STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355109	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOURIS VALLEY CARE CENTER	300 MAIN ST S VELVA, ND 58790

(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 03/09/20 and concluded on 03/12/20.	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		4/16/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/14/2020

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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: MEAL SERVICE 1. Based on observation, review of facility policy, and staff interview, the facility failed to provide care in a manner and environment that maintained or enhanced and respected each resident's dignity for 1 of 2 meals observed (noon meal 03/09/20). Failure to sit at the residents level while assisting with meals does not preserve the residents' personal dignity or enhance their quality of life. Findings include: Review of the facility policy, "Dining Room Service" occurred on 03/11/20. This policy, revised November 2017, stated, ". . . If dining assistance is needed by a resident, employees are to sit next to the resident; do not stand and feed resident. . . ." - Observation of the noon meal on 03/09/20 showed the following: * A certified nurse assistant (CNA) (#13) served Resident #28's meal, cut up the pork chop, and encouraged him to eat. When the CNA (#13) noted Resident #28 stopped eating she stood next to the resident and fed him.	F 550	Preparation and execution of this response and plan of correction does not constitute an admission of agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. For the purpose of any allegations that the facility is not in substantial compliance with Federal requirements of participations, this response and plan of correction constitutes the facility□s allegation of compliance in accordance with section 7305 of the State Operations Manual. F550 1. All Certified Nursing Assistants and Licensed Nurses were re-educated on understanding/competency of sitting next to resident #28 as well as all residents when assisting them during meal times. All staff were re-educated on understanding/competency of knocking on resident #12, 29 door as well as introduction one□s self prior to entering residents room.	

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F 550	Continued From page 2 * A CNA (#11) stood while feeding Resident #241. * A CNA (#13) stood while feeding Resident #3. - During an interview on 03/11/20 at 02:10 p.m., an administrative nurse (#1) confirmed staff should not stand over residents while feeding them. FAILURE TO KNOCK 2. Based on observation, review of facility policy, and staff interview, the facility failed to provide care in a manner and environment that maintained, enhanced, and respected each resident's dignity and individuality for 2 of 10 sampled residents (Residents #12 and #29). Failure to respect residents' personal preferences and announce themselves and wait for permission prior to entering residents' rooms does not preserve the residents' personal dignity or enhance their quality of life and places them at risk of embarrassment and/or emotional harm. Findings include: Review of the facility policy titled "Resident Dignity" occurred on 03/11/20. This policy, revised February 2013, stated, ". . . to maintain the dignity of all residents . . . Respecting resident's private space . . . Knocking on doors and requesting permission to enter . . ." - Observation on 03/09/20 showed the following: * At 2:34 p.m., a certified nurse assistant (CNA) (#15) provided personal cares for Resident #12. A second CNA (#9) knocked on the resident's door and immediately entered the room. The	F 550	2. All residents who have a need for assistance with dining have the potential to be affected. All resident that reside in our facility have the potential to be affected. 3. All staff will be re-educated on providing resident dignity, by knocking on resident□s door and introducing one□s self prior to entering resident□s room. All Certified Nursing Assistants and Licensed Nurses will be re-educated on the proper procedure to provide resident dignity during the assist dining experience. 4. DNS or designee will complete resident dignity audits daily for one week, weekly for three weeks, bi-weekly for one month, and monthly for four months. Quality Assurance committee will review and monitor audits during monthly quality meeting. Quality Assurance committee will ensure compliance.	

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F 550	Continued From page 3 CNA (#9) failed to identify herself and wait for permission to enter the room. * At 10:14 a.m., an unidentified CNA provided personal cares for Resident (#29). A CNA (#14) knocked on the resident's door and immediately entered the room. The CNA (#14) failed to identify herself and wait for permission to enter the room. * At 12:02 p.m., two CNA's (#4 and #14) provided personal cares for Resident (#29). A nurse (#1) knocked on the resident's door and immediately entered the room. The nurse (#1) failed to identify herself and wait for permission to enter the room. -During an interview on 03/11/20 at 02:10 p.m., an administrative nurse (#1) stated she expects staff to knock on resident's door, identify themselves and wait for a response before entering.	F 550		
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in	F 623		4/16/20

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F 623	Continued From page 4 paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal	F 623		

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F 623	Continued From page 5	F 623		

hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).

