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	355031	A. BUILDING _____ B. WING _____	C 11/04/2021

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

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F 000	INITIAL COMMENTS The Standard Medicare/Medicaid recertification and complaint survey started on 11/01/21 and concluded 11/04/21.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or	F 580		12/9/21

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

Electronically Signed | 12/03/2021

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F 580	Continued From page 1 State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE STANDARD SURVEY CONDUCTED ON 05/24/21. Based on information provided by the complainant, record review, review of the facility's policy and staff interview, the facility failed to notify the resident representative for 1 of 1 confidential resident (Resident F) who experienced a fall. Failure to notify the resident representative of a fall limits their ability to make informed decisions regarding medical care. Findings include: Information received from the complainant indicated the facility staff failed to notify the resident's representative of a change in the resident's condition.	F 580	If is the policy of facility to notify physician and resident representative of a resident who experienced a change in condition. 1) Resident F's representative was contacted By Director of Nursing on 11/5/21 and provided notification of an event that occurred on 10/12/21. 2) Current facility residents have the potential to be affected by the alleged practice. 3) Facility Licensed Nursing staff was educated by the Director of Nursing or designee on change in condition, starting 11/11/21. Education includes ensuring timely notification to resident representatives and physician, and ensuring notification is documented. 4) Post-incident documentation review will be completed at morning clinical meetings	

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F 580	Continued From page 2 Review of the facility policy titled "CHANGE OF CONDITION OF THE RESIDENT (OBSERVING RECORD AND REPORTING)" occurred on 11/04/21. This policy, dated December 2016, stated, ". . . When a resident presents with a possible change of condition, after a fall*[sic] or other possible injury, trauma, noted changes in mental or physical functioning . . . Notify resident's responsible party. . . . Notification of responsible party - include date, time, what was conveyed, any comments received (each time notified) . . ." Review of Resident F's medical record occurred on all days of survey. Review of the progress notes showed on 10/12/21 at 2:51 p.m. ". . . Resident was found sitting on floor. No injuries noted at this time. Denies hitting head. Pain 0/10 [pain scale]. No bruising noted at this time. Assisted to bed. Initiated neuro [neurologic] checks. MD [physician] notified." The medical record lacked evidence staff notified the resident representative of Resident F's fall. During an interview on 11/04/21 at 3:55 p.m., an administrative staff member (#3) confirmed staff failed to notify the resident representative of a fall for Resident F.	F 580	by Director of Nursing or designee. Review will include verification of notification. Audits will be completed by the Director of Nursing or designee on changes of condition, audits will include documentation of notifications to resident representatives or responsible parties. Audits will be completed 5 times weekly for 12 weeks, 4 times weekly for 4 weeks, 3 times weekly for 4 weeks, and then 2 times weekly for 4 weeks or until substantial compliance is maintained. Results of audits will be brought to QAPI for review and recommendation.	
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes	F 583		12/9/21

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F 583	Continued From page 3 accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to promote privacy and confidentiality of medication administration records (MAR) on 1 of 4 days (11/03/21) observed for medication administration. Failure to close the MAR may result in unauthorized viewing of resident records by other residents, unlicensed staff and/or visitors.	F 583	It is the policy of the facility to maintain personal privacy and confidentiality of resident medical records. 1) Licensed nursing personnel responsible for administering medications were informed of observation of laptop screen left open while away from med cart. Licensed nursing personnel were educated on using the lock button to	

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F 583	Continued From page 4 Findings include: Review of facility policy titled "Medication Administration - General Guidelines" occurred on 11/04/21. This undated policy, stated. ". . . 16. During administration of medications, . . . privacy is maintained always for all resident information (e.g., [example] MAR) by closing the MAR book/covering the MAR sheet or computer screen when not in use. . . ." Observation during medication administration on 11/03/21 showed the medication cart unattended with a resident's MAR visible on the screen during the following times: * 8:55 a.m. to 9:17 a.m. - 22 minutes * 11:25 a.m. to 11:32 a.m. - 7 minutes * 1:46 p.m. to 1:52 p.m - 6 minutes * 5:48 p.m. to 5:50 p.m. - 2 minutes During an interview the morning of 11/04/21, an administrative nurse (#3) stated she expected staff to lock the computer screen whenever they leave the medication cart.	F 583	secure laptop screens or closing lids of laptops when stepping away from cart, beginning 11/11/21. 2) Current facility residents have the potential to be affected by the alleged practice. 3) Facility licensed nursing staff educated by the Director of Nursing or designee on use of the lock feature to secure laptop screens when stepping away from the cart, beginning 11/11/21. 4) Secured laptop screens at unattended carts will be audited by the Director of Nursing or designee. Audits will be completed 5 times weekly for 12 weeks, 4 times weekly for 4 weeks, 3 times weekly for 4 weeks, and then 2 times weekly for 4 weeks or until substantial compliance is maintained. Results of audits will be brought to QAPI for review and recommendation.	
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: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 05/24/21	F 658	It is the policy of facility that services provided or arranged by the facility as outlined by the comprehensive care plan,	12/9/21

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F 658	Continued From page 5 1. Based on observation, review of professional reference, record review, and staff interview, the facility failed to follow professional standards of practice regarding physician's orders for 1 of 14 sampled resident (Resident #11). Failure to carry out physician's orders regarding application of topical medication may result in delayed treatment of the resident's skin condition. Findings include: Kozier & Erb's "Fundamentals of Nursing, Concepts, Process, and Practice," 11th Edition eText, 2021, Pearson, Boston, Massachusetts, page 64, states, ". . . It is the nurse's responsibility to seek clarification of ambiguous or seemingly erroneous orders from the prescriber. . . . If the order is neither ambiguous nor apparently erroneous, the nurse is responsible for carrying it out. . . ." Review of Resident #11's medical record occurred on all days of survey. A paper copy of physician's order, dated 10/13/21 stated, "Nystatin powder [topical medication to treat yeast] 100,000 units apply BID [twice a day]." Review of nursing progress notes, dated 10/13/2021 stated, ". . . resident has redness under both breasts . . . redness and foul odor under both breasts . . ." Review of the electronic medical record showed staff failed to enter the provider's order for nystatin powder onto the MAR [medication administration record] or the TAR [treatment administration record] which resulted in Resident #11 not recieving the Nystatin powder ordered by the physician.	F 658	must meet professional standards of quality. 1) On 11/5/21, resident #11's skin was assessed by the RN and Resident #11's physician was notified that skin irritation has resolved. Staff nurse #5 was educated on priming insulin pens by 12/9/21. 2) Current facility residents receiving insulin medications and nystatin treatments have the potential to be affected by the alleged practice. 3) Facility nursing personnel were educated by the Director of Nursing or designee on priming insulin pens and processing nystatin orders from request of treatment to receiving the order, beginning 11/11/21. Facility residents' records were reviewed for topical treatment orders and reconciled with the eMAR, completed by 12/9/21. 4) Audits will be completed on insulin pen priming procedures and processing physician orders by the Director of Nursing or designee. Audits will be completed 5 times weekly for 12 weeks, 4 times weekly for 4 weeks, 3 times weekly for 4 weeks, and then 2 times weekly for 4 weeks or until substantial compliance is maintained. Results of audits will be brought to QAPI for review and recommendation	

