STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355070	A. BUILDING _____ B. WING _____	08/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHEL LUTHERAN NURSING & REHABILITATION CENTER	1515 2ND AVE WEST WILLISTON, ND 58801

(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 08/16/21 and concluded 08/19/21.	F 000		
F 550 SS=E	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 from the facility.	F 550		9/23/21

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

Electronically Signed | 09/19/2021

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F 550	Continued From page 1 §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide care for 8 of 41 sampled residents (Resident #49, #54, #81, #93, #94, #101, #103, and #104) in a manner and environment that maintained, enhanced, and respected each resident's dignity and individuality. Failure to shave residents' facial hair, groom residents, sit when feeding residents, cover residents' catheter bags, and respond to residents' requests in a timely manner, does not preserve the residents' personal dignity or enhance their quality of life. Findings include: FACIAL HAIR Review of "Certified Nursing Assistant [CNA] Orientation Checklist" occurred on 08/19/21. The undated checklist stated, ". . . Shaving of male and female residents. . . . Any resident should be shaved prior to leaving room if required. . . ." Observations showed the following: * 08/16/21 at 2:24 p.m., Resident #81 with noticeable chin hairs. * 08/17/21 at 9:24 a.m., Resident #81 grabbed her facial hairs and told the CNA (#9), "I don't want to have a beard, but my razor is still	F 550	1. Staff members involved in the care of resident #81 were educated on shaving of female resident faces. Staff members involved in the care of resident #49, #54, #101, #103, & #104 were educated on combing of resident hair prior to leaving resident room. Staff members involved in the care of resident #49 & #93 were educated to sit (not stand) while providing assistance during meal. Both dietary & nursing staff have been educated, when possible, to provide meal to all residents at one table. Staff members involved in the care of resident #81 & #94 were educated to place cover bag over resident catheter bag. Cover bags were provided to resident #81 & #94 on August 20th, 2021. Staff members involved in the care of resident #94 were educated to listen to resident requests and to extent possible grant requests. 2. All residents have the potential to be affected. Only residents with a catheter, will have the potential to be affected with covering of catheter bags. 3. Mandatory "All Staff Meetings" were held on September 15th & 16th, 2021 to provide education on shaving of residents, grooming (combing hair) of	

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F 550	Continued From page 2 broken." During an interview on 08/17/21 at 9:24 a.m., a CNA (#9) acknowledged Resident #81 prefers no facial hairs. The CNA (#9) confirmed Resident #81 informed her of the broken razor and acknowledged she failed to notify the social worker. During an interview on 08/19/21 at 8:51 a.m., the social worker (#14) confirmed the CNA (#9) failed to inform her of Resident #81's broken razor. GROOMING Review of the facility policy titled "Nursing Practice Guidelines" occurred on 08/19/21. The policy, revised February 2020, stated, ". . . Hair Grooming will consist of . . . daily combing and/or brushing . . ." Observations showed the following: * 08/17/21 at 11:34 a.m., Resident #49 with unkempt hair during a meal. * 08/17/21 at 5:49 p.m., Resident #54, #101, #103, and #104 with unkempt hair during a meal. Resident #103 touched the back of his/her head and stated, "I need a comb." During an interview on the afternoon of 08/19/21, an administrative staff (#20) agreed staff should provide grooming daily. FEEDING ASSISTANCE/TRAY DELIVERY Staff failed to provide a copy of the policy addressing feeding assistance.	F 550	residents prior to leaving resident room, to not stand while assisting residents with eating, to extent possible, provide meal to all residents at one table, covering of resident catheter bags, and listen to resident requests and to extent possible grant requests. All residents, who have catheters, were provided cover bags. Reviewed policy and procedure for "Safe and Homelike Environment." New policy and procedures developed "Promoting/Maintaining Resident Dignity" and "Promoting/Maintaining Resident Dignity During Mealtimes." Policy & procedures reviewed during the meetings. 4. The Director of Nursing Services (DON) (or designee) will monitor female residents for shaving of facial hair, grooming (combing hair) of residents prior to leaving resident room, sit (not stand) while providing assistance during meal, to extent possible serve all residents at a table, covering of catheter bags catheter bags, and granting of resident requests. The monitoring will be conducted weekly for four weeks, every two weeks for two months, monthly for three months, then quarterly. If concerns are identified, immediate corrective action will be implemented. The DON (or designee) will report results of monitoring to the QA committee on a quarterly basis. 5. September 23rd, 2021	