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F 623	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to provide residents or their representatives and the State Long Term Care Ombudsman a written notice of transfer as soon as practicable for 1 of 6 sampled residents (Resident #31) transferred to the hospital from the facility. Failure to provide a notice of transfer does not allow residents to make informed decisions or inform the Ombudsman of the transfer. Findings include: Review of Resident #'31's medical record occurred on all days of survey. The record showed the facility transferred Resident #31 to an acute care hospital on 08/13/19. The record lacked evidence the facility completed a transfer form and/or sent a copy to the Ombudsman. During an interview on the afternoon of 04/11/19 an administrative staff member (#1) confirmed the facility failed to provide a copy of the transfer form.	F 623	1. 1. On 8/13/19 resident #31□s daughter was notified of transfer to hospital according to residents chart. Facility will re-educate nursing staff and social services on the requirements for written notice of transfers to ensure the resident is allowed to make informed decisions or inform the Ombudsman of the transfer. 2. All residents have the potential of being affected. 3. Licenses Nurses or Designee will completed transfer paperwork prior to resident being transferred from facility. 4. Social Services or designee will complete transfer audit weekly for one month, bi-weekly for one month and monthly for 4 months. Quality Assurance committee will review audits during monthly quality meeting. Quality Assurance committee will ensure compliance.	
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if	F 625		4/16/20

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F 625	Continued From page 7 any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to provide a bed hold notice upon transfer to the hospital for 1 of 6 sampled residents (Resident #31). Failure to provide a bed hold notice does not allow residents or their legal representatives to make informed choices regarding their readmission rights. Findings include: Review of Resident #31's medical record occurred on all days of survey and identified a hospital admission on 08/13/19. The record lacked evidence the facility completed a bed hold notice and /or provided Resident #31 and or his/her legal representative with the information.	F 625	1. On 8/13/19 resident #31□s daughter was notified of transfer to hospital according to residents chart. Facility unable to obtain bed hold for past incidents. 2. All residents have the potential to be affected. 3. All Licensed Nurses and Social Services will be re-educated on the policy of obtaining as bed-hold for any resident that is transfers out of the facility with intentions of returning. 4. Social Services or designee will complete bed hold audit weekly for one month, bi-weekly for one month and monthly for 4 months. Quality Assurance committee will review audits during	

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F 625	Continued From page 8 During an interview on the afternoon of 03/11/20 an administrative staff member (#1) confirmed the facility failed to provide the bed hold notice.	F 625	monthly quality meeting. Quality Assurance committee will ensure compliance.	
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review, review of the North Dakota Provider Manual for Preadmission Screening and Resident Review (PASRR), review of facility policy, and staff interview, the facility failed to complete a status change assessment for 1 of 1 sampled resident (Resident #26) with a newly diagnosed mental illness. Failure to complete a change in status assessment may result in the delivery of care and services inconsistent with residents' needs.	F 644	F 644 1. Resident #23 had a new Preadmission Screening and Resident Review completed on 3/10/20. 2. All residents have the potential to be affected. 3. Social Service will be re-educated on completing a new Preadmission Screening and Resident Review with any resident status change in mental health. Director of Nursing obtained access to be	4/16/20

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F 644	Continued From page 9 Findings include: The North Dakota PASRR Provider Manual states, ". . . Change in Status Process . . . Whenever the following events occur, nursing facility staff must contact Ascend to update the Level I screen for determination of whether a first time or updated Level II evaluation must be performed. These situations suggest that a significant change in status has occurred: . . . If an individual with MI, ID, and/or RC (Mental illness, intellectual disability, and conditions related to intellectual disability [referred to in a regulatory language as related conditions or RC]) was not identified at the Level I screen process, and that condition later emerged or was discovered. . ." Review of the facility policy titled "PASARR" occurred on 03/12/20. This policy revised, September 2017, stated, " . . . If the resident is diagnosed with a mental disorder while in the location, the social worker will contact the designated state agency for a Level II screening. . . " Review of Resident #26's medical record occurred on all days of survey. An initial PASARR, dated on 09/09/19 identified no major mental illnesses (MMI) and no PASARR II needed. A physician's order, dated 10/25/19, showed, " . . . New diagnosis . . . MAJOR DEPRESSIVE DISORDER, RECURRENT SEVERE WITHOUT PSYCHOTIC FEATURES . . . " During an interview on 03/10/20 at 4:02 p.m., a social services staff member (#12) confirmed the	F 644	able to assist Social Service in completing Preadmission Screening and Resident Review on residents with a change. 4. Social Service or designee will complete PASRR audit weekly for one month, bi-weekly for one month, and monthly for 4 months. Quality Assurance committee will review and monitor audits during monthly quality meeting. Quality Assurance committee will ensure compliance.	

