North Dakota Health and Human Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	8201	A. BUILDING: _____ B. WING _____	R-C 04/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE - WEST FARGO	645 33RD AVENUE EAST WEST FARGO, ND 58078

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{B 000}	INITIAL COMMENTS For the on site revisit, started on 04/08/24 and completed on 04/09/24, the sample included six residents for review and three supplemental residents. Tier II citations included B0924, B1230, B1320, B1400, B1540, B1700, and B2406.	{B 000}		
B 924	33-03-24.1-09,2,d GOVERNING BODY d. Infection control practices, including provision of a sanitary environment and an active program for the prevention, investigation, management, and control of infections and communicable diseases in residents and staff members. This State Licensing Rule is not met as evidenced by: Based on observation and review of facility policy, the facility failed to follow standards of infection control for 1 of 1 sampled resident (Resident #2) observed during toileting. Failure to remove soiled gloves and perform hand hygiene may result in the spread of infection to other residents. Findings include: Review of the facility policy titled "Hand Washing" occurred on 04/09/24. This policy, dated 07/07/23, stated, ". . . When hands should be washed: Team members will wash hands between resident care and whenever direct physical contact with a resident takes place. Use of gloves does not replace hand washing. Hands will be washed or decontaminated: Before and	B 924		

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B 924	Continued From page 1 after direct contact with a resident . . . If moving from a contaminated-body site to a clean-body site during resident care . . . After removing gloves or gowns . . ." Observation on 04/09/24 at 10:45 a.m. showed two certified nurse aides (CNAs) (#2 and #4) assisted Resident #2 to the bathroom. A CNA (#4) donned gloves, removed the resident's soiled brief, and provided incontinence cares. Without removing her gloves, the CNA placed a clean brief on Resident #2, assisted her to stand, pulled up her pants and brief, and assisted her to sit in the wheelchair. The CNA then removed a gait belt, smoothed down the resident's hair, and pushed the wheelchair into the bedroom. The other CNA (#2) transported Resident #2 from the room in her wheelchair. The CNA (#4) bagged the garbage and exited the room before removing her gloves, failing to perform hand hygiene prior to leaving the room.	B 924		
{B1230}	33-03-24.1-12,3 RESIDENT ASSESSMENTS/CARE PLANS 3. A care plan, based on the assessment and input from the resident or person with legal status to act on behalf of the resident, must be developed within twenty-one days of the admission date and consistently implemented in response to individual resident needs and strengths. This State Licensing Rule is not met as evidenced by: DURING THE ON SITE REVISIT COMPLETED ON APRIL 8-9, 2024, EVIDENCE SHOWED THE FACILITY FAILED TO ACHIEVE COMPLIANCE WITH THIS REQUIREMENT.	{B1230}		

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{B1230}	Continued From page 2 Based on record review, review of facility policy, and staff interview, the facility failed to consistently implement the residents' individualized plan of care for 2 of 6 sampled residents (Resident #2 and #3). Failure to implement toileting interventions may result in unnecessary incontinence and skin breakdown. Findings include: Review of the facility policy titled "Resident Service Plan" occurred on 04/09/24. This policy, dated 01/16/24, stated, ". . . A service plan addressing the individualized needs of the resident will be developed during the initial assessment and completed for each resident before nursing services are initiated . . . The nurse's initial assessment and any other Community evaluation conducted before nursing services are initiated and will be the basis for the resident's written service plan. . . . The service plan will: a. Identify the program services, frequency, and approaches the Community will provide under applicable law, to include personal care, supervision, activities, health monitoring, medication administration, behavior management, information and referral, and transportation . . . The service plan will serve as a basis for the service delivery contract between the Community and the resident. . . ." - Review of Resident #2's care plan occurred on April 8-9, 2024. The current "Resident Service Agreement," stated, ". . . Service Type: Bladder Cont [continence]: Asst [assist] 8+ x/24 hr [eight or more times in 24 hours] . . ." Review of toileting records for February and March 2024 identified staff failed to assist	{B1230}		