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F 658	Continued From page 6 During an interview on 11/04/21 at 3:25 p.m., an administrative nurse (#3) confirmed staff failed to implement the physician's order, delaying treatment. 2. Based on observation, review of professional literature, and staff interview, the facility failed to follow professional standards of practice for 1 of 2 residents (Resident #9) observed during insulin preparation. Failure to properly prepare an insulin pen per manufacturer recommendation may result in the resident receiving an inaccurate dose of insulin. Findings include: The manufacturer's instructions for the NOVOLOG® Mix 70/30 FlexPen, found at https://www.novo-pi.com/novologmix70/30.pdf, stated, ". . . Giving the airshot [prime] before each injection . . . G. Turn the dose selector to select 2 units. H. . . . with the needle pointing up. Tap the cartridge gently with your finger a few times to make sure air bubbles collect at the top of the cartridge I. 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 . . . J. Turn the dose selector to the number of units you need to inject . . ." Observation on 11/03/21 at 11:33 a.m. showed the staff nurse (#5) obtained Resident #9's insulin pen, attached a needle and without removing the needle cap, primed the insulin pen at a horizontal angle and injected the insulin.	F 658		

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F 658	Continued From page 7 During an interview the morning of 11/04/21, an administrative nurse (#3) confirmed facility staff failed to correctly prime the insulin pen.	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 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: THIS IS A REPEAT DEFICIENCY FROM THE STANDARD SURVEY CONDUCTED ON 05/24/21 Based on information provided by the complainant, observation, record review, review of facility policy, and resident and staff interviews, the facility failed to provide Activities of Daily Living (ADL) assistance for 5 of 15 sampled residents (Resident #2, #9, #20, #82, and #332) who required staff assistance for ADLs. Failure to provide assistance to residents who cannot bathe independently may result in skin irritation and/or breakdown, and decreased self-esteem. Failure to check and change/toilet residents may result in incontinence, odor, urinary tract infection, skin breakdown, and pain/discomfort. Findings include: Information received from the complainant indicated facility staff failed to provide ADL assistance to residents in a timely manner. Review of the facility policy titled "Bath, Shower"	F 677	It is the policy of facility that a resident who is unable to carry out activities of daily living receives the necessary services to maintain good hygiene. 1) Resident #2, #9, #20, and #332's care plans and Kardex were reviewed for bathing schedules by 12/9/21. Resident #82's care plan and Kardex was reviewed for toileting schedules and level of assistance by 12/9/21. 2) Current facility residents have the potential to be affected by alleged practice. Care plan and C.N.A. Kardex will be updated with cares and level of assist needed related to bathing and toileting for current residents. Documentation of bathing and ADL care delivered will be reviewed weekly for discrepancies or missed documentation. Baseline care plan will indicate level of care for ADLs upon admission for new residents. 3) Facility nursing staff were educated by Director of nursing or designee, starting 11/11/21 on need to review and follow	12/9/21

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F 677	Continued From page 8 occurred 11/4/21. This policy, dated June 2017, stated, "Purpose: To cleanse and refresh the resident, to observe skin and to provide increased circulation. . . ." BATHING - Review of Resident #2's medical record occurred on all days of survey. The care plan identified, ". . . Assist to bathe/shower Wednesday and Sunday AM shift . . ." The bathing records, dated October 07 - November 03, 2021 identified staff failed to bathe Resident #2 on four occasions and for 14 consecutive days. - During an interview on 11/01/21 at 11:36 a.m., Resident #332 stated staff did not provide him a bath twice a week. "I have been here two and a half weeks and have received two baths. I'm supposed to have a bath tomorrow but I bet I will not get one." Review of Resident #332 medical record occurred on all days of survey. The care plan stated, ". . . Resident has impaired functional mobility . . . Shower days Tues and Sat [Tuesday and Saturday] PM . . ." The bathing records from October 21, 2021 - November 03, 2021 identified staff failed to provide a bath on 11/02/21 as per care planned. During an interview on 11/03/21 at 5:10 p.m., an administrative nurse (#3) confirmed staff failed to provide a bath to Resident #322 on Tuesday (his regular bath day) or the next day (Wednesday).	F 677	residents established care plans and Kardex related to bathing and toileting. Education to include that refusal of cares or difficulty completing cares needs to be reported to the nurse so alternate arrangements can be made to complete cares. 4) Audits will be completed by the Director of Nursing or designee to ensure cares reflected on care plan are cares completed with resident. Audits will also include review of point of care charting, including shower schedules, visual check of resident and resident interview to ensure cares are completed as indicated on the resident care plan. Audits will be completed 5 times weekly for 12 weeks, 4 times weekly for 4 weeks, 3 times weekly for 4 weeks, and then 2 times weekly for 4 weeks or until substantial compliance is maintained. Results of audits will be brought to QAPI for review and recommendation.	

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F 677	Continued From page 9	F 677		

- Review of Resident #9's medical record occurred on all days of survey. The care plan stated, "ADL self care deficit . . . Assist to bathe/shower Monday and Thursdays." The bathing records from October 04, 2021 - November 2, 2021 identified staff failed to bathe the resident on 4 occasions.
- Review of Resident #20 medical record occurred on all days of survey. The care plan stated, ". . . requires total assistance with showers Monday and Thursday days . . ."

Review of Resident #20's medical record from September 20, 2021 - November 03, 2021 showed staff failed to shower the resident 6 out of 14 occasions.

