as needed."

Random observations on days of survey showed Resident #27 without ACE wraps to both lower legs per physician's order.

Review of the May 2021 Treatment Administration Record (TAR) showed staff failed to document the application of ACE wraps on 7 of

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F 684	Continued From page 52 19 days. The facility failed to ensure staff applied ACE wraps per physician's orders for Resident #27 to ensure healing and decrease risk of infection. - Review of Resident #36's medical record occurred on all days of survey and included a diagnosis of dementia. The current care plan stated, "ADL self-care deficit as evidenced by: disease process . . . Assist with daily hygiene, grooming, ..." An annual Minimum Data Set (MDS), dated 04/08/21, identified extensive assistance with transfers and bed mobility with 2 or more staff. Observations of Resident #36 showed the following: * 05/16/21 at 3:21 p.m., in Broda chair hunched over, head resting on knees. * 05/17/21 at 9:27 a.m., in Broda chair hunched over, head in lap. * 05/17/21 at 1:07 p.m., in Broda chair hunched over, head rested on left arm rest. * 05/17/21 at 4:53 p.m., in Broda chair hunched over, appeared close to falling out of the chair. During an interview on 05/19/21 at 2:11 p.m., a therapist (#22) stated the facility switched Resident #36 from a regular wheelchair to the Broda chair about six months ago. The therapist agreed the resident was not properly positioned in the Broda chair, no facility chair reevaluation completed, and no positioning devices attempted.	F 684		
F 686 SS=E	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)	F 686		6/30/21

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F 686	Continued From page 53 §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide the necessary treatment and services to prevent the development of pressure ulcers, promote healing, and prevent new ulcers from developing for 5 of 9 sampled residents (Resident #13, #17, #37, #39, and, #40) identified as having current/resolved pressure ulcers. Failure to consistently implement interventions, ensure adequate monitoring/assessment, and complete wound care as ordered may result in delayed healing of the pressure ulcers. Findings include: Review of the facility policy titled "Pressure Ulcer/Injury, prevention of" occurred on 05/19/21. This policy, dated June 2017, stated, ". . . If a pressure ulcer/injury is present, the Licensed Nurse is responsible to record condition of the skin, including stage, size, site, depth, color,	F 686	F686 E It is the policy of facility to provide the necessary treatment and services to prevent the development of pressure ulcers, promote healing and prevent new pressure ulcers from developing. 1) Resident #13 was discharged from facility on 6/16/21. Residents #17, #37, #39 and #40 had care plan reviewed and updated by Interdisciplinary Team including RD by 6/29/21 and any new recommendations were implemented including turning repositioning, devices if used and support surfaces in use identified residents. RN assigned as Wound Nurse and educated on wound process and policy by Director of Nursing, Director of Clinical Services and/or designee by 6/29/21. Facility IDT to randomly interview residents and audit positioning of residents to ensure	

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F 686	Continued From page 54 drainage and odor as well as treatment provided. . . . Establish a turning and positioning schedule in bed and the chair to meet the resident's needs . . . treatment as ordered. . . ." - Review of Resident #13's medical record occurred on all days of survey. Diagnoses included multiple sclerosis and a right and left ischial ulcer. The current physician order, stated, "Cleanse rt [right] gluteal fold with saline then pack wound with 1/4 packing strip and cover with border foam daily until wound is healed . . . [Left Ankle] Dressing Change: Change/Remove ONLY gauze dressing and telfa non adherent dressing BUT leave the mesh on the skin covering the ulcer. It's important the mesh stay in place because it is securing the graft. Change daily . . . Proheal [supplement] BID [twice a day] . . . for wound care . . ." The care plan identified, " . . . Resident has actual skin integrity break and/or pressure sore(s) . . . Surgical Wound left ankle . . . Follow pressure ulcer prevention guidelines to prevent additional skin problems, promote healing and prevent complications . . . Report wound progress or decline to MD [medical doctor] with any changes or lack of response to treatment per facility guidelines . . ." Wound assessment for the right gluteal fold pressure ulcer showed the following: * 04/14/21 - ". . . 0.5 centimeter (cm) x 0.25 cm x 0.25 cm . . . stage III . . ." * 05/13/21 - ". . . 0.6 cm x 0.8 cm x 0.5 cm . . . stage III . . ." The facility failed to document assessments on the pressure ulcer for three weeks.	F 686	repositioning of residents, dressing changes per MD, and supplements per MD order. 2) Facility in-house resident with Braden scale identifying them at risk for pressure ulcers have potential to be affected by alleged practice. IDT reviewed identified residents care plans and updated with recommendation by 6/29/21. 3) Facility Nursing staff was educated by Director of Nursing or designee starting 6/23/21 on ensuring care planned interventions and orders are followed for treatments including dietary interventions, ensuring reposition completed per care plan including notifying MD if treatment or dietary interventions unavailable for alternate orders or follow up. 4) Audits will be completed by Director of Nursing or designee 5 days per week on Skin and pressure ulcer care plan and related orders, including visualization of resident to ensure, ordered dietary interventions, repositioning and treatments are applied per MD orders. Audits also include verifying weekly measurements, MD and family notification and wound process, and ensuring notifications of wounds not making progress. Audits will be completed weekly for 12 weeks and results will be brought to QAPI for review and recommendations.	

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F 686	Continued From page 55	F 686		

A wound assessment for the left ankle, dated 04/20/21, stated, ". . . 5.5 cm x 2.5 cm x 0.25 cm . . . Plan is for patient to have a skin graft . . ." The facility failed to document assessments on the wound for three weeks.

Review of Resident #13's May 2021 electronic medication administration records (eMAR) showed the following:
* 05/10/21 at 7:32 a.m. - Proheal BID, out of stock
* 05/10/21 at 5:01 p.m. - Proheal BID, out of med, will be reordered
* 05/11/21 at 7:15 a.m. - Proheal BID, out of stock
* 05/11/21 at 4:23 p.m. - Proheal BID, out of stock
* 05/12/21 at 10:38 a.m. - Proheal BID, med not available

The facility failed to provide consistent monitoring of Resident #13's pressure ulcers, including staging and measuring of the areas which limited the facility's ability to identify improvement or worsening of the pressure ulcers. The facility also failed to provide supplement for wound care as ordered.