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F 644	Continued From page 10 staff failed to complete the required Level I screening after the new diagnoses.	F 644		
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, review of facility skill checklist, and staff interview, the facility failed to follow professional standards of practice in priming of insulin pens for 2 of 3 observations (morning of 03/11/20) of insulin administration. Failure to correctly prime the insulin pen may result in residents to receiving an inaccurate dose of insulin. Findings include: Review of the facility policy and procedure titled "Insulin Pens" occurred on 03/11/20. This policy, revised March 2018, stated, ". . . Turn the dosage knob to '2'units to prime the pen. Holding the pen with the needle pointing upwards, press the button until at least a drop of insulin appears. . . ." Review of the facility skill checklist titled, "Insulin Pens Clinical Skill Checklist" occurred on 03/11/20. This checklist dated, March 2018, stated, ". . . Holding the pen with the needle pointing upwards, press the button until at least a drop of insulin appears. . . ." Observation on 03/11/20 at 8:05 a.m., showed a	F 658	F 658 1. Nurse #2 was re-educated on the proper procedure for priming insulin pens to prepare for insulin injections. 2. All residents who receive insulin injections have the potential to be affected. 3. All Licensed Nurses will be re-educated on the proper procedure of priming and insulin pen for injection. 4. DNS or designee will do an insulin pen priming audit daily for one week, weekly for three weeks, bi-weekly for one month, and monthly for four months. Quality Assurance committee will review and monitor audits during monthly quality meeting. Quality Assurance committee will ensure compliance.	4/16/20

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F 658	Continued From page 11 licensed nurse (#2) prepared an insulin pen for injection for Resident #141. The nurse removed the needle cover and primed the insulin pen in a horizontal position. Observation on 03/11/20 at 11:31 a.m., showed a licensed nurse (#2) prepared an insulin pen for injection for Resident #10. The nurse removed the needle cover and primed the insulin pen in a horizontal position. During an interview on 03/11/20 at 2:17 p.m., an administrative nurse (#1) confirmed the staff did not follow faciltiy policy, and failed to correctly prime the insulin pen.	F 658		
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, record review, review of facility policy, and staff interview, the facility failed to provide adequate assistive devices necessary to prevent accidents for 3 of 5 sampled residents (Resident #14, #20, #140) and one supplemental resident (Resident #142) observed during transfers. Failure to use a gait belt appropriately during transfers (Resident #14, #20, and #142), and failure to cue a resident (Resident #140) to use minimal weight bearing per care plan has the	F 689	F689 1. All Certified Nursing Assistances and Licensed Nurses will be re-educated on the proper use of a gait belt and safe resident handling with altered weight bearing status. 2. All residents who require staff assistance or have altered weight bearing status with transfers have the potential to be affected	4/16/20