During an interview on the afternoon on 11/03/21, an administrative nurse (#3) confirmed staff failed to provide showers twice a week as care planned from September 20, 2021 through November 3rd, 2021.

TOILETING

- Review of Resident #82's medical record occurred on all days of survey. The care plan identified, ". . . Toileting . . . assist of 1 PRN [as needed] . . . Continent of bowel . . ."

During an interview on 11/02/21 at 4:26 p.m., Resident #82 stated, "At about midnight I told staff I had a bowel movement (BM) in my brief. The staff person told me the next shift coming on would change my brief. The resident reported he waited an hour and 15 minutes before staff changed his brief. Resident #82 also reported, on more than one occasion, staff have told him the

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F 677	Continued From page 10 next shift would provide his toileting cares.	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: THIS IS A REPEAT DEFICIENCY FROM STANDARD SURVEY ON 5/24/21. Based on observation, review of professional reference, record review, and staff interview, the facility failed to provide appropriate care and services to manage symptoms of heart disease in a manner to maintain the highest practicable well-being for 2 of 14 sampled residents (Resident #7 and #19) observed with physician orders for compression stockings. Failure to apply compression stockings placed the residents at risk for discomfort and adverse complications. Findings include: Kozier & Erb's "Fundamentals of Nursing, Concepts, Process, and Practice," 11th Edition eText, 2021, Pearson, Boston, Massachusetts, page 64, states, ". . . Nurses are expected to analyze proceedures and medications ordered by the physician or primary care provider. If the	F 684	It is the policy of facility to ensure residents receive treatment and care in accordance with professional standards of practice. 1) Resident #7 and Resident #19's care plans were discussed with each resident regarding compression stockings by 12/9/2. Two sets of stockings were provided to the resident to alternate days of use while cleaning and drying in between uses. Resident #7 and Resident #19's physicians were notified and care plans were updated based on resident preference and provider feedback by 12/9/21. 2) Current facility residents with orders for compression stockings have to the potential to be affected by the alleged practice. Current residents with orders for compression stockings were provided two sets of compression stockings to ensure availability and for use on alternate days to accommodate cleaning and drying.	12/9/21

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F 684	Continued From page 11 order is neither ambiguous nor apparently erroneous, the nurse is responsible for carrying it out . . ." - Review of Resident #7's medical record occurred on all days of survey. Diagnoses included heart disease and hypertension (high blood pressure). The current physician's orders stated, ". . . Knee high [sic] compression stockings - to be worn ON in AM [morning], off at HS [night] . . . every day shift . . . every evening shift . . . monitor feet daily . . . monitor edema . . ." The current care plan, initiated on 07/20/20, stated, ". . . wear TED hose . . Diuretic Therapy [use of medication and/or treatments to increase the passing of fluids/urine] to treat . . . heart disease, hypertension, heart failure . . . at risk for edema . . . administer medications/treatments per MD (physician) orders . . ." Observations of Resident #7 showed the following: * 11/01/21 at 12:34 p.m., no compression stockings on. * 11/02/21 at 12:21 p.m., no compression stockings on. During an interview on 11/03/21 at 2:40 p.m., the Resident #7 stated the compression stockings were still on from yesterday morning as the staff failed to help remove them last night. - Review of Resident #19's medical record occurred on all days of survey. Diagnoses included heart disease with cardiomyopathy, atrial fibrillation and hypertension. Current physician's order included, ". . . Ace wraps or TED hose to lower extremities, on in the AM, off	F 684	Care plans and Kardex were reviewed, starting 11/11/21 to include compression stockings. 3) Current facility nursing staff was educated by the Director of Nursing or designee starting on 11/11/21. On the use of compression stockings, cleaning and drying, replacing stockings when showing signs of wear or tear. Nursing staff will be educated on documentation of donning and doffing of compression stockings or resident refusal in the medical record. If resident refusal of compression stockings is a trend, care plans will reflect the facility interventions of risk versus benefit education, resident preferences, strategies to mitigate, and notification to the physician. 4) Audits will be completed by Director of Nursing or designee on the donning and doffing of compression stockings and the documentation of refusals. Audits will be completed 5 times weekly for 12 weeks, 4 times weekly for 4 weeks, 3 times weekly for 4 weeks, and then 2 times weekly for 4 weeks or until substantial compliance is maintained. Results of audits will be brought to QAPI for review and recommendation.	

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F 684	Continued From page 12 at HS until edema resolved, every morning and at bedtime . . ." The current care plan, initiated 06/28/21, stated, ". . . wear compression stockings or wraps daily . . . knee high compression stockings - to be worn ON in AM, off at HS . . . monitor feet daily . . . monitor edema . . ." Edema/excess fluid volume as evidenced by cardiac disease . . . will be free of complications related to edema/excess fluid volume . . ." Observations of Resident #19 showed the following: *11/01/21 at 3:50 p.m., no compression stockings on. *11/01/21 at 4:18 p.m., no compression stockings on. The resident stated she has pain to both feet due to the swelling. During an interview on 11/03/21 at 2:40 p.m., an administrative staff member (#3) stated if there is a physician order for compression stockings, staff are expected to follow the physician orders.	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: Based on observation, record review, review of facility policy, and resident and staff interviews, the facility failed to provide adequate supervision	F 689	1) The facility's smoking policy was reviewed by the facility's interdisciplinary team and company's divisional support	12/9/21

