STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 An on-site revisit survey, started and concluded on 08/04/21, was conducted to determine compliance with deficiencies identified during the first on-site revisit of 07/13/21 for the 05/24/21 standard survey.	{F 000}		
{F 658} SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of professional reference, and resident and staff interview, the facility failed to follow professional standards of practice for 1 of 2 sampled residents (Resident #6) observed during a dressing change. Failure to follow physician's orders regarding dressing changes may result in delayed assessment, treatment, and worsening of wound. 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, states, ". . . Carrying Out a Physician's Orders . . . If the order is neither ambiguous not apparently erroneous, the nurse is responsible for carrying it out. . . ." - Review of Resident #6's medical record occurred on the day of the survey. The current	{F 658}	1.Resident #6 wound dressing was changed by RN on 8/4/21. Wound assessed, no signs of infection, MD notified of wound status by 8/31/21. 2.Facility residents with physician orders for wound treatments have potential to be affected by the alleged practice. Facility residents with wound treatment orders were audited for wound dressing dates on dressings compared to documented completed treatments. Dressing changes for facility residents were verified to be completed as ordered by physician, unless otherwise indicated. Physicians were notified of the status of resident wounds By Director of Nursing or designee by 8/31/21. 3.Facility licensed nursing staff were re-educated by Director of Nursing or designee by 08/31/21 or prior to completion of next scheduled shift on completing wound treatments, including	8/31/21

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

Electronically Signed | 08/27/2021

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{F 658}	Continued From page 1 physician's orders identified, ". . . Clean lt. [left] inner thigh open mole with NS [normal saline]. Cover with border foam dressing until healed. Change daily and prn [as needed]. one time a day. . . ." The current treatment administration record (TAR) identified Resident #6's dressing change scheduled daily at 7:00 a.m. During an interview on 08/04/21 at 12:20 p.m., Resident #6 stated, "It has been a couple days since the nurse has changed this dressing, the date written on it is from Sunday, sometimes they don't clean it they just change the bandage, I usually have to find them and ask them to change it." Observation on 08/04/21 at 2:57 p.m. showed Resident #6 approached the nurse's station and asked the nurse (#5), "Can you come change my dressing, no one has changed it for a couple days." Observation on 08/04/21 at 3:07 p.m. showed a dressing in place to Resident #6's left inner thigh with a date of 08/01/21. A nurse (#5) changed the dressing and dated it 08/04/21. Staff failed to change the left inner thigh dressing daily as ordered. Resident #6's TAR identified identified nursing staff signed off dressing changes as completed on 08/01/21, 08/02/21, and 08/03/21. Observation showed the left inner thigh dressing was dated 08/01/21, not 08/03/21. During an interview on 08/04/21 at 3:07 p.m., a nurse (#5) confirmed the physician's order stated to change Resident #6's dressing daily.	{F 658}	necessary glove changes and hand hygiene during the procedure, dating and initialing wound dressing when completed, and documentation of resident refusals. 4.Audits of wound treatments procedure and documentation will be completed by the Director of Nursing or designee 5 times per week for 12 weeks, then 3 times per week for 4 weeks, then 2 times per week for 4 weeks, then weekly for 4 weeks or until substantial compliance is maintained. Audits of wound treatments and documentation will be reviewed by the QAPI committee for recommendations.	

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{F 658}	Continued From page 2 During an interview on 08/04/21 at 5:10 p.m., an administrative nurse (#1) confirmed the nursing staff should be changing the dressing as ordered by the physician.	{F 658}		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of the manufacturer's guidelines, and staff interview, the facility failed to provide appropriate and sufficient supervision and/or assistive devices for 2 of 2 sampled residents (Resident #7 and #8) observed during transfers utilizing a sit to stand lift. Failure to provide sufficient supervision and utilize assistive devices appropriately placed the residents at risk of an accident and/or injury. Findings include: Review of the facility policy titled "Resident Lift" occurred on 08/04/21. This policy, dated June 2017, stated, ". . . follow manufacturers [sic] operational guidelines for lifting, positioning and transfer. . . ." Review of manufacturer's guidelines titled "SARA 3000 [stand lift] Instructions for Use" occurred on	F 689	1.Identified mechanical lift sling with malfunctioning buckle was removed from use by Executive Director or designee by 8/6/21. Resident #7 transferred via mechanical lift with functioning buckles. Resident #7 and #8 were assessed for transfer status with mechanical lifts and had care plans reviewed and updated by 8/11/21. 2.Facility residents transferring by mechanical lifts have the potential to be affected by the alleged practice. Facility lifts and slings were reviewed for function and verified straps and clips are intact on 8/4/21, any lifts or slings identified with missing buckles, or impairment were removed from use. 3.Facility nursing staff were re-educated on use of mechanical lifts, including use of lift legs in an open position during	8/31/21