- Review of Resident #17's medical record occurred on all days of survey. A current physician's order, stated, "Turn patient frequently and record/document every day and night shift for offloading. Leave recording sheet in the room." A quarterly Minimum Data Set dated 03/13/21, identified total assist of 2 or more persons for bed mobility. The current care plan, stated, "At risk for alteration in skin integrity . . .

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F 686	Continued From page 56 impaired mobility . . . [Prevalon boots] (pressure relieving boot used to prevent pressure ulcers) bilateral feet at all times . . . Reposition resident every 2 hours and prn (as needed) . . . Up in [Broda chair] (a chair that provides positioning and comfort for an individual who is sitting all day that contains a patented Comfort Tension Seating® system which reduces the heat and moisture build-up that leads to skin breakdown). daily with [ROHO cushion] (a cushion that decreased the amount of pressureon the sitting area) by 11:00 a.m. . . ." Random observations on 05/17/21 showed Resident #17 positioned on back in bed, Prevalon boots not on, and no recording sheet in room. Review Resident #17's Treatment Administration Record (TAR), from April 1st through May 16, 2021 showed eleven occassions staff failed to record/document turning and repositioning. During a family interview on the afternoon of 05/17/21, a family member stated, "I would like to see [Resident #17] get up in his wheelchair in the afternoon. He has sores on his bottom and I just feel it would be good for him to change position. I know it's still on his bottom." During an interview on 05/18/21 at 11:46 a.m., an administrative nurse (#6), indicated the turning/repositioning form in the room violated privacy, and the nurse expected staff to document in the medical record. At 2:25 p.m. the nurse (#6) verified the medical record lacked an area to document turning/repositioning for Resident #17.	F 686		

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F 686	Continued From page 57 The facility failed to follow the physician's orders for turning and repositioning every 2 hours and PRN and ensure Prevalon boots on at all times . - Review of Resident #37's medical record occurred on all days of survey and included a diagnosis of multiple sclerosis. A physician's order, dated 12/21/2020, stated, ". . . Right foot. Cleanse wound with soap and water. Pat dry. Cover with border foam dressing. Change BID. . . ." Resident #37's April 2021 treatment administration record showed 17 missed dressing changes to the right foot and 7 missed dressing changes from 05/01/21-05/18/21. The current care plan stated, ". . . At risk for skin breakdown related to impaired mobility . . . Encourage and assist as needed to turn and reposition every 2-3 hours . . ." The quarterly Minimum Data Set (MDS), dated 04/13/21, identified extensive assist of two staff for bed mobility and transfers. Observations showed Resident #37 in the following positions: * 05/16/21 at 1:12 p.m. In bed on his back. * 05/16/21 at 5:15 p.m. remains in bed on his back. * 05/17/21 at 8:09 a.m. In bed on his back. * 05/17/21 at 11:43 a.m. Remains in bed on his back. * 05/18/21 at 7:48 a.m. In bed on his back. * 05/18/21 at 11:21 a.m. Remains in bed on his back. The facility failed to change Resident #37's	F 686		

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F 686	Continued From page 58	F 686		

dressing on the right foot per physician orders and failed to turn and reposition the resident, increasing the resident's risk of the current pressure ulcer not healing and/or worsening.

During an interview on 05/18/21 at 2:25 p.m., an administrative nurse (#6) agreed the facility staff failed to consistently change Resident #37's dressing per physician orders and turn and reposition the resident every 2-3 hours.

- Observations of Resident #39 on May 17, 2021 from 9:00 a.m. to 12:00 p.m. and 1:00 p.m. to 4:00 p.m. showed staff failed to reposition the resident.

Review of Resident #39's medical record occurred on all days of survey. A quarterly MDS, dated 04/7/21, identified extensive assist of 2 or more staff persons for bed mobility and three Stage IV pressure ulcers (ulcers with full-thickness) present upon admission. The current care plan stated, . . . "The skin integrity areas will show signs of progressive healing . . . Reposition every 2 hours and PRN . . . "

The facility failed to follow the care plan for repositioning Resident #39 with three stage IV pressure ulcers.

- Observations of Resident #40 on May 17, 2021 from 9:00 a.m to 12:00 p.m. and 1:00 p.m. to 4:00 p.m. showed staff failed to reposition and/or encourage the resident to reposition.

Review of Resident #40's medical record occurred on all days of survey. A quarterly MDS, dated 04/14/21, identified total dependence on

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F 686	Continued From page 59 staff for bed mobility. A physician's order, dated 04/27/21, stated, "Turn frequently while in bed every shift for open ulcers on bilateral buttocks." The current care plan, stated, "Encourage and/or assist to reposition frequently . . . Encourage to reposition every 2 to 3 hours and as needed . . ." The facility failed to ensure staff followed the care plan and physician's orders for turning and repositioning Resident #40.	F 686		
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 by: THIS IS A REPEAT DEFICIENCY FROM THE	F 692	F 692 D	6/30/21

