STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355099	A. BUILDING _____ B. WING _____	C 03/22/2021

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GOOD SAMARITAN SOCIETY - MOTT	401 MILLIONAIRE AVE MOTT, ND 58646

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F 000	INITIAL COMMENTS An unannounced onsite complaint survey was completed on March 17 - 22, 2021. The sample included five (5) sampled residents for focused review and two (2) supplemental residents for observations. Based on observation, record review, facility policy review, staff interview, review of provider notes and provider interview, some of the complaint issues investigated were substantiated.	F 000		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, review of professional reference, and staff interview, the facility failed to follow professional standards of practice for 1 of 2 sampled residents (Resident #1). Failure to observe and implement physician's orders to monitor and complete labs which has potential for increased, prolonged, abnormal bleeding and/or increased bruising. Findings include: Berman, Snyder, and Frandsen's "Kozier & Erb's Fundamentals of Nursing: Concepts, Process, and Practice," 10th ed., Pearson Education, Inc., Massachusetts, page 68, stated, ". . . Carrying Out a Physician's Orders . . . If the order is	F 658	This Plan of Correction constitutes this facility□s written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1) Resident #1 is no longer a resident in this facility. The corrective action accomplished regarding Services Provided Meet Professional Standards is establishing a workflow to track labs and acknowledging lab results. 2) The facility recognizes this deficient	4/21/21

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

Electronically Signed | 04/09/2021

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F 658	Continued From page 1 neither ambiguous nor apparently erroneous, the nurse is responsible for carrying it out. . .." Review of medical record occurred on 03/17/21. A phycian's order, dated 09/01/20, stated, "PT/INR [Protime/International normalized ratio] monthly one time a day every 30 days." A physician's order, dated 02/19/21, stated, "Coumadin tablet, 1mg [milligram]. Give 1mg by mouth in the afternoon related to atrial fibrillation." Review of lab reports from September 2020 to March 2021, showed no lab results for the months of November 2020 and January 2021. Nurse progress notes showed the following, * 02/04/21 noted, "Lab review PT/INR 3.1 with PT 36.9; Will await to see if any new orders from MD." (Therapeutic INR level is 2.0 to 3.0 for people taking Coumadin). * 03/09/21 noted, ". . . [name of family member] had several inquires about frequency of PT/INR checks, informed her that last labs were done in December and the labs are ordered by physician as he deems necessary. She [family member] reported that in the hospital they checked her [Resident #1] PT/INR and her INR was 4.1. . . ." The facility failed to: * Provide documentation of monthly laboratory draws as ordered. * Obtain a phycian's order for follow up PT/INR collection, following the 02/04/21 lab collection. * Provide a policy or procedure for PT/INR monitoring. During an interview on 03/17/2021 at 3:45 p.m.,	F 658	practice potentially affect any resident□s receiving anticoagulation medication requiring PT/INR lab draw 3) Licensed nursing staff will be educated on process regarding administration of Coumadin and PT/INR orders. PT/INR tracking tool will be implemented following education. Licensed nursing staff will monitor PT/INR. HIM will oversee process for receiving PT/INR results and filed into EMR. DNS will provide education on PT/INR tracking tool and Point Click Care software Coumadin (Warfarin) order with separate lab orders to all licensed nurses and HIM on 4/21/2021. 4) The DNS or designee will monitor and conduct audits on residents receiving anticoagulants requiring PT/INR monitoring. DNS or designee will conduct audits on HIM receiving lab results and filing into EMR. Audits will be completed weekly x4, monthly x3, then as deemed necessary per QAPI recommendations until compliance is sustained. 5) Corrective action completion date: 4/21/2021	