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F 689	Continued From page 3 08/04/21. These guidelines stated, ". . . before use . . . always make sure . . . straps do not show signs of fraying, tearing, or other damage . . . If any such damage is observed, do not use the sling. . . ." Review of manufacturer's guidelines titled "Stand Up Patient Lift RPS350-1 User Manual" occurred on 08/04/21. These guidelines illustrated the placement of sling straps around the same attachment knob on the left and right side of the lift arms. ". . . The legs of the stand up lift MUST be in the maximum open position for optimum stability and safety. . . . becomes necessary to move through a narrow passage, close the legs of the stand lift only as long as it takes to move through passage. When the stand up lift is through the passage, return the legs to the maximum open position. . . ." - Review of Resident #7's medical record occurred on 08/04/21 and identified diagnoses of morbid obesity and weakness. The annual Minimum Data Set (MDS), dated 06/30/21, identified intact cognition, extensive assistance from one person for transfers, and extensive assistance from two or more persons for toileting. The current care plan identified, "ADL [activities of daily living] self care [sic] deficit as evidenced by: need for Hoyer [full-body mechanical lift] at this time; weakness related to: physical limitations. . . . At risk for falls due to: history of falls, unsteady gait, incontinence, medication side effects. Use the Mechanical/Hoyer lift lift [sic] for all transfers and toileting; use a bedside commode. Observation on 08/04/21 at 10:55 a.m., showed a	F 689	transfers and use of straps on slings, including not using damaged or frayed slings, or not to use faulty equipment, by Director of Nursing or designee by 08/31/21 or prior to start of next scheduled shift. Return demonstration of mechanical lift transfers and correct operation of mechanical lifts of nursing staff, starting on 8/24/21 by Director of Nursing or designee . 4.Audits will be conducted 5 times per week for 12 weeks by the Director of Nursing or designee on mechanical transfer lift competency and condition of mechanical lift slings. Following 12 weeks of auditing, audits will be reduced to 3 times per week for 4 weeks, then 2 times per week for 4 weeks, then once weekly for 4 weeks or until substantial compliance is maintained. Results of audits will be reviewed by QAPI for recommendations.	

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F 689	Continued From page 4	F 689		

nurse (#5) and a certified nursing assistant (CNA) (#6) transferred Resident #7 using a SARA 3000 stand lift from her recliner to the wheelchair. The CNA (#6) placed the lift in front of the recliner, positioned the sling behind Resident #7's back, and handed the chest fixation strap to the nurse (#5). The nurse (#5) stated, "This is missing a buckle" and the CNA (#6) replied, "We always just tie it." The nurse (#5) asked the CNA (#6) to go find another sling. Resident #7 stated, "That has been broken for a while, they always tie it." The CNA (#6) returned without another sling and stated, "The other one is missing the buckle also, but we just tie it." The nurse (#5) tied the strap with the missing buckle on the resident's left side. The CNA (#6) started to apply the leg strap and resident stated, "We don't use that." The CNA (#6) handed the leg strap buckle to the nurse (#5), and she secured it with the buckle. The CNA (#6) attached the right side of the sling using the proximal sling clip, while the nurse (#5) attached the left side of the sling using the distal sling clip. The CNA (#6) then positioned herself to resident's right side and the nurse (#5) began to raise the resident using the controls. The CNA (#6) stated, "Stop, stop, you need to lower her, I need to switch to the other clip." The nurse lowered the resident and the CNA (#6) attached the left side of the sling to the proximal sling clip. Resident #7 transferred back to the wheelchair.

