| 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 _____ | R-C 07/31/2019 |

| 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<br><br>An unannounced onsite revisit complaint survey was completed on July 30-31, 2019. The sample included twelve (12) sampled residents for focused review. | {F 000} | | |
| {F 657} SS=D | Care Plan Timing and Revision<br>CFR(s): 483.21(b)(2)(i)-(iii)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(2) A comprehensive care plan must be-<br>(i) Developed within 7 days after completion of the comprehensive assessment.<br>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--<br>(A) The attending physician.<br>(B) A registered nurse with responsibility for the resident.<br>(C) A nurse aide with responsibility for the resident.<br>(D) A member of food and nutrition services staff.<br>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.<br>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.<br>(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.<br>This REQUIREMENT is not met as evidenced by:<br>DURING THE ON-SITE REVISIT COMPLETED | {F 657} | Care plans were updated by DON or | 8/9/19 |

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

Electronically Signed | 08/08/2019

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

| 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 _____ | R-C 07/31/2019 |

| 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 657} | Continued From page 1<br>ON 07/31/19, EVIDENCE SHOWED THE FACILITY FAILED TO ACHIEVE COMPLIANCE WITH THIS REQUIREMENT. Refer to 06/11/19 CMS-2567<br><br>Based on observation, record review, review of facility policy, and staff interview, the facility failed to review/revise the comprehensive care plan to reflect the current status of 2 of 10 sampled residents (Resident #4 and #6). Failure to revise the care plan limited the ability of staff to communicate care needs and ensure continuity of care for each resident.<br><br>Findings include:<br><br>Review of the facility policy titled "Care Plans - Comprehensive" occurred on 07/31/19. This policy, dated December 2016, stated, ". . . develops and maintains a comprehensive care plan for each resident that identifies the highest level of functioning the resident may be expected to attain . . . Incorporate identified problem areas . . . Incorporate risk factors associated with identified problems . . . Identifying problem areas and their causes, and developing interventions that are targeted and meaningful to the resident . . . care plans are revised as information about the resident and the resident's condition change . . ."<br><br>- Review of Resident #4's medical record occurred on all days of survey. The current physician order stated, " . . . Cleanse RLL [right lower leg] with NS [normal saline] and sterile gauze. Apply Xeroform to exposed tendon. Apply collagen powder to wound bed (may mix with NS to make paste). Place calcium alginate with silver | {F 657} | designee for residents #4 and #6 on July 31, 2019 to reflect current needs.<br><br>Residents who have changes in condition or specific positioning needs have the potential to be impacted by this practice. Care plan reviews will be completed by DON or designee by August 8, 2019 of like residents and care plans updated as needed.<br><br>Education was provided by the DON or designee beginning on Friday August 2, 2019 to nursing staff regarding updating care plans to reflect current needs and reviewing the Kardex prior to providing care to ensure individualized needs are identified and met.<br><br>Care plan audits will be completed by DON or designee to ensure the care plan is up to date no less than 5 audits per week for 12 weeks, then weekly for eight months. Audits will be submitted to QAPI committee for review and recommendations each month.<br><br>Compliance date August 9, 2019. | |

| 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 _____ | R-C 07/31/2019 |

| 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 657} | Continued From page 2<br>sheet over collagen powder. Cover with non adherent dressing and wrap with kerlix. Change daily, but check Q [every] 12 hours, change if dressing is saturated. every day and evening shift [started 07/15/19]. . ."<br><br>The facility failed to initiate a care plan related to right lower leg pressure ulcer/infection.<br><br>- Observation on 07/30/19 at 12:00 p.m., showed Resident #6 sat in his geri-chair at an approximate 45 degree angle next to an assisted table in the dining room. An unidentified certified nursing assistant (CNA) fed Resident #6, alternating between puree foods and thin liquids. Ten minutes into the meal, Resident #6 began coughing. A second unidentified CNA approached Resident #6 and raised the back of his chair to an approximate 85 degree angle. After being repositioned, no further signs/symptoms of aspiration were noted.<br><br>Review of Resident #6's medical record occurred on all days of survey. The current care plan stated, ". . . Reposition at routine intervals before and after meals . . ."<br><br>During an interview the afternoon of 07/31/19, an administrative nurse (#1) confirmed Resident #6 should be seated as close to 90 degrees as possible during meals.<br><br>The facility failed to individualize Resident #6's care plan identifying how he should be positioned during meals to ensure swallow safety/reduce his risk of aspiration.<br><br>Refer to F677. | {F 657} | | |