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SOURIS VALLEY CARE CENTER	300 MAIN ST S VELVA, ND 58790

(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 689	Continued From page 12 potential to result in avoidable accidents and injury. Findings include: Review of the facility policy titled "Gait (Transfer) Belt" occurred on 3/12/20. This policy dated, October 2017, stated, ". . . Place the belt around the resident's waist over clothing. . . . Make sure the belt is securely buckled so it does not slide. . . . Do no use the pants/slacks. . . as a gait (transfer) belt. . . ." - Observation on 03/10/20 at 1:00 p.m. showed two certified nursing assistant's (CNAs) (#3 and #4) applied a gait belt to Resident #14 and assisted him to the toilet. During the transfer, both CNA's (#3 and #4) reached under the resident's arms and lifted him to a standing position. The CNA's (#3 and #4) failed to utilize the gait belt during the transfer. - Observation on 03/10/20 at 10:18 a.m. showed two CNAs (#5 and #6) applied a gait belt to Resident #142 and trasnferred him from the bed to the wheelchair. During the transfer, the CNA (#5) reached under the resident's arm and lifted him to a standing position. The CNA (#5) failed to utilize the gait belt during the transfer. -Review of Resident #20's medical record occurred on all days of survey. Diagnosis included low back pain, and osteoarthritis. Resident #20's care plan stated "Assist of 1 for transfers with gaitbelt and front wheel walker or assist bar/rail". - Observation on 03/09/20 at 10:49 a.m. showed	F 689	3. All Certified Nursing Assistances and Licensed Nurses will be re-educated on the Safe Resident Handling policy including proper use of a gait belt for transfers and how to transfer a resident with altered weight bearing status. 4. DNS or designee will do audit for proper safe resident handling daily for one week, weekly for three weeks, bi-weekly for one month, and monthly for four months. Quality Assurance committee will review and monitor audits during monthly quality meeting. Quality Assurance committee will ensure compliance.	

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F 689	Continued From page 13	F 689		

a CNA (#4) transferred Resident #20 into the tub room to use the commode. The CNA (#4) assisted Resident #20 to stand and transferred him/her on and off the commode. The CNA failed to utilize a gaitblet during the transfer.

Observation on 03/09/20 at 3:50 p.m. showed a CNA (#9) transferred Resident #20 into the tub room to use the commode. The CNA pulled the resident's brief and pants up while holding onto the resident's waistband and attempting to move the commode. Resident #20 became unsteady and had to sit on the edge of the commode. The CNA (#9) failed to utilize a gait belt during the transfer.

Observation on 03/10/20 at 8:51 a.m. showed a CNA (#10) guided Resident #20's hands to the hand rail and assisted him/her stand. The CNA had Resident #20 take a few steps, turn, and sit in the wheelchair. The CNA (#10) failed to use a gait belt during the transfer.

Observation on 03/10/20 at 1:40 p.m. showed a CNA (#10) placed a gait belt around Resident #20's waist and instructed him/her to use the assist rail on the bed and stand. The CNA pulled the resident up by the waistband of his/her pants. The CNA (#10) failed to use the gait belt during the transfer.

During an interview on 03/11/20 at 2:30 p.m. an administrative nurse (#1) stated she expected staff to use gait belts for non-mechanical lift transfers and gait belt application/use is part of yearly staff competencies.

- Review of Resident #140's medical record

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F 689	Continued From page 14 occurred on all days of survey and showed the resident experienced fractured left fibula. Resident #140's current CNA card, stated, "Partial weight bearing to left leg". Observation on 03/10/20 at 11:50 a.m. showed two CNAs (#4 and #5) assisted Resident #140 to transfer to and from a wheelchair to a commode. During the transfers Resident #140 lifted his/her right leg and put full weight on the left leg. Failure of the CNAs (#4 and #5) to cue the resident to partial weight bearing has the potential to aggravate the injury to Resident #140's left leg.	F 689		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;	F 758		4/16/20

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F 758	Continued From page 15 §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to ensure each resident's medication regimen was free from unnecessary medications for 1 of 5 sampled residents (Resident #29) reviewed for unnecessary meds. Failure to include documentation regarding the clinical justification/specific circumstances for continued use of as needed (PRN) psychotropic medication beyond 14 days and failure to establish a specific	F 758	F758 1. Resident #29□s PRN anti-psychotropic medication was reviewed by the primary physician. Primary physician determined resident #29 no longer required her PRN anti-psychotropic medication, therefore this medication was discontinued on 3/11/20. 2. All residents who may obtain a	

