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 _____	08/16/2018

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 survey started on 08/13/18 and concluded on 08/16/18.	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 from the facility.	F 550		9/20/18

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

Electronically Signed | 09/07/2018

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F 550	Continued From page 1 §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide care for 6 of 18 sampled residents (Resident #6, #8, #14, #15, #35, and #46) in a manner and environment that maintained, enhanced, and respected each resident's dignity and individuality. Failure to speak respectfully, knock on doors/announce themselves, and wait for permission prior to entering residents' rooms, does not preserve the residents' personal dignity or enhance their quality of life and placed them at risk of embarrassment and/or emotional harm. Findings include: The facility failed to provide a policy regarding dignity per request. Observations on 08/14/18 showed the following: * At 9:52 a.m., two certified nursing assistants (CNAs) (#8 and #9) entered Resident #35's room to provide personal cares. A third unidentified CNA entered the room without knocking, and addressed the other two CNAs before exiting the room. The staff member failed to knock /announce herself and/or wait for permission to enter. * At 11:40 a.m., an unidentified CNA assisted Resident #14 to the bathroom. The CNA left the	F 550	Education on dignity & resident rights began as soon as administrative staff was made aware of the concerns during survey. Residents in the facility could be impacted by this practice. Residents who reside in the facility have the potential to be impacted by this practice. Therefore, residents were identified through direct observations. Education was presented to nurse managers on September 5, 2018. The Executive Director, DON or designee will provide education to staff members regarding resident□s rights and dignity. Education included the providing care in a manner & environment that maintained, enhanced, and respected each resident□s dignity and individuality. Education also included speaking to residents respectfully, knocking on doors/ announces themselves and waiting for permission prior to entering residents□ rooms. Education was/ will be provided on September 5 through September 11. Education will be audited to validate the completion of education by staff and reviewed by the QAPI committee for review and recommendation. Audits will	

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F 550	Continued From page 2 bathroom door wide open and failed to pull the privacy curtain between the bathroom and Resident #6's side of the room while she sat in the wheelchair facing bathroom. The CNA assisted Resident #14 with cares, then opened door for Resident #6 to leave the room while Resident #14 remained in bathroom. * At 4:20 p.m., observation showed Resident #46 seated in a wheel chair beside her bed with her call light sounding. Observation revealed a large brown stain approximately 6 by 8 inches on a white sheet covering the center of the bed. A CNA (#23) responded to call light, transferred the resident to her bed onto the soiled sheet, changed her brief, and left the room. A second CNA (#11) entered and transferred the resident back to her wheel chair, then changed the soiled sheet. During an interview on 08/15/28 at 2:30 p.m. two administrative nurses (#16 and #17) confirmed staff should have changed the sheet on Resident #46's bed at the time it became soiled. Observations on 08/15/18 showed the following: * At 9:11 a.m., two CNAs (#10 and #11) entered Resident #35's room to provide personal cares. A third unidentified CNA knocked on the door as she entered the room, and asked to use the mechanical lift before exiting the room. The staff member failed to announce herself and/or wait for permission to enter. * At 3:59 p.m., Resident #8 sat on the commode next to her bed drinking coffee and holding a cookie. She told the CNA (#4), who was washing his hands in the sink in her room, that she had a bowel movement. An unidentified CNA opened the door to Resident #8's room and said, "Knock.	F 550	be initiated the week of September 3, 2018 and completed weekly to ensure compliance of staff educated. Additionally, audits of direct care through observation of staff interactions with residents will be completed three times weekly for four weeks, two times weekly for four weeks, weekly for four weeks, and monthly for three months. Results of audits will be forwarded to the QA Committee which consists of the Executive Director, Director of Nursing, or designee to monitor its performance monthly to make sure solutions are sustained.	

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F 550	Continued From page 3 Knock." She spoke briefly to the other CNA (#4) before exiting the room. A few minutes later, an unidentified nurse opened the door to Resident #8's room, saw the surveyor, and backed out of the room. Two staff members failed to knock/announce themselves and/or wait for permission to enter. * At 4:19 p.m., two CNAs (#4 and #7) entered Resident #15's room to provide personal cares. One of the CNAs (#4) walked over to the resident, who was lying in bed, and stated, "We are going to change your diaper. I'm going to change your diaper right quick, so we can get you up for dinner." As the two CNAs (#4 and #7) performed pericares, a third CNA knocked on the door to Resident #15's room, entered, and asked his coworkers how they were doing. After transferring the resident to her wheel chair, the second CNA (#7) asked Resident #15 if she wanted her "blankie" or a drink of water. One staff member failed to knock/announce himself and/or wait for permission to enter, and two staff members failed to address the resident with age-appropriate terminology.	F 550		
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.	F 578		9/20/18

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F 578	Continued From page 4 §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (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, facility policy, and staff interview, the facility failed to ensure the medical record for 1 of 16 sampled residents (Resident #38) accurately reflected the resident's Advanced Directive regarding code status. Failure to ensure the resident's medical record accurately reflected her wishes may prevent emergency personnel from knowing the resident's choices in the event	F 578	Code status was validated with resident #38 and orders updated to reflect current choices. Residents with advanced directives that differ from their desired/ordered code status order have the potential to be impacted by this practice. An audit will be completed of advanced directives to	

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F 578	Continued From page 5 of a medical emergency. Findings include: Review of the facility policy titled "Code Status" occurred on 08/16/18. This undated policy, stated, ". . . Every resident or responsible party signs a consent for full code or no code upon admission . . . Red sheet of paper with DNR [do not resuscitate]/No Code is placed in the front of the chart with consent choice sheet signed right behind it. . . . Green sheet of paper with Full Code is placed in the front of the chart with the consent choice sheet signed right behind it. . . . The full code or no code order is noted on physician orders. . . . " Review of Resident #38's medical record occurred all days of survey. A "Living Will" form signed and dated on 06/25/14 by Resident #38, indicated DNR status. A physician's order, dated 10/04/17, indicated Full Code status. A green sheet of paper for Full Code was placed in the front of Resident #38's medical record with a copy of the signed physician's order attached. During an interview on the morning of 08/16/18, an administrative staff member (#16) indicated nursing staff asks the resident on admission and/or readmission what he/she would like their code to be. The facility failed to ensure the code level status was consistent in all areas of the medical record and accurately reflected the residents' current wishes.	F 578	validate they concur with code status. Orders will be updated if indicated. The universal POLST form will be implemented for new admissions and updated for existing admissions with their quarterly MDS assessments. DON will provide education to Unit Managers, licensed social workers/designee and nurses on using the POLST form. New admission and quarterly MDS charts will be audited to validate the presence of the POLST form. Audits will be initiated the week of September 3, 2018. Audits will be conducted three times weekly for four weeks, two times weekly for four weeks, weekly for four weeks, and monthly for three months. Results of audits will be forwarded to the QA Committee which members consist of the Executive Director, Director Of Nursing, or designee to monitor its performance monthly to make sure solutions are sustained.	
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii)	F 622		9/20/18

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F 622	Continued From page 6 §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health	F 622		

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F 622	Continued From page 7 or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c)(1)(A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for	F 622		

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F 622	Continued From page 8 ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to provide written notification for 2 of 7 sampled residents (Resident #24 and #38) transferred to the hospital. Failure to provide the resident and/or resident's family member/legal representative, in writing of a transfer, including the destination and reason for the transfer, and the resident's right to appeal the action, did not allow the resident or family member/legal representative to make an informed decision. Findings include: - Review of Resident #24's medical record occurred on all days of survey, and identified the facility transferred the resident to the hospital on 06/08/18 and 06/23/18. The medical record lacked evidence the facility provided the resident and/or their family member/legal representative written notice of the transfers, including the reason for the transfers, the effective date of the transfers, the location to which they transferred the residents, and the right to appeal the actions. During an interview on 08/16/18 at 9:21 a.m., a medical records staff member (#2) stated staff failed to complete Transfer Notices for Resident #24's hospital stays on 06/08/18 and 06/23/18.	F 622	Review of policy & procedure regarding Transfer & Discharge requirements were reviewed with Medical Records & Licensed Nursing personnel. Residents residing at the facility have the potential to be impacted by this practice. Residents who are transferred or discharged from the facility have the potential to be impacted by this practice. The Executive Director, DON or designee will continue education on Transfer & Discharge requirements with the Unit Managers, Medical Records Clerk, and licensed nursing personnel. Education included the importance of providing the resident and/or legal representative written notice of transfers, including the reason for the transfer, the effective date of the transfer, the location to which they transferred the residents, and the right to appeal the actions. Education was/ will be provided September 5 through September 11. Audits will continue by ED, DON, or designee three times weekly for four weeks, two times weekly for four weeks, weekly for four weeks, and monthly for three months. Results of audits will be forwarded to QAPI committee for review	