| 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 _____ | R-C 07/31/2019 |

| 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 658} SS=D | Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)<br><br>§483.21(b)(3) Comprehensive Care Plans<br>The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br>(i) Meet professional standards of quality.<br>This REQUIREMENT is not met as evidenced by:<br>DURING THE ON-SITE REVISIT COMPLETED ON 07/31/19, EVIDENCE SHOWED THE FACILITY FAILED TO ACHIEVE COMPLIANCE WITH THIS REQUIREMENT. Refer to 06/11/19 CMS-2567<br><br>Based on observation, record review, review of professional reference, review of facility policy, and staff interview, the facility failed to follow professional standards of practice for 2 of 2 supplemental residents (Resident A and B) observed during insulin administration. Failure to correctly label an insulin pen and offer food within 5-10 minutes of the administration of a rapid acting insulin may result in hypoglycemia (low blood sugar) and reduced medication efficacy.<br><br>Findings include:<br><br>Prescribing information for Novolog insulin, found at www.novo-pi.com/novolog.pdf, stated, ". . . NOVOLOG R is rapid acting human insulin analog indicated to improve glycemic control in adults and children with diabetes mellitus . . . Inject subcutaneously within 5-10 minutes before a meal into the abdominal area, thigh, buttocks or upper arm . . . ."<br><br>Review of the facility policy titled "Insulin | {F 658} | Date of receipt for insulin pens for Residents A and B were validated July 31, 2019 by the DON or designee, 2 pens were replaced based on the date of receipt. Blood sugars for residents A and B were monitored as ordered, with no significant abnormal findings. Times for insulin were adjusted to correlate with mealtimes.<br><br>Residents who require routine or PRN insulin administration have the potential to be impacted by this practice. Insulin orders were updated to correlate with mealtimes by the DON or designee on August 1, 2019. An audit of insulin pens for date opened was completed August 1, 2019 by the DON or designee and pens were either dated as being opened the day they were received or replaced if more than the recommended time had passed since the insulin was received at the facility.<br><br>The DON or designee provided education to licensed nurses beginning August 2, 2019 on labeling and storing insulin once opened. Information was provided for different types of insulin, as the length of | 8/9/19 |

| 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 _____ | R-C 07/31/2019 |

| 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 658} | Continued From page 4<br>Administration - Pen" occurred on 07/31/19. This policy, with a revised date January 2018, stated, ". . . If a new pen is obtained . . . document the "date open" on the pen body . . . . "<br><br>- Review of Resident B's medical record on 07/30/19 showed a current physician's order for Novolog 10 units three times a day with meals and a Novolog sliding scale.<br><br>Observation on 07/30/19 showed Resident B received Novolog 14 units subcutaneously at 4:20 p.m. and received her supper tray at 5:42 p.m. (82 minutes after insulin administration). The insulin pen lacked the "open date" label.<br><br>- Review of Resident A's medical record on 07/30/19 showed a current physician's order for Novolog 25 units injected subcutaneously twice a day before lunch and supper.<br><br>Observation on 07/30/19 showed Resident A received Novolog 25 units subcutaneously at 4:28 p.m. and received his supper tray at 5:30 p.m. (62 minutes after insulin administration). The insulin pen lacked the "date open" label.<br><br>During an interview on 07/31/19 at 2:45 p.m., an administrative nurse (#1) stated she expected food to be offered within 30 minutes of administration of a rapid acting insulin and staff to follow the facility policy, regarding Insulin Administration with an insulin pen. | {F 658} | time these can be stored varies. Information was provided on the action and onset of different types of insulin. Education was provided on the need to administer insulin at times that correlate with meals.<br><br>Audits of insulin storage and administration will be completed by the DON or designee three times weekly for twelve weeks, then weekly for eight months. Results of audits will be forwarded to the QAPI committee for review and recommendations.<br><br>Compliance date August 9, 2019 | |
| {F 677} SS=D | ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)<br><br>§483.24(a)(2) A resident who is unable to carry out activities of daily living receives the | {F 677} | | 8/9/19 |