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F 550	Continued From page 3 Observation showed the following: * 08/16/21 at 6:10 p.m., an unidentified staff member stood next to Resident #93's dining room table, cut her sandwich in quarters, handed her a portion of the sandwich, and encouraged her to eat. The staff member failed to sit next to Resident #93. * 08/17/21 at 11:34 a.m., a staff member (#20) alternately stood and sat next to Resident #49's dining room table while assisting her to eat and drink. The staff member failed to remain seated while assisting Resident #49. * Observations of meals showed staff often served only one of two residents seated at the same table. On 08/17/21 at 5:47 p.m., one resident began banging her empty cup on the table as she waited to be served. Two other residents in the dining room began yelling at her to "stop." During an interview on the afternoon of 08/19/21, an administrative staff (#20) agreed staff should sit while feeding residents. CATHETER PRIVACY BAG Review of the facility policy titled "Nursing Practice Guidelines" occurred on 08/19/21. This policy, revised February 2020, stated, ". . . Maintain resident rights . . . Respecting each individual's need, including privacy . . ." Observations showed the following: * 08/16/21 at 2:24 p.m., Resident #81 self-propelled through the hall with the catheter bag hanging from the wheelchair. * 08/16/21 at 5:12 p.m., Resident #81's catheter bag hung from the bed frame and visible from the	F 550		

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F 550	Continued From page 4	F 550		

doorway.
* 08/16/21 at 5:52 p.m., Resident #94 in the dining room with the catheter bag hanging from the wheelchair.

During an interview on 08/19/21 at 9:48 a.m., a managerial nurse (#4) confirmed she expects staff to use privacy bags to ensure the resident's dignity.

RESIDENT REQUESTS

Review of the facility policy titled "Nursing Practice Guidelines" occurred on 08/19/21. This policy, revised February 2020, stated, ". . . Maintain resident rights . . . Allowing resident to make choices regarding care . . ."

Observations showed the following:
* 08/16/21 at 2:23 p.m., Resident #94 laid in bed and requested to sit up for the interview. When the surveyor informed the CNA (#11) of the resident's request, the CNA replied, "Yes, I was just in there and I told him we would get him up later." Resident #94 still laid in bed at 3:01 p.m. and 4:03 p.m and questioned if staff are coming to transfer him to the chair.
* 08/17/21 at 11:16 a.m., two CNAs (#9 and #17) placed the Volaro [total body lift] sling under Resident #94, and attached the sling to the lift. The resident identified that he needed to have a bowel movement. Both CNAs continued to transfer resident from the bed to the wheelchair and unhooked the lift sling. A CNA (#17) asked the resident "Are you ready to go to lunch, I will take you there." Resident #94, yelling, again identified the urgency that he needed to have a bowel movement. The CNAs looked at the

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F 550	Continued From page 5 surveyor and CNA (#9) said to CNA (#17), "I guess we have to put him back in bed and let him use the bedpan." At 11:37 a.m. both CNAs transferred the resident back to bed and assisted him onto the bedpan. During an interview on 08/19/21 at 9:48 a.m., a managerial nurse (#4) confirmed she expected the staff to assist with resident requests and agreed that the CNAs failed to assist the resident in a timely manner.	F 550		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: ALTERNATIVE COMMUNICATION TOOLS 1. Based on observation, record review, and staff interview, the facility failed to accommodate the needs and preference for 1 of 1 sampled resident (Resident #47) with a language barrier. Failure to accommodate the language preference of residents may affect the facility's ability to effectively communicate with residents and has the potential to impact the resident's quality of life. Findings include: Review of the medical record for Resident #47	F 558	1. Picture cue cards obtained for Resident #47. Staff caring for Resident #47 have been educated on the use of the picture cue cards. Speech and Occupation therapy consults obtained for Resident #47. Adaptable tables were installed on the dining room tables for Resident #69 and #89. 2. Residents, who speak another language or have dementia, have the potential to be affected. All residents have the potential to be affected with positioning at the table. 3. Mandatory "All Staff Meetings" were held on September 15th & 16th, 2021 to	9/23/21