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{B1230}	Continued From page 3 Resident #2 with toileting eight or more times per day as care planned on 29 of 29 days in February and 31 of 31 days in March. - Review of Resident #3's medical record occurred on April 8-9, 2024. The current "Resident Service Agreement," dated 11/06/23, stated, ". . . Bladder Cont: 2 [staff] Asst 8+ x/24 h . . ." Review of Resident #3's record identified staff assisted the resident to toilet five times every day in February and March 2024, not the eight or more times as care planned. During an interview on 04/09/24 at 1:30 p.m., two CNAs (#1 and #2) stated staff last toileted Resident #3 at 9:00 a.m. and he refused several offers to assist him to the toilet. The CNAs stated the resident will take himself to his room or tell them when he needs to use the toilet. The facility failed to either provide toileting a minimum of eight times daily or update Resident #2 and #3's care plans to reflect their needs.	{B1230}		
{B1320}	33-03-24.1-13,2 RESIDENT RECORDS 2. Resident records must include: a. The resident's name, social security number, marital status, age, sex, previous address, religion, personal licensed health care practitioner, dentist, and designated representative or other responsible person. b. The licensed health care practitioner's orders and report of an examination of the resident's current health status.	{B1320}		

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{B1320}	Continued From page 4 c. An admission note. d. A copy of an initial and current assessment and care plan. e. Documentation of resident observations by authorized staff. f. Documentation of death, including cause and disposition of the resident's personal effects, money, or valuables deposited with the facility. g. A quarterly progress note documenting the resident's current health condition, level of functioning, activity involvement, nutritional status, psychosocial interactions, and needs. h. Documentation of review of prescribed diets. i. Transfer forms that are completed, signed, and sent with the resident when transferred to another facility. j. A medication administration record documenting medication administration consistent with applicable state laws, rules, and practice acts. k. Documentation of an annual medication regimen review. l. A written report of any funds kept at a resident's request. Such record shall show deposits to and withdrawals from the fund.	{B1320}		

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{B1320}	Continued From page 5 m. Documentation of a fire drill walk-through within five days of admission. n. All agreements or contracts entered into between the facility and the resident or legal representative. o. A discharge note. This State Licensing Rule is not met as evidenced by: DURING THE ON SITE REVISIT COMPLETED ON APRIL 8-9, 2024, EVIDENCE SHOWED THE FACILITY FAILED TO ACHIEVE COMPLIANCE WITH THIS REQUIREMENT. Based on record review, review of facility policy, and staff interview, the facility failed to ensure a complete medical record for 1 supplemental resident (Resident #8) transferred to the emergency room (ER) with subsequent hospitalization. Failure to complete and provide residents and families/guardians with a "Notice of Transfer or Discharge" form and place a copy of the form in the medical record does not protect the residents' rights nor ensure an appropriate and safe transfer/discharge from the facility. Findings include: Review of the facility policy titled "Transfer and Termination" occurred on 04/09/24. This policy, dated 03/21/23, stated, "A notice of transfer or discharge may be issued to a resident in accordance with applicable state law in response to a change in the resident's level of care resulting in the Community's inability to meet the resident's medical needs. . . ."	{B1320}		

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{B1320}	Continued From page 6 Review of Resident #8's medical record occurred on 04/09/24. The facility transferred Resident #8 to the emergency room with a subsequent admission to the hospital on 03/31/24. The record lacked evidence staff completed a "Notice of Transfer" and provided copies to the resident/representative. During an interview on 04/09/24 at 10:25 a.m., an administrative nurse (#3) after viewing a blank "Notice of Transfer" form stated the facility has "never given out these forms."	{B1320}		
B1400	33-03-24.1-14 PERSONAL CARE SERVICES 33-03-24.1-14. Personal care services. The facility shall provide personal care services to assist the residents to attain and maintain their highest level of functioning consistent with the resident assessments and care plans. These services must include assistance with: This State Licensing Rule is not met as evidenced by: Based on observation, record review, and review of facility policy, the facility failed to ensure personal care services consistent with the resident's plan of care for 1 of 1 sampled resident (Resident #2) observed during a transfer. Failure to properly use a gait belt may result in injury to the resident. Findings include: Review of the policy titled "Mobility Assistance/Gait Belts" occurred on 04/09/24. This policy, dated 08/22/23, stated, ". . . Gait belts will be used whenever it is determined that their use	B1400		