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F 622	Continued From page 9 - Review of Resident #38's medical record occurred on all days of survey, and identified the facility transferred the resident to the hospital on 06/23/18 and 06/26/18. The medical record lacked evidence the facility provided the resident and/or their family member/legal representative written notice of the transfers, including the reason for the transfers, the effective date of the transfers, the location to which they transferred the residents, and the right to appeal the actions. During an interview on the morning of 08/15/18, a medical records staff member (#2) stated staff failed to complete Transfer Notices for Resident #38's hospital stays 06/23/18 and 06/26/18.	F 622	and recommendations. Audits were initiated the week of September 3, 2018.	
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or	F 623		9/20/18

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F 623	Continued From page 10 discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual	F 623		

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F 623	Continued From page 11 and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to provide the Office of the State Long Term Care (LTC) Ombudsman a written	F 623	Review of policy & procedure regarding the Notice Requirements before Transfer/ Discharge requirements were reviewed	

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

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F 623	Continued From page 12 notice of transfer, including the destination, the reason for transfer, and the resident's right to appeal the action for 2 of 7 residents (Resident #24 and #38) transferred to the hospital. Failure to provide a notice of transfer or discharge does not allow the Ombudsman to keep informed of all transfers/discharges. Findings include: - Review of Resident #24's medical record occurred on all days of survey. Progress notes identified Resident #24 was hospitalized 06/08/18 and 06/23/18. The record lacked evidence the facility provided the State LTC Ombudsman written notice of transfer for these hospitalizations. During an interview on 08/16/18 at 9:21 a.m., a medical records staff member (#2) confirmed staff failed to complete Transfer Notices or Bed Hold for Resident #24's hospital stays on 06/08/18 and 06/23/18, and failed to notify the ombudsman of either hospital transfer. - Review of Resident #38's medical record occurred on all days of survey, and identified the facility transferred the resident to the hospital on 06/23/18 and 06/26/18. The medical record lacked evidence the facility provided the State LTC Ombudsman written notice of transfer for the hospitalization. During an interview on the morning of 08/15/18, a medical records staff member (#2) stated confirmed staff failed to complete a Transfer Notice for Resident #24's hospital stay on 06/23/18, and failed to notify the ombudsman.	F 623	with Medical Records & Licensed Nursing personnel. Residents residing at the facility have the potential to be impacted by this practice. Residents who require transfer or discharge from the facility have the potential to be impacted by this practice. The Executive Director, DON or designee will provide education on Notice Requirements before Transfer/ Discharge requirements with the licensed nursing personnel on September 5, 2018. Education included the importance of providing a notice of transfer or discharge to the Ombudsman to allow the Ombudsman to keep informed of transfers/ discharges. Audits to monitor Transfer/ Discharge requirements will continue by ED, DON, or designee three times weekly for four weeks, two times weekly for four weeks, weekly for four weeks, and monthly for three months. Results of audits will be forwarded to QAPI committee for review and recommendations. Audits were initiated the week of September 3, 2018.	

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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 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 and staff interview, the facility failed to provide a bed-hold notice upon transfer to the hospital for 3 of 7 sampled residents (Resident #23, #24, and #38) transferred to the hospital. Failure to provide the facility's bed-hold policy does not allow residents	F 625	Review of policy & procedure regarding the Notice of Bed Hold Policy/ Upon Transfer requirements were reviewed with Medical Records & Licensed Nursing personnel. residents residing at the facility have the	9/20/18

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F 625	Continued From page 14 or their legal representatives to make informed choices regarding their readmission rights. Findings include: - Review of Resident #23's medical record occurred on all days of survey, and identified the facility transferred the resident to the hospital on 06/16/18. The medical record lacked evidence the facility staff provided Resident #23 and/or their family member/legal representative written notice of the bed-hold policy upon transfer to the hospital. During an interview on 08/15/18 at 10:58 a.m., a business office manager (#3) stated facility staff failed to provide the bed-hold notice. - Review of Resident #24's medical record occurred on all days of survey, and identified the facility transferred the resident to the hospital on 06/08/18 and 06/23/18. The medical record lacked evidence the facility provided Resident #24 and/or their family member/legal representative written notice of the the bed-hold policy upon transfers to the hospital. During an interview on 08/16/18 at 9:21 a.m., a medical records staff member (#2) stated facility staff failed to provide the bed-hold notice. - Review of Resident #38's medical record occurred on all days of survey, and identified the facility transferred the resident to the hospital on 06/23/18 and 06/26/18. The medical record lacked evidence the facility provided Resident #38 and/or their family member/legal representative written notice of the the bed-hold	F 625	potential to be impacted by this practice. Residents who require transfer or discharge from the facility have the potential to be impacted by this practice. The Executive Director, DON or designee will continue education Bed Hold Policy/ Upon Transfer requirements with licensed nursing personnel. Education will be provided on September 5, 2018 through September 11, 2018. Education addresses the importance of providing the appropriate notices before a transfer to a hospital or a therapeutic leave, the nursing facility must provide written information to the resident or resident representative that will residents or legal representatives to make informed choices regarding their readmissions rights. Audits to monitor Bed Hold Policy will continue by ED, DON, or designee three times weekly for four weeks, two times weekly for four weeks, weekly for four weeks, and monthly for three months. Results of audits will be forwarded to QAPI committee for review and recommendations. Audits were initiated the week of September 3, 2018.	

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F 625	Continued From page 15 policy upon transfers to the hospital. During an interview on the morning of 08/15/18, a medical records staff member (#2) agreed the facility failed to provide the bed-hold notice.	F 625		
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: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.15), and staff interview, the facility failed to ensure accurate coding of Minimum Data Sets (MDSs) for 2 of 18 sampled residents (Resident #6 and #46). Failure to accurately complete Section N (Medications) and Section O (Special Treatments, Procedures,and Programs) of the MDS does not allow each resident's assessment to reflect their current status/needs, and may affect the accurate development of a comprehensive care plan and the care provided to the residents. Findings include: SECTION N: Medication The Long-Term Care Facility RAI Manual, page N12 - N13, stated, ". . . Coding Instructions for N0450A: Code 0, no: if antipsychotic were not received . . . Code 1, yes: if antipsychotic's were received on a routine basis only: Continue to N0450B, Has a GDR [gradual dose reduction]	F 641	Review of resident□s #6 and #46 Resident Assessment Instrument were completed during the survey process and modification/correction requests were completed by the Resident Assessment Coordinator during the annual survey process. Residents who receive antipsychotics or require the use of supplemental oxygen have the potential for inaccurate information being submitted in Section N and Section O. Review of like residents most recent MDS entries has been initiated and will be completed by September 20, 2018. Modification/correction requests will be submitted as needed for these residents. The DON or designee provided education on RAI coding accuracy on September 5, 2018. Education included the need for MDS to reflect resident□s current status/ needs and develop an accurate comprehensive care plan to develop the care provided to the residents. Audits of Section N and Section O of the	9/20/18

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F 641	Continued From page 16 been attempted? . . . Code 0, no: if a GDR has not been attempted. Skip to N0450D, Physician documented GDR as clinically contraindicated. Code 1, yes: if GDR has been attempted. Continue to N0450C, Date of last attempted GDR. . . . " - Review of Resident #6's medical record occurred on all days of survey and identified a physician's order, dated 06/20/18, for Quetiapine (an antipsychotic) 25 milligrams (mg) daily at bedtime. Review of the July medication administration record (MAR) showed staff administered the Quetiapine at bedtime daily in July. The record also showed the physician rejected a GDR in January 2018 for the Quetiapine. The quarterly MDS, dated 07/22/18, failed to identify the use of an antipsychotic. Failure to identify antipsychotic use resulted in the system not triggering staff to identify the physician's rejection of a GDR in January 2018. During an interview on 08/15/18 at 3:21 p.m., an administrative staff member (#18) confirmed she coded section N0450 incorrectly on Resident #6's 07/22/18 MDS. SECTION O 0100: Special Treatments, Procedures, and Programs The Long-Term Care Facility RAI Manual, page O-3, stated, ". . . O 0100C Oxygen therapy, Code continuous or intermittent oxygen administered via mask, cannula, . . . delivered to a resident to relieve hypoxia [low oxygen in tissues] in this item. . . . This item may be coded if the resident	F 641	MDS will be initiated the week of September 3, 2018. Audits will be conducted three times weekly for four weeks, two times weekly for four weeks, weekly for four weeks, and monthly for three months. Results of audits will be forwarded to the QA Committee which members consist of the Executive Director, Director Of Nursing, or designee to monitor its performance monthly to make sure solutions are sustained.	