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F 692	Continued From page 60 STANDARD SURVEY CONDUCTED ON 10/21/19 Based on observation, record review, review of facility policy, review of professional references, and staff interview, the facility failed to ensure acceptable parameters of nutritional status for 2 of 2 sampled residents (Resident #17 and #40) receiving tube feedings. Failure to implement interventions in a timely manner, to obtain a complete tube feeding order, and date/time tube feeding formula bags has the potential for unintended weight changes, inability to determine amount of calories/protein/fluid being administered, and the potential for adverse side effects related to not maintaining microbiological safety of tube feeding formulas. Findings include: Review of the facility policy titled "Enteral Nutritional Therapy (Tube Feeding)" occurred on 05/19/21. This undated policy stated, ". . . Identify enteral feeding as ordered. . . ." Review of the facility policy titled "RECEIVING AND RECORDING MEDICATION ORDERS" occurred on 05/19/21. This policy dated 06/01/17 stated, ". . . When recording orders for nasogastric tube feedings, specify the type of feeding, amount, frequency . . ." The 2015 Abbott Nutrition Best Practices for Managing Tube Feeding A Nurse's Pocket Manual, page 8, stated, "Identify and take preventive measures against contamination hazards associated with the formula, delivery system, and patient. . . . (record date and time of	F 692	It is the policy of facility to maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless resident□s condition demonstrates that this is not possible or residents preferences indicate otherwise. 1) Resident #17 had new tube feeding initiated and feeding/tubing was dated on 6/24/21. Resident #40 had RD recommendations reviewed and primary care physician was consulted on weights and recommendations and order implemented with date feeding on 6/25/21. 2) Facility in house residents receiving tube feedings have ability to affected by alleged practice. 3) Facility licensed nursing staff was educated by Director of Nursing or designee starting 6/23/21 on implementing RD recommendations, ensuring tube feeding tubing is labeled with date and time hung and notifications of primary care physician and responsible party of significant weight changes per weight policy. RD will exit in-in person with DON, ED or designee after each visit with recommendations or will email the facility designee after each remote review with recommendations. DON or designee will ensure dietary recommendations are reviewed with MD. 4) Random Audits will be completed 3 times per week by Director of Nursing or designee on ensuring tube feeding dated, RD recommendations and weights	

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F 692	Continued From page 61 opening) . . ." The 2018 Academy of Nutrition and Dietetics Snapshot for the Nutrition Care Process, page 4, stated, ". . . The purpose of nutrition monitoring and evaluation is to determine and measure the amount of progress made for the nutrition intervention and whether the nutrition related goals/expected outcomes are being met. . . ." The 2018 American Society for Parenteral and Enteral Nutrition Safe Practices for Enteral Nutrition, page 1, stated, . . . "Required EN [enteral nutrition] order elements . . . formula name (generic and/or trade name) Delivery site (route) and enteral access device Administration method and rate . . ." - Observation in Resident #17's room on 05/17/21 at 9:11 a.m. showed a bag of Isosource 1.5 (tube feeding formula) hanging with feeding pump beeping finished and without a date or time on the bag. Review of Resident #17's medical record occurred on all days of survey. The current physician order, stated, "Enteral ISO Source [sic] 1.5 250 ml [milliliters]250/hr [per hour] every 4 hours . . . then flush with 120 ml of water." During an interview 05/18/21 at 2:02 p.m., two administrative nurses (#2 and #6) stated they expected the enteral feeding bag to be labeled with the resident's name, date, and time bag opened. - Observation in Resident #40's room on 05/17/21 at 9:17 a.m. showed a bag of Isosource	F 692	completed and notifications as needed implemented. Audits will be completed for 12 weeks and results of audits will be brought to QAPI for review and recommendation.	

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1.5 hanging with feeding pump beeping finished and without a date or time on the bag.

Review of Resident #40's medical record occurred on all days of survey. A dietary recommendation form, dated 03/12/21, stated, ". . . CONCERN: Weight gain Current Total Volume 1440 ml. RECOMMENDATION: 1356 ml Isosource . . ."

A physician's order, dated 03/24/20, stated, "Enteral Feed Order at bedtime related to GASTROSTOMY STATUS . . . Run at 120 ml/hr [hour] for 12 hrs with total volume of 1440." A May 2021 medication administration record (MAR), stated, "Enteral Feed Order at bedtime related to GASTROSTOMY STATUS . . . Run at 120 ml/hr [hour] for 12 hrs with total volume of 1440."

A nutrition assessment, dated 04/16/21, stated, ". . . Nutritional Goal Summary: wt [weight] 160-170# [pounds] . . . Plan: 1. Feeding per MD [Medical Doctor] Recommend decreasing feeding to 1350ml total volume 2034cal [calories] 88 gms [grams] pro.[protein], 1000ml free water. (was sent to MD and he did not return) . . . " Facility failed to ensure the physician responded to the recommendation.

Review of Resident #40's weight record identified an 11/21/20 weight of 174.6# and a 05/02/21 weight of 182.4#.

The facility failed to:
- Notify the physician regarding weight gain
- Ensure the physician responded to the nutritional recommendations for decreasing the

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F 692	Continued From page 63 feeding volume that resulted in Resident #40's continued weight gain above the stated goal range of 160-170# - Obtain/clarify a physician order identifying the type of enteral feeding to be administered to Resident #40 - Date/time tube feeding formula bags for Resident #17 and #40	F 692		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE STANDARD SURVEY CONDUCTED ON 10/21/19 Based on observation, record review, review of the facility's policy, and resident interview, the facility staff failed to provide the necessary care and services for 2 of 5 sampled residents (Resident #13 and #29) with orders for oxygen. Failure to provide oxygen as ordered, monitor the oxygen saturations, or change oxygen tubing has the potential for residents to experience complications related to inadequate oxygen saturation levels. Findings include:	F 695	F695 It is the policy of the facility to provide respiratory care consistent with professional standards. 1) Resident #13 discharged from the facility on 6/16/21. Resident #29 oxygen flow rate has been set per physician orders and oxygen tubing and humidifier has been replaced on 6/25/21 . Resident #29□s oxygen saturations are being monitored on the treatment record. 2) Facility in-house residents receiving oxygen therapy have the potential to be affected by the alleged practice. 3) Facility nursing staff has been educated by the Director of Nursing on	6/30/21

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F 695	Continued From page 64 Review of the facility policy titled "Oxygen Administration" occurred on 05/19/21. This policy, dated June 2017, stated, ". . . Check physician's order for liter flow and method of administration . . . Prefilled, sealed, disposable humidifiers may be changed per facility policy . . . Label humidifier with date and time opened. Change humidifier and tubing per facility policy . . . At regular intervals, check and clean oxygen equipment, masks, tubing and cannula . . ." - Review of Resident #13's medical record occurred on all days of survey. Diagnoses included chronic obstructive pulmonary disease and chronic respiratory failure with hypoxia. Current physician's orders identified continuous oxygen at four liters/minute per nasal cannula. Observation on 05/16/21 at 11:55 a.m. showed Resident #13 sitting in bed with oxygen via nasal cannula at three liters per minute. The humidifier and tubing lacked a label with date and time opened. The resident stated staff have not changed the oxygen tubing since admission (5 months ago). Observation on 05/17/21 at 9:50 a.m. showed Resident #13 sitting in bed with oxygen via nasal cannula at three liters per minute. The humidifier and tubing lacked a label with date and time opened. The facility failed to provide Resident #13's oxygen at the ordered flow rate of four liters and failed to label the humidifier and tubing with the date and time opened.	F 695	oxygen administration, flow rates, changing oxygen tubing and humidifiers, and monitoring oxygen saturations, starting on 6/23/21. 4) Audits will be completed on oxygen flow rates, oxygen orders, oxygen tubing and humidifiers change dates, and oxygen saturations. Audits will be completed 3 times weekly for 12 weeks or until compliance is maintained. Audits will be brought forward to the QAPI Committee for review and recommendations.	