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B1400	Continued From page 7 will provide a safe method of transferring or ambulating for both the resident and the team member. This will be noted on the resident's service plan. . . ." Resident #2's current service agreement stated, ". . . Transfer: Assist of 1 . . . Use one person and a gait belt to assist with transferring resident. . . ." Observation on 04/09/24 at 10:45 a.m. showed two certified nurse aides (CNAs) (#2 and #4) brought Resident #2 into the bathroom in her wheelchair. The CNA (#4) instructed the resident to use the grab bars to pull herself up. Then the CNA (#2) instructed the other CNA (#4) to use a gait belt with Resident #2. The CNA (#4) placed a gait belt around the resident's waist and assisted her to stand by grabbing the back of the resident's pants and lifting her under the arm. The CNA (#4) failed to use the gait belt properly.	B1400		
{B1540}	33-03-24.1-15,4 PHARMACY/MED ADM SERVICES 4. All medications used by residents which are administered or supervised by staff must be: a. Properly recorded by staff at the time of administration. b. Kept and stored in original containers labeled consistently with state laws. c. Properly administered. This State Licensing Rule is not met as evidenced by:	{B1540}		

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{B1540}	Continued From page 8 DURING THE ON SITE REVISIT COMPLETED ON APRIL 8-9, 2024, EVIDENCE SHOWED THE FACILITY FAILED TO ACHIEVE COMPLIANCE WITH THIS REQUIREMENT. Based on observation, record review, and review of manufacturer's guidelines, the facility failed to ensure proper administration of medications for 2 of 2 residents (Resident #5 and #7) observed during insulin administration. Failure to properly prime an insulin pen may result in adverse consequences for the residents. Findings include: The NovoCare quickguide, titled "How to use FlexPen," dated September 2021, stated, "Checking the insulin flow (Priming): Turn the dose selector to 2 units. Hold your FlexPen with the NovoFine needle pointing upwards. Tap the cartridge gently with your finger a few times to make any air bubbles collect at the top of the cartridge. Keep the NovoFine needle upwards and press the push-button all the way in. The dose selector should return to 0. A drop of insulin should appear at the needle tip. If not, change the NovoFine needle and repeat the procedure . . ." - Review of Resident #5's medication administration record (MAR) occurred on 04/09/24. A physician's order included Novolog insulin 12 units three times daily with meals. Observation of insulin administration for Resident #5 occurred on 04/09/24 at 11:05 a.m. with a medication aide (MA) (#2). To prime the Novolog FlexPen, the MA (#2) turned the dial to two units and held the pen with the needle pointing downward as she pushed the plunger to expel the air from the needle. The MA failed to prime the	{B1540}		

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{B1540}	Continued From page 9 insulin pen vertically in the upward position or observe for a drop of insulin at the needle tip. - Review of Resident #7's MAR occurred on 04/09/24. A physician's order included Novolin-R insulin 18 units with meals. Observation of insulin administration for Resident #7 occurred on 04/09/24 at 11:17 a.m. with a MA (#2). To prime the Novolin-R FlexPen, the MA (#2) turned the dial to two units and held the pen pointing downward as she pushed the plunger. The MA failed to prime the insulin pen vertically in the upward position or observe for a drop of insulin at the needle tip.	{B1540}		
{B1700}	33-03-24.1-17 NURSING SERVICES 33-03-24.1-17. Nursing services. Nursing services must be available to meet the needs of the residents either by the facility directly or arranged by the facility through an appropriate individual or agency providing nursing services. This State Licensing Rule is not met as evidenced by: DURING THE ON SITE REVISIT COMPLETED ON APRIL 8-9, 2024, EVIDENCE SHOWED THE FACILITY FAILED TO ACHIEVE COMPLIANCE WITH THIS REQUIREMENT. Based on record review, policy review, and staff interview, the facility failed to provide nursing services to meet the needs of 2 of 2 sampled residents (#3 and #4) reviewed for falls. Failure to provide adequate monitoring after a fall may	{B1700}		