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F 641	Continued From page 17 places or removes his/her own oxygen mask, cannula. . . . " - Resident #46's medical record, reviewed August 14-16, 2018, identified a physician's order, dated 06/28/18 for continuous oxygen at 2 liters per minute for mild dyspnea [shortness of breath], 3 liters per minute for moderate dyspnea, and 4 liters per minute for severe dyspnea. Progress notes, dated 07/28/18 at 2:09 p.m. and 07/29/18 at 3:10 p.m. identified the resident receiving oxygen at 2 liters per minute via a nasal cannula. A quarterly MDS, dated 07/30/18, failed to identify oxygen use. During an interview on 08/16/18 10:30 a.m. an administrative nurse (#18) confirmed she should have coded Resident #46's oxygen use at O 0100C on the 07/29/18 MDS.	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	F 644		9/20/18

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F 644	Continued From page 18 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 (PASARR) and Level of Care Screening Procedures For Long Term Care Services, and staff interview, the facility failed to complete a status change assessment for 2 of 4 sampled residents (Resident #2 and #48) reviewed for PASARR requirements. Failure to complete a change in status assessment may result in the delivery of care and services that are inconsistent with residents' needs. Findings include: The North Dakota PASARR Provider Manual page 13 states, ". . . Change in Status Process . . . Whenever the following events occur, nursing facility staff must contact Ascend [contracted service provider for screening process] 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. . . ." - Resident #2's medical record, reviewed August	F 644	Review of resident□s #2 and #48 PASARR requirements were reviewed when concerns where made aware during the survey. In depth reviews of PASARR were completed August 17 through August 20. Residents residing at the facility have the potential to be impacted by this practice due to possible changes in status or with a new diagnosis. The DON or designee provided education on RAI coding accuracy on September 5, 2018. Education included the need for the PASARR to reflect resident□s current status/ needs. PASARR's will be audited for updates during the morning clinical meeting by the interdisciplinary team. Validation of audits and completion of updates to PASARR's will be completed by the DON or designee three times weekly for four weeks, two times weekly for four weeks, weekly for four weeks, and monthly for three months. Results of audits will be forwarded to the QA Committee which members consist of the Executive Director, Director Of Nursing, or designee to monitor its performance monthly to make sure solutions are sustained.	

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F 644	Continued From page 19	F 644		

14-16, 2018, identified the facility admitted the resident on 11/13/10. The record identified a diagnoses of Unspecified Psychosis, dated 02/24/10 and Post Traumatic Stress Disorder, dated 02/10/12. The record lacked evidence staff completed a Level I assessment at the time of her admission or an updated Level I assessment with the new diagnosis on 02/10/12.

During an interview on 08/15/18 at 10:15 a.m., an administrative nurse (#17) stated she was unable to provide information indicating staff had completed the admission PASARR or an updated assessment in 2012.

- Resident #48's medical record, reviewed on August 14-16, 2018, identified the facility admitted the resident on 10/19/15. A Level I PASARR, dated 09/03/15, stated "It is reported he has no diagnosis of Major Mental Illness . . . If there is a change of status it is the facilities [sic] responsibility to submit proper documentation and forms." Resident #48's record identified a new diagnosis of Schizophrenia, dated 02/18/16, but lacked evidence staff completed an updated Level I PASARR at that time.

During an interview on 08/15/18 at 10:15 a.m. an administrative nurse (#17) stated she was unable to find additional information identifying staff had completed an updated Level I PASARR after the Schizophrenia diagnosis.

During an interview on the afternoon of 08/15/18, a second administrative nurse (#16) provided information showing Resident #48 has had diagnosis of Schizophrenia since 2009, but staff were unaware of the diagnosis, so failed to

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F 644	Continued From page 20 identify it on his admission PASARR.	F 644		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:	F 655		9/20/18

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F 655	Continued From page 21 (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to develop a baseline care plan for 1 of 2 sampled residents (Resident #229), newly admitted to the facility. Failure to develop and implement a baseline care plan limited staff's ability to provide effective and person-centered care for the resident. Findings include: Review of Resident #229's medical record, on all days of survey, identified an admission date of 08/08/18. The facility staff could not locate a baseline care plan for the resident completed prior to 08/14/18. During an interview on 08/14/18 at 8:56 a.m., the unit manager (#5) stated a baseline care plan should be completed on paper in the first 48 hours of a resident's admission and placed in the facility's baseline care plan book. The unit manager (#5) stated she started, but had not completed a baseline care plan for Resident #229. The facility failed to complete a baseline care plan within 48 hours of the resident's admission.	F 655	Resident #229 baseline care plan was updated during survey. Residents who are admitted or readmitted have the potential to be impacted by this practice. IDT reviewed admissions over past 30 days at survey exit to validate current baseline care plans. All new admissions will have a Baseline Care Plan completed within 48 hours of admission. Baseline care plans will be kept at the nurses station for staff access and review. DON provided education to the IDT on September 5, 2018. The IDT was educated on the need to complete the baseline care plan. Baseline care plans will be kept at the nurses station for staff access and review. Audits will be initiated the week of September 3, 2018. Audits will be conducted three times weekly for four weeks, two times weekly for four weeks, weekly for four weeks, and monthly for three months. Results of audits will be forwarded to the QA Committee which members consist of the Executive Director, Director Of Nursing, or designee to monitor its performance monthly to	

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F 655	Continued From page 22	F 655	make sure solutions are sustained.	
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 community was assessed and any referrals to	F 656		9/20/18

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F 656	Continued From page 23 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 record review and staff interview, the facility failed to develop a comprehensive care plan for 1 of 18 sampled residents (Resident #277). Care planning drives the type of care and services that a resident receives. 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 #277's medical record occurred on all days of survey. Diagnoses included a non-pressure chronic ulcer on the right foot, pressure ulcer on the sacral region, and a blister on the right foot. A skin assessment, dated 08/07/18, indicated a stage 2 pressure ulcer to the coccyx measuring 5 centimeters (cm) x (by) 5 cm, red with a small amount of drainage, and treated with foam bordered dressing. Review of Resident #277's care plan occurred on 08/16/18. The care plan failed to address the resident's current stage 2 pressure ulcer and failed to provide goals and interventions to manage Resident #277's pressure ulcer. During an interview on the afternoon of 08/16/18 an administrative staff member (#16) stated the care plan was currently in process.	F 656	Resident #277 comprehensive care plan was updated following survey to include pressure ulcer and interventions. Residents with pressure ulcers at admission or whom develop pressure ulcers have the potential to be impacted by this practice. Care plans for residents with pressure areas and new admissions who have pressure related skin breakdown were reviewed to validate this is a focus on their care plan and that interventions are in place. DON will educate unit managers on implementation of comprehensive care plan accuracy. DON or designee will provide written education and review during post survey sessions beginning September 5, 2018. Audits will be initiated the week of September 3, 2018. Audits will be conducted three times weekly for four weeks, two times weekly for four weeks, weekly for four weeks, and monthly for three months. Results of audits will be forwarded to the QA Committee which members consist of the Executive Director, Director Of Nursing, or designee to monitor its performance monthly to make sure solutions are sustained.	

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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-- (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 CITATION FROM THE SURVEY COMPLETED ON 07/26/17. Based on observation, record review, and staff interview, the facility failed to review and revise the comprehensive care plan to reflect the current status for 2 of 18 sampled residents	F 657	Resident #8 and resident #35 care plans were reviewed and updated following survey. Residents who require the use of TED hose or positioning devices or who require specific positioning with oral intake have the potential to be impacted	9/20/18

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F 657	Continued From page 25 (Resident #8 and #35). Failure to revise the care plan limited staff's ability to communicate care needs and ensure continuity of care for each resident. Findings include: The facility failed to provide a policy regarding care plans per request. - Review of Resident #8's medical record occurred on all days of survey. The current physician's orders stated, ". . . TED hose (compression stockings) on in the morning/off at bedtime. . . ." Observations on 08/15/18 at 3:59 p.m. and 08/16/18 at 9:33 a.m. showed Resident #8 not wearing her TED hose. The current care plan stated, ". . . Cardiac disease . . . Administer medications as ordered, Assist with activities as needed, Dangle at edge of bed/chair before transfers, Encourage rest periods as needed, Obtain vital signs as indicated, report changes to physician, Obtain weights as needed/ordered, Report significant change. . . ." The facility failed to care plan the resident's need for/use of TED hose. - Review of Resident #35's medical record occurred on all days of survey. Diagnoses included bilateral contractures of the knees and pain. The current care plan stated, ". . . Potential for skin breakdown . . . Keep skin clean and dry, Use lotion on dry skin, Provide wound care as ordered, [brand name] [blue] boots at night as resident allows, Reposition at routine intervals,	F 657	by this practice. Residents were identified through order and care plan review and care plans updated when indicated. DON will educate unit managers on September 5, 2018 on requirement to update care plans and ensure that resident specific interventions are on the care plan and populate to the KARDEX for CNAs review. DON or designee will provide education and review to IDT and direct care staff. Education will include importance of accuracy of care plan interventions and KARDEX accuracy. Education will be provided during post survey sessions beginning September 5, 2018. Audits will be initiated the week of September 3, 2018. Audits of five care plans will be conducted three times weekly for four weeks, two times weekly for four weeks, weekly for four weeks, and monthly for three months. Results of audits will be forwarded to the QA Committee which members consist of the Executive Director, Director Of Nursing, or designee to monitor its performance monthly to make sure solutions are sustained.	