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F 558	Continued From page 6 occurred on all days of survey. The current care plan, stated, "Focus: I have a communication problem r/t [related to] Language barrier. . . . Interventions: . . . Use communications techniques which enhance interaction: Ask yes/no questions if appropriate, Use simple, brief, consistent words/cues, Use alternative communication tools translation App [an application for a cellular phone] and pictures." Observations on 08/17/21 at 05:15 p.m. showed Resident #47 tried to move another resident's walker upsetting the resident. An unidentified CNA (certified nurse aide) intervened, took Resident #47's hand, and walked around with the resident. Resident #47 talked to the CNA, but the CNA could not understand the resident. The CNA attempted to use an app on a cell phone but could not get it to work. Other CNAs in the lounge/hall could not understand Resident #47. The CNA directed Resident #47 to a list of questions on the wall posted at a level higher than the residents head, and Resident #47 did not look up at the questions. The CNA identified the questions are written in both the primary language of the facility and Resident #47's primary language, and it sometimes works to communicate with Resident #47. The staff available could not identify what Resident #47 attempted to tell them. The staff failed to use pictures as indicated by the care plan. During an interview on 08/18/21 at 1:35 p.m., an administrative nurse (#4) identified the nursing staff are to use an electronic device to show Resident #47 pictures.	F 558	provide education on the use of picture cue cards and proper positioning of residents at the dining room table. New policy & procedure developed "Effective Communication Resident." Education provided on policy and procedure to staff at the meeting. 4. The Director of Nursing Services (DON) (or designee) will monitor the effectiveness/use of the picture cue cards and position of residents at the dining room table. The monitoring will be conducted weekly for 4 weeks, then every two weeks for two months, then monthly for three months, then quarterly. If concerns are identified, immediate corrective action will be implemented. The DON (or designee) will report results of monitoring to the QA committee on a quarterly basis. 5. September 23rd, 2021.	

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F 558	Continued From page 7 POSITIONING DURING MEALS 2. Based on observation, record review, and resident/staff interviews, the facility failed to ensure reasonable accommodation of individual needs regarding positioning at the dining room table for 2 of 2 sampled residents (Resident #69 and #89) positioned inappropriately during meals. Failure to provide a dining room table at an appropriate height to meet individual needs may limit the residents' access to meal items contributing to weight loss, limit the quality of the dining experience, and/or cause discomfort related to improper positioning. Findings include: - Record review for Resident #69 occurred on all days of survey. Medical diagnoses included lack of coordination, left wrist/hand contractures, muscle weakness, and pain. The care plan identified, ". . . I have problem or potential nutritional problem . . . [History of] Insufficient fluid intake . . . significant unplanned weight loss . . . declined to change tables in dining room for proper positioning [in 2019] . . . I report coughing on liquids at times. . . . At times meal intake averages less than 75%. . . ." Observations of the dining room showed the following: * 08/16/21 at 6:10 p.m., 08/17/21 at 5:47 p.m., and 08/18/21 at 12:00 p.m., Resident #69 sat in her low wheelchair approximately 6-12 inches from the dining room table, with the top of the table at the level of her neck/clavicle. Resident #69 fed herself following tray set-up and leaned	F 558		

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F 558	Continued From page 8	F 558		

forward to access the items on the table. Some of the items remained outside her reach. Resident #69 also placed dishes on her lap for easier access.