| 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 _____ | R-C 07/31/2019 |

| 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 677} | Continued From page 5<br>necessary services to maintain good nutrition, grooming, and personal and oral hygiene;<br>This REQUIREMENT is not met as evidenced by:<br>DURING THE ON-SITE REVISIT COMPLETED ON 07/31/19, EVIDENCE SHOWED THE FACILITY FAILED TO ACHIEVE COMPLIANCE WITH THIS REQUIREMENT. Refer to 06/11/19 CMS-2567<br><br>Based on information received from the complainants, observation, record review, review of facility policy, review of professional reference, and staff interview, the facility failed to provide assistance to reposition for 1 of 5 sampled residents (Resident #6) observed during meals. Failure to reposition Resident #6 as close to 90 degrees as possible while eating/drinking resulted in Resident #6 aspirating food/liquid and put him at risk of further aspiration.<br><br>Findings include:<br><br>Information provided by the complainants indicated nursing staff failed to provide cues/assistance for residents with vision and/or mobility deficits.<br><br>Review of the facility policy titled "Assistance with Meals" occurred on 07/31/19. This policy, dated September 2013, stated, "Residents shall receive assistance with meals in a manner that meets the individual needs of each resident. . . ."<br><br>Swigert's "The Source for Dysphagia," 3rd ed., Pro-Ed, Inc., Texas, 2007, pages 9, 10, 125, and educational handouts, identified, ". . . Signs and Symptoms of Dysphagia . . . coughing . . . during | {F 677} | Care plan for R#6 was updated by the DON on July 31, 2019 to include positioning at meals in a safe and comfortable position to allow for meal intake.<br><br>Residents who require assistance with positioning at meals have the potential to be impacted by this practice. Care plans and Kardex's for like residents were reviewed and will be updated by August 8, 2019.<br><br>The DON or designee educated the IDT and nursing staff on positioning for meals and ensuring safe positioning for eating beginning on August 1, 2019<br><br>Audits of positioning during meals will be completed by the DON or designee three times weekly for twelve weeks and then weekly for eight months. The results of audits will be forwarded to the QAPI committee monthly for review and recommendations.<br><br>Compliance date August 9, 2019 | |

| 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 _____ | R-C 07/31/2019 |

| 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 677} | Continued From page 6<br>a meal . . Some patients cough and choke when they aspirate . . . During the oral intake of . . . food and/or liquids, it is optimal for a patient to be seated at a 90 degree angle, whether in bed or in a chair. . . . Even a slightly reclined position while eating greatly increases the risk of premature loss of food over the back of the tongue. . . ."<br><br>Review of Resident #6's medical record occurred on all days of survey, and identified staff assistance required during meals. The current care plan stated, ". . . Reposition at routine intervals before and after meals . . ."<br><br>Observation on 07/30/19 at 12:00 p.m., showed Resident #6 seated in his geri-chair at an approximate 45 degree angle next to an assisted table in the dining room. An unidentified certified nursing assistant (CNA) fed Resident #6, alternating between puree foods and thin liquids. Ten minutes into the meal, Resident #6 began coughing. A second unidentified CNA approached Resident #6 and raised the back of his chair to an approximate 85 degree angle. After being repositioned, no further signs/symptoms of aspiration were noted.<br><br>During an interview on the afternoon of 07/31/19, an administrative nurse (#1) confirmed Resident #6 should be seated as close to 90 degrees as possible during meals.<br><br>Staff failed to position Resident #6 in a manner that increased his swallow safety/reduced his risk of aspiration. | {F 677} | | |
| {F 686} SS=D | Treatment/Svcs to Prevent/Heal Pressure Ulcer<br>CFR(s): 483.25(b)(1)(i)(ii) | {F 686} | | 8/9/19 |