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{B1700}	Continued From page 10 result in negative health outcomes for residents. Findings include: Review of the facility policy titled "Falls Management" occurred on 04/09/24. This policy, dated 05/22/23, stated, ". . . Fall-related forms will be available for use to document findings post a resident fall. . . . The team member follow-up documentation will include: . . . (3) Post-Fall Vital Signs and Observations . . ." The Post-Fall Vital Signs and Observations (Head Impact) form, dated 06/22/23, stated, "Complete the Post-Fall Vital Signs and Observations and obtain vital signs after a fall involving a known or potential impact to a resident's head or face. Vital signs and observations are to occur at the time of fall. If the resident does not have a fever, the nurse will direct team members to obtain vital signs and observations, with the exception of temperature, every two (2) hours thereafter for 24 hours - totaling twelve (12) times - in an effort to identify increased intracranial pressure or other signs of internal head injury. . . ." - Review of Resident #3's medical record occurred on April 8-9, 2024. A progress note, dated 12/15/23 at 1:23 p.m., stated, "Resident had unwitnessed fall and was found laying on the floor in front of his recliner on 12/12/23 at 3pm. . . . Positive headstrike on floor. . . . [Staff] instructed to complete vital signs every 2 hours x [times] 24 hours. . . ." Resident #3's Post-Fall Vital Signs and Observation form, dated 12/12/23, showed staff only completed eight of the 12 required checks. - Review of Resident #4's medical record occurred on April 8-9, 2024. A progress note,	{B1700}		

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{B1700}	Continued From page 11 dated 02/01/24 at 7:18 a.m., stated, "0107 [1:07 a.m.] TRIAGE CALL from staff to report unwitnessed fall for resident. Per staff, resident was found on safety check sitting on her bottom in room . . . no evidence of pain or head strike, scrape to L [left] arm . . . VS [vital signs] Q2H [every two hours] x 24 hours. . . ." Resident #4's Post-Fall Vital Signs and Observation form, dated 02/01/24, showed staff only completed three of the 12 required checks. During an interview on 04/09/24 at 10:57 a.m., an administrative nurse (#3) stated she expected staff to complete the post fall vital signs and observations every two hours.	{B1700}		
{B2406}	33-03-24.1-24,6 Optional Alzheimer's, Demential, Special Mem The person-centered care plans must be reviewed quarterly and anytime there is a change in need by the resident based on the assessment, and modified as needed. This State Licensing Rule is not met as evidenced by: DURING THE ON SITE REVISIT COMPLETED ON APRIL 8-9, 2024, EVIDENCE SHOWED THE FACILITY FAILED TO ACHIEVE COMPLIANCE WITH THIS REQUIREMENT. Based on record review and review of facility policy, the facility failed to develop an Alzheimer's/Dementia behavioral care plan based on the comprehensive assessment for 6 of 6 sampled residents (Resident #1, #2, #3, #4, #5, and #6) residing in the memory care unit. Failure	{B2406}		

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{B2406}	Continued From page 12 to develop and implement behavioral interventions may result in increased behaviors and unmet care needs. Findings include: Review of the facility policy titled "Assessments and Evaluations" occurred on 04/09/24. This policy, dated 07/11/23, stated, ". . . The Community will conduct assessments, observation, and reassessments in accordance with state law to determine the level of assistance required by each resident in an effort to maximize their quality of life. Assessments should be thorough and timely to ensure that a resident's care needs are identified, and an individualized care plan is maintained. . . ." Review of the facility policy titled "Resident Service Plan" occurred on 04/09/24. This policy, dated 01/16/24, stated, ". . . A service plan addressing the individualized needs of the resident will be developed during the initial assessment and completed for each resident before nursing services are initiated . . . The nurse's initial assessment and any other Community evaluation conducted before nursing services are initiated and will be the basis for the resident's written service plan. . . . The service plan will: a. Identify the program services, frequency, and approaches the Community will provide under applicable law, to include personal care, supervision, activities, health monitoring, medication administration, behavior management, information and referral, and transportation . . . The service plan will serve as a basis for the service delivery contract between the Community and the resident. . . ." - Review of Resident #1's medical record	{B2406}		