During an interview on 08/18/21 at 12:20 p.m., when asked if she would prefer to sit at a table that would accommodate her small stature, Resident #69 stated, "That would be so nice."

- Record review for Resident #89 occurred on all days of survey. Medical diagnoses included adult failure to thrive, dementia, muscle weakness, and pain. The care plan identified, ". . . I have problem or potential nutritional problem . . . Potential insufficient fluid intake @ meals/ med [medication] pass . . . [History of] significant unplanned weight loss . . ."

Observations of the dining room showed the following:
* 08/16/21 at 5:40 p.m., Resident #89 sat in her low wheelchair approximately 6 inches from the dining room table, with the top of the table at the level of her chin. Her tray contained both mechanical soft chopped and pureed consistency food items and thin liquids. She fed herself following tray set-up, leaned forward to access the items on the table, and picked up sliced carrots with her fingers.
* 08/17/21 at 11:50 p.m., Resident #89 sat in her low wheelchair approximately 6 inches from the dining room table, with the top of the table at the level of her chin. Her tray contained both mechanical soft ground and pureed consistency food items and thin liquids. She fed herself following tray set-up and leaned forward to access the items on the table.

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F 558	Continued From page 9 * 08/18/21 at 12:10 p.m., Resident #89 sat in her low wheelchair approximately 6 inches from the dining room table, with the top of the table at the level of her chin. Her meal remained untouched. During interviews on 08/18/21 at 12:00 p.m. and 12:10 p.m., a therapy staff member (#27) agreed the height of Resident #69 and #89's dining room tables failed to accommodate their small stature.	F 558		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the	F 580		9/23/21

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F 580	Continued From page 10 resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to notify the physician of a change in condition for 1 of 1 sampled resident (Resident #24) who required the Heimlich maneuver after choking on food. Failure to notify the physician limited his ability to make informed decisions regarding Resident #24's medical care. Findings include: Review of the facility policy titled "Notification of Changes" occurred on 08/19/21. This policy, revised November 2016, stated, ". . . The facility will immediately . . . consult with the resident's	F 580	1. The physician was notified of #24 choking episode on March 19th, 2021. 2. Any resident has the potential to be affected. 3. A task was created, on September 15th, 2021 for all residents to be documented on both the day and evening shift and as needed. The task reads "Monitor/document/report to physician as needed for signs and symptoms of dysphagia, pocketing, choking, drooling, holding food in mouth, several attempts at swallowing, refusing to eat, appears concerned during meals, emergency care required." An alert, will be trigger in the	

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F 580	Continued From page 11 physician . . . when there is . . . A significant change in the resident's physical . . . status (that is, a deterioration in the health . . . status in either life-threatening conditions or clinical complications) . . ." Review of Resident #24's medical record occurred on all days of survey. Diagnoses include dementia, Parkinson's disease, and dysphagia (swallowing disorder). The physician's orders identified, "Small Portion . . . Pureed texture, Nectar consistency, Pinched straw sips with ALL beverages. Monitor for coughing." The current care plan identified, ". . . I am coughing with food and fluid . . . Monitor/document/report to doctor as needed for signs/symptoms of dysphagia: Pocketing, Choking, Coughing, Drooling, Holding food in mouth, Several attempts at swallowing, Refusing to eat, Appears concerned during meals. . . ." A progress note, dated 03/08/21 at 4:27 p.m., identified, "Resident eating Lunch in dinning [sic] room. Resident began choking CNA [certified nursing assistant] applied abd [sic] thrust and chunk of ground meat was dislodged from resident's throat. Resident continued to cough but no other difficulty breathing. Resident suctioned with small amount yellow phlegm removed from back of mouth. Resident continues to cough occasionally but breath sounds are clear and no other signs of resp. [respiratory] distress. . . ." During an interview on 08/19/21 at 11:50 a.m., a managerial nurse (#5) stated, "I called the nurse	F 580	electronic medical record, if yes is documented. Mandatory "All Staff Meetings" were held on September 15th & 16th, 2021. Staff were educated to notify physician of chocking episodes and on new alert developed. 4. The Director of Nursing Services (DON) (or designee) will monitor all alerts for residents, who are documented as having chocking episodes. The monitoring will be conducted weekly for four weeks, every two weeks for two months, monthly for three months, then quarterly. If concerns are identified, immediate corrective action will be implemented. The DON (or designee) will report results of monitoring to the QA committee on a quarterly basis. 5. September 23rd, 2021.	