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F 689	Continued From page 13 for 2 of 2 sampled residents (Resident #5 and #19) who smoked. Failure to ensure staff followed facility policy placed Resident #5 and #19 at risk of injury while smoking. Findings include: Review of the facility policy titled "Smoking Policy" occurred on 11/04/21. The policy, dated 05/09/19, stated, ". . . All residents shall use nicotine or tobacco products in designated areas on center grounds and sign themselves out for smoking . . . Residents who smoke will keep nicotine materials in a locked box in a secured designated area when not in use . . . locked in a fire proof container that is maintained by the licensed nurse. Residents are not to maintain items in their rooms. Residents who do not abide to safe nicotine use practices will have restrictions placed on [their] ability to use nicotine . . ." - Review of Resident #19's medical record occurred on all days of survey. A quarterly Minimum Data Set (MDS), dated 06/06/21, identified moderate cognitive impairment and assistance required for all Activities of Daily Living (ADL's). A "Smoking Assessment", dated 08/27/21, identified the resident as safe to smoke independently and indicated the facility would secure his cigarettes and lighter. The current care plan stated, " . . . Resident chooses to smoke cigarettes multiple times per day . . . maintain ability to smoke independently in the designated areas . . . smoking materials will be locked in a safe place at the nurses' station, per smoking policy . . . staff will monitor	F 689	personnel after on-going consultation with the Ombudsman, beginning 11/19/21. The facility updated the smoking policy and will transition to a smoke-free campus by 11/19/21. Resident #5 and Resident #19's smoking supplies have been collected and secured by 12/1/21. Smoking times were posted by 11/19/21 for current smokers who need assistance to follow leading up to policy change. The designated smoking area has been marked with signage by 11/19/21. Current facility residents who smoke were educated on 11/19/21 and 12/3/21 on facility policy and procedures to follow leading up to policy change. 2) Current facility residents and those who are admitted who elect to smoke have the potential to be affected by the alleged practice. 3) The facility admission agreements, policies, and forms were reviewed and updated to reflect the smoking policy changes. Notification to residents via in-person visits by the Executive Director or designee were conducted beginning 11/19/21 and 12/3/21. Notifications of the smoking policy changes were discussed at Resident Council on 11/18/21. Consultation with the Ombudsman on policy change and roll out began on 12/1/21. Resident representatives were notified of smoking policy change via letters from the Executive Director beginning 12/3/21. Facility staff were educated by the Executive Director on the smoking policy on 11/30/21 and 12/1/21. The Medical Director and primary	

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F 689	Continued From page 14 resident's ability to smoke safely . . . periodic nicotine assessments and staff notification to charge nurse when misuse is observed . . ." Observation on 11/01/21 at 4:16 p.m., showed Resident #19 left the facility in his wheelchair without signing out at the nurses' station, removed cigarettes and a lighter from his coat pocket, and began to smoke. The resident drove around the parking lot in his wheelchair instead of smoking in the facility's designated smoking area. He then entered the facility and went back to his room without returning the cigarettes and lighter to the nurse. During an interview on 11/02/21 at 9:36 a.m., Resident #19 reported he keeps his cigarettes and lighter in his room, goes outside to smoke when he wants and does not sign out, and likes to drive around the parking lot even though he understands the facility policy. - Review of Resident #5's medical record occurred on all days of survey. A quarterly MDS, dated 07/28/21, identified Resident #5 required assistance with all ADL's due to hemiparesis (partial paralysis). A "Smoking Assessment", dated 08/04/21, identified the resident as safe to smoke independently and indicated the facility would secure his cigarettes and lighter. The current care plan stated, ". . . Resident chooses to smoke cigarettes multiple times per day . . . maintain ability to smoke independently in the designated areas . . . smoking materials will be locked in a safe place at the nurses' station, per smoking policy . . . staff will monitor resident's ability to smoke safely . . . periodic nicotine assessments and staff notification to	F 689	physicians were notified of the facility's smoking policy change by 12/3/21, smoking cessation treatments were ordered for residents as indicated. The smoking policy allows current residents admitted prior to 11/19/21 to continue smoking, while complying to the facility labeling and securing resident smoking supplies when not in use. Ad-Hoc QAPI was conducted on 11/18/21 to review the smoking policy changes with the QAPI committee. 4) Audits will be conducted by the Executive Director or designee on the smoking policy and procedure, including securing smoking supplies in the medication cart. Audits begin 12/5/21 will be completed 5 times weekly for 12 weeks, 4 times weekly for 4 weeks, 3 times weekly for 4 weeks, and then 2 times weekly for 4 weeks or until substantial compliance is maintained. Results of audits will be brought to QAPI for review and recommendation.	

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F 689	Continued From page 15 charge nurse when misuse is observed . . ." Observation on 11/02/21 at 10:56 a.m. showed Resident #5 left the facility in his wheelchair without signing out at the nurses' station, removed cigarettes and a lighter from his coat pocket, and began to smoke. He then entered the facility and went back to his room without returning the cigarettes and lighter to the nurse. During an interview on 11/03/21 at 9:49 a.m., Resident #5 reported he keeps his cigarettes and lighter in his room and does not sign out. He also said he understands the policy and chooses not to always follow it. During an interview on 11/02/21 at 9:54 a.m., an administrative nurse (#3) confirmed Resident #5 and #19 should sign out at prior to going outside to smoke, obtain their cigarettes and lighters from the nurse, smoke in the facility's designated smoking areas, and return their smoking supplies to the nurse when they re-enter the building.	F 689		
F 692 SS=G	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition	F 692		12/9/21

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F 692	Continued From page 16 demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 05/24/21 Based on observation, record review, and review of facility policy, the facility failed to ensure acceptable parameters of nutritional status for 1 of 2 sampled residents (Resident #11) with weight loss. Failure to adequately monitor and evaluate weights, assess the effectiveness of interventions and consistently implement existing interventions, and re-evaluate the need for updated or additional interventions resulted in severe weight loss for Resident #11. Findings include: Review of facility policy titled "WEIGHT ASSESSMENT AND INTERVENTION" occurred on 11/04/21. This policy, revised 10/14/20, stated, ". . . Any weight change of five (5) or more pounds since the last weight assessment will be retaken for confirmation. . . . The Dietician will review the monthly weights . . . Weight trends will be evaluated by the interdisciplinary team . . . The threshold for significant weight change will be based on the following criteria . . . . 1 month - 5% weight change is significant; greater than 5%	F 692	It is the policy of facility to maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless resident's condition demonstrates that this is not possible or residents' preferences indicate otherwise. 1) Resident #11's physician was notified on 11/5/21 to review weights and RD recommendations. Order received for weekly weights and processed into the medical record by 11/5/21. 2) Current facility residents have the potential to be affected by the alleged practice. 3) Facility nursing personnel were educated by the Registered Dietician or designee on the process for dietary recommendations being communicated and processed, beginning 11/11/21. If the Registered Dietician enters order template into the EMR, facility nursing staff will notify and obtain physician orders. Other requests for orders may be communicated to the Director of Nursing by the Registered Dietician via email and	