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{B2406}	Continued From page 13 occurred on April 8-9, 2024. Resident #1's "Comprehensive Assessment," dated 02/14/24, stated, ". . . Cognitive Pattern/Behavioral Expressions: . . . Expressions: All behavioral expressions selected and interventions needed to manage expressions must be added to the resident's service plan/care plan: . . . Forgetful . . . Minor socially inappropriate behaviors . . . Uncooperative with care . . . Wanders . . . Refusals . . . Does not accept redirection . . . Anxious . . . Hoarding, Rummaging . . ." Resident #1's current "Resident Service Agreement" stated, ". . . Cues:7-9X [times]/24hrs [hours] . . . Provide cues and prompts to meals, activities, apartment, and away from egress doors when she appears lost or exit seeking. Provide short, simple questions with time to respond. Behavioral expressions: forgetful-minor socially inappropriate behaviors-uncooperative with cares-wanders-refusals-does not accept redirection-anxious-hoarding-rummaging . . . . Caregivers to provide interventions as described and report changes in need for cues to nursing. . . ." The facility failed to identify further individualized behavioral interventions. - Review of Resident #2's medical record occurred on April 8-9, 2024. Resident #2's "Comprehensive Assessment," dated 02/21/24, stated, ". . . Cognitive Pattern/Behavioral Expressions: . . . Expressions: All behavioral expressions selected and interventions needed to manage expressions must be added to the resident's service plan/care plan: . . . Forgetful . . . Wanders . . . Anxious . . . Depressed/Withdrawn . . ." Resident #2's current "Resident Service Agreement" stated, ". . . Cues:7-9X/24hrs . . .	{B2406}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	8201	A. BUILDING: _____ B. WING _____	R-C 04/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE - WEST FARGO	645 33RD AVENUE EAST WEST FARGO, ND 58078

(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) COMPLETE DATE
{B2406}	Continued From page 14 Provide cues/prompts for meals, activities, and toileting. Prompt away from exit doors. Resident forgetful-anxious-depressed/withdrawn. Caregivers to provide interventions as described and report changes in need for cues to nursing. . . ." The facility failed to identify further individualized behavioral interventions. - Review of Resident #3's medical record occurred on April 8-9, 2024. Resident #3's "Comprehensive Assessment," dated 01/24/24, stated, ". . . Cognitive Pattern/Behavioral Expressions: . . . Expressions: All behavioral expressions selected and interventions needed to manage expressions must be added to the resident's service plan/care plan: . . . Forgetful . . . Minor socially inappropriate behaviors . . . Uncooperative with Care . . . Refusals . . . Verbally aggressive . . . Delusions . . . Hallucinations . . . Anxious . . . Depressed/Withdrawn . . . Suspicious/Paranoid . . ." Resident #3's "Resident Service Agreement," dated 03/13/23, for Service Type: "Cues:4-6X/24hrs," stated, "Provide cues for meals, activities and toileting. Utilize 'Rule of 3.' Provide reassurance when resident is agitated and/or experiencing delusions/hallucinations. Behavioral expressions presented by resident: forgetful, minor socially inappropriate behaviors, uncooperative with care, refusals, verbally aggressive, delusions, hallucinations, depressions/withdrawal, suspicious/paranoid. Caregivers to provide interventions as described . . ." The facility failed to identify anxiety and also failed to develop further individualized behavioral interventions. - Review of Resident #4's medical record	{B2406}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	8201	A. BUILDING: _____ B. WING _____	R-C 04/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE - WEST FARGO	645 33RD AVENUE EAST WEST FARGO, ND 58078