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F 580	Continued From page 12 who was working [on 03/08/21] and she did not contact the doctor." The facility failed to notify Resident #24's physician of the choking episode and need for staff intervention (Heimlich maneuver).	F 580		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);	F 584		9/23/21

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F 584	Continued From page 13 §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide a homelike environment for dining on 1 of 4 units (Legacy). Failure to remove plates from the serving tray emphasizes an institutional character to the dining experience and does not provide a homelike environment for residents. Findings include: Observation of meals on the Legacy unit on 8/16/21 at 5:40 p.m. through 6:31 p.m. showed meals served on plastic trays. The staff placed the residents' supper trays on the tables and failed to remove the trays. During an interview on the afternoon of 8/18/21, a dietary manager (#2) confirmed staff should remove trays from residents' tables during meals.	F 584	1. All nursing staff/dietary staff were educated to not serve Legacy resident meals on a plastic tray unless resident requests. 2. All residents have the potential to be affected. 3. Mandatory "All Staff Meetings" were held on September 15th & 16th, 2021 to provide education to not serve resident meals on a plastic tray and on new policy & procedure "Safe and Homelike Environment." 4. The Dietary Service Manager (or designee) will monitor for placement of food on a plastic tray at dining room table during meal service. The monitoring will be conducted weekly for four weeks, every two weeks for two months, monthly for three months, then quarterly. If concerns are identified, immediate corrective action will be implemented. The Dietary Service Manager (or designee) will report results of monitoring to the QA committee on a quarterly basis. 5. September 23, 2021	
F 656	Develop/Implement Comprehensive Care Plan	F 656		9/23/21

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F 656 SS=E	Continued From page 14 CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.	F 656		

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F 656	Continued From page 15 (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to develop a comprehensive care plan for 4 of 41 sampled residents (Resident #16, #24, #80, and #102). Failure to develop a care plan that includes the care and services staff provide to the resident may negatively impact the resident's quality of life. Findings include: Review of the facility policy titled "Comprehensive Care Plans" occurred on 08/19/21. This policy, revised July 2014, stated, ". . . The plan of care will be reviewed and revised quarterly, annually, with a significant change of status and as needed to enhance the resident's ability to meet his/her objectives. . . ." HEART DISEASE/ANTIGOAGULANT USE - Review of Resident #16's medical record occurred on all days of survey and identified diagnoses of atrial fibrillation, cerebral infarction due to occlusion or stenosis, hypertension, and tachycardia. The physician's order, dated 05/10/21, identified, ". . . Apixaban [a blood thinner] Tablet 2.5 MG [milligrams] Give 2.5 mg by mouth two times a day related to UNSPECIFIED ATRIAL FIBRILLATION . . ." The quarterly Minimum Data Set (MDS), dated 05/16/21, identified Resident #16 received	F 656	1. Resident #16 care plan was updated on 8/24/2021 to address the resident□s anticoagulant use and goals/interventions to manage residents□ coagulation status. Resident #102 care plan was updated on 9/13/2021 to address resident□s anticoagulant use and goals/interventions to manage residents□ coagulation status. Resident #24 care plan was updated on 8/20/2021 to address resident□s antibiotic use and goals/interventions to manage the residents multiple UTI□s. Resident # 80 care plan was updated on 9/15/2021 to address residents□ oxygen needs and goals/interventions provided to manage respiratory status. 2. Any resident requiring an implementation of a care plan has the potential to be affected. 3. Mandatory "All Staff Meetings" were held on September 15th & 16th, 2021 to educate staff on the importance of implementing a current comprehensive care plan (new urinary tract infections, new anticoagulant use, & new oxygen orders). Policy & procedure "Comprehensive Care Plans" was reviewed during meetings. 4. The Director of Nursing Services (DON) (or designee) will run a weekly report for residents experiencing a urinary tract infection, new anticoagulant use, &	