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F 657	Continued From page 26	F 657		

encourage to lay down between meals and to limit time spent sitting up in chair, Special mattress/cushion on wheelchair. . . ." The facility failed to care plan the resident's need for/use of a pillow between his knees to prevent skin breakdown.

Observations showed the following:
* 08/14/18 at 9:52 a.m., two certified nursing assistants (CNAs) (#8 and #9) transferred Resident #35 to bed using a mechanical lift. One of the CNAs (#9) placed a pillow between the resident's knees, covered him with a blanket, and handed him his call light.
* 08/15/18 at 9:11 a.m., two CNAs (#10 and #11) transferred Resident #35 into bed using a mechanical lift and provided personal cares. One CNA remarked, "His knees must be so painful." The staff members failed to place a pillow between Resident #35's knees.
* 08/16/18 at 10:00 a.m., Resident #35 laid in bed, with a pillow between his knees.

Resident #35's medical record also identified diagnoses including history of dysphagia and reflux.

A "Speech Therapy Progress [and] Discharge Summary," dated 01/18/18, identified, ". . . Precautions: Position at 90 degree angle during and 20 minutes after oral intake. Positioning during oral intake must be Approx. [approximately] 90 degrees. . . ."

The current care plan stated, ". . . ADL [Activities of Daily Living] self care deficit . . . Assist with . . . eating as needed. . . ." The facility failed to care plan the resident's need to be seated at a 90

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F 657	Continued From page 27 degree angle prior to eating/drinking to prevent aspiration. Observation showed the following: * 08/14/18 at 9:52 a.m., Resident #35 laid on his left side in bed, with the head of the bed reclined to an approximate 20 degree angle. A certified nursing assistant (CNA) (#9) raised Resident #35's bed (with the head of the bed in the reclined position) and gave him a drink of water via a straw. * 08/15/18 at 9:11 a.m., Resident #35 laid flat on his back in bed, with his head resting on two pillows (an approximate 20 degree angle). Two CNAs (#10 and #11) gave him a drink of water via a straw. In both instances, the staff members failed to raise the head of Resident #35's bed to a 90 degree angle prior to offering him a drink of water.	F 657		
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: PRIMING INSULIN PENS 1. Based on observation and manufacturer's guidelines, the facility failed to follow professional standards of practice in priming insulin pens for 2 of 3 residents observed receiving insulin (Resident #16 and #42). Failure to remove the needle shield prior to priming an insulin pen and	F 658	Blood glucose monitoring results were reviewed for Resident #16 and Resident #42 and no untoward effects were noted. Accuchecks were discontinued on Resident #71 on July 25, 2018; clarification order was written during survey to discontinue insulin. Resident #65 was ordered daily weights on June	9/20/18

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F 658	Continued From page 28 inverting the pen during priming may result in the resident receiving an inaccurate amount of insulin. Findings include: Prescribing information for NovoLog insulin found at www.nov-pi.com/novolgpdf, stated, ". . . Before each injection small amounts of air may collect in the cartridge during normal use. To avoid injecting air and to ensure proper dosing: Turn the dose selector to select 2 units. Hold your NovoLog FlexPen with the needle pointing up. Tap the cartridge gently with your finger a few times to make any air bubbles collect at the top of the cartridge. Keep the needle pointing upwards, press the push-button all the way in. The dose selector returns to 0. A drop of insulin should appear at the needle tip. If not, change the needle and repeat the procedure no more than 6 times. . . ." - Observation on 08/14/18 at 12:10 p.m. showed a licensed nurse (#1) prepared an insulin pen for injection for Resident #16. After placing the needle on the insulin pen, the nurse failed to remove the outer needle shield before priming the insulin pen. With the shield still in place, the nurse was unable to visualize a stream of insulin from the needle. - Observation on 08/15/18 7:47 a.m. showed a licensed nurse (#24) prepared an insulin pen for injection for Resident #42. The nurse placed the needle on the pen, removed the needle shield, and primed the pen with two units of insulin while holding it with the needle pointing downward. Priming the pen with the needle pointing	F 658	20, 2018, physician was updated post survey with documented weights since admission, will proceed with weekly weights for four weeks then monthly weights, notify MD per parameters. Care plan was updated to reflect TED hose applied/removal for Resident #8. Residents who receive insulin are at risk for improper priming of insulin pens, and residents with physician orders who require daily weights or the use of TED hose or devices can be negatively impacted if these orders are not implemented. Education was/will be provided by DON to Unit Managers and Licensed Nursing personnel on correct priming of insulin pens, correct steps involved in physician orders and follow up necessary on physician□s orders and validating that CNAs are providing cares as specified on MD orders. DON or designee will provide education to CNAs on following directives for resident specific orders such as TED hose or daily weight. Education will be initiated the week of September 5, 2018. Unit Managers will review physician□s orders for accuracy and to ensure orders are complete. DON or designee will complete audits through direct observation of priming insulin pens and review of physician□s orders and will be conducted three times weekly for four weeks, two times weekly for four weeks, weekly for four weeks, and monthly for three months. Audits will be initiated the week of September 3, 2018. Results of audits will be forwarded	

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F 658	Continued From page 29 downward does not ensure an adequate amount of insulin is expelled during the priming process. OBTAINING/FOLLOWING PHYSICIAN'S ORDERS 2. Based on observation, record review, review of professional reference, and staff interview, the facility failed to obtain/follow physician's orders for 3 of 18 sampled residents (Resident #8, #65, and #71). Failure follow physician's orders and failure to obtain a physician's order prior to discontinuing a medication may result the use of unnecessary medications. 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 nor apparently erroneous, the nurse is responsible for carrying it out. . . . Documentation . . . Nurses, therefore, need to provide accurate and complete documentation of the nursing care provided to clients. . . ." - Review of Resident #71's medical record occurred on all days of survey. The resident's Medication Administration Record (MAR) identified both the blood glucose monitoring and insulin discontinued on 07/25/18. The record further identified a physician's order, dated 07/25/18, to discontinue the blood glucose monitoring, but failed to identify an order to discontinue the insulin.	F 658	to the QA committee for review and recommendations.	

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F 658	Continued From page 30 During an interview on the afternoon of 08/15/18, a licensed nurse (#6) stated he was unable to locate an order to discontinue Resident #71's insulin. - Review of Resident #65's medical record occurred on all days of survey. The current physician's orders identified an order, dated 06/20/18 for daily weights. The resident's record identified staff weighed Resident #65 on 13 of the 42 days since 06/20/18 and last weighed the resident on 08/06/18. During an interview on the morning of 08/16/18, an administrative staff member (#16) stated the physician had not discontinued Resident #65's daily weights. - Review of Resident #8's medical record occurred on all days of survey. The current physician's orders stated, ". . . TED hose (compression stockings) on in the morning/off at bedtime. . . ." Observations showed the following: * 08/15/18 at 3:59 p.m., Resident #8 not wearing her TED hose. * 08/16/18 at 9:33 a.m., Resident #8 lying in bed not wearing her TED hose. During an interview on 08/16/18 at 9:38 a.m., a licensed nurse (#19) confirmed staff failed to apply Resident #8's TED hose per the physician's order.	F 658		
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	F 677		9/20/18