(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) COMPLETE DATE
{B2406}	Continued From page 15 occurred on April 8-9, 2024. Resident #4's "Comprehensive Assessment," dated 04/02/24, stated, ". . . Cognitive Pattern/Behavioral Expressions: . . . Expressions: All behavioral expressions selected and interventions needed to manage expressions must be added to the resident's service plan/care plan: . . . Forgetful . . . Socially inappropriate (including inapprop. elimination) . . . Uncooperative with Care . . . Wanders . . . Exit seeking . . . Refusals . . . Does not accept redirection . . . Verbally aggressive . . . Physically aggressive . . . Anxious . . ." Resident #4's "Resident Service Agreement," dated 10/02/23, for Service Type: "Cues:7-9X/24hrs," stated, "Caregivers to provide interventions as described and report changes in need or cues to nursing." The facility failed to identify the behaviors: forgetful, socially inappropriate including elimination, uncooperative with care, wandering, exit seeking, refusals, not accepting redirection, verbal and physical aggression, and anxiety, and failed to develop and implement individualized interventions related to those behaviors. - Review of Resident #5's medical record occurred on April 8-9, 2024. Resident #5's "Comprehensive Assessment," dated 02/13/24, stated, ". . . Cognitive Pattern/Behavioral Expressions: . . . Expressions: All behavioral expressions selected and interventions needed to manage expressions must be added to the resident's service plan/care plan: . . . Forgetful . . . Wanders . . . Exit Seeking . . . Anxious . . ." Resident #5's current "Resident Service Agreement" stated, ". . . Cognition: Uncooperative . . . will exit seek and frequently request to go to his apartment to winterize and will need frequent	{B2406}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	8201	A. BUILDING: _____ B. WING _____	R-C 04/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE - WEST FARGO	645 33RD AVENUE EAST WEST FARGO, ND 58078

(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) COMPLETE DATE
{B2406}	Continued From page 16 reminders that this is his new home. Re-direct him away from exit doors. 2.) Has had a traumatic brain injury and presents with learning deficits. Talk slowly and allow him time to process what you're saying . . . Cues:4-6X/24hrs . . . Caregivers to provide interventions as described and report changes in need for cues to nursing. . . ." The facility failed to identify further individualized behavioral interventions. Nurses' notes also identified a resident-to-resident incident which occurred on 02/02/24. The care plan failed to include the incident or any interventions to attempt to prevent reoccurrence. - Review of Resident #6's medical record occurred on April 9, 2024. Resident #6's "Comprehensive Assessment," dated 02/22/24, stated, ". . . Cognitive Pattern/Behavioral Expressions: . . . Expressions: All behavioral expressions selected and interventions needed to manage expressions must be added to the resident's service plan/care plan: Forgetful . . . Refusals . . . Does not accept redirection . . . Anxious . . ." Resident #6's "Resident Service Agreement," dated 09/09/22, for Service Type: "Cognition: Uncooperative," stated, "Assist resident with redirection and orientation to the unit and their apartment." The facility failed to identify the behaviors: forgetful, refusals, not accepting redirection, and anxiety, and failed to develop and implement individualized interventions related to those behaviors.	{B2406}		

(B 924)

1. All active C.N.A.s will be educated and provide return demonstration to practice proper handwashing techniques and infection control standards that minimize the spread of infection to other residents.

2. All residents have the potential to be affected by infection control practices.

3. All active C.N.A.s will practice infection control standards. Infection Control in-services will be completed for all care team members. Routine weekly audits will be completed on all shifts to identify compliance with infection control practices and handwashing.

4. The deficiency will be corrected by 5/24/24.

5. The Executive Director and Health and Wellness Director will monitor compliance with community's corrective action weekly x4 weeks, biweekly x4 weeks, then monthly x 3 months, and then as needed.

{B1230}

1. The facility has developed a care plan based on the comprehensive assessment and implemented an individualized plan of care. Resident #2 and #3 Individualized Plan of Care has been reviewed and developed to reflect necessary care.