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F 658	Continued From page 2 an administrative nurse (#1) agreed the staff failed to follow physician's orders to collect and monitor monthly PT/INR as ordered.	F 658		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policies, provider notes, provider interview, and information submitted by the complainant, the facility failed to provide necessary care and treatment for 1 of 2 sampled residents (Resident #1) with foot ulcers. Failure to complete wound care and dressing changes as ordered resulted in delayed healing and the development of additional skin issues/ulcers. Findings include: Review of the facility policy titled "Physician/Practitioner Orders - Rehab/Skilled" occurred on 03/17/21. This policy dated 11/20/20, stated, ". . . Wounds: Orders must be obtained for wound care including product to be used, when to change and when to reassess. A licensed nurse must provide the wound care. . . . Procedure: Physician/Practitioner orders are a critical component to providing quality care to	F 684	This Plan of Correction constitutes this facility□s written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1) Resident #1 is no longer a resident in this facility. The corrective action accomplished regarding Quality of Care failure to provide necessary cares and treatment for wound care as ordered 2) This practice has potential to Affect all residents with wounds requiring treatments as ordered by the provider. 3) The DNS or designee will re-educate licensed nursing staff on wound care orders and treatments on 4/21/2021. HIM will monitor process for ensuring that	4/21/21

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F 684	Continued From page 3 residents. . . . Once the order is entered into [electronic medical record], depending on order category, the order will populate the appropriate electronic administration documentation location within the application: eTAR [electronic Treatment Administration Record]" Review of Resident #1's medical record occurred on 03/17/21. Diagnoses included venous thrombosis [clot] and embolism [obstruction], and non-pressure chronic ulcer of left foot limited to breakdown of skin. The eTAR's from October 2020 to March 2021, showed the specific order entries for wound care, which included types of dressing to use, types of dressing not to use, such as, "no non-stick dressings, do not apply anything besides 4 x 4's between toes, keep toes exposed to dry out, loosley [sic] cover/wrap with kerlix around foot, no sock." Order on 01/29/21-"No wrap of any kind, apply stockinette over foot." The eTAR's showed the nurse's documentation indicated dressing changes completed as ordered. Review of the nurse progress notes showed: * 10/15/20 at 4:00 p.m., Note Text: "Resident returned from appointment in [name of town]. Keep dressing intact to left foot. If gets soiled, contact [name of provider] office prior to removing it. Leave right 2nd and 3rd toes open to air. NO BANDAIDS. Continue with offloading boots . . ." * 10/24/20 at 5:21 p.m., Note Text: "During assessment of wound of left foot/surgical area, nursing noted quite a bit of odor . . . The visible ace wrap exposed at the toe was discolored with dried blackish old blood stains, . . . Dressing was removed . . . The foot was rewrapped with clean	F 684	physician documents are received following appointments, reviewed by licensed nurse, and scanned into resident spaces 4) The facility plans to monitor its performance to make sure solutions are sustained. DNS or designee will monitor with by auditing wound treatment performed as ordered.. Social services or designee will monitor compliance for physician visit progress notes received following the appointment and noted reviewed by licensed nurse. Audits will be completed weekly x4, monthly x3, then as deemed necessary by QAPI committee until compliance is sustained 5) Corrective action completion date: 4/21/2021	

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F 684	Continued From page 4 gauze pads to the outside of the foot. Cotton gauze warp and a roll of 2 in [inch] kerlix. . . ." Review of provider notes showed the following: * 10/15/20: ". . . Dressing was replaced today and will be left in place. I will see patient back in about one week for further care . . ." * 10/26/20: ". . . she does have a large macerated new onset ulceration between digits 2 and 3. Previous orders to the nursing home dictated that this dressing not be changed without notification as I did fear they would apply this incorrectly and cause further issue. . . . nursing home was contacted . . . charge nurse indicated that a 'travel nurse' had changed this over the weekend without contacting me. . . . it does appear to be a new issue and is potentially limb threatening . . ." * 11/03/20: ". . . continue to have a substantial wound to the left foot between digits 2 and 3, though this is much more stable compared with previous. I do still feel that the dressing is being applied to aggressively in this area. . . ." * 11/10/20: ". . . I do find that there has been significant worsening of previous wound between 2nd and 3rd digits. . . there is a new onset wound between 1st and 2nd digits. I feel that this is due to no consistency and dressing application and did explain this to the patient's daughter and social worker. . . . there should be no dressing between the digits, otherwise we risk worsening of her wound which could lead to 2nd digit amputation, or even more proximal amputation. The importance of proper dressing application was reviewed with the patient's caretakers today. . . ." * 11/17/20: ". . . Patient does have a new onset pressure injury to the medial 2nd digit as well as	F 684		