| 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 _____ | R-C 07/31/2019 |

| 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 686} | Continued From page 7<br>§483.25(b) Skin Integrity<br>§483.25(b)(1) Pressure ulcers.<br>Based on the comprehensive assessment of a resident, the facility must ensure that-<br>(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<br>(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.<br>This REQUIREMENT is not met as evidenced by:<br>DURING THE ON-SITE REVISIT COMPLETED ON 07/31/19, EVIDENCE SHOWED THE FACILITY FAILED TO ACHIEVE COMPLIANCE WITH THIS REQUIREMENT. Refer to 06/11/19 CMS-2567<br><br>Based on information received from the complainants, observation, record review, and staff interview, the facility failed to provide the necessary care and services to prevent the development and promote healing of pressure ulcers for 2 of 2 sampled residents (Resident #3 and #4) at risk of developing and/or with known pressure ulcers. Failure to implement, monitor, and modify interventions to reduce risk factors and consistently provide treatment to prevent the development of new pressure ulcers and/or heal current pressure ulcers resulted in Resident #3 and #4 developing avoidable facility-acquired pressure ulcers.<br><br>Findings include: | {F 686} | Resident #3 will continue to be followed on weekly wound rounds with updated to wound tracker completed at regular intervals. Resident #3 care plan was updated July 31, 2019 by DON or designee to reflect current wounds, the use of protective heels boots and the use of the APM, heels were assessed and no areas of breakdown were noted. A pain assessment was completed regarding heel pain. Resident #4 care plan was updated on July 31, 2019 by the DON or designee to include present wound to RLE.<br><br>Residents who have pressure related wounds or those at risk for pressure related injury have the potential to be impacted by this practice. Care plans and orders for these residents will be reviewed and validated by the DON or designee by Aug 8, 2019. Weekly skin | |

| 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 _____ | R-C 07/31/2019 |

| 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 686} | Continued From page 8<br><br>Information provided by the complainants indicated nursing staff failed to consistently utilize physician ordered interventions in a timely manner to prevent and/or heal ulcers.<br><br>Review of the facility policy titled "Skin Management System" occurred on 07/31/19. This undated policy stated, ". . . Pressure Ulcers, Venous Ulcers, and Arterial Ulcers, and surgical sites will be documented on . . . form or EMR [electronic medical record]. Use one form per wound. Wound progress is to be documented each week with measurement and wound descriptions. Daily treatments are also documented on the same form. . . . Skin issues such as skin tears, bruises, rashes, abrasions, burns etc. will be documented . . ."<br><br>- Review of Resident #4's medical record occurred on all days of survey. The Significant Change Minimum Data Set (MDS), dated 05/31/19, identified extensive assistance from two or more people for bed mobility, one Stage II pressure ulcer, and one venous and arterial ulcer. The current physician order stated, ". . . Skin review weekly [facility ]assessment on Tuesday PM [afternoon] . . ."<br><br>Resident #4's current physician order stated, ". . . Cleanse RLL [right lower leg] with NS [normal saline] and sterile gauze. Apply Xeroform to exposed tendon. Apply collagen powder to wound bed (may mix with NS to make paste). Place calcium alginate with silver sheet over collagen powder. Cover with non adherent dressing and wrap with kerlix. Change daily, but check Q [every] 12 hours, change if dressing is | {F 686} | assessments were scheduled on shifts to correlate with any scheduled dressing changes to ensure measurements are obtained.<br><br>On Aug 2, 2019 the DCS provided education to the DON on making certain that any abnormal findings on audits are immediately addressed and corrected. The DON provided education to unit managers and licensed nurses beginning on Aug 2, 2019. Education included the need to obtain measurements of pressure wounds a minimum of weekly and to update wound trackers weekly. Nurses were also educated on the need to provide measurements of non-pressure related wounds on the weekly skin assessments. Weekly skin assessments were scheduled on shifts to correlate with any scheduled dressing changes to ensure measurements are obtained. Education was provided to nursing staff beginning on Aug 2, 2019 regarding checking the Kardex for needed interventions to reduce the risk for skin breakdown and validating interventions are in place.<br><br>The DON or designee will complete audits of five weekly skin assessments and of current and new weekly wound trackers on an ongoing basis as a change in practice. Results of audits will be forwarded to the QAPI team for review and recommendations.<br><br>Compliance date August 9, 2019 | |