2. All residents have the potential to be affected by this practice.

3. C.N.As received education to revisions made within the EHR to document the care is provided to the individual. Updates to the Electronic Care Record have been made to include CNA documentation for toileting throughout the shift. Audits of the care provided and documentation of services will be conducted.

4. The deficiency was corrected on 5/24/24.

5. The Executive Director and Health and Wellness Director will monitor compliance with community's corrective action weekly x4 weeks, biweekly x4 weeks, then monthly x 3 months, and then as needed.

{B1320}

1. Resident transfer form is completed for all residents discharging or transferring from the community.

2. All residents have the potential to be affected by this practice.

3. Education and clarification of the rule's interpretation was provided at the time of surveyors visit. Community will provide transfer form to Resident/Representative with all discharges and transfers. Community will provide facility accepting resident with required healthcare information upon each transfer or discharge.

4. The deficiency was corrected on 4/10/24.

5. The Executive Director and Health and Wellness Director will monitor compliance with community's corrective action weekly x4 weeks, biweekly x4 weeks, then monthly x 3 months, and then as needed.

(B1400)

1. Residents requiring assistance with transfers will be provided of safe method of transfer with use of a gait belt as necessary. Residents will be encouraged to maintain their highest level of functioning as directed by the Individualized Service Agreement.

2. Community reviewed resident records to determine those with ability to be impacted.

3. Education will be provided to all care team members to provide education for safe transfers with use of gait belt.

4. The deficiency will be corrected on 5/26/24.

5. The Executive Director and Health and Wellness Director will monitor compliance with the corrective action plan weekly x4 weeks, biweekly x4 weeks, then monthly x 3 months, and then as needed.

{B1540}

1. MA #2 received verbal education on priming the flex pen in accordance with the manufacturer's instruction. All medication aides will receive education on priming the flex pen to follow manufacturer's instructions.

2. A review of resident records will be conducted to identify individuals with potential to be affected.

3. Education with demonstration of knowledge will be conducted with all Med Aides to correct this deficiency. Audits will be conducted to monitor effectiveness of correction.

4. Deficiency will be corrected by 5/24/24.

5. The Executive Director and Health and Wellness Director will monitor compliance with the corrective action plan weekly x4 weeks, biweekly x4 weeks, then monthly x 3 months, and then as needed.

{B1700}

1. Nursing services are provided to meet the individual's needs and mitigate negative outcomes for residents via monitoring and completion of the Post Vall Vital Signs and Observations form.

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2. Review of residents' condition is conducted daily and as needed. Residents who have sustained a fall are monitored with completion of Post Fall Vital Signs and Observation forms. Post Fall Vital Signs and Observation forms are completed for monitoring after a fall based on known or suspected head impact or no head impact.

3. Education was provided to staff regarding the post fall vital signs and observations form. Instructions are provided within the Post-Fall Vital Signs and Observations form, which indicate when to notify a nurse. Post Fall Vital Signs and Observation forms are completed with monitoring for each resident sustaining a fall. Routine review of the Post Fall Vital Signs and Observation Forms are completed by a nurse.

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4. Deficiency will be corrected by 5/24/24.

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5. The Executive Director and Health and Wellness Director will monitor compliance with the corrective action plan weekly x4 weeks, biweekly x4 weeks, then monthly x 3 months, and then as needed.

{B2406}

1. Resident's dementia behavioral care plan is developed with implementation of behavioral interventions to meet care needs while decreasing behaviors. Resident #1, #2, #3, #4, #5, and #6's care plans were reviewed and updated with behaviors and interventions specific to each resident.

2. All residents have the potential to be affected by this practice.

3. Review of all memory residents care plans reviewed and updated.

4. Deficiency will be corrected by 5/24/24.

5. The Executive Director and Health and Wellness Director will monitor compliance with the corrective action plan weekly x4 weeks, biweekly x4 weeks, then monthly x 3 months, and then as needed.