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F 684	Continued From page 5 to the lateral forefoot which I feel is due to over tightening of her dressing. . . ." * 12/08/20: ". . . I do find that her wound has deteriorated once more . . . The importance of not over tightening the dressing was once more expressed on the notes to the nursing home, though so far we have continued to have only worsening issues. . . ." * 01/28/21: ". . . the most concerning wound is now to the lateral aspect of her forefoot. I feel this has formed as result of daily wrapping with Kerlix that has killed the skin in this area. . . We will discontinue having any wrap applied to the patient's foot . . . They will instead use a stockinette to hold the whole package together. . . ." * 02/11/21: "Chief Complaint . . . The patient had iodine soaked 4x4 between her toes and to the dorsal left foot with kerlix around the [sic] that. She also had tubigrip [elastic support bandage] over the foot with 2 abrasions noted to the anterior ankle where the tubigrip ended. She has bilateral offloading boots. . . . Staff will need to follow dressing rules explicitly and will discontinue using any sort of compression wrap to the area as this has caused new onset anterior ankle wounds as well. . . ." * 03/04/21: ". . . Chief Complaint . . . looks like new breakdown on top of foot. Maybe having breakdown on heel as well. . . . there is worsening of the lateral 5th MPJ [little toe joint] wound. . . . Specific note was made to forbid the usage of any compressive dressing as I do feel this is causing further complication as far as the patient is concerned. She was given several lengths of stockinette to use as an alternative which should be changed daily. We discussed the patient's posterior heel wound which appears	F 684		

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F 684	Continued From page 6 to be due to pressure. I would like the staff to keep offloading boots in place at all times both in her chair as well as in bed . . ." During a phone interview on 03/22/21 at 7:50 a.m., Resident #1's podiatrist (A) reported the notes made following clinic appointments were clear on the procedure for the dressing change. The dressings rarely resembled anything like what was ordered. "The whole thing started when we had to remove a little bit of bone from her toe and basically because the dressing was changed when we specifically wrote not to, a new ulcer was caused and that is what we have been dealing with. . . . The dressings aren't done properly so we got new ulcers virtually every time we see her." The podiatrist (A) stated he/she requested facility staff to avoid tight or compression wraps as it worsened skin issues and created new skin breakdown. The clinic staff provided detailed instructions and supplies to the facility to perform correct dressing changes. The facility staff failed to follow the written instructions or use the correct dressing supplies. The initial skin condition had resolved over a short time. The continued treatment orders are related to the skin issues that developed as a result of inconsistent and improper dressing change technique completed by the facility staff. The provider notes identified facility staff failed to follow physician orders for wound care and dressing changes and lacked communication with the provider which resulted in wound deterioration and new foot ulcers/skin breakdown for Resident #1.	F 684		
F 692 SS=G	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3)	F 692		4/21/21

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F 692	Continued From page 7 §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on review of professional reference, record review, review of facility policy, information submitted by the complainant, and staff interview, the facility failed to ensure acceptable parameters of nutritional status for 2 of 2 sampled residents (Resident #1 and #2) with significant weight loss. Failure to adequately monitor and evaluate weights, assess the effectiveness of existing interventions, and ensure consistent implementation, and re-evaluate the need for updated or additional interventions resulted in the residents' severe weight loss.	F 692	This Plan of Correction constitutes this facility□s written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1) Residents #1 and #2 no longer reside in the facility. The corrective action accomplished regarding Nutrition/Hydration Status Maintenance documentation of correct weights in EMR,	