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F 695	Continued From page 65 - Review of Resident #29's medical record occurred on all days of survey and included a diagnosis of chronic obstructive pulmonary disease. The current care plan identified ". . . Administer oxygen per MD [medical doctor] orders . . ." Current physician's orders stated ". . . 4L [four liters] oxygen PRN [as needed] to keep saturations above 90% [percent] as needed for SOB [shortness of breath] . . ." Random observations on all days of survey showed Resident #29 with continuous oxygen via nasal cannula with a flow rate of 2 to 6 liters, and the humidifier and tubing lacked a label with the date and time opened. The facility failed to provide Resident #29's oxygen at the ordered flow rate of four liters to keep saturations above 90%, label the humidifier and tubing with the date and time opened, monitor and document oxygen saturations in the medical record.	F 695		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).	F 725		6/30/21

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F 725	Continued From page 66 §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE STANDARD SURVEY CONDUCTED ON 10/21/19 Based on information provided by complainants, observation, and resident, family, and staff interviews, the facility failed to provide sufficient nursing staff and related services to meet the residents' needs for 8 of 14 confidential resident interviews (A, B, C, D, G, L, M, and N) and 2 confidential family interviews (#2 and #3). Failure to provide sufficient staffing may result in residents experiencing falls, poor hygiene, incontinence, and skin issues and may negatively affect the residents' physical, mental, and psychosocial well-being. Findings include: Information provided by the complainants indicated the facility failed to promptly respond to resident needs including Activities of Daily Living	F 725	F725 E It is the policy of facility to provide sufficient nursing staff and related services to meet the residents□ needs. 1) Facility in-house residents have the ability to be affected by alleged practice. Facility IDT will interview residents 5-7 days weekly regarding general care and responsiveness to call lights.Resident Council will include review of call-light responsiveness. Negative response on call wait times will be brought to morning meetings and reviewed by the IDT. 2) Facility staff was educated by Executive Director or designee on facility staff can respond to call lights and assist in obtaining needs or assistance. During education Executive Director tried to solicit staff input on barriers to resident care and remove barriers that prevent	

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F 725	Continued From page 67 (ADLs) and answering call lights. Refer to F677. Information provided during the survey by Staff D stated they are "often low staffed" resulting in incomplete resident cares. During interviews, when asked about sufficient staff/response to call lights, residents and family members made the following statements: * 05/16/21 at 12:19 p.m., Resident C stated it takes staff "five to six hours" to answer the call light and "I feel sorry for residents who can't help themselves." * 05/16/21 at 12:30 p.m., Resident L stated, "Some staff don't ever come in to see how I'm doing, walk by but don't stop to see how I'm doing. I have to call to get assistance. It takes one-half to one hour to answer my call light." * 05/16/21 at 1:24 p.m., Resident B stated "wait a long time, the majority of the time 15-20 minutes." * 05/16/21 at 2:30 p.m., Resident D stated he/she waited up to 45 minutes for staff to respond to the call light and staff have said he/she doesn't really need to use the bathroom. He/she stated the facility is short staffed and the certified nursing assistants (CNAs) complain about being short of help. * 05/16/21 at 2:31 p.m., Resident A stated, "It often takes up to two hours for staff to answer my call light at night." * 05/16/21 at 2:44 p.m., Resident N stated staff's response to his/her call light is "sometimes up to 30 minutes wait." * 05/16/21 at 4:03 p.m., Resident M stated, "Can have the call light on from 1:45 p.m. to 3:15 pm when they are changing shifts before someone answers it, also happens at night sometimes."	F 725	staff from assisting residents. Facility personnel share equal responsibility in answering call lights. 3. To seek to assure sufficient personnel available to be responsive to residents needs and call lights, facility shall continue to engage agency staff and seek to hire new full and part-time staff to fill open nursing staff positions. Staffing levels and schedules ratios reviewed by IDT and adjusted daily, as needed based on census and acuity level to maintain adequate staffing levels. 4) Random audits will be completed 3 times per week on varying shifts, these audits will include staff and resident or responsible party interview of staff responsiveness and call light audits. These audits will be completed by Executive Director or designee and will be completed for 12 weeks. Results of audits will be reviewed by Interdisciplinary Team and adjustments to staffing may be implemented based on audits. Audits will be brought to QAPI for review and further recommendations. 5) Facility will reinforce internal "Guardian Angel" program and resident grievance process to assure residents are comfortable advancing concerns related to care and responsiveness to needs. QAPI shall review grievances and Guardian Angel reports for review and further recommendations.	

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The resident indicated discomfort caused from prolonged sitting while waiting for assistance.
* 05/16/21 at 4:57 p.m., a family member (#2) reported staff stated they are short staffed and unable to complete tasks. The family member stated staff failed to complete cares timely.
* 05/17/21 at 5:27 p.m., a family member (#3) stated, "It doesn't seem like the facility has adequate staff to properly care for the residents," and a nurse once commented the facility lacked enough staff to "keep up." The family member (#3) indicated while visiting, staff took 45 minutes to answer a call light.
* 05/17/21 afternoon, Resident G stated, "The facility is understaffed, weekends are bad, and I have had to wait up to 20 minutes for a call light to be answered."