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F 656	Continued From page 16 anticoagulation (blood thinning) medication on all seven days of the assessment period. Resident #16's care plan failed to address the resident's anticoagulant use and/or provide goals/interventions to manage the resident's coagulation status. - Review of Resident #102's medical record occurred on all days of survey and identified diagnoses of chronic embolism and thrombosis [blood clot blocking a vessel] and long-term use of anticoagulants [blood thinning]. The physician's order, dated 09/03/18, identified, ". . . Rivaroxaban Tablet 20 MG . . ." The annual MDS, dated 07/19/21, identified Resident #102 received anticoagulation medication on all seven days of the assessment period. Resident #102's care plan failed to address the resident's anticoagulant use and/or provide goals/interventions to manage the resident's coagulation status. During an interview on 08/19/21 at 9:48 a.m., two supervisory nurses (#4 and #5) acknowledged the residents' care plans failed to address their need for anticoagulant therapy. RESPIRATORY DISEASE/OXYGEN USE - Review of Resident #80's medical record occurred on all days of survey and identified a diagnosis of chronic obstructive pulmonary disease (lung disease). The physician's orders identified, ". . . oxygen at (2) L [liters]/min [minute] NC [nasal cannula]/Mask every shift for SOB [shortness of breath]/Decreased oxygen	F 656	new oxygen use. All weekly cases will have a care plan review. Monitoring will be completed weekly for 12 weeks, then monthly for three months, then quarterly. The results of the monitoring will be reported to the QA committee on a quarterly basis by the DON (or designee). 5. September 23rd, 2021	

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F 656	Continued From page 17 saturation . . ." The significant change MDS, dated 07/07/21, identified Resident #80 required oxygen therapy during the assessment period. Resident #80's care plan failed to address oxygen needs and/or provide goals/interventions to manage her respiratory status. During an interview on 08/19/21 at 9:48 a.m., two supervisory nurses (#4 and #5) acknowledged the residents' care plan failed to address the need for oxygen use. URINARY TRACT INFECTION (UTI)/ANTIBIOTIC USE - Review of Resident #24's medical record occurred on all days of survey and identified diagnoses of dementia, urinary urgency, and a history of 12 UTIs in 11 months. A progress noted, dated 08/13/21 at 2:43 p.m., identified, ". . . [Physician] review results of monthly UA's [urinary analysis] with new order received for Augmentin 875 [mg] every 12 hours with food for 14 days for diagnosis of UTI. . . ." Resident #24's care plan failed to address the resident's antibiotic use and/or provide goals/interventions to manage the resident's repetitive UTIs.	F 656		
F 658 SS=E	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-	F 658		9/23/21