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F 758	Continued From page 16 start and stop date may result in the resident receiving a medication for an excessive duration and/or experiencing adverse side effects related to its use. Findings include: Review of the facility policy titled "Psychotropic Medications" occurred on 03/11/20. This policy, revised June 2017, stated " . . . PRN orders for psychotropic drugs are limited to 14 days. If the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. . . ." Review of Resident #29's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease and anxiety disorder. A physician's order for lorazepam (antianxiety medication), dated 10/24/2019, stated, " . . . Lorazepam Tablet 0.5 MG [milligram] by mouth as needed for anxiety at least 4 hours between doses AND Give 0.5 mg by mouth one time a day related to OTHER SPECIFIED ANXIETY DISORDERS . . . " The record lacked documentation regarding the provider's rationale for extending the PRN lorazepam. During an interview on 03/11/20 at 2:07p.m., an administrative nurse (#1) confirmed the staff failed to ensure the provider indicated the rationale for extending the duration for the PRN lorazepam for Resident #29.	F 758	physician□s order for PRN anti psychotropic medications have the potential to be affected. 3. Social Services and Nurse Management will be re-educated on the policy regarding GDR□s including PRN psychotropic medications that extend beyond fourteen days. 4. DNS or designee will complete audit on GDS□s for anti-psychotropic medications weekly for one month, Bi-weekly for one month, and monthly for four months. Quality Assurance committee will review and monitor audits during monthly quality meetings. Quality Assurance committee will ensure compliance.	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)	F 761		4/16/20

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F 761	Continued From page 17 §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to label two multi-dose insulin pens in 1 of 1 medication storage room. Failure to label multi-dose pens with the date opened increases the risk of residents receiving outdated medications with reduced medication efficacy. Findings include.	F 761	F 761 1. All Licensed Nurses and Certified Medication Assistances re-educated on proper labeling of medications. 2. All residents have the potential to be affected. 3. All License Nurses and Certified Medication Assistances will be re-educated on the proper policy of labeling of medications.	

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F 761	Continued From page 18 Review of the facility policy titled "Insulin Pens" occurred on 03/11/20. This policy, revised on March 2018, stated, ". . . Verify provider order, the expiration date and the number of days the pen has been open . . ." Observation of the medication storage room occurred on 03/11/20 at 1:40 p.m. One Basaglar Kwik Pen [insulin pen] and one Levemir Flex Touch Pen [insulin pen] label failed to identify an open date or an expiration date. During an interview on 03/11/20 at 2:10 p.m., an administrative nurse (#1) stated she expects staff to date insulin pens with open and expiration dates.	F 761	4. DNS or designee will complete an audit on medication labeling. Audit will be completed weekly for four weeks, Bi-weekly for one month, and monthly for four months. Quality Assurance committee will review and monitor audits during monthly quality meeting. Quality Assurance committee will ensure compliance.	
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional	F 812		4/16/20

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F 812	Continued From page 19 standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, review of manufacturer's labeling, review of facility policy, and staff interview, the facility failed to properly store fluids/supplements and dishware in a sanitary manner in 1 of 1 kitchen and 1 of 1 nourishment center. Failure to identify the date/time sensitive fluids are opened, dispose of time sensitive fluids that have expired, properly store scoops for liquid supplementation, and clean/handle dishware in a sanitary manner may result in altered consistency of thickened fluids and cause foodborne illnesses from cross contaminated dishware. Findings include: FOOD STORAGE Review of the facility policy/procedure titled "Food/Supply Storage" occurred on 03/12/20. This policy, dated August 2019, stated, ". . . Use By and Freeze by (expiration) dates are checked on a regular basis; foods/fluids that have expired or are otherwise unsafe for use are discarded. . . ." The manufacturers' label for the thickened fruit juice stated, "Use within seven days of opening." Observations during the dietary tour on 03/11/20 at 1:38 p.m. with a dietary staff member (#7) showed the following undated, expired items, and improperly stored item: - Kitchen, reach in cooler, one undated/opened cranberry juice, and one opened juice dated	F 812	F 812 1. Unlabeled and expired juice was discarded immediately on 3/11/20. Thickening powder was also discarded immediately on 3/11/20. Staff member #8 re-educated as well as all dietary staff re-educated on expectation of wearing an apron while washing dishes and use of an alcohol based sanitizer between dirty and clean sides of the dish machine. 2. All residents have the potential to be affected 3. All dietary staff will be re-educated on the proper procedure of dish washing including wearing of apron and hand sanitization between dirty and clean sides of the dish washing machine. All dietary staff will be re-educated on the proper procedure of labeling opened food and liquid items as well as when to discard these items. All dietary and nursing staff will be re-educated on infection control when leaving scoops in powered items. 4. Dietary Manager or designee will complete audit weekly for one month, bi-weekly for one month, and monthly for 4 months. Quality Assurance committee will review and monitor audits during monthly quality meeting. Quality Assurance committee will ensure compliance.	