| 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 _____ | R-C 07/31/2019 |

| 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 686} | Continued From page 9<br>saturated. every day and evening shift [started 07/15/19]. . ."<br><br>The "Wound Evaluation Tracker" started 07/18/19 showed a stage IV pressure ulcer to the right lower leg identified on 03/06/19, measuring 6.7 centimeters (cm) x 13.5 cm.<br><br>The current physician order also stated, ". . . Paint wound on RT [right] 1st MTPJ [metatarsophalangeal joint] wound, with Betadine and cover with a Mepilex type bandage change daily [started 02/28/19] . . ."<br><br>The "Wound Evaluation Tracker" started 07/30/19 showed an unstageable pressure ulcer to the right toe was identified on 02/18/19, measuring 0.6 cm x 0.4 cm.<br><br>The facility completed an initial skin assessment on 06/18/19 without wound measurements and description. The facility failed to complete the wound tracker on a weekly thereafter.<br><br>- Review of Resident #3's medical record occurred on all days of survey. A progress note, dated 07/18/19, identified, ". . . Resident complaining of her bilateral feet hurting . . ." The current care plan stated, ". . . Float heels with a pillow while in bed. . . ."<br><br>Observations showed the following:<br>* 07/30/19 at 4:50 p.m., Resident #3 laid in bed with her heels resting directly on the mattress. Resident #3 pointed at her feet and stated, "They hurt." When asked what specifically hurt, she replied, "My heels."<br>* 07/31/19 at 10:50 p.m., Resident #3 laid in bed | {F 686} | | |

| 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 _____ | R-C 07/31/2019 |

| 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 686} | Continued From page 10<br>with a pillow behind her knees and her heels resting directly on the mattress.<br><br>During an interview the afternoon of 07/31/19, an administrative nurse (#1) confirmed she expects staff to float Resident #3 heels whenever she is lying down.<br><br>Staff failed to ensure Resident #3's heels were floated as care-planned. | {F 686} | | |
| {F 689} SS=D | Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>.<br>DURING THE ON-SITE REVISIT COMPLETED ON 07/31/19, EVIDENCE SHOWED THE FACILITY FAILED TO ACHIEVE COMPLIANCE WITH THIS REQUIREMENT. Refer to 06/11/19 CMS-2567<br><br>Based on observation, record review, and staff interview, the facility failed to provide adequate supervision necessary to prevent accidents for 1 of 10 sampled residents (Resident #7) observed during a gait belt transfer. Failure to provide the appropriate amount of assistance during a transfer placed the resident at risk of accidents/injury. | {F 689} | The employee who transferred R#7 was counseled with 1:1 education provided on reviewing the Kardex prior to transferring a resident as changes in transferring needs are documented in the care plan and carried through to the Kardex as a standard of practice in the facility. R#7 was assessed on Aug 1, 2019 for any injury or pain related to transfer with one staff and none were noted.<br><br>Residents who require assistance with transfers have the potential to be impacted by this practice. The Kardex and care plans were validated for correct | 8/9/19 |

| 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 _____ | R-C 07/31/2019 |

| 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 689} | Continued From page 11<br><br>Findings include:<br><br>- Observation on 07/30/19 at 2:53 p.m. showed a certified nursing assistant (CNA) (#5) placed a gait belt around Resident #7's waist and assisted her to stand-pivot transfer from her wheelchair onto the toilet. A few minutes later, the CNA (#5) assisted Resident #7 to stand. After providing peri-cares, the CNA (#5) instructed Resident #7 to "stand up straight" as she attempted to stand-pivot her back into the wheelchair. Resident #7 sat down heavily as the CNA (#5) attempted to guide her into the wheelchair.<br><br>Review of Resident #7's medical record occurred on all days of survey. The current care plan stated, ". . . Resident requires a [assist] x [times] 2 with gait belt for transferring and toileting . . ."<br><br>During an interview on the afternoon of 07/31/19, an administrative nurse (#1) confirmed Resident #7 requires the assistance of two staff members for transfers. | {F 689} | transfer status and updated if needed on Aug 4, 2019. The DON or designee provided education beginning on Aug 2, 2019 to nursing staff on the need to review the Kardex prior to transferring the resident and reporting changes in transfer ability on the 24 Hour Report Sheet and the shift to shift report, to ensure changes in needs are communicated.<br><br>Observation of transfers will be completed by the DON or designee three times weekly for twelve weeks then weekly for eight months. Results of audits will be forwarded to the QAPI committee for review and recommendations.<br><br>Compliance date August 9, 2019 | |
| {F 692} SS=E | Nutrition/Hydration Status Maintenance<br>CFR(s): 483.25(g)(1)-(3)<br><br>§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-<br><br>§483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte | {F 692} | | 8/9/19 |