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F 692	Continued From page 8 Findings include: The Centers for Medicare and Medicaid Services (CMS) has outlined the parameters for evaluating significance of unplanned & undesired weight loss: Interval — Significant Loss — Severe Loss 1 month — 5% — Greater than 5% 3 months — 7.5% — Greater than 7.5% 6 months — 10% — Greater than 10% Review of the facility policy titled "Identifying Residents With Impaired Nutrition Status And Nutritional Risk - Food and Nutrition Services" occurred on 03/17/21. This policy, revised 06/22/20, stated, ". . . Residents with impaired nutritional status or nutritional risk may be identified by nursing, food and nutrition services and other members of the care plan team . . . The director of food and nutrition services (DFN) and the dietitian will identify residents with impaired nutrition or at nutritional risk, such as . . . Significant weight change, gain or loss, (3 pounds in one week, 5 percent in one month, 7.5 percent in three months, 10 percent in six months) . . ." - Review of Resident #1 medical record occurred on 03/17/21. The current physician order identified "Regular diet Level 1-Puree texture, Regular fluid consistency, Add Fortified due to weight loss." Current care plan stated, ". . . The resident has potential nutritional problem R/T [related to] hypothyroidism, decreased appetite, dementia, occasional refusal of supplements E/B [evidence	F 692	monitored by dietary manager and established weekly weight committee, and notification of Registered Dietician in a timely manner. 2) The facility recognizes this deficient practice has the potential to affect any resident who is at risk for weight loss. 3) Measures were put into place to ensure the practice will not recur. Residents that receive supplements will be entered on the MAR/TAR and recorded per policy/procedure titled Medical Nutritional Supplements- Food and Nutrition Services. Dietary staff will enter and record consumption of supplements that are administered with meals. All documented supplement records will be available for dietary and nursing. effective 04/07/2021. Weight committee will meet each week for review for any and all weight loss in the past month; care plans will be reviewed and revised with input from this committee; dietary manager will notify dietitian for appropriate recommendations effective 04/15/2021. Dietician will be present at meetings on a monthly basis as requested. Nursing will notify physician of resident with 3% or more weight loss in 2 weeks effective 04/07/2021. Nursing staff and dietary staff will be educated by the DNS on 04/21/2021 on the policy/procedure titled Weight and Height. Dietary staff will be educated by dietary manager on recording intake of supplements on 4/7/2021. 4) The facility plans to monitor its performance to make sure solutions are	

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F 692	Continued From page 9 by] weight loss . . . Resident has order for a texture modified diet . . . Talk with the resident/family and provide information pertaining to the current therapeutic diet. Resident on fortified diet for extra calorie intake for weight loss . . . Scheduled resident specific snack/food interventions #1 4 oz [ounces] mighty shake at 10a. [a.m.] . . . Scheduled resident specific snack/food intervention #2 4oz mighty shake at 3p. [p.m.] . . . Scheduled resident specific snack/food intervention #3 4oz mighty shake at 6p with supper meal. . . ." Resident #1's weights included the following: * 09/01/20 - 124.4 pounds (lbs.) * 09/17/20 - 111.5 lbs. (10.4% weight loss in 2 weeks) * 10/15/20 - 110.5 lbs. * 10/29/20 - 106.5 lbs. * 11/06/20 - 103.5 lbs. * 11/12/20 - 102.5 lbs. * 11/19/20 - 102.0 lbs. * 12/10/20 - 101.5 lbs. * 01/22/21 - 101.5 lbs. * 01/28/21 - 100.5 bs. * 02/03/21 - 97.5 lbs. * 02/10/21 - 97.5 lbs. * 02/18/21 - 96.5 lbs. * 02/24/21 - 93.5 lbs. * 03/04/21 - 89.5 lbs. (8.3% severe weight loss in one month, 28.1% severe weight loss in six months) Meal intake records for 02/16/21 to 03/08/21 showed Resident #1 consumed 25% or less at 31 of 63 meals and refused 17 of 63 meals documented. Fluid intake records for 02/16/21 to 03/08/21 showed Resident #1 consumed 120	F 692	sustained by assigning the Dietary Manager or designee to monitor by using audits to ensure that weights and supplements are documented properly for each resident. Audits will be completed weekly x4, monthly x 3, and then quarterly x 1 year. Results will be reported to the QAPI team with corrective action implemented. 5) Corrective action accomplish date: 04/21/2021	