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F 677	Continued From page 31 out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, record review, and family interview, the facility failed to provide dining assistance for 2 of 18 sampled residents (Resident #8 and #15) and 3 supplemental residents (Resident #39, #40, and #49) observed during meals. Failure to cue and/or assist a resident who required assistance may result in decreased intake and/or unwanted weight loss. Findings include: The facility failed to provide a policy regarding dining assistance per request. - During an interview on 08/13/18 at 11:30 a.m., when asked questions regarding the food being served and the assistance offered to residents, a family member (AA), stated, "No, [there is] not sufficient staffing. It shows up in the dining room. [The residents] barely eat and [the staff] take them back to their rooms." Review of Resident #8's medical record occurred on all days of survey. Diagnoses included dysphagia and reflux. The current care plan identified, ". . . Encourage and assist as needed to consume foods and/or supplements and fluids offered. . . ." A progress note, dated 07/21/18, identified, ". . . Resident [#8] has been noted to have a weight loss from 106 pounds on 1/2018 to 97.4 pounds on 7/2018. . . ."	F 677	Following survey exit dining room monitors provided verbal reminders to staff of the importance of ensuring residents are awakened and offered assistance with meal intake. Dining room monitors validated staff followed through with this directive while providing oversight in the dining areas. Residents requiring assistance during meals are at risk for decreased intake and/or unwanted weight loss. DON or designee will provide education on identifying and recognizing residents whom require assistance with nutritional intake; to include verbal cues and physical assistance with meals. The executive director will provide written education to the management team on the role of the dining room monitor and ensuring staff are providing adequate assistance with meal intake while observing dining room process. Education will be initiated September 5, 2018 during post survey educational sessions. Audits will be completed by the Executive Director or designee through direct observation of dining process. These audits will be completed five times weekly for four weeks, three times weekly for four weeks, two times weekly for four weeks, then weekly for three months. Audit cycle will ensure that observation of a.m. noon and p.m. meals are completed on a	

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F 677	Continued From page 32 Observations showed the following: * 08/13/18 at 12:22 p.m., A family member assisted Resident #8 throughout the noon meal and also provided cueing to Resident #8's tablemate. * 08/13/18 at 5:35 p.m., Resident #8 received her tray. At 5:43 p.m. [8 minutes later] an unidentified certified nursing assistant (CNA) cut her meat and potatoes into smaller pieces. No further assistance was provided, and staff later documented 26-50% intake. - Review of Resident #15's medical record occurred on all days of survey. The current care plan identified, ". . . Encourage and assist as needed to consume foods and/or supplements and fluids offered. . . ." Observations showed the following: * 08/13/18 at 12:17 p.m., Resident #15 fed herself, demonstrating a very slow rate of intake. Staff failed to provide consistent cueing/assistance, and later documented 0-25% intake. * 08/13/18 at 5:35 p.m., Resident #15 fed herself, demonstrating a very slow rate of intake. Staff failed to provide cueing/assistance, and later documented 26-50% intake. * 08/14/18 at 8:58 a.m., Staff placed Resident #15's tray on the table in front of her, as she slept in her wheelchair. Staff failed to provide consistent cueing/assistance, and later documented 0-25% intake. - Review of Resident #39's medical record occurred on all days of survey. The current care plan identified, ". . . Encourage and assist as	F 677	revolving schedule. Audits will be initiated the week of September 3, 2018. Results of audits will be forwarded to the QAPI committee for review and recommendations.	

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F 677	Continued From page 33 needed to consume foods and/or supplements and fluids offered. . . ." Observations showed the following: * 08/13/18 at 12:22 p.m., Resident #39 called out for "fish" as she fed herself, demonstrating a very slow rate of intake. An unidentified CNA cut her fish into smaller pieces. A few minutes later, a second unidentified CNA observed her taking very large bites of cake and cut the cake into smaller pieces. Resident #39 was observed coughing during the meal. No further assistance was provided, and staff later documented 26-50% intake. * 08/13/18 at 5:35 p.m., Resident #39 called out for a "doctor" as she fed herself, demonstrating a very slow rate of intake. An unidentified CNA stated, "As soon as you are done eating, [the nurse] will give you some pain medicine." At 5:45 p.m. (10 minutes later) an unidentified CNA asked Resident #39, "Are you done? Okay." She made no effort to cue and/or assist Resident #39, but asked another CNA to remove her from the dining room. Staff later documented 0-25% intake. * 08/14/18 at 8:55 a.m., Staff placed Resident #39's tray on the table in front of her, as she slept in her wheelchair. Staff failed to provide cueing/assistance, and later documented 0-25% intake. - Review of Resident #40's medical record occurred on all days of survey. The current care plan identified, ". . . Encourage and assist as needed to consume foods and/or supplements and fluids offered. Assist with meal set up. . . ." Observations showed the following:	F 677		

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F 677	Continued From page 34 * 08/14/18 at 8:55 a.m., Staff placed Resident #40's tray on the table in front of her, as she slept in her wheelchair. An unidentified CNA stated, "[Resident #40], are you going to drink your coffee." Resident #40 awoke, and took a sip of her coffee. The CNA turned to the surveyor and stated, "It's probably cold by now." No further cueing or assistance was provided, and staff later documented 0-25% intake. - Review of Resident #49's medical record occurred on all days of survey. The current care plan identified, ". . . Encourage and assist as needed to consume foods and/or supplements and fluids offered. Assist with meal set up. . . ." Observations showed the following: * 08/13/18 at 12:17 p.m., Resident #49 fed herself, eating cake directly from the bowl, which resulted in frosting smeared across her face and pieces of cake spilled onto her clothing. An unidentified CNA sat down to assist Resident #49 after she noticed the surveyor observing the resident.	F 677		
F 684 SS=D	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:	F 684		9/20/18

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	355031	A. BUILDING _____ B. WING _____	08/16/2018

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

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F 684	Continued From page 35 SWALLOW SAFETY 1. Based on observation and record review, the facility failed to ensure 1 of 1 sampled resident (Resident #35) observed being assisted to drink while lying in bed received the necessary care and services to ensure his safety. Failure to properly position Resident #35 in bed has the potential to negatively affect his overall swallow safety and placed him at risk of aspiration. Findings include: The facility failed to provide a policy regarding dysphagia or feeding assistance per request. Review of Resident #35's medical record occurred on all days of survey. Diagnoses included history of dysphagia and reflux. A "Speech Therapy Progress [and] Discharge Summary," dated 01/18/18, identified, ". . . Precautions: Position at 90 degree angle during and 20 minutes after oral intake. Positioning during oral intake must be Approx. [approximately] 90 degrees. . . ." Observation showed the following: * 08/14/18 at 9:52 a.m., Resident #35 laid on his left side in bed, with the head of the bed reclined to an approximate 20 degree angle. A certified nursing assistant (CNA) (#9) raised Resident #35's bed (with the head of the bed in the reclined position) and gave him a drink of water via a straw. * 08/15/18 at 9:11 a.m., Resident #35 laid flat on his back in bed, with his head resting on two pillows (an approximate 20 degree angle). Two	F 684	Resident #35 care plan was updated to indicate the recommendations given by ancillary department. Resident #8 had a skin assessment completed and skin report updated to reflect current status. Resident #35 and #8 had care plans updated and KARDEX reviewed to ensure interventions were updated. Residents with specific interventions for safe oral intake and those with fragile skin have the potential to be impacted by this practice. Care plans were reviewed and updated for like residents. DON or designee will provide education to nurses and nursing assistants starting on September 5th, 2018. Education will include monitoring skin alterations, care with transfers, and following resident specific instructions for care. Audits will be completed by DON or designee through direct observation of transfers, oral intake, and audits of care plans and skin sheets. Audits will be initiated the week of September 3, 2018. Audits will be completed three times weekly for four weeks, two times weekly for four weeks, weekly for four weeks, and monthly for three months.	

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F 684	Continued From page 36 CNAs (#10 and #11) gave him a drink of water via a straw. In both instances, the staff members failed to raise the head of Resident #35's bed to a 90 degree angle prior to offering him a drink of water. TRANSFER SAFETY/BRUISES 2. Based on observation, record review, and family and staff interviews, the facility failed to provide the necessary care and services for 1 of 18 sampled resident (Resident #8) observed being transferred into their wheelchair. Failure to report, assess, and document residents' bruises may result in lack of identification of additional bruises and/or the cause for these bruises. Findings include: The facility failed to provide a policy regarding transfers and/or skin care per request. During an interview on 08/13/18 at 11:30 a.m., when asked questions about accident hazards, a family member (AA), reported her mother has "Bruises all over. [Her] legs are covered. [The facility] thinks it may be from the side rails." Review of Resident #8's medical record occurred on all days of survey. The record showed she was at risk of alterations in skin integrity. A "Weekly Skin Review," dated 08/15/18, identified, ". . . bruising to bilateral shins. . . ." The skin assessment failed to identify the number of and location of the bruises on Resident #8's legs. Observations showed the following:	F 684		