During the survey the following observations occurred:
* 05/16/21 at 12:20 p.m., a resident's call light activated while a licensed nurse (#21) stood outside the room at the medication cart. At 12:26 p.m., the nurse (#21) sat at the nurses' station desk. At 12:32 p.m., three unidentified staff in addition to the nurse (#21) stood at the nurses' station talking. At 12:34 p.m., staff answered the light, 14 minutes after the resident activated the call light.
* 05/17/21 at 8:04 a.m., a resident's call light activated. At 8:28 a.m., a staff member entered the room to assist the resident, 14 minutes after the resident's call for help.
* 05/18/21 at 9:42 a.m., a resident's call light activated. Staff responded to the call light at 9:56 a.m., 14 minutes later.

During an interview on 05/18/21 at 5:06 p.m., two

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MINOT HEALTH AND REHAB, LLC	600 S MAIN ST MINOT, ND 58701

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F 725	Continued From page 69 administrative staff members (#6 and #7), when asked about staffing and call light concerns stated they completed audits of call light response time.	F 725		
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced	F 726		6/30/21

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F 726	Continued From page 70 by: Based on information provided by complainants, record review, and staff interview, the facility failed to ensure competent staff for 1 of 2 contact staff members reviewed (Staff C). Failure to provide timely facility orientation may result in staff lacking competencies and skill sets and increased the risk of physical or psychological harm to the residents through improper care. Findings include: Information provided by the complainants indicated the facility failed to provide contact staff with adequate training to perform their duties and provide appropriate cares. On 05/18/21, the survey team requested information regarding orientation of travel/contract staff for two travel nurses. Review of the facility ' s orientation files for travel/contract staff identified facility orientation for Staff C not completed. During an interview on the afternoon of 05/19/21, an administrative nurse (#2) confirmed the facility failed to complete orientation with Staff C. Failure to provide orientation increased the potential for lack of appropriate care, services, and monitoring of residents consistent with their individualized plan of care.	F 726	F 726 D It is the policy of facility to have sufficient nursing staff with appropriate competencies and skill sets to provide nursing and related services. 1) Facility agency nurses have completed orientation on 6/25/21, including staff C. 2) Facility new hire staff have potential to be affected by alleged practice. 3) Facility Interdisciplinary Team met with Director of Nursing or designee on 6/23/21 and were educated on need to ensure new hired staff are trained oriented. Procedure for new hire orientation was put into place. 4) Audits will be completed by Executive Director 3 per week for 12 weeks or until substantial compliance is maintained. Audits will include completion of new hire orientation completion. Results of Audits will be brought to QAPI for review and recommendation.	
F 730 SS=D	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12	F 730		6/30/21

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F 730	Continued From page 71 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on review of employee files and staff interview, the facility failed to ensure 2 of 3 nurse aides (Staff A and B) reviewed received an annual performance evaluation. Failure to complete performance evaluations on an annual basis does not ensure all staff have the skills and knowledge necessary to meet the needs of the residents. Findings include: Review of facility's certified nursing assistant (CNA) employee files occurred on 05/19/21 and identified Staff A's hire date as 04/08/03 and Staff B's hire date as 08/21/18. The facility failed to complete performance evaluations. During an interview on 05/19/21, an administrative staff member (#6) confirmed the facility failed to complete performance evaluations for Staff A and B.	F 730	F 730 D It is the policy of facility to complete a performance review of every nurses aide at least every 12 months and regular in-service education based on outcome of these reviews. 1) Facility staff have the ability to be affected by alleged practice. Staff A had a performance evaluation completed on 6/21/21 and staff B resigned on 6/18/21. Business office personnel to track anniversary dates and evaluations and provide to department heads. 2) Interdisciplinary Team was educated by Director of Human Resources on ensuring performance evaluations are completed annually. Team completed sweep of employee records and evaluations, evaluations were obtained as needed starting 6/15/21. 3) Audits will be completed by Executive Director or designee using anniversary employee roster to audit and ensure evaluations completed per procedure. Audits will be completed once monthly for 12 months or until substantial compliance is maintained. Results of audits will be brought to QAPI for review and recommendations.	
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5)	F 758		6/30/21

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F 758	Continued From page 72 §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their	F 758		

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F 758	Continued From page 73 rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review, facility policy review, and staff interview, the facility failed to monitor and assess the continued need for psychotropic medications for 3 of 5 sampled residents (Resident #17, #38, and #97) reviewed for unnecessary medications. Failure to ensure orders for as needed (PRN) antipsychotic medications were limited to 14 days and/or re-evaluated by the physician prior to renewal (Resident #17 and #38) and failure to monitor residents for tardive dyskinesia (abnormal involuntary movements) (Resident #38 and #97) may result in the residents receiving unnecessary medications and experiencing adverse reactions. Findings include: Review of the facility's policy titled "Psychoactive Medication" occurred on 05/19/21. This policy, dated February 2017, stated, ". . . Procedure: Upon noting an order for psychoactive medication . . . Complete a baseline Abnormal Involuntary Movement Scale (AIMS) at the initiation of psychoactive medication therapy. . . . Care plan the targeted behavior . . . Abnormal Involuntary Movement Scale (AIMS) completed on admission, readmission, initiation of therapy and every six months. . . ."	F 758	F 758 It is the policy of facility to monitor and assess the continued need for psychotropic medications. 1) Resident #17 had AIMS scale assessment completed 6/8/21, Primary Care Physician was consulted on PRN Antipsychotic, orders received and implemented. Resident #38 had AIMS assessment completed on 6/21/21, Primary Care physician was consulted on PRN antipsychotic and orders received and implemented. Resident #97 had AIMS assessment completed 5/24/21, primary care physician was consulted and orders received and implemented. Antipsychotic PRN orders will be reviewed by IDT in morning meetings for 14-day end dates. DON or designee will notify staff and providers when evaluations are due to be completed. Pharmacy Consultants will review PRN antipsychotic orders and AIMS testing monthly then will provide facility and MD recommendations as indicated. 2) Interdisciplinary Team was educated	