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F 658	Continued From page 18 (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: NEUROLOGICAL CHECKS 1. Based on record review, review of facility policy, and staff interview, the facility failed to provide care in accordance with professional standards for 7 of 9 sampled residents (Resident #18, #24, #29, #36, #72, #80, and #87) with a history of falls. Failure to perform neurological assessments following an unwitnessed fall or fall with head injury has the potential to delay identification and treatment of signs/symptoms of a closed head injury. Review of the facility policy titled "Accidents/Incidents" occurred on 08/19/21. This policy, revised April 2020, stated, ". . . Following the Accident/Incident, vital signs will be monitored as follows . . . head injuries (or an unwitnessed fall) will be monitored every 15 minutes x [times] 2; every 30 minutes x 2; every hour X 2; every four hours X 2. Neurological assessment will be documented on the neurological flowsheet . . ." - Review of Resident #18's medical record occurred on all days of survey. Diagnoses included abnormal gait/mobility, muscle weakness, and difficulty walking. The care plan, dated 07/21/21, identified, ". . . I have had a fall with minor injury . . ." The progress notes identified the following: * 07/21/21 at 2:27 a.m., ". . . Resident [#18] was heard calling out from room, certified nursing assistant (CNA) discovered resident on floor in	F 658	1. Staff involved in the care of resident #18, #24, #29, #36, #72, #80, and #87 were educated on the frequency, and when to completed neurological assessments according to the policy & procedure for "Accidents/Incident." Staff involved in the care of Resident #102 have been educated on the timing of follow up finger stick blood sugars following a hypoglycemic episode. 2. Any resident who has a fall has the potential to be affected. Any resident, who is diabetic, or requires a finger stick blood sugar has the potential to be affected. 3. Mandatory "All Staff Meetings" were held on September 15th & 16th, 2021. Staff were educated on the frequency, and when to complete neurological assessments according to the "Accident/Incident" policy & procedure. Fall Packets (fall checklist, neurological documentation form, and fall scene investigation report) placed on each of the neighborhoods. Neurological assessment (Neuro Check-Post Fall Vital Signs) was changed from electronic to paper. Policy & procedure for "Hypoglycemia Management" was developed and education provided during meeting. Staff were educated during meeting on frequency of follow up finger stick blood sugar following a hypoglycemic episode. 4. The Director of Nursing Services (DON) (or designee) will monitor timing of neurological assessments after a fall and	

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F 658	Continued From page 19 room . . ." * 07/29/21 at 7:30 p.m., ". . . Resident [#18] found on floor by staff . . ." Review of Resident #18's medical record identified facility staff failed to complete neurological assessments per facility policy. - Review of Resident #24's medical record occurred on all days of survey. Diagnoses included dementia, Parkinson's disease, lack of coordination, muscle weakness, and reduced mobility. The care plan identified, ". . . I am high risk for falls. . . I often transfer myself to the bathroom without calling for assistance. I have a history of falls. . . ." The progress noted identified the following: * 01/12/21 at 12:30 a.m., "Resident was found in room sitting on floor mat, back against bed . . . neuro[check]'s started as per facility policy. . . ." * 01/20/21 at 8:28 a.m., "At [10:15 p.m.] resident found on hands and knees crawling to bathroom. . . . Neuro checks started and WNL." * 06/24/21 at 12:00 a.m., "Resident was heard on the video monitor calling out for help and was seen crawling out of her bed. Nurse and CNA on duty then saw her on the floor beside the fall mat. . . . Vital signs were taken . . ." Review of Resident #24's medical record identified facility staff failed to complete neurological assessments per facility policy. - Review of Resident #29's medical record occurred on all days of survey. Diagnoses included cerebral infarction (stroke), abnormal gait/mobility, dizziness, muscle weakness,	F 658	the timing of follow up finger stick blood sugars following a hypoglycemic episode. All resident, who sustain a fall, and/or who experience a hypoglycemic episode will be monitored weekly for 12 weeks, monthly for three months, then quarterly. If concerns are identified, immediate corrective action will be implemented. The DON (or designee) will report results of monitoring to the QA committee on a quarterly basis. 5. September 23rd, 2021	

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orthostatic hypotension, shortness of breath, syncope and collapse, history of falling and traumatic fracture. The care plan identified ". . . I am [at] Moderate risk for falls . . . Unaware of safety needs . . . I am known to self-transfer without calling for assistance. . . ."

The progress note, dated 06/28/21 at 3:05 p.m., identified, "Resident was found laying on his back on the floor of his restroom. . . . neuro checks performed . . . Resident stable with vital signs within baseline. . . ."

Review of Resident #29's medical record identified facility staff failed to complete neurological assessments per facility policy.