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F 692	Continued From page 17 is severe . . . 3 months - 7.5% weight change is significant; greater than 7.5% is severe . . . 6 months - 10% weight change is significant; greater than 10% is severe . . . . The nursing staff will notify the responsible party . . . of any individual with an unintended significant weight change . . . ." Observation on 11/02/21 at 11:47 a.m. showed Resident #11 in the community living area eating candy. The resident chewed on the candy with the wrapper still on and staff failed to assist her to remove the wrapper. Review of Resident #11's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease and Dementia. The current care plan stated, ". . . . At risk for nutritional status change r/t [related to] H/O [history of] Dementia/Alzheimer's Disease . . . . Follow RD [Registered Dietician] recommendation and MD [Medical Doctor] orders . . . Review weights and notify RD, MD, and responsible party of significant weight change . . . . Provide additional calories/protein at meals . . . . Provide supplements as ordered . . . ." Resident #11's current provider orders showed the following: * 05/07/21: "WEIGHT . . . . one time a day for 3 Days, one time a day every Sunday for 3 weeks, one time a day every 1 month." * 08/15/21: "one time a day nutritional juice 6 oz (180 mL) as mid-morning 10:00 AM snack." * 08/15/21: "one time a day fortified hot cereal at breakfast AND in the afternoon fortified pudding afternoon snack."	F 692	verbally, either in-person or via phone. Education will include the documentation of percentages consumed on the supplement order. Education will also include the frequency of weights, the indications for reweights with weight changes, and physician and registered dietician notifications of significant weight changes. 4) Audits will be completed on Registered Dietician recommendations by the Director of Nursing or designee. Audits will be completed 5 times weekly for 12 weeks, 4 times weekly for 4 weeks, 3 times weekly for 4 weeks, and then 2 times weekly for 4 weeks or until substantial compliance is maintained. Results of audits will be brought to QAPI for review and recommendation.	

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F 692	Continued From page 18	F 692		

Resident #11's dietary progress notes occurred on all days of survey and included the following:
* 05/23/21: ". . . Weekly weight until stable . . . . Fortified breakfast cereal . . . . Fortified pudding 3 p.m. . . ."
* 08/14/21: ". . . Significant weight change present . . . -3.9% x2 month, -11.7% x3 month . . . . follow a regular diet to promote improved PO [by mouth] intake . . . ."
* 09/12/21: ". . . appears to have preference for sweets, recommend to add supplemental nutritional juice . . . . follow resident weight weekly . . . . If resident continues further weight loss trend may try adding more sweets and desserts to resident meals."

Review of Resident #11's provider notes showed an office visit note dated 06/23/21 stated, ". . . . Nursing staff mentioned that the patient has been losing weight . . . . [resident] states appetite is good and [resident] does not want to eat more . . . .". The note failed to show additional interventions to address resident's weight loss.

Meal intake records, dated 10/12/21 to 11/01/21, showed Resident #11 consumed 50% or less at 24 of 60 meals and refused 4 of 60 meals. The record lacked evidence of staff documentation/monitoring of Resident #11's intakes of supplements (nutritional juice, fortified pudding).

Resident #11's weights included the following:
* 05/10/21 147.0 pounds (Lbs)
* 05/23/21 138.7 Lbs (>5 lb weight loss without evidence of a re-weigh)
* 05/31/21 134.0 Lbs
* 06/1/21 135.0 Lbs

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F 692	Continued From page 19 * 06/28/21 128.4 Lbs * 06/29/21 126.6 Lbs * 07/1/21 126.6 Lbs * 07/2/21 131.4 Lbs * 08/1/21 129.8 Lbs * 09/1/21 122.0 Lbs (>5 lb weight loss without evidence of a re-weigh) * 09/9/21 119.0 Lbs * 09/16/21 118.8 Lbs * 10/6/21 119.0 Lbs * 11/3/21 117.0 Lbs The above weights identified a 30 pound (over a 20%) weight loss in approximately a six months period, indicating a severe weight loss. The record lacked evidence of consistent weekly weights as suggested by the dietician. Failure to consistently obtain weekly weights, ensure implementation of current interventions, evaluate interventions for effectiveness, monitor intakes of supplements, and promptly communicate weight changes to the doctor and dietician resulted in continued, severe weight loss for Resident #11.	F 692		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in	F 725		12/9/21

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F 725	Continued From page 20 accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE STANDARD SURVEY ON 05/24/21. Based on information provided by the complainant, review of facility policy, and resident and group interviews, the facility failed to ensure sufficient nursing staff to meet residents' needs for 5 of 7 confidential residents (Resident A, B, C, F, and G) who required staff assistance. Failure to provide sufficient staffing and answer call lights in a timely manner does not promote the resident's rights and physical, mental, and psychosocial well-being. Findings include: Information received from the complainant indicated facility staff failed to answer call lights in a timely manner.	F 725	It is the policy of facility to provide sufficient nursing staff and related services to meet the residents' needs. 1) Resident A, B, C, F, and G remained anonymous. 2) Current facility residents have the potential to be affected by the alleged practice. 3) Facility staff were educated by the Executive Director or designee on timely call light response and responsibilities in providing the requested services or cares, starting on 11/30/21 and 12/1/21. Facility personnel share equal responsibility in answering call lights. Facility interdisciplinary team will interview residents 5-7 days weekly regarding general care and responsiveness to call lights. Resident Council will include	

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F 725	Continued From page 21 Review of the facility policy titled "Call Light, Use of" occurred on 11/04/21. This policy, dated June 2017, stated, "Purpose: To respond promptly to resident's call for assistance . . . Answer ALL call lights promptly whether or not assigned to the resident . . ." Resident interviews on 11/01/21 identified the following: * In the morning, Resident A stated "On Sunday I had my call light on for one and a half hours waiting to use the bathroom. I was in a lot of pain when staff answered the light." * At 2:28 p.m., Resident F reported he/she waited one hour and 35 minutes for assistance on 10/31/21. * At 3:24 p.m., Resident C reported waiting one hour for a call light to be answered. A group interview occurred on the afternoon of 11/02/21 with residents determined by facility staff as interviewable. The residents identified the following: * Residents B and G reported they have waited up to one hour for their call lights to be answered. They also reported staff enter their rooms, turn their call lights off, tell them they will be back, and do not return. * Resident B reported he/she recently observed a CNA (certified nursing assistant) talking on a personal cell phone while walking down the hallway. The CNA failed to answer any of the five call lights that were on prior to exiting the unit. Resident interviews on 11/03/21 identified the following: * At 8:20 a.m. Resident A stated, "I had my call	F 725	review of call light responsiveness. Negative responses on call wait times will be brought to morning meetings and reviewed by the interdisciplinary team. Adjustments to staffing may be implemented based on audits. 4) Audits of call light response time and resident or representative feedback on responsiveness will be completed by the Executive Director or designee. Audits will start 12/7/21 and be completed 5 times weekly for 12 weeks, 4 times weekly for 4 weeks, 3 times weekly for 4 weeks, and then 2 times weekly for 4 weeks or until substantial compliance is maintained. Results of audits will be brought to QAPI for review and recommendation.	