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F 812	Continued From page 20	F 812		

"2/23" [02/23/20], opened 17 days.
- Nutrition Center, container of supplement for thickening liquids with a scoop stored in the product.

During the tour, the dietary staff member (#7) reported she expected staff to label thickened beverages when opened, to dispose of the expired thickened juice, and store the scoop in a separate container.

DISHWARE

Review of the facility policy/procedure titled "Ware Washing" occurred on 11/12/20. This policy, dated July 2018, stated, ". . . Mechanical Ware Washing, 1. Employees wash hands between dirty/clean side of dish machine. . . ."

Review of the facility policy/procedure titled "Hand Hygiene And Handwashing" occurred on 11/12/20. This policy, dated January 2018, stated, ". . . Sanitizers are not used in food service or dining except immediately after proper handwashing."

Observation during the dietary tour on 03/11/20 at 1:38 p.m. showed a dietary staff member (#8) failed to wear an apron to prevent soiling of her uniform during dishwashing. Two observations showed the dietary staff member (#8) moved from the soiled dishwashing area to handling clean dishes without washing her hands with soap and water. The dietary staff member (#8) rinsed her hands in a bucket of kitchen sanitizer and moved clean dishes from the drying area to the dishware storage area.

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F 812	Continued From page 21 During the tour, the dietary staff member (#7) reported staff are expected to wear an apron while washing dishes, and to use an alcohol based hand sanitizer between the dirty and clean side of the dish machine. This staff member's expectation is not consistent with facility policy. Failure to clean and store dishware in a sanitary manner placed residents, visitors, and staff at risk for foodborne illness.	F 812		
F 880 SS=E	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 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,	F 880		4/16/20

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F 880	Continued From page 22 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 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	F 880		

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F 880	Continued From page 23 IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to follow standard infection control practices for 4 of 4 sampled residents (Resident #16. #17. #20 and #241) observed during cares, and 1 of 1 meal observed (noon meal on 03/09/20). Failure to follow standard infection control practices may result in the spread of infections within the facility. Findings include: Review of the facility policy titled, "Hand Hygiene and Handwashing", occurred on 03/12/20. This policy, dated January 2018, stated, ". . . wash hands with plain soap and water . . . use and alcohol-based hand rub . . . before having direct contact with residents . . . after having contact with another person's skin . . . After having contact with bodily fluids, wound or broken skin . . . After removing gloves . . . During service of meals . . . Wash hands before meal service begins,whenever visible soiled and whenever hands are contaminated by touching a resident, self, or any surface (eg. table, chair, counter) . . . Do not touch any food or eating surfaces with bare hands (ie., fork tines, eating surfaces of plates, drinking surfaces of glasses) . . ." - Observation on 03/09/20 at 10:55 a.m., showed Resident #17 seated on the bedside with his catheter bag lying on the bare floor. Observation on 03/10/20 at 11:39 a.m. showed Resident #17 seated on the bedside with the	F 880	F 880 1. Staff obtained an order for a leg bag for resident #17 on 3/12/20 resident refused. Certified Nursing Assistances and Licensed nurses re-educated about placing catheter bags in cloth bag to prevent them from laying on the floor. Certified Nursing Assistances and Licensed nurses re-educated on proper hand washing, including when donning and doffing gloves. 2. All residents have the potential to be affected. 3. All Certified Nursing Assistants and Licensed Nurses will be re-educated on caring for catheters as well as proper storage and handling of catheter bags. All Certified Nursing Assistants and Licensed Nurses will be re-educated on proper hand washing. All Certified Nursing Assistants and Licensed Nurses will be re-educated on infection control during dining services. 4. Infection Preventionist or designee will do infection control during dining service audits, proper handling of catheter bag audits, and proper hand washing audits. These audits will be completed daily for one week, weekly for three weeks, bi-weekly for one months, and monthly for four months. Quality Assurance committee will review and monitor audits during monthly quality meeting. Quality Assurance committee will ensure compliance.	

