STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355076	A. BUILDING _____ B. WING _____	05/31/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHWOOD DEACONESS HEALTH CNT	4 N PARK ST NORTHWOOD, ND 58267

(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 05/29/18 and concluded 05/31/18,	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal	F 550		7/5/18

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

Electronically Signed | 06/13/2018

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F 550	Continued From page 1 from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to provide care in a manner that maintained or enhanced resident dignity for 3 of 6 sampled residents (Resident #6, #16, and #28) observed during toileting. Failure to provide privacy during personal cares does not enhance residents' dignity. Findings include: Review of the facility policy titled "Promoting/Maintaining Resident Dignity" occurred on 05/31/18. This policy, dated February 2014, stated, ". . . It is the practice of NDHC [Northwood Deaconess Health Center] to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect. . . . PROCEDURE . . . Maintain resident privacy. . . ." - On 05/29/18 at 11:57 a.m., two certified nursing assistants (CNAs) (#3 and #4) assisted Resident #16 to the bathroom. Observation showed the bathroom door was open and faced toward the window, which had open blinds. The CNAs gave the resident his call light and left the room. When Resident #16 pulled his call light, the CNA	F 550	To assure that residents #6, #16, and #28 privacy is respected and to assure that all of our residents privacy is respected, we will review and update the policy titled Promoting/Maintaining Resident Dignity. Nursing staff will be given a copy of the updated policy for education. This will be completed by 7-5-2018. We will also monitor resident #6, #16, and #28 weekly for one month to ensure care is provided in a manner that maintains and enhances their dignity. QA will be monitored by a nursing professional and reported to the QAPI committee. A nursing professional will then continue to monitor dignity QA weekly on 3 residents for 1 month, then quarterly thereafter until compliance is determined, for a minimum of 6 months. The QA data will be reported to and reviewed by the QAPI committee on a monthly basis. In addition, the annual CNA skills evaluation for competency: Resident Care Audit form has been updated to ensure resident privacy compliance checks for the closure of privacy curtains, resident room doors, window blinds, and bathroom doors.	

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F 550	Continued From page 2 re-entered the room and closed the blinds at that time. - On 05/30/18 at 4:46 p.m., a CNA (#6) assisted Resident #28 to the bathroom. Observation showed the bathroom door was open and faced toward the window, which had open blinds. - On 05/30/18 at 5:21 p.m., a CNA (#5) assisted Resident #6 to the bathroom. Observation showed the bathroom door was open and faced toward the window, which had open blinds. During an interview on the morning of 05/31/18, a supervisory nurse (#1) agreed staff should shut the bathroom door or close the blinds to provide privacy.	F 550		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the	F 578		7/5/18

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F 578	Continued From page 3 resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure the medical record for 2 of 12 sampled residents (Resident #13 and #134) accurately reflected the resident's Advanced Directive regarding code status. Failure to ensure the resident's medical record accurately reflected their wishes limited emergency personnel from knowing the residents' wants in the event of a medical emergency. Findings include: - Review of Resident #13's medical record occurred on all days of survey. The electronic health record and the face sheet in the paper	F 578	Residents #13 and #134 medical records were reviewed and updated to assure the correct code level is consistent in all areas. To assure that all residents have the accurate code level on their charts, all charts were reviewed to ensure consistency throughout the face sheets, physician order, and facility code level paper form, no further discrepancies were noted. A new LTC admission checklist has been developed which gives reminders to, the Ward secretary/CNA, Medication Nurse, and Charge Nurse, different checks in assuring the code level is consistent throughout the resident	

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F 578	Continued From page 4 chart identified code level 1 (full code). This was inconsistent with the physician order and a facility form located in the paper chart, signed and dated by the resident on 03/14/18, which identified, code level 2 (no CPR [cardio pulmonary resuscitation]). The admission Minimum Data Set (MDS), dated 03/15/18, identified Resident #13 as cognitively intact. - Review of Resident #134's medical record occurred on all days of survey. The electronic health record and face sheet in the paper chart identified code level 1 (full code). A facility form in the paper chart, dated 05/23/18, identified a full code. A second facility form in the paper chart, dated 05/26/18, identified code level 2 (no CPR). The facility failed to ensure the code level status was consistent in all areas of the medical record and accurately reflected the residents' current wishes.	F 578	chart. Code status on the resident□s face sheets will also be reviewed each resident□s care conference, any discrepancy noted between the face sheet, physician orders, and facility code level sheet will immediately be corrected by Social Services or a Nursing Professional. A Nursing professional will monitor code level consistency on 3 resident charts per month for 3 months, then quarterly thereafter until compliance is determined, for a minimum of 6 months. This data will be submitted and reviewed by the QAPI committee on a monthly basis.	
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, review of facility policy, record review, and staff interview, the facility	F 689	To assure that residents #28 will not be at risk for falls and/or injuries due to	7/5/18