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F 725	Continued From page 22 light on this morning from about 6:10 a.m. until 7:10 a.m. "A staff member came into my room, took my temperature but could not help me to the bathroom. I had to pee so bad." * In the afternoon, Resident F reported staff come into his/her room, turn off the call light, and leave without helping, and reported waiting one hour and 15 minutes for staff to change his/her soiled brief. Resident F stated, "I was told to quit pushing the light." Failure to respond to call lights in a timely manner may result in a decreased quality of life or increased pain for residents dependent on staff for assistance with personal cares.	F 725		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug	F 761		12/9/21

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F 761	Continued From page 23 Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, review of professional literature, and staff interview, the facility failed to safely store and discard expired medications/biologicals and laboratory and medical supplies in 1 of 1 medication storage areas and 1 of 2 medication carts (North Unit Cart) observed. Failure to safely store and discard expired medications/biologicals and laboratory and medical supplies increases the risk of residents receiving outdated medications/biologicals with reduced efficacy and staff utilizing outdated laboratory and medical supplies. Findings include: Review of the facility policy titled "Storage of Medication" occurred on 11/04/21. This policy dated, 06/01/17, stated, ". . . No discontinued, outdated or deteriorated medications are available for use in this facility. All such medications are destroyed according to facility policy. . . ." The manufacturer's instructions for the NOVOLOG® Mix 70/30 FlexPen, found at https://www.novo-pi.com/novologmix70/30.pdf, stated, ". . . Throw away all opened Novolog Mix 70/30 after 28 days even if they still have insulin left in them. . . ."	F 761	It is the policy of the facility to store medications in a secure manner. 1) Medication carts and the medication room were audited on 11/5/21. Any expired medications were disposed, including IV, wound, and lab supplies, according to facility policy. 2) Current facility residents have the potential to be affected by the alleged practice. 3) Facility licensed nursing staff and medication assistants were educated by the Director of Nursing or designee on expiration dates of medications and the proper disposal and timely disposal of expired medications, beginning 11/11/21. The medication room will be organized and labeled for designated areas to store medications and supplies. The designee responsible for ordering supplies and stock medications will rotate stock accordingly. 4) Audits will be completed by the Director of Nursing or designee to ensure medication carts and medication rooms contain medications that are not expired. Consulting pharmacist will also conduct monthly audits of medication carts and medications rooms, and will provide the Director of Nursing with findings. Audits will be completed 5 times weekly for 12	

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F 761	Continued From page 24 - Observation of the medication storage area occurred on 11/03/21 at 08:25 a.m. with a nurse (#4) and showed the following: * Medication room cabinets, drawers, and portable totes contained one bag D5 500 ml (milliliters) (intravenous fluids), expired July 2020; four bags 5% Dextrose 1000 ml (intravenous fluids), expired March 2021; one Genadyne canister (wound vac), expired 02/04/18; six vacutainers (lab blood tubes), three yellow, expired 09/30/21, two purple, expired 08/31/21, and one blue, expired 07/31/21; one safety needle, expired 06/2020; and primary IV (intravenous) set, expired 06/01/21. * Medication fridge contained seven boxes Influenza vaccines, expired 06/30/21. * Emergency cart contained four heparin flushes (blood thinner), expired 02/12/21 and five IV extension sets, expired 10/2021. * Items stored under sink included 5 bags of IV fluids, tube feeding pump, three sharps containers, personal alarm pendant, and box of Velcro. During an interview on 11/03/21 at 1:51 p.m., a staff nurse (#4) stated, "I do not know who checks the medication storage area and emergency cart for expired medications and supplies." During an interview on 11/03/21 at 2:20 p.m., an administrative nurse (#3) stated, "The night nurse is responsible for checking the emergency cart", and confirmed staff should discard expired medications/biologicals and supplies, and store nothing under the sink. - Observation on 11/03/21 at 11:33 a.m., showed	F 761	weeks, 4 times weekly for 4 weeks, 3 times weekly for 4 weeks, and then 2 times weekly for 4 weeks or until substantial compliance is maintained. Results of audits will be brought to QAPI for review and recommendation.	

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F 761	Continued From page 25 a licensed nurse (#5) prepared a Novolog Mix 70/30 FlexPen for Resident #9. When asked to verify the FlexPen open/discard date prior to administration of the insulin, the nurse identified the open date as 09/10/21. The nurse obtained a second FlexPen located in the medication cart and identified the open date as 09/22/21. When asked why Resident #9 had two open pens of the same insulin, the licensed nurse (#5) stated, "I don't know." The nurse identifed both FlexPens as past the discard dates. During an interview on the morning of 11/04/21, an administrative nurse (#3) confirmed staff failed to discard the expired insulin pens.	F 761		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.	F 812		12/9/21