The staff failed to transfer Resident #7 safely by not following the mechanical lift's manufacturer's guidelines related to the damaged waist strap. The staff showed lack of knowledge/consistency with use of the lift as indicated by the resident's statement that staff "don't use" the leg strap and

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F 689	Continued From page 5	F 689		

the observation of staff attaching the sling to opposing clips and raising the resident in the lift before realizing their mistake. The staff failed to follow the care plan to transfer the resident with a full-body lift.

- Review of Resident #8's medical record occurred on 08/04/2021 and identified a diagnosis of muscular sclerosis. The quarterly MDS, dated 04/08/21, identified intact cognition and extensive assistance from one person for transfers and toileting. The current care plan identified, "ADL self care [sic] deficit as evidenced by: inability to perform own ADL'S related to: disease process (Multiple Sclerosis), physical limitations. . . . Hoyer transfer with assist of two. . . . Staff to use the Purple SARA lift only. . . . Transfer with hoyer until determined otherwise. . . ."

Observation on 08/04/21 at 12:50 p.m., showed an administrative nurse (#1) and a medication aide (MA) (#2) transferred Resident #8 from the recliner to the toilet. The staff (#1 and #2) positioned the SARA 3000 stand lift in front of the recliner. The MA (#2) positioned the RPS350-1 sling behind the resident's back, the administrative nurse (#1) grabbed the left sling strap and attempted to place the loop around the attachment knob on the left lift arm. The administrative nurse (#1) stated, "This isn't going to work, we need the other lift." Both staff (#1 and #2) left the room, removing the SARA 3000 lift and returned with the RPS350-1 lift. The MA (#2) positioned the RPS350-1 lift in front of Resident #8's recliner. The MA (#2) placed the left sling strap around the proximal attachment knob of the left lift arm, while the administrative nurse (#1)

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F 689	Continued From page 6	F 689		

placed the right sling strap around the distal attachment knob of the right lift arm. The staff (#1 and #2) transported Resident #8 to the bathroom and lowered to toilet. At 1:02 p.m., while the resident remained on the toilet, the administrative nurse (#1) removed the right sling strap from the distal attachment knob on the lift arm and moved the strap to the proximal attachment knob on the lift arm. The staff (#1 and #2) returned Resident #8 to the recliner using the lift correctly.

Observation on 08/04/21 at 2:39 p.m., showed a Clinical Consultant (CC) (#3) and a CNA (#4) transferred Resident #8 from the wheelchair to the toilet using the RPS350-1 lift. The CNA (#4) placed the lift in front of the wheelchair and positioned the transfer sling behind Resident #8's back. The CC (#3) placed the left sling strap around the distal attachment knob of the left lift arm, while the CNA (#4) placed the right sling strap around the middle attachment knob of the right lift arm. The staff (#3 and #4) transported Resident #8 to the bathroom and back to the wheelchair. Staff failed to open lift legs for optimum stability and safety when transporting and turning during the transfer.

The staff failed to transfer Resident #8 safely by not following the mechanical lift's manufacturer's guidelines related to opening the lifts' legs during transfer. The staff showed lack of knowledge/consistency with use of the lift as indicated by the observations of staff attaching the sling to opposing clips. The staff failed to follow the care plan to transfer the resident with a full-body lift.