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F 689	Continued From page 5 failed to provide adequate supervision and assistive devices necessary to prevent accidents for 1 of 1 sampled resident (Resident #28) observed during a sit to stand lift transfer. Failure to use the sit to stand lift appropriately placed the resident at risk for falls and injury. Findings include: Review of the facility policy titled "Safety Training" occurred on 05/31/18. This undated policy stated, ". . . EZ Stand [sit to stand mechanical lift] (residents need to be able to bear weight in order to use the EZ Stand) . . . wheelchair . . . using the hand control, raise the resident slightly and position the seat strap underneath the buttocks then lift resident into a standing position. . . . Use of the seat strap: Always use the seat strap . . . when toileting with the seat strap in place you loosen the seat strap as you lower them to the toilet, then slide the seat strap up over top of the buttocks to mid back & lower clothing . . ." Review of Resident #28's medical record occurred on all days of survey. The care plan stated, ". . . I have mobility issues and I am unable to transfer without staffs assist. . . . Approach: EZ Stand for all transfers . . ." The most recent Minimum Data Set (MDS), dated 05/12/18, identified extensive assistance from one person for transfers, unsteady balance, and upper and lower extremity range of motion impairment. Observation on 05/30/18 at 10:32 a.m. showed a certified nursing assistant (CNA) (#7) transferred Resident #28 to and from the toilet using a sit to	F 689	improper use of the sit to stand lift, resident #28 will be monitored weekly, by a nursing professional, for one month. Prior to July 5, 2018, all other residents, who currently use the sit to stand lift, will be monitored once by a Nursing professional, for correct use of the sit to stand lift for transfers. A Nursing professional will monitor sit to stand lift transfers, for correct and safe techniques, weekly on 2 residents for 1 month, then quarterly thereafter until compliance is determined, for a minimum of 6 months. All QA data will be reported to and reviewed by the QAPI committee on a monthly basis. All active CNA□s will be monitored, by a Nursing professional prior to July 5, 2018, on the proper use of the sit to stand lift for transfers. Competency will also be evaluated on an annual basis, the form Competency: Sit to Stand Lift Transfer has been added to the Annual CNA□s Skills evaluation packet and is the form that will be used to monitor all active CNAs. In addition, nursing staff will be provided with a copy of the Proper Positioning of Seat Strap educational hand out.	

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F 689	Continued From page 6 stand lift without the seat strap in place. Observation showed the resident did not stand up straight, and his knees were bent at a 90 degree angle. Observation on 05/30/18 at 4:46 p.m. showed a CNA (#6) assisted Resident #28 to the toilet. The CNA used the seat strap, but placed it under the resident's mid thighs. Upon completion of toileting, the CNA transferred the resident to his wheelchair. During the transfer, the resident's feet were several inches off the platform (i.e., not bearing weight) and the seat strap remained in place under the resident's mid thighs. Observation also showed the resident's knees were bent at a 90 degree angle and his shoulders shrugged upward. During an interview on 05/31/18 at 11:49 a.m., a supervisory nurse (#1) stated she expected staff to use the seat strap with all transfers, and staff should place it under residents' buttocks, not under their thighs.	F 689		
F 700 SS=E	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of	F 700		7/5/18

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F 700	Continued From page 7 bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy review, and staff interview, the facility failed to attempt appropriate alternatives to bed rails, assess resident safety with the use of bed rails, review risks and benefits with the resident/representative, and obtain informed consent prior to installation for 4 of 4 sampled residents (Resident #18, #23, #26, and #31) assessed for side/bed rail use. These failures did not allow the resident/representative to make an informed decision and increased the residents' risk of injuries from the bed rails. Findings include: Review of the facility policy titled "Side Rails" occurred on 05/31/18. This policy, revised 09/17/12, stated, ". . . 5. Resident, family, guardian should be educated regarding risks and benefits of side rail use. . . . 7. The use of side rails will be re-evaluated quarterly . . . considering reducing side rail use and reducing risks associated with the rail use. 8. Use of side rails will also be re-evaluated with any injury or potential injury involving side rails . . . 10. Side rails will be monitored for safety hazard . . .	F 700	Residents #18, #23, #26, and #31 will be re-assessed for bed rails with documentation to include: attempted alternatives to the rails, the completed assessment for safety and appropriate use of the rails, explained risks/benefits of the rails (to include risk of entrapment), and/or obtained consent from the resident /resident representative for the use of bed rails. This will be completed by July 5, 2018. N.D.H.C. has revised its current Side Rail policy and its Bed Rail Assessment form, and has also developed a Bed Rails Informed Consent for use form. The bed rail assessment will continue to be performed upon admission, quarterly, and on an as needed basis. Bed Rails Informed Consent for use form will be implemented for all residents whom are utilizing bed rails. Implementation of the new process will occur as resident are admitted, or for current residents, as their quarterly assessment is due, or on an as needed basis. To assure all residents whom are utilizing bed rails have the appropriate	

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F 700	Continued From page 8 following any occurrence involving a side rail . . ." On all days of survey, observation showed Resident #18, #23, #26, and #31's beds with side/bed rails attached to and elevated on one or both sides of the head of the bed. Review of the above listed residents' medical records occurred on all days of survey. The records showed Resident #18, #23, #26, and #31's current care plans included the use of bilateral top half rails to aid in transfers and/or bed positioning. Facility staff completed a quarterly side/bed rail assessment for each resident which addressed the reason staff instituted the bed rails and whether or not the rails were a restraint. The residents' records failed to show evidence staff attempted alternatives to the rails, completed an assessment for safety and appropriate use of the rails, explained the risks/benefits of the rails, including a risk of entrapment, or obtained consent from the resident/resident representative for the use of the side/bed rails. During an interview on 05/31/18 at 10:40 a.m., two administrative nurses (#1 and #2) stated the facility's side/bed rail assessment lacked an assessment related to the risk of entrapment and staff failed to obtain informed consent for the use of the rails from the resident and /or resident representative.	F 700	documentation present on their charts, a nursing professional will monitor 3 resident charts monthly, for 3 months for accuracy of documentation, then quarterly thereafter until compliance is determined, for a minimum of 6 months. This data will be submitted and reviewed by the QAPI committee on a monthly basis.	