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F 684	Continued From page 37 * 08/14/18 at 12:12 p.m., a CNA (#21) assisted Resident #8 to stand-pivot into her wheelchair. The CNA bumped/scraped Resident #8's shin when she applied the pedals to the chair. Resident #8 stated, "Ow! Watch what you are doing! I have soft skin." The staff member failed to report the incident to the nurse, who is responsible for assessing Resident #8's skin. * 08/15/18 at 3:59 p.m., Resident #8 with several bruises to both legs. Both lower legs were visible, as she was not wearing her TED hose. During an interview on 08/16/18 at 9:38 a.m., a nurse (#19) confirmed staff failed to apply Resident #8's TED hose, and stated the hose would add another barrier, protecting her skin.	F 684		
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: THIS IS A REPEAT DEFICIENCY FROM SURVEY COMPLETED ON 07/26/17 Based on observation, review of facility policy, record review, and staff interview, the facility failed to provide adequate supervision and assistive devices necessary to prevent accidents for 2 of 8 sampled residents (Resident #2 and #23) observed during gait belt transfers. Failure	F 689	Review of resident□s #2 and #23 Kardex occurred on August 16, 2018, and both resident□s transfer types were updated. Residents residing at the facility who require gait belts during transfers have the potential to be impacted by this practice. Residents were identified through direct observation and review of the care plan.	9/20/18

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F 689	Continued From page 38 to properly use a gaitbelt and to ensure adequate assistance during gaitbelt transfers placed the residents at risk of accidents and injury. Findings include: Review of the facility policy titled "Lifting and Movement of Residents" occurred on 08/16/18. The policy, dated December 2016, stated, ". . . In order to protect the safety and well-being of staff and residents, and to promote quality care, this facility uses appropriate techniques and devices to lift and move residents. . . . 2. Manual lifting of residents shall be eliminated when feasible. 3. Nursing staff, in conjunction with the rehabilitation staff, shall assess individual residents' needs for transfer assistance on an ongoing basis. Staff will document resident transferring and lifting needs in the care plan . . . 6. Gait belts will be used when the resident can bear some weight, has some upper body strength, and is easily managed by one or more staff with non-mechanical lifting devices. . . ." - Review of Resident #23's medical record occurred on all days of the survey. A significant change Minimum Data Set (MDS), dated 06/25/18, identified the resident required extensive assist of two for transfers. The resident's current care plan stated, ". . . Transfer with two assist with gait belt. . . ." During an observation on 08/14/18 at 5:00 p.m., a certified nursing assistant (CNA) (#7) placed a gait belt around Resident #23 and transferred him from the recliner to wheelchair without the assistance of a second staff member. Resident #23 showed difficulty with bearing weight and	F 689	The DON or designee provided/will provide education to licensed nursing staff on September 5, 2018. Education included the proper use of gait belt and ensuring adequate assistance during gait belt transfers to prevent from placing the residents at risk of accidents and injury. Gait belt transfers will be audited through direct observation audits three times weekly for four weeks, two times weekly for four weeks, weekly for four weeks, and monthly for three months. Audits will be initiated the week of September 5, 2018. Results of audits will be forwarded to the QA Committee which members consist of the Executive Director, Director Of Nursing, or designee to monitor its performance monthly to make sure solutions are sustained.	

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F 689	Continued From page 39 standing during the transfer. - Review of Resident #2's medical record occurred on August 14-16, 2018. A quarterly MDS, dated 08/07/18, identified the resident required extensive assist of two staff for transfers. The resident's current care plan stated, ". . . Transfer with two assist with gait belt. . . ." Observation on 08/14/18 at 10:10 a.m. showed two CNAs (#9 and #21) assisted Resident #2 to bed utilizing a gait belt, the CNAs held Resident #2 under her arms as well as holding the gait belt during the transfer. After changing her brief, the CNAs (#9 and #21) assisted Resident #2 back to her chair utilizing a gait belt. Observation showed Resident #2 was not able to stand upright. One CNA (#21) lifted the resident under her arms while the second CNA (#9) lifted the resident's legs to position her in the chair. Observation on 08/14/18 at 2:44 p.m. showed Resident #2 resting in bed. Two CNAs (#13 and #23) transferred the resident from her bed to her chair utilizing a gait belt. Observation showed Resident #2 did not bear weight during the transfer, but half stood with her legs bent and her feet not touching floor. When informed of the above observations, during an interview on 08/15/18 at 2:30 p.m., an administrative nurse (#16) stated she was not aware of the resident's inability to bear weight and would schedule a therapy evaluation for the resident's transfer status.	F 689		
F 730 SS=C	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7)	F 730		9/20/18

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F 730	Continued From page 40 §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 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 performance evaluations, review of twelve months of education records, and staff interview, the facility failed to provide twelve hours of in-service education per year for 3 of 3 certified nursing assistants (CNAs) (CNA A, B, and C) based on their individual performance review. Failure to provide twelve hours of in-service education per year to CNA A, B, and C may result in staff lacking the necessary skills and knowledge to provide care and services addressing special resident needs. Findings include: Review of staff performance evaluations and twelve months of education records occurred on August 15-16, 2018. The records showed the facility failed to provide twelve hours of in-service education for 3 of 3 CNAs (CNA A, B, and C). During an interview on 08/16/18 at 3:34 p.m., an administrative nurse (#17) confirmed the facility failed to ensure all staff members were provided and/or completed twelve hours of in-service education during the period between August 2017-July 2018. The administrative nurse (#17) did report one of the three employees had recently returned from over-seas.	F 730	Review of nurse aide 12 hours per year in service occurred August 16, 2018 as the concern was brought forward during survey. In depth reviews of nurse aide evaluations were completed August 17, 2018. Nurse aides who are employed by the facility who require 12 hours per year of in-service education were identified through employee record review. The DON or designee provided/will provide education to nurse aide staff on September 5, 2018. Education will review necessary skills and knowledge to provide care and services that address special resident needs. In-service audits will be conducted through review of Relias data, and in-service education forms monthly and throughout the remainder of the year to ensure 12 hours of in-services are being completed by staff. Results of audits will be forwarded to the QA Committee which members consist of the Executive Director, Director Of Nursing, or designee to monitor its performance monthly to make sure solutions are sustained.	
F 756	Drug Regimen Review, Report Irregular, Act On	F 756		9/20/18

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F 756 SS=D	Continued From page 41 CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take	F 756		

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F 756	Continued From page 42 when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the consulting pharmacist failed to identify and report drug regimen irregularities regarding duplicate therapy of opiate pain medications to the attending physician, the medical director, and the director of nursing for 1 of 18 sampled residents (Resident #35) reviewed. Failure to ensure the pharmacist reported the medication irregularities may result in the residents receiving unnecessary medications and experiencing adverse consequences related to the medications. Findings include: Review of the facility policy titled "Consultant Pharmacist Reports" occurred on 08/16/18. This policy, dated September 2011, stated, " . . . The administration schedule is appropriate for the resident, considering side effects (such as sedation), compatibility with other medications and manufacturer's recommendations. . . ." Resident #35's record identified the following physician's orders for opiate pain medications: * 04/05/18: Tramadol 50 milligrams (mg) by mouth three times a day for uncontrolled pain * 04/13/18: Hydrocodone-Acetaminophen 5-325 mg one tablet by mouth four times a day for pain Review of the resident's Medication Administration Record identified staff administered the Tramadol at 8:00 a.m., 1:00 p.m., and 8:00 p.m. daily and administered the	F 756	Resident #35 had a pharmacy review completed and no recommendations for change in scheduled medication was made. Residents who receive scheduled opiate pain medication concurrently have the potential to be impacted by this practice. Review of medications with physician indicated that he is aware of current dosing and wishes for pain medication to continue as currently scheduled due to the concurrent medications have been effective in managing the residents pain. DON or designee will provide education to Unit Managers and Licensed Nursing personnel on identifying and recognizing residents whom receive scheduled opiate pain medication concurrently. Education will be initiated the week of September 3rd, 2018 during post survey educational sessions. Audits will be initiated the week of September 3, 2018. Audits will be completed by DON or designee through direct observation of MAR review. These audits will be completed three times weekly for four weeks, two times weekly for four weeks, weekly for four weeks, and monthly for three months.	