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F 692	Continued From page 10 milliliters (mL) or less at 34 of 43 meals documented. Review of Resident #1's progress notes identified the following: * 12/04/20 at 11:35 a.m. - (MDS Coordinator) "Informed by Dietary manager that resident is losing weight so fortified diet will be added after this nurse receives an order. Order received." * 01/19/21 at 4:57 a.m. - (Nurse) ". . . Review resident for poor meal intake, food intake varies widely from 0-50% weight range 102.5 to 101.5. [sic] Snacks are encouraged." * 02/09/21 at 10:49 p.m. - (Nurse) ". . . Review resident for poor meal intake . . . Intake at most meals is only 0-25% , [sic] she has lost weight going from 100.5# down to 97.5# . . ." * 02/12/21 at 12:40 p.m. - (Dietary Manager) - "Resident is on 4oz mighty shakes at 10a, 3p, and 6p for weight loss, along with fortified foods for extra calorie intake." * 03/02/21 at 9:25 p.m. - (Nurse) ". . . Review resident for poor meal intake: resident's last recorded weight on 2/24 is 93.5 lbs. She is recorded more consistently eating 0-25% of meals but has an occasional 100% and on several occasions is recorded as consuming 25-50%." * 03/07/21 at 2:10 p.m. - (Nurse) ". . . Discussed resident refusing meals (all meals 3/6/2021) . . . Refused breakfast and lunch today; offered ensure, refused that. Resident cont [continues] refusing fluids . . . Discussed other methods of nutrition, [resident's family] voiced PEG/feeding tube not an option; will not pursue that. Discussed staff will cont to offer/push fluids, and encourage meals/supplements. . . ." * 03/09/21 at 11:50 a.m. - (Dietitian) "Resident w/	F 692		

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F 692	Continued From page 11	F 692		

[with] significant wt [weight] loss- presently 89.5lb (down 8%/1mo- 99lb, down 11.8%/3mo- 101.5lb. Extreme poor oral intakes/refusal to eat. Had been receiving Healthshake [sic]/ Magic cups ea [each] meal."

Interview on 03/17/21 at 3:45 p.m., a dietary supervisor (#3) stated she would notify the registered dietitian to complete an assessment when the resident had a weight loss of 5% in one month and/or 10% in six months. She also stated the supplements intakes are documented with the fluid intakes and not separately.

The facility failed to notify the registered dietitian and implement interventions in a timely manner after Resident #1 experienced severe weight loss.

- Review of Resident #2's medical record occurred on 03/17/21. The current physician order identified "Special diet Level 1-Puree texture, Nectar consistency, Sit up 90 degrees if possible."

Current care plan stated, ". . . The resident has a nutritional problem R/T Hypothyroidism, Alzheimer's disease [sic], dementia . . . and poor meal intake E/B weight loss . . . Resident has order for a therapeutic diet . . . Resident has order for a texture modified diet . . . Resident requires nectar thickened liquids . . . "

Resident #2's weights included the following:
* 09/15/20 - 148.0 lbs.
* 10/13/20 - 146.5 lbs.
* 11/17/20 - 142.5 lbs.
* 11/24/20 - 141.5 lbs.

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	355099	A. BUILDING _____ B. WING _____	C 03/22/2021

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F 692	Continued From page 12 * 12/15/20 - 142.0 lbs. * 12/29/20 - 141.0 lbs. * 01/05/21 - 140.0 lbs. * 01/12/21 - 138.5 lbs. * 01/19/21 - 136.5 lbs. * 01/26/21 - 133.0 lbs. * 02/09/21 - 130.0 lbs. * 02/16/21 - 128.0 lbs. * 03/09/21 - 126.0 lbs. * 03/16/21 - 125.0 lbs. (9.8% severe weight loss in three months, 15.6% severe weight loss in six months) Meal intake records for 02/16/21 to 03/17/21 showed Resident #2 consumed 25% or less at 45 of 88 meals documented. Fluid intake records for 02/16/21 to 03/08/21 showed Resident #2 consumed 120 milliliters or less at 51 of 81 meals documented. Review of Resident #2's progress notes identified the following: * 11/10/20 at 7:36 a.m. - ". . . Dietitian Assessment . . . Inadequate oral Intake . . . r/t decreased ability to consume sufficient energy evidenced by meal records and gradual insignificant weight loss. Wt 142.5lb (down 4%/3mo, 6.2%/6mo, 10%/year. BMI 27-healthy body wt range. Intakes have been slipping-25-50% ave [average]. Resident is receiving Regular diet at present. Would advise addition of Healthshake [sic] or Magic Cup daily for additional kcal/ protein . . ." * 11/30/20 at 10:33 a.m. - (Nurse) ". . . Appetite is fair as resident eats very slowly and needs reminding and cueing to eat by staff. Resident has a slight weight loss with family being concerned on this with reassurance provided and	F 692		