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F 758	Continued From page 74 - Review of Resident #38's medical record occurred on all days of survey. Diagnoses included metabolic encephalopathy, depression, and cognitive communication deficit. The current care plan stated, "Resident has behavior concerns as manifested by: Resistive to care, Agitation . . . Administer medication per physician order. . . . Cognitive loss as evidenced by confusion, forgetful, agitation. . . . At risk for adverse effects r/t [related to]: use of antidepressant medication, use of antipsychotic medication . . . Evaluate effectiveness and side effects of medications for possible decrease/elimination of psychotropic drugs (i.e. [such as] AIMS, DISCUS [Dyskinesia Identification System: Condensed User Scale], etc.) . . ." Resident #38's medical record lacked an AIMS assessment. Physician's orders included: * 04/10/21, "SEROquel [antipsychotic medication] Tablet 25 MG (QUEtiapine Fumarate) Give 25 mg [milligrams] by mouth in the morning for Agitation" * 04/13/21, "SEROquel Tablet 25 MG (QUEtiapine Fumarate) Give 25 mg by mouth every 24 hours as needed for agitation." The order failed to contain a stop date. A Medication Regimen Review, dated 05/09/21, the pharmacist reviewed the PRN Seroquel and recommended "reeval clinical appropriateness of therapy [Seroquel] and add a 14 day stop to antipsychotic."	F 758	on 6/8/21 by Director of Clinical Services on ensuring AIMS monitoring completed with antipsychotic usage and PRN antipsychotic medications requiring 14-day physician evaluation for new order to document ongoing need. Audit was completed on facility in house residents with PRN antipsychotic use, to verify 14-day evaluation and completion of AIMS scale. 3) Facility Licensed Nursing staff was educated by Director of Nursing or designee on completion of AIMS assessment procedure and need for MD evaluation for PRN antipsychotic medications. Education started on 6/23/21. 4) Audits will be completed at a frequency of 2 residents per week for 12 weeks, then 12 weeks, then monthly for 3 months by Social Worker or Designee to verify AIMS assessment and PRN antipsychotic evaluations. Results of audits will be brought to QAPI for review and further recommendation.	

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F 758	Continued From page 75 The medical record lacked a physician's order to discontinue the PRN Seroquel after 14 days or re-evaluate Resident #38's need for continuing the antipsychotic. - Review of Resident #97's medical record occurred on all days of survey. Diagnoses included dementia and cognitive communication deficit. A physician's order, dated 05/07/21, stated, "QUEtiapine Fumarate Tablet 25 MG Give 0.5 tablet by mouth at bedtime for depression." The record lacked an AIMS assessment. During an interview on 05/19/21 at 3:30 p.m., a supervisory nurse (#2) confirmed the facility staff failed to complete an AIMS assessment for Resident #38 and #97. - Review of Resident #17's medical record occurred on all days of survey. Diagnoses included major recurrent depression, restlessness/agitation, and psychosis. A physician's order, dated 05/04/21, stated, "Seroquel 0.5 mg via PEG [gastric]-Tube as needed." The record lacked an end date for the PRN medication and evidence the attending physician or prescribing practitioner evaluated the resident for the appropriateness of the medication after 14 days. During an interview on the afternoon of 05/19/21, a supervisory nurse (#2) confirmed the medical record lacked an end date for the PRN medication and evidence the provider reviewed the PRN medication since the original order received on 05/04/21.	F 758		
F 760 SS=G	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2)	F 760		6/30/21

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F 760	Continued From page 76 The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE STANDARD SURVEY CONDUCTED ON 10/21/19 Based on observation, record review, review of professional references, review of the facility's policy, and resident and staff interviews, the facility failed to ensure residents remained free from significant medication errors for 1 of 3 sampled residents (Resident #5) receiving Coumadin (an anticoagulant medication) who experienced a significant medication error. Failure of facility staff to clarify and obtain a signed physician order ergarding Coumadin dose change resulted in a critically high INR value (international normalized ratio, a test to ensure blood clots normally), a hematoma, and excessive bruising. Findings include: Berman, Snyder, and Frandsen's "Kozier & Erb's Fundamentals of Nursing: Concepts, Process, and Practice," 10th ed., Pearson Education, Inc., Massachusetts, page 68, stated, ". . . Carrying Out a Physician's Orders . . . If the order is neither ambiguous nor apparently erroneous, the nurse is responsible for carrying it out. . . . Question and record verbal orders to avoid miscommunications . . . In addition to recording the time, the date, the primary care provider's name, and the orders, the nurse documents the	F 760	F 760 G It is the policy of facility to ensure residents are free of any significant medication errors. 1) Incident involving resident #5 was investigated with MD notified and new orders received for resident #5. Resident #5 returned to therapeutic range and discharged from facility on 6/1/21. Tracking process includes Coumadin Clinic fax form in substitution of verbal orders and Coumadin/INR calendar initiated for IDT to concurrently track orders. IDT to review INRs that are due at morning meetings. IDT to review Coumadin orders and received and transcribed correctly at stand down meetings. 2) Facility in-house residents with orders for anticoagulants have potential to be affected by practice. Facility in-house resident had anticoagulant orders audited and associated lab to verify correct resident and dose. This audit was completed by 6/8/21. 3) Interdisciplinary Team was educated by Director of Clinical services on 6/23/21 on need to verify orders for anticoagulant and verify associated labs are obtained	

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F 760	Continued From page 77 circumstances that occasioned the call to the primary provider, reads the orders back to the primary care provider confirmed the orders as the nurse read them back . . ." pg. 752, stated, ". . . nurses should question any order that appears unreasonable and refuse to give medication until the order is clarified . . ." Wolters Kluwer "Nursing 2017 Drug Handbook," 37th Edition, page 1512, stated, ". . . Warfarin . . . Usual maintenance dosage is 2 to 10 mg [milligrams] P.O. [by mouth] daily . . . Recommended INR range is usually 2 to 3 for most patients . . ." Review of the facility policy titled "RECEIVING AND RECORDING MEDICATION ORDERS" occurred on 05/19/21. This policy, dated 06/01/17, stated, ". . . Supervision by a Physician . . . Orders will be written/signed and placed in chronological order in the medical record . . . Telephone or verbal orders must be countersigned by the physician within forty-eight (48) hours of receiving the order . . ." During an interview on 05/16/21 at 2:30 p.m. Resident #5 stated she was receiving double the amount of coumadin she normally received and developed a hematoma (collection of blood) on her right side. Resident #5 showed this surveyor her hematoma on right lower abdomen which had a light purplish color. The resident also described the area as hard when touched. Review of the medical record for Resident #5 occurred on all days of survey and included a diagnosis of atrial fibrillation.	F 760	and timely reported, are addressed and followed up on including investigations of incidents. Audit was completed by Director of Nursing or designee of anticoagulants requiring lab monitoring, doses and next lab date verified and are being reviewed daily in morning meeting to verify proper reporting and follow through. Facility Nursing staff was educated by Director of Nursing or designee on anticoagulant monitoring, and ensuring physician order for medications and treatments are completed per order. 4) Audits will be completed 5 days per week by Director of Nursing or designee of anticoagulants and prescribed treatments. Any discrepancies will be brought to Interdisciplinary Team for review and further investigation or recommendations. Audits will continue for 12 weeks, then 2 per week for 3 months.Results of audits will be brought to QAPI for review and ongoing recommendations.	