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F 756	Continued From page 43 Hydrocodone-Acetaminophen at 8:00 a.m., 12:00 p.m., 4:00 p.m., and 8:00 p.m. daily. This schedule resulted in the resident receiving two opiate medications at 8:00 a.m. and at 8:00 p.m. each day. During an interview on 08/16/18 at 11:00 a.m., an administrative nurse (#16) reported she was unable to locate any Pharmacy reviews pertaining to either of these two pain medications.	F 756		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by:	F 757		9/20/18

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F 757	Continued From page 44 Based on record review and staff interview, the facility failed to ensure the resident's medication regimen was free of unnecessary medications for 1 of 18 sampled residents (Resident #35) reviewed. Failure to ensure the resident's medication regimen did not include duplicate therapy of opiate pain medications may result in the resident receiving unnecessary medication and experiencing adverse consequences related to the medication. Findings include: Resident #35's record identified the following physician's orders for opiate pain medications: * 04/05/18: Tramadol 50 milligrams (mg) by mouth three times a day for uncontrolled pain * 04/13/18: Hydrocodone-Acetaminophen 5-325 mg one tablet by mouth four times a day for pain Review of the resident's Medication Administration Record (MAR) identified staff administered the Tramadol at 8:00 a.m., 1:00 p.m., and 8:00 p.m. daily and administered the Hydrocodone-Acetaminophen at 8:00 a.m., 12:00 p.m., 4:00 p.m., and 8:00 p.m. daily. This schedule resulted in the resident receiving two opiate medications at 8:00 a.m. and at 8:00 p.m. each day. During an interview on 08/16/18 at 11:00 a.m., when shown a copy of Resident #35's MAR, an administrative nurse (#16) stated, "You are wondering why these [pain medications] aren't staggered," and made no further comment.	F 757	Resident #35 did not demonstrate any adverse outcomes related to current schedule for pain medication. Review of resident MDS indicated that the use of these medications on this schedule have had a significantly positive impact on his level of pain. Pharmacist review of this patient□s pain medication schedule was completed, and no recommendations were made to change the schedule. The physician reviewed the prescribed pain medication and scheduled dosing for resident #35. Review of medications with physician indicated that he is aware of current dosing and wishes for pain medication to continue as currently scheduled due to the concurrent medications have been effective in managing the residents pain. Residents who receive schedule opiate pain medication concurrently have the potential to be impacted by this practice. DON or designee will provide education to Unit Managers and Licensed Nursing personnel on identifying and recognizing residents whom received scheduled opiate pain medication concurrently. Education will be initiated the week of September 3rd, 2018 during post survey educational sessions. Audits will be initiated the week of September 3, 2018. Audits will be completed by DON or designee through direct observation of MAR review. These audits will be completed three times weekly for four weeks, two times weekly for four weeks, weekly for four weeks, and monthly for three months.	

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F 803 SS=E	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, group interview, and staff interview, the facility failed to ensure staff consistently followed dietary menus for all residents for 6 of 11 residents with food concerns (Resident #29, #BB, #CC, #EE, #GG, and #HH). Failure to offer the residents all the menu items listed, does not allow for residents' personal food choices or follow nutritional	F 803	Review of posted meal menus were reviewed on August 16, 2018 after a concern was made aware during survey. Residents residing at the facility have the potential to be impacted by this practice due to lack of foods prepared or in storage with regards to what is posted on the meal menu.	9/20/18

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F 803	Continued From page 46 guidelines for a balanced meal. Findings include: - Observation on 08/13/18 at 12:15 p.m., showed the lunch meal consisted of chicken, noodles, and cauliflower with an alternative option of fish. Observation showed the facility ran out of foods listed on the posted menu. The menu posted by the dining area identified Sunday's menu. - During an interview on 08/13/18 at 12:20 p.m., Resident #29 stated she did not receive the food she ordered. The resident stated she wanted the chicken and two breadsticks, instead she received roast beef, fish, and one breadstick. - During an interview on 08/13/18 at 12:23 p.m., Resident BB stated the facility ran out of both meal options during lunch. Resident BB expressed he, Resident GG, and Resident HH received a different meal which consisted of cold sandwiches or corndogs. - During an interview on 08/13/18 at 3:15 p.m., Resident EE stated the facility frequently runs out of food at meal times. - During an interview on 08/13/18 at 5:39 p.m., Resident HH stated french toast has been on the menu the last couple weeks, however they have been unable to have this due to the syrup not coming on the food truck. He also mentioned the menu does not match the food the residents are served at the meal. - During an interview on the afternoon of 08/13/18, Resident CC stated the meal tickets do	F 803	The ED and Dietary Manager or designee provided/will provide education to Dietary Manager on September 5, 2018. Education will review following dietary menus for residents to allow for resident□s personal food choices or following nutritional guidelines. Executive Director, Dietary Manager or designee will ensure that we will order and prepare enough food for an additional 10 servings per meal to ensure that there will be enough food that is listed on the menu. Executive Director, Dietary Manager will audit the menu will be audited through direct observation of ensuring that each resident receives what they requested for a breakfast, lunch, or dinner meal. Audits three times weekly for four weeks, two times weekly for four weeks, weekly for four weeks, and monthly for three months. Audits will be initiated the week of September 5, 2018. Results of audits will be forwarded to the QA Committee which members consist of the Executive Director, Director Of Nursing, or designee to monitor its performance monthly to make sure solutions are sustained.	

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	355031	A. BUILDING _____ B. WING _____	08/16/2018

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F 803	Continued From page 47 not always match the meal served. - During the resident council meeting, held the morning of 08/14/18, five of ten residents stated the facility often runs out of food before they are served and the menu frequently does not match what is served. During an interview on 08/16/18 at approximately 10:00 a.m., a dietary manager (#22) stated the meals are determined by a meal tracker/production program. The kitchen staff make the minimal amount and on occasion have run out of the main meal.	F 803		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, family interview, and group interview, the facility failed to serve foods at palatable temperatures for 7 of 12 resident/family interviews (Resident #55, #70, #BB, #CC, #DD, #FF, and family member AA). Failure to serve foods at a temperature acceptable to residents may result in decreased intake, weight loss, and inadequate nutrition. Findings include:	F 804	Review of palatable temperatures of foods were reviewed on August 16, 2018 after a concern was made aware during survey. Residents residing at the facility have the potential to be impacted by this practice due to lack of foods prepared or served at palatable temperatures. The ED and Dietary Manager or designee provided/will provide education to Dietary	9/20/18

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F 804	Continued From page 48 - During an interview on the morning of 08/13/18, when asked questions about the meals being served, Resident #55 stated, "The food is just terrible. A lot of things come cold." She reported complaining to a staff member, who replied, "You can eat it, cause that's all we got." - During an interview on 08/13/18 at 11:30 a.m., when asked questions about the meals being served to residents, a family member (AA), stated, "It would be nice to have a microwave in there [dining room]. Mom will say, 'Now it's cold.' It takes her a while to eat. I complained about the fish. It was horrible. I couldn't eat it." - During an interview on the 08/13/18 at 12:08 p.m., when asked questions about the meals being served, Resident #70 stated, "This morning my hot cereal was cold." - During an interview on the afternoon of 08/13/18, Resident BB stated the food is usually cold. - During an interview on the afternoon of 08/13/18, Resident CC stated the food is terrible and it is impossible to gain weight at the facility. - During an interview on 08/13/18 at 3:15 p.m., Resident EE voiced concerns with temperatures of the food being cold. - During an interview on 08/13/18 at 3:54 p.m., Resident DD stated the food is cold sometimes when delivered to her room. - During an interview on 08/13/18 at 4:30 p.m.,	F 804	Manager on September 5, 2018. Education will review serving foods at acceptable temperatures to residents that may result in decreased intake, weight loss, and inadequate nutrition. Palatable temperatures will be audited through direct observation audits three times weekly for four weeks, two times weekly for four weeks, weekly for four weeks, and monthly for three months. Audits will be initiated the week of September 5, 2018. Results of audits will be forwarded to the QA Committee which members consist of the Executive Director, Director Of Nursing, or designee to monitor its performance monthly to make sure solutions are sustained.	

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F 804	Continued From page 49 Resident FF voiced concerns with temperatures of the food not hot enough. During the group interview on the morning of 08/14/18, four of ten residents stated the food is usually cold. The surveyors received a lunch test tray on 08/14/18 at approximately 12:05 p.m. The test tray consisted of fish, rice, vegetables, pears, and cornbread. The 3 surveyors confirmed the food did not maintain a palatable texture or temperature. Failure to serve foods at palatable temperatures may negatively impact residents' meal consumption.	F 804		
F 840 SS=D	Use of Outside Resources CFR(s): 483.70(g)(1)(2) §483.70(g) Use of outside resources. §483.70(g)(1) If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility must have that service furnished to residents by a person or agency outside the facility under an arrangement described in section 1861(w) of the Act or an agreement described in paragraph (g)(2) of this section. §483.70(g)(2) Arrangements as described in section 1861(w) of the Act or agreements pertaining to services furnished by outside resources must specify in writing that the facility assumes responsibility for- (i) Obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility;	F 840		9/20/18