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F 692	Continued From page 13 will talk with dietary department regarding family's concerns . . ." * 12/03/20 at 5:25 p.m. - (Nurse) "Resident has had ten pound weight loss since September. Will sit et [and] not eat et refused to be fed. Faxed [physician] et he did order compassionate care to allow spouse to come in et sit with her if needed." * 01/19/21 at 2:43 a.m. - (Nurse) ". . . Review resident for poor meal intake . . . a slow gradual weight loss." * 01/26/21 at 12:18 a.m. - (Nurse) ". . . Review resident for poor meal intake resident has progressively loss [sic] weight . . ." * 02/09/21 at 4:46 p.m. - ". . . Resident receiving Regular diet- poor oral intakes. Receiving Healthshakes [sic] ev [sic] meals . . . questioning if resident experiencing dysphagia/aspiration. Will be discussing w/ [with] MD [Doctor of Medicine]. Also question if element of depression-may consider antidepressant/appetite stimulant. Rec [recommend] Fortified diet." * 02/09/21 at 10:13 p.m. - (Nurse) ". . . resident continues to have poor intake of food, her weight has decreased from 133.5 down to 130 in one week . . . Dietary do provide her with a supplement which she is also not taking . . ." * 02/17/21 at 8:02 a.m. - "Resident is on a Level 1 diet with regular liquids. Her meals are fortified for weight loss and has mighty shakes in place to help. Resident will refuse to eat and drink most of the time . . ." * 02/17/21 at 6:55 p.m.- (Nurse) ". . . now down to 128# and continues to lose every week. Physician and family aware of her status . . ." * 02/18/21 at 9:35 a.m. - "[Physician] . . . Did write order for Compassionate Cares with life expectancy less than6 [sic] months." * 03/09/21 at 11:34 a.m. - (Dietitian) "Resident w/	F 692		

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F 692	Continued From page 14 significant wt loss- 13.5/6mo. Present weight 128lb down form [sic]148lb 9/15. Very poor oral intakes recorded. Has been receiving Healthshake/ magic cup combo ev [each] meal. Noted resident to receive end of life /compassionate care. Will discontinue Healthshakes [sic] as not taking. Continue to provide supportive care as indicated." During an interview on 03/17/21 at 4:15 p.m., two administrative staff member (#1) and (#2) stated the facility had requested compassionate care visits as Resident #2 had been declining, however the resident wasn't end of life and should continue to receive supplements. The facility failed to: * notify the registered dietitian in a timely manner of a significant weight loss, * document and assess supplement intakes, * recognize continued weight loss despite receiving supplements, and initiate/monitor additional interventions, and * care plan the various interventions they had attempted, identifying if they were successful or needed to be modified.	F 692		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control	F 880		4/21/21

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F 880	Continued From page 15 program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a 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	F 880		

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F 880	Continued From page 16 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 professional references, and staff interview, the facility failed to follow infection control standards for 2 of 4 supplemental residents (Resident #5 and #6) placed on isolation precautions due to their unknown COVID-19 status. Failure of the facility to place newly admitted/re-admitted residents on droplet precautions and ensure the doors to their rooms remain closed may result in residents and staff being exposed to COVID-19 (a viral infection) or other healthcare-associated infections. Findings include: Review of the Centers for Disease Control and Prevention (CDC) guidance found at: https://www.cdc.gov, updated Oct. 28, 2020,	F 880	This Plan of Correction constitutes this facility□s written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1. Resident #5 and #6 are no longer in isolation. The facility will immediately implement an appropriate infection prevention and intervention plan consistent with the requirements of ¿483.80 for the affected resident(s)/neighborhood(s) identified in the deficiency. The infection preventionist (IP), director of nursing (DON), in	