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F 812	Continued From page 26 This REQUIREMENT is not met as evidenced by: Based on observation, professional reference, and staff interview, the facility failed to prepare and serve food under sanitary conditions in 1 of 1 kitchen. Failure to sanitize the dishes, pots/pans, and utensils between uses and follow proper food handling during meal service may result in the spread of illness and/or foodborne illness to residents. Findings include: DISHWASHER The FDA Food Code 2013, Page 135, stated, ". . . the temperature of the fresh hot water SANITIZING rinse as it enters the manifold may not be . . . less than . . . (180 degrees F)." Pages 145-146, stated, ". . . EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be SANITIZED in . . . Hot water mechanical operations . . . achieving a UTENSIL surface temperature of . . . (160 degrees F) as measured by an irreversible registering temperature indicator . . ." Staff failed to provide a copy of the facility's policy specific to dishwashing machine use or the manufacturer's guidelines. Observations showed the following: * 11/03/21 at 1:40 p.m., a dishwasher currently in use in the main kitchen. Upon the completion of the rinse cycle, the plate simulator (a type of irreversible registering temperature indicator) indicated the food-contact surface of 150.3 degrees F. A dietary manager (#1) stated, "it is a	F 812	F812 #1 Food Procurement, Store/Prepare/Serve 1.) The facility implemented disposable plates and utensils, and three-step washing process as indicated by low dishwasher temperatures on 11/4/21. Dishwasher water source temperatures were adjusted to meet the Food and Drug Administration's recommended temperature ranges by 11/6/21 with service to dishwasher completed 11/15/21. 2.) Current facility residents have the potential to be affected by the alleged practice. 3) Dietary staff will be educated on 11/04/2021 by the Dietary Manager or designee on manufacturer's instructions for dishwasher temperature ranges, monitoring temperatures at each use, and staff response if temperature drop below recommended temperature ranges, including using disposable plates and utensils and three-step washing process. 4) Audits will be completed by the Dietary Manager or designee on appropriate starting 12/6/21 on dishwasher temperatures 5 times weekly for 12 weeks, 4 times weekly for 4 weeks, 3 times weekly for 4 weeks, and then 2 times weekly for 4 weeks or until substantial compliance is maintained. Results of audits will be brought to QAPI for review and recommendation.	

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F 812	Continued From page 27 hot water dishwasher and the rinse [cycle] needs to be 180 [degrees F]." * 11/03/21 at 2:55 p.m., the dial temperature display on the outside of the dishwasher showed 138 degrees F during the rinse cycle. A dietary manager (#1) stated, "this [low temperatures] happens several times a day and it can take several runs before the temperature gets up." * 11/03/21 at 2:57 p.m., rinse 160 degrees F; and plate simulator 141.5 degrees F. A dietary manager (#1) drained the dishwasher. * 11/03/21 at 3:37 p.m., rinse 182 degrees F; and plate simulator 163.5 degrees F. A contract employee (#10) stated, "I had to turn the heat to the max to get acceptable rinse temperatures." * 11/04/21 at 10:00 a.m., A dietary manager (#1) stated she runs a T-Stick (a type of irreversible registering temperature indicator) with the dishes once a week but was unable to provide October 2021's results or identify the expiration date of the T-Sticks. During an interview on11/04/21 at 1:21 p.m., an administrative nurse (#3) and an administrative staff (#9) agreed the dishwasher temperatures were a concern and transitioned to paper and plasticware and a three-step wash, rinse, and sanitize method until the the facility could resolve the issue. FOOD HANDLING The FDA Food Code 2013, Page 65, stated, ". . . FOOD EMPLOYEES may not contact exposed, READY-TO-EAT FOOD with their bare hands and shall use suitable UTENSILS such as deli tissue, spatulas, tongs, single-use gloves, or dispensing EQUIPMENT. . . ."	F 812	F812 #2 Handling Food 1) Cook #2 was directed to refrain from touching food with bare hands by using utensils or using gloves when handling food is necessary on 11/4/21. 2) Current facility residents have the potential to be affected by the alleged practice. 3) Cook #2, dietary, and nursing staff were educated by the Executive Director to refrain from handling food with bare hands, beginning 11/30/21 and 12/01/21. Education to include that if food must be handled, staff must don gloves. 4) Audits will be completed by the Dietary Manager or designee on appropriate starting 12/6/21 on food contact handling 5 times weekly for 12 weeks, 4 times weekly for 4 weeks, 3 times weekly for 4 weeks, and then 2 times weekly for 4 weeks or until substantial compliance is maintained. Results of audits will be brought to QAPI for review and recommendation.	

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F 812	Continued From page 28 Staff failed to provide a copy of the facility's policy specific to proper food handling. Observation on 11/01/21 at 12:02 p.m. showed the lunch meal service in progress. A cook (#2) touched her eye protection with her bare left hand, grabbed a slice of pizza with the same hand, and placed it on a plate. The cook returned to the service line, scratched her head with her bare left hand, grabbed the slice of pizza with the same hand, and placed it on a plate. During an interview on 11/04/21 at 09:50 a.m., a dietary manager (#1) stated she expects staff to use serving utensils when plating food, not their bare hands.	F 812		
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and	F 842		12/9/21

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F 842	Continued From page 29 (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments;	F 842		

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F 842	Continued From page 30 (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident and staff interviews, the facility failed to ensure a complete and accurately documented medical record for 4 of 14 sampled residents (Resident #7, #19, #20, and #322). Failure to have a complete and accurate medical record limited staff access to the most recent medical information. Findings include: - Review of Resident #332 medical record occurred on all days of survey. The care plan stated, ". . . Resident has impaired functional mobility . . . Shower days Tues and Sat [Tuesday and Saturday] PM . . ." Review of the bathing records dated October 21 - November 03, 2021 showed staff documented the resident received a bath on Tuesday 11/02/21. During an interview on 11/03/21 at 8:20 a.m., Resident #322 reported staff failed to bathe him on Tuesday 11/02/21. During an interview on 11/03/21 at 5:10 p.m., an	F 842	1) Resident #7 was assisted by nursing staff with compression stockings on 11/3/21. Resident #19 was assisted by nursing staff with compression stockings on 11/3/21. Resident #20's oxygen was verified by the Director of Nursing to be at the physician ordered flow rate on 11/2/21. Resident #322 was assisted with bathing on 11/3/21. 2) Current facility residents have the potential to be affected by the alleged practice. 3) Current facility residents will have shower schedules reviewed for accommodations to preferences by 12/9/21. Care plans and Kardex will be updated to indicate shower days and schedules by 12/9/21. Residents with orders for compression stockings will have care plans and Kardex reviewed for assistance with donning and doffing by 12/9/21. Facility residents with orders for oxygen administration had flow rate orders reviewed and reconciled with flow rates being administered on 12/9/21. Facility nursing staff will be educating on accurate documentation for delivering	

