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 _____	C 09/25/2024

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 and complaint survey started on 09/23/24 and concluded 09/25/24. The issues identified by the complainant were found to be in compliance with regulatory requirements.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.18.11), and staff interview, the facility failed to ensure accurate coding of the Minimum Data Set (MDS) for 2 of 9 sampled residents (Resident #7 and #17). Failure to accurately complete the MDS does not allow each resident's assessment to reflect their current status/needs and may affect the accurate development of a comprehensive care plan and the care provided to the residents. Findings include: SECTION I: ACTIVE DIAGNOSES The Long-Term Care Facility RAI User's Manual, revised October 2023, pages I-7 to I-8, stated, ". . . Code diseases that have a documented diagnosis in the last 60 days and have a direct relationship to the resident's current functional status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of	F 641	To ensure all 18 residents at NDHC are receiving Accuracy of Assessments, in terms of accurately completing an MDS, a thorough review of 9 residents' MDS section I and section M has been completed by two nursing professionals. The other 9 residents' MDS reviews took place by the state survey team from 9/23/24 to 9/25/24. Of the 9 MDSs reviewed by the state survey team, 2 records were found to have inaccuracies reported in section I and section M. Those inaccuracies were immediately corrected, the inaccuracies did not affect residents' payments, the correct MDSs were immediately submitted to the CMS QIES Assessment Submission and Processing Systems and to the N.D. Department of Human Services. To ensure that the residents of NDHC are receiving Accuracy if Assessments, in terms of accurately completing an MDS, QA measures will be put into place.	10/10/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/16/2024

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F 641	Continued From page 1 death during the 7-day look-back period. . . ." Review of Resident #17's medical record occurred on all days of survey. The annual MDS, dated 08/27/24, identified a multi-drug resistant organism (MDRO) infection as an active diagnosis. Resident #17's medical record lacked documentation of an MDRO in the past 60 days. SECTION M: SKIN CONDITIONS The Long-Term Care Facility RAI User's Manual, revised October 2023, pages M-8 stated, "M0300: Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage . . . Determine "Present on Admission" For each pressure ulcer/injury, determine if the pressure ulcer/injury was present at the time of admission/entry or reentry and not acquired while the resident was in the care of the nursing home. Consider current and historical levels of tissue involvement. 1. Review the medical record for the history of the ulcer/injury. 2. Review for location and stage at the time of admission/entry or reentry. Pages M-12 through M-13 stated, ". . . M0300B: Stage 2 Pressure Ulcers . . . Steps for Assessment . . . Identify the number of these pressure ulcers that were present on admission/entry . . . Coding Instructions for M0300B . . . M0300B1 . . . Enter the number of pressure ulcers that are currently present and whose deepest anatomical stage is Stage 2 . . . M0300B2 . . . Enter the number of these Stage 2 pressure ulcers that were first noted at the time of admission/entry . . . Enter 0 if no Stage 2 pressure ulcers were first noted at the time of admission/entry or reentry. . . ."	F 641	Starting in November 2024, a nursing professional will review 3 random resident MDSs, section I and section M, to ensure accuracy of coding. This review will occur monthly x 3 months, then resident MDS section I and section M will be reviewed x 1 month, and then 1 resident for MDS section I and M will be reviewed monthly thereafter until compliance is determined for a minimum of 6 months. The QA data will be reported to the QAPI committee monthly.	

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F 641	Continued From page 2 Review of Resident #7's medical record occurred on all days of survey. A nursing progress note, dated 06/17/24 at 8:35 p.m., stated, ". . . Skin assessed: . . . Mepilex [a protective dressing] intact to right Heel [sic] wound noted with minimal yellow drainage, no tunneling, no eschar [a scab like covering over wounds], no slough [dead tissue] noted, surrounding tissue intact. . . ." The quarterly MDS, dated 06/23/24, identified one stage 2 pressure ulcer, present on admission. During an interview on 09/25/24 at 8:30 a.m., an administrative nurse (#9) confirmed Resident #7's pressure injury was acquired in the facility. She also confirmed Resident #17 did not have an active MDRO infection and staff failed to code Resident #7 and #17's MDSs correctly.	F 641		
F 868 SS=D	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c) §483.75(g) Quality assessment and assurance. §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (iv) The infection preventionist. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's	F 868		10/15/24