| 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 _____ | R-C 07/31/2019 |

| 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 692} | Continued From page 12<br>balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;<br><br>§483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;<br><br>§483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.<br>This REQUIREMENT is not met as evidenced by:<br>DURING THE ON-SITE REVISIT COMPLETED ON 07/31/19, EVIDENCE SHOWED THE FACILITY FAILED TO ACHIEVE COMPLIANCE WITH THIS REQUIREMENT. Refer to 06/11/19 CMS-2567<br><br>Based on information provided by the complainants, observation, record review, review of facility policy, review of professional reference, and staff interviews, the facility failed to offer fluids to 4 of 10 sampled residents (Resident #3, #4, #7, and #8) who required staff assistance for fluid intake and were at risk for dehydration. Failure to provide assistance with fluid intake may result in dehydration, constipation, and urinary tract infections (UTIs).<br><br>Findings include:<br><br>Information provided by the complainants indicated nursing staff failed to provide dependent residents assistance with fluid intake.<br><br>Swigert's "The Source for Dysphagia," 3rd ed., Pro-Ed, Inc., Texas, 2007, page 137, identified, ". . . One of the most difficult challenges when | {F 692} | R#3, R#4, and R#7 were assessed by licensed nurses on Aug 8, 2019 and were noted to have moist mucus membranes and skin turgor was WNL.<br><br>Residents have the potential to be impacted by this practice. Review of current ice water pass times was completed and adjusted if indicated. A hydration cart was implemented to include a variety of fluids passed at routine times and offered to residents.<br><br>Education was provided beginning Aug 1, 2019 by the DON or designee on the new process of hydration carts to the nursing staff. Education was also provided during this education session to nursing staff on the need to offer fluids and ensure the availability of fluids at bedside.<br><br>Audits of compliance with new processes of the hydration carts by the ED or designee three times weekly for twelve weeks then weekly for eight months. Audits of the availability of fluids at | |

| 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 _____ | R-C 07/31/2019 |

| 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 692} | Continued From page 13<br>working iwth patients is getting them to take enough thickened liquids to meet their fluid needs. . . ."<br><br>Review of facility policy titled, "Hydration Policy" occurred on 07/31/19. This policy, dated January 2017, stated, ". . . each resident receives adequate fluids to maintain proper hydration . . ."<br><br>- Review of Resident #3's medical record occurred on all days of the survey. The current physician's orders indicated Resident #3 received nectar thickened liquids. The current care plan stated, ". . . Encourage and assist as needed to consume fluids . . ."<br><br>Observation on 07/31/19 at 10:26 a.m., showed a licensed nurse (LPN) (#4) provided cares for Resident #3 and exited the room. The LPN failed to offer the resident fluids.<br><br>- Review of Resident #4's medical record occurred on all days of the survey. The current care plan stated, ". . . Encourage fluids . . ."<br><br>Observations showed the following:<br>* 07/30/19 at 3:00 p.m., a certified nursing assistants (CNAs) (#2 and #3) provided cares for Resident #4 and exited the room. The CNAs failed to offer the resident fluids.<br>* 07/31/19 at 10:26 a.m., an LPN (#4) provided cares for Resident #4 and exited the room. The LPN failed to offer the resident fluids.<br><br>- Review of Resident #7's medical record occurred on all days of the survey. The current physician's orders indicated Resident #7 received nectar thickened liquids. The current | {F 692} | bedside will be completed by an IDT member three times weekly for twelve weeks then weekly for eight months. Audits for direct observation of cares to validate that fluids are offered will be completed by the DON or designee three times weekly for twelve weeks then weekly for eight months. Results of audits will be forwarded to the QAPI committee for review and recommendations.<br><br>Compliance date August 9, 2019 | |