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F 880	Continued From page 24	F 880		

catheter bag lying on the bare floor. A certified nurse assistant (CNA) (#5) picked the catheter bag off the floor, emptied the catheter bag, then returned the catheter bag on to the bare floor. The CNA (#5) failed to hang the catheter on the bed side or place it in a storage bag/cover to prevent contact with the floor surface.

Observation on 03/10/20 at 2:08 p.m., showed Resident #17 sitting on the bedside with his catheter bag lying on the bare floor. A CNA (#4) picked the catheter bag off the floor, emptied the catheter bag, then returned the catheter bag on to the bare floor. The CNA (#4) failed to hang the catheter bag on the bed side or place it in a storage bag/cover to prevent contact with the floor surface.

During an interview on 03/11/20 at 2:11 p.m., an administrative nurse (#1) stated she would expect staff to store the catheter bag in a storage bag or hang it on the bedside and not allow contact with the floor.

- Observation on 03/09/20 at 4:05 p.m. showed a CNA (#9) assisted Resident #16 to the commode. The CNA (#9) donned gloves, removed a soiled brief, and provided pericares. Observation showed stool on the peri-wipe. Without removing his/her gloves the CNA (#9) applied a new incontinence brief, pulled up Resident #16's pants, placed his/her gloved hand on the gait belt around resident's waist and assisted him/her back to the recliner.

- Observation on 03/09/20 at 10:49 a.m. showed a CNA (#4) assisted Resident #20 to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355109	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOURIS VALLEY CARE CENTER	300 MAIN ST S VELVA, ND 58790

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F 880	Continued From page 25	F 880		

commode, provided pericares, and removed his/her gloves. The CNA then pulled Resident #20's pants up and assisted him/her to the wheelchair. The CNA failed to perform hand hygiene before exiting the room.

- Observation on 03/09/20 at 3:50 p.m. showed a CNA (#9) donned gloves and assisted Resident #20 to the commode. The CNA removed the soiled brief and, without removing his/her gloves or performing hand hygiene, the CNA applied a clean brief, restocked the garbage bags, opened a new bag of wipes, provided pericares, and assisted Resident #20 to the wheelchair. The CNA (#9) removed his/her gloves, and without performing hand hygiene pushed Resident #20 out of the room.

- Observation on 03/10/20 at 2:02 p.m. showed two CNAs (#10 and #11) entered Resident #241's room. Both CNAs donned gloves and CNA (#10) removed the resident's soiled brief and performed pericare. With the same gloves the CNA (#10) applied a new brief and pulled up Resident #241's pants. The CNA (#11) disposed of the soiled brief and, without removing gloves or performing hand hygiene, assisted CNA (#10) to position Resident #241 on the right side and placed a pillow behind his/her back.

DINING OBSERVATION:

- Observation on 03/09/20 at 12:13 p.m. showed an unidentified CNA wiped Resident #7's face with a napkin and without performing hand hygiene, fed bites of food to another resident (Resident #13). The unidentified CNA periodically wiped Resident #7's face with the same paper

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	355109	A. BUILDING _____ B. WING _____	03/12/2020

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F 880	Continued From page 26 napkin and then touched and fed bites of food to Resident #13. The CNA failed to perform hand hygiene between contact with Resident #7 and Resident #13. - Observation on 03/09/20 at 12:28 p.m. showed a CNA (#4) adjusted Resident #20's oxygen tubing and then touched the resident's hair. Without performing hand hygiene, the CNA picked up another resident's glass and assisted him/her to drink. During an interview on 03/11/20 at 2:30 p.m. an administrative nurse (#1) stated she expected staff to remove gloves after peri-care/toileting hygiene, perform hand hygiene after glove removal, and perform hand hygiene after touching a resident or resident equipment.	F 880		