STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355122	A. BUILDING _____ B. WING _____	01/15/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHARDTON HEALTH CENTER INC	8885 HIGHWAY 10 RICHARDTON, ND 58652

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F 000	INITIAL COMMENTS The Standard Medicare/Medicaid recertification survey started on January 13, 2020 and concluded on January 15, 2020.	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 observation, review of facility policy, and staff interview, the facility failed to follow professional standards of practice for 2 of 2 observations (morning and afternoon on 01/14/20) of insulin administration. Failure to correctly prime and administer insulin via flexpen has a potential for the resident to receive an inaccurate dose of insulin. Findings include: Review of the facility policy titled "Insulin Pen" occurred on 01/17/20. This policy, revised April 2019, stated, ". . . Attach safety pen needle: . . . Twist open and remove outer cover from the safety pen needle . . . Prime the insulin pen . . . With the needle pointing up, push the plunger, and watch to see that at least one drop of insulin appears on the tip of the needle. If not, repeat until at least one drop appears. . . . Injecting the insulin: . . . Fully depress the plunger until the dosing numbers count back to zero. . . . While still pressing the plunger, keep the needle in the skin for up to 6-10 seconds and then remove the	F 658	1.F – 658 a.Plan of Correction: i.For resident #11 the director of nursing or her designee will review the resident's A1C and continue to monitor per provider to ensure insulin levels are acceptable and make changes as directed by the physician. ii.All residents who have a diagnosis of diabetes and receive insulin via Insulin Pen as of January 15, 2020 will be reviewed by the director of nurses and the attending physician to ensure blood glucose levels remain within ordered parameters. If blood glucose levels are outside of parameters, the attending provider will be notified to adjust. iii.The director of nursing or her designees shall do the following: to review and revise policy and procedure	2/19/20

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

Electronically Signed | 01/30/2020

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 658	Continued From page 1 needle from the skin. . . ." - Observation on the morning of 01/14/20 showed a licensed nurse (#1) set up and administered Humalog insulin via flexpen to Resident #11. The nurse (#1) primed the insulin pen with the cap on while holding the pen horizontally and failed to keep the needle in the skin for 6 -10 seconds. - Observation on 01/14/20 at 12:15 p.m. showed a licensed nurse (#1) set up and administered Humalog insulin via flexpen to Resident #11. The nurse (#1) primed the insulin pen holding it downward and failed to keep the needle in the skin for 6 -10 seconds. During an interview on 01/15/20 at 10:51 a.m., an administrative nurse (#4) confirmed staff failed to correctly prime the insulin pen.	F 658	as titled, Insulin Pen; the policy will communicate correct procedure for administering insulin through an insulin pen; and to educate all appropriate staff that administer insulin. The deficient practice will be corrected on or before February 19, 2020; the documentation, review, and adoption will be discussed with the attending physicians; and to conduct and document an in-service on or before February 19, 2020 for all staff to be informed and educated on this deficiency and plans to address. iv.Date of completion: February 19, 2020. v.Through the QAPI program the director of nursing or her designees shall be responsible for the following: To develop a QA monitor to monitor the following of the Insulin Pen policy; to monitor and report initially documenting compliance in addressing this deficiency; to monitor and report at least weekly for the first four weeks then monthly for the first six months then quarterly for two quarters or until 100% compliance is achieved; then to monitor and report thereafter as appropriate.	
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	F 880		2/19/20

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F 880	Continued From page 2 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 §483.70(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	F 880		

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F 880	Continued From page 3 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 and review of the facility policy, the facility failed to follow infection control practices for 1 of 5 sampled residents (Resident #7) and one supplemental resident (Resident #9) observed during personal cares. Failure to follow infection control practices for hand hygiene has the potential to spread infection to other residents, personnel, and visitors. Findings include: Review of the facility policy titled "Hand Hygiene" occurred on 01/15/20. This policy, dated October 2019, stated, ". . . Hand hygiene is indicated and will be performed . . . after removing personal	F 880	F – 880 a.Plan of Correction: i.For resident #7 and resident #9 an infection log will be completed by the director of nursing or her designee if there are any abnormal findings the attending physician will be notified. All nursing staff will be educated on proper hand hygiene. Communication regarding infections logs and education will be completed on or before February 19, 2020. ii.All residents have the potential to be	

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F 880	Continued From page 4 protective equipment (PPE), including gloves . . . After assistance with personal body functions (e.g., elimination . . ." - Observation on 01/13/20 at 12:03 p.m. showed two certified nursing assistants (CNAs) (#5 and #6) assisted Resident #7 off the toilet after having a small bowel movement. The CNA (#5) performed perineal care, removed her gloves, applied a clean brief and assisted Resident #7 into the wheelchair. Without performing hand hygiene, the CNA (#5) unlocked the wheelchair brakes, adjusted the resident's clothing, covered the resident with a blanket, combed the resident's hair, collected the garbage and performed hand hygiene. The CNA (#5) failed to perform hand hygiene after completing perineal care, prior to completing other tasks. Observation on 01/14/20 at 9:52 a.m. showed two CNAs (#2 and #3) assisted Resident #7 off the toilet. The CNA (#3) performed perineal care, removed her gloves, and assisted Resident #7 into bed. Without performing hand hygiene, the CNA (#3) positioned Resident #7 in bed, gave the resident her call light and performed hand hygiene. The CNA (#3) failed to perform hand hygiene after completing perineal care, prior to completing other tasks. - Observation on 01/14/20 at 9:33 a.m. showed two CNAs (#2 and #3) provided incontinence care to Resident #9. The CNA (#2) removed the resident's brief, performed perineal care, placed a new brief, removed her gloves, and transferred Resident #9 from the bathroom to the wheelchair using a sit-to-stand lift. Without performing hand hygiene, the CNA (#2) removed the mechanical	F 880	affected. All resident infections will be monitored, and findings will be communicated to the attending physician for acceptable treatment. Communication regarding infections will be completed on or before February 19, 2020. iii.The director of nursing or her designee shall do the following: to review and revise policy and procedure as appropriate, as titled Hand Hygiene; the deficient practice will be completed on or before February 19, 2020; the documentation, review, and adoption will be discussed with the attending physicians; and to conduct and document an in-service on or before February 19, 2020 for all staff to be informed and educated on this deficiency and plans to address. iv.Date of completion: February 19, 2020 v.Through the QA program the director of nursing or her designee shall be responsible for the following: To develop a QA to monitor following of the Hand Hygiene policy; to monitor and report initially documenting compliance in addressing this deficiency; to monitor and report at least weekly for the first four weeks then monthly for the first six months then quarterly for two quarters or until 100% compliance is achieved; then to monitor and report thereafter as appropriate.	

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F 880	Continued From page 5 lift sling, placed foot pedals on the wheelchair, donned gloves, wiped down the mechanical lift, removed her gloves and performed hand hygiene. The CNA (#2) failed to perform hand hygiene after providing perineal care, prior to completing other tasks.	F 880		