During an interview on 08/04/21 at 5:10 p.m., an

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F 689	Continued From page 7 administrative nurse (#1) confirmed all staff that operate lifts received education and completed the "Mechanical Lift Competency Checklist" between June 24-30, 2021, and identified the education provided to the staff as the same, regardless of the type of lift. The administrative nurse (#1) confirmed staff failed to utilize assistive devices appropriately when using the SARA 3000 lift with a damaged lift sling, incorrectly placed the sling straps around the attachment knobs on the lift arms when using the RPS350-1 lift, and failed to open the legs of the lift for optimum stability and safety when transporting and turning during transfers with both lifts.	F 689		
{F 880} SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention 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	{F 880}		8/31/21

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{F 880}	Continued From page 8 facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct 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.	{F 880}		

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{F 880}	Continued From page 9 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: DURING THE ON-SITE REVISIT COMPLETED ON AUGUST 4, 2021, EVIDENCE SHOWED THE FACILITY FAILED TO ACHIEVE COMPLIANCE WITH THIS REQUIREMENT. Refer to 05/24/21 and 07/13/2021 CMS-2567. Based on observation, review of the facility's policy, and staff interview, the facility failed to ensure staff followed standard infection control practices for 1 of 2 sampled residents (Resident #6) during dressing changes. Failure to follow infection control practices related to hand hygiene/glove use may result in the spread of infection within the facility. Findings include: Review of the facility policy titled "Dressing Change - Clean" occurred on 08/04/21. This policy, dated June 2017, stated, ". . . Put on first pair of disposable gloves. . . . Remove soiled dressing . . . Put on second pair of disposable gloves. . . . Pour prescribed solution onto gauze to be used for cleaning. . . . Cleanse wound. . . Apply dressing. . . ." - Review of Resident #6's medical record occurred on 08/04/21. The current physician's orders identified, ". . . Clean lt. [left] inner thigh	{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 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 hand hygiene or handwashing when donning PPE i.e. gloves, moving between tasks i.e. wound care, residents, and after touching potentially contaminated surfaces, in accordance with CDC guidelines. The DON, staff development coordinator (SDC), IP or designee, in conjunction with applicable IDT members, will: (1) Educate all staff on correctly completing hand hygiene after changing tasks, moving between residents, changing gloves, and touching potentially contaminated surfaces. To	

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{F 880}	Continued From page 10 open mole with NS [normal saline]. Cover with border foam dressing until healed. Change daily and prn [as needed]. one [sic] time a day. . . ." Observation of Resident #6's dressing change occurred on 08/04/21 at 3:07 p.m. and showed a nurse (#5) applied gloves, wiped down table, set up the supplies, removed gloves, and performed hand hygiene. The nurse (#5) pulled gloves from uniform pocket and applied the gloves. The nurse (#5) removed the soiled dressing and, without performing hand hygiene and donning clean gloves, cleansed the wound with a normal saline moistened 4x4 gauze, used second 4x4 gauze to dry skin, and applied clean dressing. The nurse (#5) failed to perform hand hygiene and apply clean gloves according to the facility policy. During an interview on 08/04/21 at 5:10 p.m., an administrative nurse (#1) confirmed staff are expected to follow the facility's policy when performing wound care and not to use gloves from their pockets.	{F 880}	verify these staff understands hand hygiene and handwashing, these staff will perform a successful return demonstration of identifying the need and correct procedure for performing hand hygiene and handwashing. 2. System Changes On or before 09/01/2021 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 handwashing or hand hygiene in accordance with CDC guidelines. Information about root cause analysis can be found at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/GuidanceforRCA.pdf (2) The DON, SDC, IP or suitable designee will ensure the following: a. All staff will receive education keeping hands clean between tasks, contacts with potentially contaminated surfaces, i.e. wound care, and between residents. This education will include the CDC's lesson on clean hands available at https://youtu.be/xmYMUly7qiE. (3) The facility leadership will contact the North Dakota Quality Improvement	

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{F 880}	Continued From page 11	{F 880}	Organization (QIO), to inquire about the assistance and services available from the QIO in improving infection prevention and control within the facility through quality assurance process improvement (QAPI) methods. 4. Monitoring Weekly for no less than 12 weeks, the DON, IP, SDC or a designee will conduct on-going monitoring to ensure, via observation, the approaches to correct deficient practice related to infection control and prevention are consistently implemented and effective. Such monitoring will include: (1) Observations of all staff types to ensure performance of proper handwashing and hand hygiene, and glove usage, when indicated, in the course of their routine duties, including during wound care. 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. 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	

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 08/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 880}	Continued From page 12	{F 880}	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 09/01/2021	