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F 760	Continued From page 78	F 760		

Resident #5's nurses' notes (NN) and physician orders (PO) identified the following:
* (NN) 03/23/21 at 5:24 p.m. - "INR 2.2 . . . Received orders from [doctor's name]/INR Clinic to change Coumadin to 5 mg 5mg [sic] today then 7.5 mg daily. Recheck INR 3/29/2021."
* An unsigned verbal (PO) 03/29/21 - "Coumadin Tablet (Warfarin Sodium) Give 7.5 mg by mouth in the evening for INR 2.3 . . ."
* An unsigned verbal (PO) 04/05/21 - "Coumadin Tablet (Warfarin Sodium) Give 17 mg by mouth one time a day for anticoagulant therapy. INR today 2.6 . . ."
* (NN) 04/15/21 at 1:52 p.m. - "Resident has some reddened area to her lower abdomen, site is used for insulin injections. Currently resident hematoma is intact with no drainage . . . Per protocol we need to informed [sic] her primary care physician. Will continue to monitor."
* (NN) 04/19/21 at 11:20 a.m. - "Resident continues to have hematoma on R) [right] lower abdomen . . . Resident is on long term coumadin . . . Resident has large, hard area to R)abdomen warm to touch. This area is noted to have began on 4/15/22 [sic] after insulin injection. Provider was contacted. Resident INR 8.0 [critical level] per INR machine and venous INR will be drawn at this time . . . Phone call to MD [medical doctor], awaiting response . . ."

The venous INR collected on 04/19/21 at 11:28 a.m. showed a prothrombin time (PT) 162.6 seconds (high level) (reference range 9.4 - 12.5) and an INR 14.1 (critical level) (suggested therapeutic range 2.0 - 4.0).

A fax received from the physician, dated 04/19/21 at 2:06 p.m., stated, "Hold Warfarin till INR below

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F 760	Continued From page 79 3 . . . Vitamin K 2.5 mg PO today . . . Daily INR x [times] 3 days & [and] fax results to Anticoagulant clinic daily . . ." An assessment form from the Anticoagulation Clinic, dated 04/23/21, stated, ". . . I spoke with [doctor name] today and she confirmed that patient not have [sic] any medication changes from her appt [appointment]. [Doctor] noticed the MAR [medication administration record] read Warfarin 17 mg daily and that the patient received that dose x2 weeks . . ." During an interview on the afternoon of 05/18/21, an administrative nurse (#2) confirmed staff failed to transcribe the Coumadin order correctly, administered 17 mg of coumadin for two weeks instead of 7.5 mg, and failed to complete an investigation related to the significant medication error.	F 760		
F 761 SS=E	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 §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.	F 761		6/30/21

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F 761	Continued From page 80 §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 and staff interview, the facility failed to store medications in a secure manner on 3 of 4 days of survey (May 16-18, 2021). Failure to store medications in a secure manner may result in unauthorized access to medications. Findings include: Observations during the survey showed the following: * 05/16/21 at 12:04 p.m.: a unlocked and unattended medication cart located in the hallway on the second floor. * 05/16/21 at 12:37 p.m.: a unlocked and unattended medication cart located in the hallway on the first floor. * 05/17/21 at 8:13 a.m.: a unidentified facility nurse left the medication cart unlocked several times as he/she proceeded down the second floor hallways and administered medications to residents in their rooms. * 05/17/21 at 1:37 p.m.: a facility nurse left the medication cart and a treatment cart unlocked and unattended for 22 minutes while completing a dressing change in a resident's room.	F 761	F 761 E It is the policy of the facility to store medications in a secure manner. 1) Upon audit completed by DON on 6/15/21 no missing medications were noted from unlocked cart. 2) In-house facility residents receiving medications have the ability to be affected by alleged practice. 3) Facility licensed Nursing staff and Medication Assistants were educated By Director of Nursing or Designee on securing medications and ensuring cart is locked if leaving unattended. Education started 6/15/21. 4) Audits will be completed by Director of Nursing or designee to ensure carts and medications are secured if nurse leaving storage areas. Audits will be completed 3 per week for 12 weeks or until substantial compliance is maintained. Results of audits will be brought QAPI for review and recommendations.	

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	355031	A. BUILDING _____ B. WING _____	C 05/24/2021

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F 761	Continued From page 81 * 05/18/21 at 11:17 a.m.: a unlocked and unattended medication cart located in the hallway on the second floor. During an interview on 05/18/21 at 2:25 p.m., an administrative nurse (#6) stated she expected medication carts to be locked at all times when unattended.	F 761		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on review of the North Dakota Department of Health, Division of Health Facilities provider files, and staff interview, the facility failed to maintain a Quality Assessment and Assurance (QAA) process, which identified and addressed quality issues; and failed to develop and implement appropriate plans of action to correct deficient practice and ensure compliance with federal requirements. These failures have the potential to result in adverse outcomes for all the residents. Findings include: Review of the North Dakota Department of Health, Division of Health Facilities provider files identified the facility failed to maintain compliance in the following areas cited during the 10/21/19 standard survey and/or the 09/01/20	F 867	F 867 It is the policy of facility that the quality assessment and assurance committee must develop and implement appropriate plans of correct identified quality deficiencies. 1) Executive Director and Director of Nursing were educated on Quality Assurance Program by Director of Clinical Services including importance implementing plans of actions to prevent repeat deficient practices on 6/22/21. 2) Executive Director educated Interdisciplinary Team on Quality Assurance Program and need to implement appropriate plans of action to avoid repeat deficient practices. This education occurred on 6/22/21. 3) Quality Assurance Meeting was	6/30/21