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F 840	Continued From page 50 and (ii) The timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on review of facility documentation and staff interview, the facility failed to obtain a written agreement or arrangement between the nursing home and the Medicare Certified Dialysis Facility regarding the roles and responsibilities for the provision of dialysis care/services and failed to have policies and procedures regarding dialysis care for 1 of 1 sampled resident receiving dialysis (Resident #277). Failure to ensure an agreement/arrangement and specific dialysis polices/procedure has the potential to place dialysis residents at risk for not receiving care and services in accordance with current standards of practice. Findings include: Review of documentation provided by the facility regarding dialysis occurred on the afternoon of 08/13/18. The documentation stated, "A formal contractual agreement between the [name of local dialysis unit] and skilled care facilities is not required because the patients receiving services are patients of the physician who work directly with dialysis." During interview on the afternoon of 08/16/18, an administrative staff member (#16) confirmed the facility had no contract with the local dialysis unit and the facility had no policies regarding dialysis.	F 840	Resident #277 continues to receive dialysis services as ordered and scheduled with Trinity Dialysis. Residents residing at the facility have the potential to be impacted by this practice are those who receive dialysis By this practice a written agreement will be entered with Trinity Medical Center by September 20, 2018 to validate that they will provide dialysis services, and that the contract will define the responsibilities of Trinity Dialysis and of Minot Health & Rehab regarding resident care and reporting resident's condition, etc. The facility will ensure that a contract is in place yearly to ensure that the problem does not recur. Audits will include monitoring the expectations of both parties through the QA process. Audits will take place through direct observation of resident's in dialysis and audited three times weekly for four weeks, two times weekly for four weeks, weekly for four weeks, and monthly for three months. Audits will be initiated the week of September 5, 2018. Results of audits will be forwarded to the QA Committee which members consist of the Executive Director, Director Of Nursing, or designee to monitor its performance monthly to make sure solutions are sustained.	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		9/20/18

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F 880	Continued From page 51 §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;	F 880		

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F 880	Continued From page 52 (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. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to follow infection control practices for 9 of 19 sampled residents (Resident #6, #8, #14, #15, #35, #37,#46, #48, and #55). Failure to follow infection control practices during personal cares and in the laundry has the potential to transmit infections to other residents, staff, and visitors.	F 880	Residents #48, #55, #35, #6, #14, #37, #46, #8 and #15 were monitored for signs and symptoms of an active infection; no infections were observed/identified following this practice. Two fans in the laundry area were found to have dust build up present. Residents who require assistance with	

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F 880	Continued From page 53 Finding include: Review of the facility policy titled "Infection Prevention and Control Manual Standard Precautions" occurred on 08/16/18. The policy, dated 2017, stated, ". . . Gloves . . . Sterile gloves and examination gloves are removed: . . . Between resident contacts. . . . Before touching uncontaminated surfaces or other areas of the same resident's body that may be contaminated. . . ." Review of the facility policy titled, "Hand Hygiene" occurred on 08/16/18. The policy, dated 2017, stated, ". . . Appropriate hand hygiene is essential in preventing transmission of infectious agents. . . . Staff must perform hand hygiene even if gloves are utilized. . . ." - Observations on all days of survey showed the following infection control breaches: * 08/13/18 at 11:36 a.m., Two certified nursing assistants (CNAs) (#10 and #25) assisted Resident #48 to the toilet utilizing a gait belt. One CNA (#10) removed the resident's wet brief, and without performing perineal care, placed a clean brief. The second CNA (#25) placed an oxygen tank on Resident #48's wheel chair, bagged the trash, and left the room with the trash without performing hand hygiene. * 08/13/18 at 3:08 p.m., A CNA (#20) transferred Resident #55 to the toilet using a mechanical lift. The CNA (#20) removed her gloves, exited the room without performing hand hygiene, and pushed the stand lift to another unit. * 08/14/18 at 9:52 a.m., Two CNAs (#8 and #9) transferred Resident #35 into bed using a	F 880	personal cares have the potential to be impacted by this practice. Fans in the laundry department have the potential to be impacted by this practice. DON or designee will provide education to staff that will include proper infection prevention and control methods to include removal of soiled gloves, properly cleanse and dry hands/apply hand sanitizer, re-apply clean gloves and finish task. Executive Director, DON or designee will provide education to housekeeping/laundry staff on routine cleaning of fans in the laundry. Education will be initiated the week of September 3rd, 2018 during post survey educational sessions. Audits will be initiated the week of September 3, 2018. Audits will be completed by DON or designee through direct observation of hand washing techniques of staff. Fan cleaning schedules will be implemented and audited to ensure proper cleaning of fans. These audits will be completed three times weekly for four weeks, two times weekly for four weeks, weekly for four weeks, and monthly for three months. Results of audits will be forwarded to the QA Committee which members consist of the Executive Director, Director Of Nursing, or designee to monitor its performance monthly to make sure solutions are sustained.	

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F 880	Continued From page 54	F 880		

mechanical lift and provided personal cares. One of the CNA's (#8) removed her gloves and exited the room with the lift. The other CNA (#9) checked Resident #35's brief, removed her gloves, placed a pillow between his knees, covered him with a blanket, handed him his call light, then performed hand hygiene.
* 08/14/18 at 11:40 a.m., An unidentified CNA entered Resident #6 and #14's room. The CNA provided personal cares to Resident #6 and failed to perform hand hygiene. The CNA then assisted Resident #14 to the bathroom. The CNA provided personal cares to Resident #14 and failed to perform hand hygiene. The CNA wheeled Resident #14 into the hallway, and discarded the garbage in the soiled utility room, then performed hand hygiene.
* 08/14/18 at 11:48 a.m., Two CNAs (#9 and #10) transferred Resident #35 to his wheelchair using a mechanical lift. One of the CNAs (#10) removed her gloves, pushed Resident #35 out into the hallway, re-entered the room, then washed her hands.
* 08/14/18 at 3:23 p.m., two CNAs (#14 and #15) provided perineal care to Resident #37 after an incontinent bowel movement. The CNA (#14) failed to remove her gloves before she placed a new brief on the resident, straightened the bed linens, adjusted the resident's pillow, and opened the room blinds.
* 08/14/18 at 4:20 p.m., A CNA (#23) donned gloves and assisted Resident #46 to bed utilizing a sit to stand lift. Observation showed the resident's brief soaked with urine. The CNA (#23) performed perineal care and applied a new brief, then removed her gloves and left the room without performing hand hygiene.
* 08/15/18 at 9:11 a.m., Two CNAs (#10 and #11)

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F 880	Continued From page 55 transferred Resident #35 to bed using a mechanical lift, and provided personal cares. The CNAs (#10 and #11) checked Resident #35's brief, removed their gloves, placed a pillow behind his back, placed blue boots on his feet, gave him a drink of water via a straw, covered him with a blanket before lowering the bed, then performed hand hygiene. The uncovered catheter bag laid directly on the floor when the bed was in it's lowest position. * 08/15/18 at 3:59 p.m., Observation showed Resident #8 sitting on the commode next to her bed drinking coffee and holding a cookie. She told the CNA (#4) she had a bowel movement. The CNA (#4) gloved, assisted Resident #8 to stand, performed perineal cares, adjusted the resident's clothing, and assisted her to pivot into her wheelchair, then emptied the commode bucket into the toilet. The CNA (#4) then walked back to the sink in Resident #8's room, rinsed the bucket with water obtained from the faucet, walked into the bathroom, and emptied the bucket into the toilet for a second time. The CNA (#4) failed to sanitize the sink after rinsing the commode bucket. Observation showed no bedpan washer device available in the bathroom for rinsing the commode bucket. * 08/15/18 at 4:19 p.m., Two CNAs (#4 and #7) provided Resident #15's incontinence cares, changed her clothing, transferred her into her wheelchair using a mechanical lift, brushed her hair, placed her nasal cannula (oxygen), and removed their gloves. One of the CNAs (#4) washed his hands, while the other CNA (#7) offered Resident #15 a drink of water via a straw before washing her hands. The above staff members failed to sanitize and/or	F 880		

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F 880	Continued From page 56 perform hand hygiene after removing soiled gloves, prior to providing additional cares, and/or prior to exiting the residents' rooms, and failed to properly sanitize the sink and rinse the commode bucket. During an interview on 08/15/18 at 2:30 p.m. two administrative nurses (#16 and #17) confirmed staff should perform perineal care after urinary incontinence and should perform hand hygiene before exiting the resident's room. Review of the facility policy titled, "Laundry Area and Equipment" occurred on 08/16/18. The policy, dated 12/18/06, stated, ". . .ceiling vents, floor fans and table fans are cleaned to remove lint and dust once a week. . . ." - Observation in the laundry occurred on 08/15/18 09:25 a.m. with a Housekeeping/Laundry administrator (#26). Observation in the clean linen folding area identified two fans with heavy lint/dust build up blowing on clean linen. The staff member (#26) confirmed the fans needed cleaning and stated the facility had no cleaning schedule for the fans.	F 880		