STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355102	A. BUILDING _____ B. WING _____	09/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NAPOLEON CARE CENTER	311 E 4TH ST NAPOLEON, ND 58561

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The standard Medicare/Medicaid recertification survey started on 09/13/21 and concluded 09/15/21.	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		10/19/21

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

Electronically Signed | 09/30/2021

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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: Based on record review, review of facility policy, and staff interview, the facility failed to notify the physician and/or resident representative for 1of 1 sampled resident (Resident #29) who experienced an injury. Failure to promptly notify the physician and/or resident representative of an injury limited their ability to make informed decisions regarding medical care. Findings include: Review of the facility policy "Accident and Incident Reports: Residents" occurred on 09/15/21. This policy, revised October 2010, stated, ". . . Any staff member who witnesses an incident will report the incident to the charge nurse for them to assess the situation, provide first aide if needed, and complete an incident report . . . obtain a statement of what occurred from anyone who witnessed the incident and/or	F 580	Napoleon Care Center (NCC) will immediately inform the resident; consult with the resident's provider and notify, consistent with his or her authority, the resident representative when there is (A) an accident involving the resident which results in injury and has the potential for requiring physician intervention. 1. Resident no. 29 will have an incident report completed with any injury or near miss according to NCC policy, in addition to notifying their provider and resident representative promptly. 2. All residents will have incident reports completed with any injury or near miss completed per NCC policy, in addition to their provider and resident representative being notified promptly. 3. Education specific to resident no. 29 incident was discussed and educated on	

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F 580	Continued From page 2 the resident if capable . . . if the fall involved a possible head injury, complete neuro checks per policy . . . notify the attending physician . . . notify the family or responsible party . . . document in the nurses notes . . . notify your supervisor . . . notify oncoming nurse . . ." -Review of Resident #29's medical record occurred on all days of survey. The nursing progress notes identified the following: * On 08/20/21 at 04:18 p.m., ". . . an administrative staff (#2) noted . . . Resident did share she has had pain occasionally within the past 5 days on her head . . . rated the pain as mild . . . informed the charge nurse (#2) of residents pain . . ." * On 08/20/21 at 6:24 p.m., ". . . Resident voices headache . . . Tylenol given for pain . . ." * 08/20/21 at 08:51 p.m., ". . . Resident rated pain a 3 on pain scale . . ." A facility incident report completed 08/20/21 at 12:00 p.m. described the following: ". . . a staff member (#3), presents to nurse following her assessment with Resident (#29) where resident reported her head hurts from the fall she had in the bathing room. There is no charting about this incident that staff (#3) saw so she brought it to Nurse (#7) attention. I questioned resident and she reports it happened 'a few days ago in the bathing room' and she hit her head and has a bump. Nurse (#7) assessed resident's head and no bump noted however she does report tenderness to back right side of head. The bath aide (#5) that gave Resident #29 a bath was not here today to verify information, but another CNA	F 580	at the September 2nd CNA meeting and Sept 9th Nurses meeting. NCC Accident/Near Miss Investigation policy will be updated and educated on with staff at the October 11 and 12th CNA and Nurses meetings, in addition education will be provided on NCC's neuro-check policy. Maintenance supervisor will develop a policy on equipment maintenance and documentation of work completed due to resident no. 29 incident involving a whirlpool tub. 4. NCC will monitor resident no. 29 and a random sample of residents for proper completion/action with incident and near miss reports monthly starting in October x 3, then quarterly by an office nurse or QA Coordinator. When QA is being completed any concerns will be reported to the DON to address with staff immediately. QA data will be reviewed by the QA committee and board of directors meeting monthly. DON reviews the QA data at monthly staff meetings and re-educates as needed. Maintenance Supervisor will monitor his documentation list of equipment repairs monthly starting in October x 3, then quarterly. QA data will be reviewed at monthly QA committee meeting and board meeting.	