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F 867	Continued From page 82 complaint/Focused Infection Control survey: F641 Accuracy of Assessments F657 Care Plan Revision F658 Services Provided Meet Professional Standards F677 ADL Care Provided to Dependent Residents F692 Nutrition/Hydration Status Maintenance F695 Respiratory/Tracheostomy Care F725 Sufficient Nursing Staff F760 Residents are Free of Significant Med Errors F880 Infection Prevention & Control During an interview on 05/19/21 at 4:03 p.m., an administrative staff member (#7) stated the facility utilized a corporate Quality Assurance program to monitor quality measures such as falls, pressure ulcers, and short/long term stay, and compared metrics to prior months and how the measures ranked at the state and national level. The Quality Assurance committee started a performance improvement project on family conferences to help address family concerns and currently audited high-touch surfaces, call light response, wound care, and type of food served. The facility failed to develop and implement appropriate plans of action to correct the repeat deficient practices listed above. Failure of the facility to effectively utilize QAA resulted in continued noncompliance at F641, F657, F658, F677, F692, F695, F725, F760, and F880.	F 867	conducted on 6/17/21 with IDT in attendance. Annual survey concerns were discussed and plan of correction expected were reviewed. 4) Facility will have monthly QA meetings and Ad hoc if needed, QA meetings will review annual survey results and monitoring and will incorporate any new identified performance improvement needed through QM review. QA meeting will be audited by ED monthly for 4 months to ensure survey identified issues are addressed and plan to continue to monitor remains in place. Results of Audits will be brought to QAPI for review and recommendations.	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		6/30/21

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F 880	Continued From page 83 §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 infections; (iv)When and how isolation should be used for a	F 880		

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F 880	Continued From page 84 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: THIS IS A REPEAT DEFICIENCY FROM THE STANDARD SURVEY CONDUCTED ON 10/21/19 Based on observation, policy review, and staff interview, the facility failed to ensure staff followed standard infection control practices for 4 of 5 sampled residents (Resident #17, #27, #29 and #40) and 1 supplemental resident (Resident	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. The infection preventionist (IP), director of	

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F 880	Continued From page 85 #20) observed during perineal cares. Failure to follow standard infection control practices related to hand hygiene and perineal cares may result in the spread of infectious agents to residents, staff and visitors. Findings include: Review of the facility policy titled "Handwashing" occurred on 05/19/21. This policy dated, June 2017, stated, ". . . Wash hands . . . Before and after resident contact (i.e. [for example], meds, treatments, cares) . . ." Review of facility policy titled "Incontinence Care" occurred on 05/19/21. This policy, revised October 2010, stated, " . . .Cleanse from front to back a.) Female: Separate labia with one hand and cleanse the area with downward strokes using a new wipe with each stroke . . ." - Observation on 05/17/21 at 4:13 p.m., showed a licensed nurse (#18) entered Resident #17's room, donned gloves, hung a bag of enteral formula, checked gastric residuals and returned residuals to stomach, removed gloves, exited the room, went to the nurse's station and made a phone call. After obtaining a new feeding pump, the nurse returned to Resident #17's room, removed the enteral formula from the original pump, connected the formula bag to the new pump, removed gloves, and left the room. The licensed nurse failed to perform hand hygiene prior to donning gloves, after checking gastric residuals, when returning to the room, and when leaving the room. - Observation on 05/18/21 at 8:23 a.m., showed	F 880	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 prior to and after resident contact, after garbage removal, after removing gloves, and after performing perineal care, in accordance with CDC guidelines. (2) Ensuring staff demonstrate appropriate infection control practices when performing perineal care. 2. Identification of Others The IP and DON, in conjunction with the applicable the interdisciplinary team (IDT) members, will review current COVID-19 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 06/30/2021 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. Information about root cause analysis can be found at	

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F 880	Continued From page 86 two certified nurse assistants (CNAs) (#13 and #17) assisted Resident #20 with morning cares. During incontinent cares the CNA (#13) cleansed the resident's perineal area two times from back to front. Failure to cleanse the perineal area from front to back has the potential to transfer bacteria and result in an infection. - Observation on 05/17/21 at 2:04 p.m., showed a therapy staff member (#3) monitored Resident #27's oxygen saturation levels, assisted the resident to bed, and exited the room without performing hand hygiene. - Observation on 05/16/21 at 3:29 p.m. showed a CNA (#10) donned gloves, assisted Resident #29 with incontinent cares, transferred the resident into the wheelchair, removed the resident's gait belt, emptied the garbage and removed her gloves. The CNA exited the room, took the garbage to the soiled utility room, and then sanitized her hands. After performing incontinent cares and performing other tasks, CNA (#10) failed to remove her gloves and perform hand hygiene. - Observation on 05/17/21 at 1:45 p.m. showed a CNA (#13) applied barrier cream and a clean brief, removed gloves, and handed an oral suction wand to Resident #40 without performing hand hygiene. During an interview on 05/18/21 at 5:06 p.m., an administrative nurse (#6) agreed she expected staff to follow standard infection control practices with proper hand hygiene and proper incontinent	F 880	https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/GuidanceforRCA.pdf (2) The DON, IP or suitable designee will ensure the following: a. All staff will receive education keeping hands clean between tasks, contacts with potentially contaminated surfaces and between residents. This education will include the CDC's lesson on clean hands available at https://youtu.be/xmYMUly7qiE. 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, licensed nursing staff, and therapy staff to ensure performance of proper hand hygiene, when indicated, in the course of their routine duties. (2) Observations of certified nursing staff to ensure performance of proper perineal care in the course of their routine cares. 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.	

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F 880	Continued From page 87 cares.	F 880	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 06/30/2021	