| 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 _____ | R-C 07/31/2019 |

| 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 692} | Continued From page 14<br>care plan stated, ". . . Assist with . . . eating as needed . . ."<br><br>Observations showed the following:<br>* 07/30/19 at 2:53 p.m., a CNA (#5) provided cares for Resident #7 and exited the room. The CNA failed to offer the resident fluids and no fluids were observed in the room.<br>* 07/31/19 at 10:26 a.m., two unidentified CNAs provided cares for Resident #7. One of the CNAs offered Resident #7 water, only to realize there were not fluids in the room.<br><br>- Review of Resident #8's medical record occurred on all days of the survey. Diagnoses included chronic obstructive pulmonary disease (COPD) and weakness. The current care plan stated, ". . . Assist with . . . eating as needed . . ."<br><br>Observation on 07/30/19 at 4:15 p.m., showed two CNAs (#6 and #7) provided cares for Resident #8 and exited the room. The CNAs failed to offer the resident fluids.<br><br>During an interview on the afternoon of 07/31/19, an administrative nurse (#1) confirmed she expected staff to provide fluids during cares. | {F 692} | | |
| {F 695} SS=D | Respiratory/Tracheostomy Care and Suctioning<br>CFR(s): 483.25(i)<br><br>§ 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning.<br>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, | {F 695} | | 8/9/19 |

| 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 _____ | R-C 07/31/2019 |

| 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 695} | Continued From page 15<br>and 483.65 of this subpart.<br>This REQUIREMENT is not met as evidenced by:<br>DURING THE ON-SITE REVISIT COMPLETED ON 07/31/19, EVIDENCE SHOWED THE FACILITY FAILED TO ACHIEVE COMPLIANCE WITH THIS REQUIREMENT. Refer to 06/11/19 CMS-2567<br><br>Based on information provided by the complainants, observation, record review, review of professional reference, and staff interview, the facility failed to provide the necessary care and services for 2 of 4 residents (Resident #8 and #10) receiving oxygen. Failure to provide oxygen as ordered has the potential for residents to experience complications related to inadequate oxygen saturation levels.<br><br>Findings include:<br><br>Information provided by the complainants indicated nursing staff failed to ensure oxygen was administered per physician's order.<br><br>Review of the facility policy titled "Oxygen Administration" occurred on 07/31/19. This policy, revised August 2017, stated, ". . . Validate physician orders for oxygen and set liter flow according to physician order. . . ."<br><br>- Review of Residents #8's medical record occurred on all days of survey. A physician's order stated, ". . . oxygen 2 L [liters] NC [nasal cannula]. Check sats [saturations] every shift . . ."<br><br>Observation on 07/30/19 at 4:15 p.m., showed Resident #8 wearing a nasal cannula attached to | {F 695} | Oxygen liter flow was set to the correct amount for R#8 and R#10 when staff were informed of the finding July 31, 2019. O2 saturations were validated at the correct liter flow.<br><br>Residents who use supplemental oxygen have the potential to be impacted by this practice. Liter flows were checked after survey exit July 31, 2019 by the DON or designee to validate correct liter flows. Nurses on duty were reminded that they must turn on concentrators and portable O2 devices and set the liter flow on July 31, 2019.<br><br>Nurses were educated by the DON for designee beginning on Aug 1, 2019 on the need to turn on and set liter flow on oxygen devices in accordance with MD orders.<br><br>Audits of oxygen liter flow will be completed by the DON or designee five times weekly for twelve weeks and then weekly for eight months. Results of audits will be forwarded to the QAPI committee for review and recommendations.<br><br>Compliance date August 9, 2019 | |

| 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 _____ | R-C 07/31/2019 |

| 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 695} | Continued From page 16<br>a portable oxygen tank set at 3 liters per minute. Two certified nursing assistants (#6 and #7) disconnected her from the portable tank and reconnected her to a room concentrator, setting the flow at 3 liters per minute. The CNAs (#6 and #7) reported, "It [setting] was just changed a day or two ago."<br><br>During an interview on the afternoon of 07/31/19, an administrative nurse (#1) confirmed no changes were made to Resident #8's physician orders.<br><br>- Review of Residents #10's medical record occurred on all days of survey. A physician's order stated, ". . . oxygen at 2L/min [minute] via NC sats > [greater than] 90% every shift . . ."<br><br>Observation on 07/30/19 at 3:14 p.m., and 07/31/19 at 1:59 p.m., showed Resident #10 wearing a nasal cannula attached to an oxygen concentrator set at 5 liter per minute.<br><br>The facility failed to consistently provide Resident #8 and #10 oxygen via nasal cannula at the ordered concentration. | {F 695} | | |