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F 880	Continued From page 17 "COVID-19 most commonly spreads during close contact . . . infections occur mainly through exposure to respiratory droplets when a person is in close contact with someone who has COVID-19. . . ." CDC definition for Droplet Precautions: "Use droplet precautions for patients known or suspected to be infected with pathogens transmitted by respiratory droplets that are generated by a patient who is coughing, sneezing or talking." - Review of Resident #5's medical record occurred on 03/17/21. The current physician order, identified, ". . . Is to be in isolation for two weeks as new admit R/T [related to] Covid protocol. . . . one time only for NEW ADMIT PROTOCOL for 14 Days . . ." An observation on 03/17/21 at 10:12 a.m., showed a "Contact Precautions" sign on Resident #5's door and the door wide open. - Review of Resident #6's medical record occurred on 03/17/21. The current physician order, identified, ". . . Is to be in isolation for two weeks as new admit et [and] Covid protocol. . . ." Observations showed the following: * 03/17/21 at 10:12 a.m., a "Contact Precautions" sign on Resident #6's door and the door half way open. * 03/17/21 at 12:05 p.m., a "Contact Precautions" sign on Resident #6's door and the door half way open. * 03/17/21 at 12:40 p.m., a "Contact Precautions" sign on Resident #6's door and the door half way	F 880	conjunction with applicable interdisciplinary team (IDT) members, shall identify and implement a consistent system for: a. Ensuring appropriate signage to include the specific personal protective equipment (PPE) required for droplet precautions. b. Ensuring staff consistently assist residents to keep the doors to their rooms closed, in accordance with guidelines from the CDC. New signs were made 4/13/2021 for the doors to let staff know the proper precautions and when the last day of isolation would be. The DON, staff IP or designee, in conjunction with applicable IDT members, will: a. Educate staff on appropriate signage for droplet precautions. b. Educate all staff on the importance of assisting residents to keep the doors to their rooms closed. Immediate individual on the spot re-education to keep doors shut in order to help prevent any spread of infectious diseases happened on 3/18/2021. The facility will also readdress the issue on 4/21/2021 2. The IP and DON, in conjunction with applicable interdisciplinary team (IDT) members, will review current COVID-19 nursing facility guidelines from CDC and CMS. The IP, DON and applicable IDT members will evaluate the facility compliance with the guidelines and develop action plans to address any newly identified non-compliance. 3. The facility shall complete the following actions: (1) The DON, IP, and applicable IDT members will conduct	

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F 880	Continued From page 18 open. During an interview on 03/17/21 at 1:00 p.m., an administrative staff member (#1) confirmed the facility required droplet precautions for newly admitted/re-admitted residents and the doors should remain closed.	F 880	root-cause analysis to identify and address the reasons for non-compliance related to: a. Failure to post appropriate signage to include the appropriate PPE required for droplet precautions in accordance with CDC guidelines. (2) The DON, IP or suitable designee will ensure the following: a. Educate all staff whose normal duties include entering resident rooms on the correct procedure for selecting, donning, using and doffing PPE when entering a droplet isolation/quarantine precaution room. This education will include the CDC lesson on personal protective equipment developed for nursing home staff available at https://youtu.be/YYTATw9yav4. b. The facility leadership will contact the North Dakota Quality Improvement Organization (QIO), to inquire about the assistance and services available from the QIO in improving infection prevention and control within the facility through quality assurance process improvement (QAPI) methods. 4. The DON, IP, or a designee will conduct on-going monitoring to ensure, via observation, the approaches to correct deficient practice related to infection control and prevention are consistently implemented and effective. Such monitoring will include: a. Appropriate signage to include the specific personal protective equipment (PPE) required for droplet precautions. b. Observations of all staff types to ensure correct selection, donning, use and doffing of PPE when entering and exiting droplet precaution	

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F 880	Continued From page 19	F 880	isolation/quarantine rooms, and doors remain closed. Observations will be made across all shifts and neighborhoods/units. Observations of noncompliance with the above will result in ad hoc education for the involved staff. Such education will be documented on monitoring forms. Weekly for no less than 12 weeks, after twelve weeks of monitoring, provided that such monitoring demonstrates expectations are consistently met, monitoring may be reduced to monthly. Monthly monitoring will continue for no less than three months. All monitoring will be reported to the quality assurance process improvement (QAPI) committee as part of QAPI activities. Monitoring will not be discontinued until the facility completes three consecutive rounds of monthly monitoring that demonstrate sustained compliance as approved by the QAPI committee and medical director. 5. Correction Date: 04/21/2021	