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F 868	Continued From page 3 governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (i) Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects required under the QAPI program, are necessary. §483.80(c) Infection preventionist participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is not met as evidenced by: Based on review of Quality Assurance and Performance Improvement (QAPI) meeting minutes, facility policy, and staff interview, the facility failed to ensure participation by the medical director for a minimum of quarterly of the facility's monthly meetings from January 2024 to September 2024. Failure to ensure the medical director participates in the facility's Quality Assurance activities deprived the committee of the physician's unique contributions for analyzing and correcting problems with identified resident care areas. Findings include: Review of the facility policy titled, "Quality	F 868	To obtain compliance, the NDHC facility policy for Quality Assessment and Assurance Committee has been updated to include the current process: Report quarterly QAPI data to Medical Staff Chart Review members, which includes the Medical Director. Verbiage within the NDHC Quality Assurance and Performance Improvement Plan has also been adjusted to state: The Quality Committee may be held in conjunction with the medical staff chart review committee. This committee is chaired by the Medical Director. The committee will meet on at least a quarterly basis and as often as necessary to conduct its	

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F 868	Continued From page 4 Assurance and Performance Improvement" occurred on 09/25/24. This policy, revised October 2022, stated, ". . . The facility will maintain a Quality Assessment and Assurance (QAA) Committee to identify quality issues and develop appropriate plans of action to correct quality deficiencies through a interdisciplinary approach. . . . The QAA committee will be composed of, at a minimum: . . . The Medical director or his/her designee. . . . " Review of QAPI meeting minutes occurred on 09/25/24. The QAPI meeting minutes failed to identify the medical director attended a meeting from January - September 2024, or reviewed meeting minutes. During an interview on 09/25/24 at 3:40 p.m. an administrative staff member (#1) confirmed the medical director failed to attend meetings and there is no process for the medical director to acknowledge the meeting minutes.	F 868	business. The medical staff chart review committee reviews the QAPI data, can discuss individual quality indicators and concerns, and approves the quarterly QAPI report. The NDHC Medical Director has read and acknowledged understanding of the NDHC facility policy on Quality Assessment and Assurance Committee and is aware of the QAA committee's requirement of the Medical Director's participation, for a minimum of quarterly, of the facility's monthly meetings. The Medical Director agrees to attend, at least quarterly, as stated in the policy. The Medical Director was in attendance of the QAPI meeting on 10/15/2024. To ensure participation by the Medical Director for a minimum of quarterly of the facility's monthly meetings, participation will be monitored by a nursing professional and reported to the QAPI committee. QA will take place monthly for 6 months, it will be based on attendance of the Medical Director as reported in monthly meeting minutes. A nursing professional will then continue to monitor the Medical Director's participation quarterly until compliance is determined for a minimum of 6 months. This QA data will be reported to the QAPI committee monthly.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control	F 880		10/23/24

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F 880	Continued From page 5 The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 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:	F 880		

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F 880	Continued From page 6 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to follow standards of infection control and prevention for 3 of 9 sampled residents (Resident #5, #7, and #18) observed during cares. Failure to practice infection control standards related to enhanced barrier precautions and hand hygiene has the potential to spread infection throughout the facility.	F 880	To ensure that resident #5, #7, #18, and other potential residents receive proper Infection Prevention and Control standards, related to hand hygiene and enhanced barrier precautions, the facility will educate the LTC nursing staff in the following way. The LTC nursing staff will be expected to read and review the following policies: Hand Hygiene and Enhanced Barrier Precautions. The	