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F 842	Continued From page 31 administrative nurse (#3) reviewed bathing records and confirmed staff documented they bathed Resident #322's on Tuesday 11/02/21. When the administrative nurse (#3) questioned the certified nursing assistant (CNA) (#8) regarding the documentation, the CNA stated, "I did not give him a bath. I was told he had a bath so I documented it." During an interview on the morning of 11/04/21, an administrative nurse (#3) confirmed staff failed to provide a bath for Resident #322 on 11/02/21 although the medical record identified the resident received a bath. - Review of Resident #7 medical record occurred on all days of survey. The physician orders stated, ". . . Knee hi [sic] compression stockings - On in AM [morning], off at HS [night] every day shift . . . every evening shift . . ." Review of the care plan stated, ". . . wear TED hose . . . compression stockings or wraps daily . . . Knee hi compression stockings - to be worn ON in AM , off at HS . . ." Observations on 11/01/21 at 1:39 p.m. and 4:54 p.m. and 11/02/21 at 12:21 p.m. and 4:30 p.m. showed Resident #7 without compression stockings on. During an interview on 11/03/21 at 10:43 a.m., an administrative staff member (#3) reviewed Resident #7's medical record and confirmed staff documented Resident #7 wore compression stockings on November 1 and 2, 2021. The administrative staff member (#3) stated staff are expected to document accurately.	F 842	care, omitted cares, and resident refusals. Education will include that if staff are unable to provide care related to resident refusal or time management, staff must notify nursing management so resident accommodations can be made. 4) Audits of cares documentation of completed cares and resident refusals will be completed by the Director of Nursing or designee 5 times weekly for 12 weeks, 4 times weekly for 4 weeks, 3 times weekly for 4 weeks, and then 2 times weekly for 4 weeks or until substantial compliance is maintained. Results of audits will be brought to QAPI for review and recommendation.	

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F 842	Continued From page 32	F 842		

-Review of Resident #19 medical record occurred on all days of survey. The physician orders stated, ". . . Knee hi [sic]compression stockings - On in AM, off at HS every day shift . . . every evening shift . . ." Review of the current care plan, initiated 06/28/21, stated, ". . . wear compression stockings or wraps daily . . . knee high compression stockings - to be worn ON in AM, off at HS . . . monitor feet daily . . . monitor edema . . ."

Observation of Resident #19 showed the following:
* 11/01/21 at 12:34 p.m., and 4:15 p.m., without compression stockings on. At 4:15 p.m., the resident reported having pain in both feet.
* 11/03/21 at 2:40 p.m., the resident reported staff failed to remove the stockings the previous evening.

During an interview on 11/03/21 at 2:40 p.m., an administrative staff member (#3) reviewed Resident #19's medical record and confirmed staff documented compression stockings worn on 11/01/21 and staff removed his stockings on the evening of 11/02/21. The administrative staff member (#3) reported staff are expected to document accurately.

- Review of Resident #20 medical record occurred on all days of survey. The physician orders stated, ". . . Oxygen on 2.5 Liters continuous every morning and at bedtime for pulmonary hypertension . . . O2 [oxygen] sats [saturations] above 90% . . ." The care plan stated, ". . . keep O2 setting at 2.5 Liters as ordered by MD [medical doctor] . . . Oxygen 2.5 LPM [liters per minute] via NC [nasal cannula]

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F 842	Continued From page 33 continuous using concentrator while in room and portable when outside of room. Alert nurse if oxygen is not at correct setting . . ." Observation on 11/02/21 at 11:41 a.m. to 4:37 p.m., showed Resident #20 with oxygen on per nasal cannula at 4.5 LPM. During an interview on 11/02/21 at 4:37 p.m., a staff nurse (#6) confirmed Resident #20's oxygen rate/dose is ordered continuous at 2.5 Liters. The nurse documented in the medical record the oxygen rate at 2.5 L on 11/02/21 at 1:02 p.m. During an interview on 11/04/21 at 9:45 a.m., an administrative staff member (#3) stated Resident #20's physician orders and care plan stated oxygen at 2.5 LPM and staff need to verify the correct oxygen rate and document accurately.	F 842		
F 886 SS=D	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility;	F 886		12/9/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355031	A. BUILDING _____ B. WING _____	C 11/04/2021

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

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F 886	Continued From page 34 (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in	F 886		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 886	Continued From page 35 emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by: Based on review of Covid 19 testing logs, review of facility policy, and staff interview, the facility failed to ensure routine testing of 2 of 2 (Staff AA and BB) unvaccinated staff for Covid 19. Failure to test unvaccinated staff for Covid-19 at the required testing intervals has the potential to allow for the spread of Covid-19. Findings include: Review of the facility policy titled "SUSPECTED OR CONFIRMED POSITIVE COVID 19 MANAGEMENT" occurred on 11/04/21. This policy, revised September 2021, stated, ". . . Routine Testing of Staff: 1. Routine testing of unvaccinated staff should be based on the extent of the virus in the community. . . . Facilities should use their community level as the trigger for staff testing frequency. Reports of COVID-19 level of community transmission are available on the CDC COVID- 19 Integrated County View site . . ." During an interview on the morning of 11/03/21, an administrative nurse (#3) stated their county positivity rate has remained high (red) for a long time and they require twice a week testing of unvaccinated employees. Review of the facility's Covid-19 testing information from September 13 - November 27,	F 886	1) Staff AA and Staff BB were tested by 11/08/21. 2) Current facility residents have the potential to be affected by the alleged practice. 3) Current facility staff were educated by the Director of Nursing or designee, beginning on 11/30/21 and 12/01/21, on requirements for unvaccinated staff to be vaccinated per county transmission rates. Education to unvaccinated staff included that testing is a condition of employment; disciplinary actions may result for non-compliance of testing requirements. Audit of test dates on unvaccinated staff was completed on 11/08/21 and tests were administered on staff who had not received a test within the past 3 days. 4) Audits of unvaccinated staff test dates will be completed starting 12/06/21 by the Director of Nursing or designee 5 times weekly for 12 weeks, 4 times weekly for 4 weeks, 3 times weekly for 4 weeks, and then 2 times weekly for 4 weeks or until substantial compliance is maintained. Results of audits will be brought to QAPI for review and recommendation.	

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F 886	Continued From page 36 2021 showed the following: * Employee (AA) tested eight times in seven weeks (instead of 14 times) * Employee (BB) tested 4 times in 7 weeks (instead of 14) During an interview on 11/04/21 at 10:15 a.m., an administrative nurse (#3) confirmed the above staff members failed to test for Covid-19 according to current standards.	F 886		