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F 580	Continued From page 3 (#8) here today was aware of the incident because the bath aide told her Tuesday (sic) what had happened. Appears the bathing chair wasn't completely connected when bringing chair out of the tub to the bath stand with wheels so the black plastic seat ended up falling when it got to the connecting point and resident hit her head . . . no documentation noted in the chart of the incident." A timeline report provided by the facility administrative nurse (#1) of the incident identified the following: * On 08/16/21, ". . . Resident #29 was in the bathing room finishing her bath when staff (#5) brought the chair out of the tub and it did not latch on the rail, causing the resident to be unsteady/jerk . . . the staff (#5) stating she was unaware of resident hitting her head, or did not see it happen . . .the staff (#5) did not report the incident to the nurse (#6) on duty . . . reported it to maintenance (#4) . . . another CNA [certified nursing assistant] (#8) told the staff nurse (#6) . . . the nurse did not write up any notes/incident at this time. . . " * On 08/20/21 at 5:25 p.m., ". . . a staff member, (#3) indicated in the report following the assessment with Resident #29 . . . resident reported her head hurt from the fall in the bathing room . . . there is no charting about this incident . . . it was brought to staff member (#9) attention . . . staff member (#3) questioned the resident and resident reports it happened a few days ago in the bathing room . . . staff nurse (#7) assessed resident's head and no bump noted however she does report tenderness to the back right side of head . . ."	F 580		

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F 580	Continued From page 4 During an interview on 09/15/21 at 10:30 a.m., an administrative staff (#1) acknowledged staff failed to notify Resident #29's physician and/or resident representative.	F 580		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:	F 609		10/19/21

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F 609	Continued From page 5 Based on record review, review of the facility policy and staff interview, the facility failed to report a violation involving potential neglect immediately to the State Survey Agency and the results of the investigation within five working days for 1 of 1 sampled resident (Resident #29) who experienced an injury of unknown origin. Failure to identify Resident #29's injury may have resulted from neglect, report the incident, and report the results of the facility's investigation to the State Survey Agency per the facility's policy, placed Resident #29 and other residents at risk for possible neglect and/or injury. Findings include: Review of the facility policy titled, "ABUSE POLICY" occurred on 09/15/21. This policy, revised September 2017, stated, ". . . NEGLECT: Means . . . it includes failure to carry out resident services as directed or ordered by the physician or other authorized personnel, failure to give proper attention to resident or failure to carry out resident services through careless oversight . . . any facility staff witnessing or possessing knowledge of any act or suspected act involving neglect . . . including injuries of unknown source . . . must immediately notify the charge nurse, who will then contact the Director of Nursing . . . all allegations must be reported to the Department of Health . . . no later than two hours . . . all allegations must be thoroughly investigated . . . final written investigation results will be submitted to the Department of Health within five working days . . ." Review of facility policy titled "Accident and Near Miss Investigation" occurred on 09/15/21. This	F 609	NCC will report any allegations of abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, immediately, but no later that 2 hours after the allegation is made, if the events that cause the allegation involve abuse, or result in serious bodily injury, or no later than 24 hours if the the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administration (including to the state survey agency and adult protective services where state law provides jurisdiction in long term care facilities) in accordance with state law through established procedures. 1. Resident no. 29 will have timely investigations of incident occurrences. Any incident with concern of abuse/neglect will be reported within 2 hours to the administrator and state health department, and a completed investigation report with abuse findings will be submitted within 5 days to the state health department. 2. All residents will have timely investigations with all incidents and near miss occurrences. Any incidents with concern of abuse/neglect will be reported within 2 hours to the administrator and the state health department. A final investigation report will be completed and submitted within 5 days to the state health department. 3.Education will be provided at the October 11 and 12th nursing/CNA staff meetings on abuse investigations and	

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F 609	Continued From page 6 policy, revised August 2010, stated, ". . . An accident/incident/near miss is defined as any unusual happening that may or does cause physical harm to a resident . . . All maintenance problems noted in the facility are potential safety hazards and therefore are treated as near-miss incidents . . . all of the above should be reported immediately to supervision . . . recommendations for prevention/correction are required . . . every accident/near miss will be investigated . . . reported to the immediate supervisor within 10 minutes . . . supervisor required to fill out an ACCIDENT/INCIDENT REPORT." During an interview on 09/15/21 at 11:02 a.m., an administrative nurse (#1) confirmed the facility's failure to identify Resident #29's injury may have resulted from neglect and therefore failed to report the incident to the State Survey Agency, complete a thorough investigation, and report the results of their investigation to the State Survey Agency. Refer to F580	F 609	policy of reporting to the state health department. 4. NCC will monitor resident no. 29 and a random sample of residents who have incident reports completed, that the investigation was done timely and reported to the administrator and state health department per policy monthly x 3, then quarterly by an office nurse or QA coordinator. When QA is being completed, any concerns will be immediately reported to DON. QA data is reviewed monthly by the QA committee and the board of directors. DON reviews the QA data at monthly staff meetings and re-educates as needed.	