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F 880	Continued From page 7 Findings include: Review of the facility's policy titled "Enhanced Barrier Precautions" occurred on 09/25/24. This policy, revised 03/21/24, stated, ". . . Enhanced Barrier Precautions (EBP) expand the use of PPE [personal protective equipment]. . . refers to the use of gown and gloves during high-contact care activities. . . for transfer of Novel or Targeted MDRO's [multi drug resistant organisms] to staff hands and clothing. . . . EBP are indicated for residents with any of the following: Infection. . . Wounds/and or indwelling medical devices. . .Wear gloves and a gown for the following High-Contact Resident Care Activities: Dressing, Bathing/Showering, Transferring, Changing Linens, Providing Hygiene, changing briefs or assisting with toileting. . . Device care or use: . . . Urinary Catheter. . . Wound Care: any skin opening requiring a dressing. . . ." Review of the facility's policy titled "Hand Hygiene" occurred on 09/25/24. This policy, dated 07/20/23, stated, ". . . Hand hygiene will be performed by employees. . . Upon entering or leaving the patient/resident care area, isolation precautions. . . Before direct contact with patients. . . After contact with patient's intact skin, body fluids or excretions, mucous membranes. . . and wound dressings. . . Moving from contaminated body site to clean body site during patient care. . . After contact with contaminated surfaces and/or objects/medical equipment in the immediate vicinity of the patient. . . Donning . . . gloves. . . After removing gloves. . . ." - Review of Resident #5's medical record occurred all days of survey. The medical record	F 880	nursing staff will also be expected to read and review the handout titled "Your 5 Moments of Hand Hygiene". Acknowledgement of this education by the nursing staff will be complied with a signature page by October 23, 2024. Starting on October 16, 2024, residents #5, 7, and 18 will be monitored on the day shift and on the evening shift for 3 consecutive dates, to ensure that infection prevention and control standards are being met related to hand hygiene and enhanced barrier precautions. We will then continue to monitor residents #5, 7, 18, and two other random residents weekly for one month to ensure the residents are receiving proper Infection Prevention and Control standards related to hand hygiene and enhanced barrier precautions. QA will be monitored by a Nursing Professional and reported to the QAPI committee. A Nursing Professional will then continue to monitor, on a weekly basis, for proper Infection Prevention and Control standards related to hand hygiene and enhanced barrier precautions, on one random resident for one month, and then once quarterly on one random resident thereafter until compliance is determined for a minimum of 6 months. The QA data will be reported to the QAPI committee monthly.	

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F 880	Continued From page 8	F 880		

identified a physician's order to transfer the resident with a full body lift and assist of two.

Observation on 09/24/24 at 9:24 a.m. showed two certified nurse aides (CNAs) (#6 and #7) performed hand hygiene and donned gloves prior to transferring Resident #5 from the wheelchair to the bed to provide incontinent cares after a bowel movement. While providing cares, a CNA (#6), without removing the soiled gloves, retrieved new pants from the closet, opened a bedside table drawer to retrieve wipes, and retrieved a garbage bag. The CNA (#6) removed the soiled gloves, and without performing hand hygiene, applied clean gloves and finished dressing Resident #5. Both CNAs (#6 and #7) transferred the resident back to the wheelchair. The CNA (#7) removed soiled gloves, and without performing hand hygiene, exited the room.

- Review of Resident #7's medical record occurred on all days of survey and identified an open stage two pressure ulcer to the right heel.

Observation on 09/23/24 at 4:05 p.m. showed an EBP sign and supply cart outside of Resident #7's room. A CNA (#4) donned a gown and gloves and took a full body mechanical lift into the room. A nurse (#2) entered the room without donning a gown or gloves and both staff transferred Resident #7 from the wheelchair to the toilet with the full body mechanical lift.

The nurse (#2) failed to don appropriate PPE to transfer a resident on EBP.

- Review of Resident #18's medical record

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F 880	Continued From page 9 occurred on all days of survey and identified a surgical wound dressing to the left hip. Observation on 09/24/24 at 10:30 a.m. showed an EBP sign and a supply cart outside of Resident #18's room. While in the bathroom, the CNA (#7) performed morning cares and handed a wet washcloth to the resident to wash his face. The CNA (#7) then removed her gloves, and failed to complete hand hygiene or don clean gloves, took the washcloth from the resident, wet/applied more body wash, and continued to wash Resident #18's back, chest, both underarms with ungloved hands, and then dried the areas. The CNA (#7) continued cares, without performing hand hygiene and/or donning gloves, shaved Resident #18 with an electric razor, and dressed Resident #18. During an interview on the morning of 09/25/24, an administrative nurse (#3) stated he expected staff to don PPE and perform hand hygiene per policy.	F 880		