- Review of Resident #36's medical record occurred on all days of survey. Diagnoses included Parkinson's disease, abnormal posture, lack of coordination, muscle weakness, restless legs syndrome, and history of falling. The significant change Minimum Data Set (MDS), dated 05/31/21, identified Resident #36 had a fall with injury. Resident #36's care plan identified ". . . I am high risk for falls r/t [related to] Parkinson's, Deconditioning, Incontinence, unsteady gait. I do attempt to transfer myself at times . . ." The kardex report (CNA care plan) identified, ". . . video monitor at night for safety . . . Fall mat besides bed when in bed. . . ."

A progress note, dated 07/24/21 at 4:33 p.m., identified, "Resident [#36] found on floor between wall and bed, prone position . . ."

Review of Resident #36's medical record identified facility staff failed to complete

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F 658	Continued From page 21 neurological assessments per facility policy. - Review of Resident #72's medical record occurred on all days of survey. Diagnoses included abnormal gait/mobility, unsteadiness on feet, weakness, history of falling and traumatic fractures. The care plan identified ". . . I am moderate risk for falls . . ." The progress note identified the following: * 09/23/20 at 10:47 a.m., "Nurse manager found resident on floor. . . . neuros initiated . . ." * 10/19/20 at 2:49 a.m., "Staff member reported to nurse that she heard someone calling out and went down hallway to see what it was and found resident on the floor in her room. . . . Due to fall being unwitnessed, neuro checks started. . . ." * 11/12/20 at 4:14 a.m., ". . . Resident was found on flor [sic] next to her bed and mattress half deflated. . . . Neuro checks started and continued with stable vitals. . . ." * 11/26/20 at 2:42 p.m., "Resident found on floor next to bed, on left side. . . . Neuro checks initiated. . . . VSS [vital signs] . . ." * 06/17/21 at 7:30 a.m., "Resident was sent to ER [emergency room] via ambulance by night shift nurse due to a fall and head injury. . . . Resident is stable vital signs . . . Bump noted to back of the head to left side with a small cut about 1 inch of length. Dry blood noted to cut, no bleeding noted. . . ." Review of Resident #72's medical record identified facility staff failed to complete and document neurological assessments at the time frame and frquency required. - Review of Resident #80's medical record	F 658		

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F 658	Continued From page 22 occurred on all days of survey. Diagnoses included abnormalities of gait/mobility, hip pain, osteoarthritis, spinal stenosis, weakness, history of falls, and fall with laceration to scalp. The significant change MDS, dated 07/07/21, identified Resident #80 had a fall with injury. Resident #80's care plan identified ". . . I am at high risk for falls r/t Deconditioning, Incontinence. . . . I have had an actual fall with (No Injury) Poor Balance, Unsteady gait . . . Neuro [neurological]-checks Q [every] 15 minutes X 4, 30 min X 4, Q 1 hour X 4, Q 4 hours X 4. . . . I have an ADL [activities of daily living] Self Care Performance Deficit r/t Activity Intolerance, Fatigue. . . . I require (2) staff participation with transfers with HOYER [mechanical lift] . . ." The kardex report identified, ". . . video monitor . . . Follow facility fall protocol. . . ." Progress notes identified the following: * 05/01/21 at 6:19 a.m., "resident was on the floor. . . . laying in front of her bed with her head underneath her bed. . . . fall was not observed. . . ." * 06/16/21 at 2:29 p.m. (late entry), "CNA found [Resident #80] on floor next to bed @ [at] 6:30 am. . . . her head was resting by garbage can and blood noted from laceration. . . . laceration measured approx. [approximately] 3 cm [centimeters] and gapping. small bruises starting to form on cheek and left arm. Neuro checks performed and at baseline for resident. . . . sent to ER [emergency room]. . ." * 06/23/21 at 3:56 p.m., "Resident found o [on] floor under bed. . . . small bruise to right side of face near eye. . . ." Review of Resident #80's medical record	F 658		

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F 658	Continued From page 23 identified facility staff failed to complete and document neurological assessments at the time frame and frquency required. - Review of Resident #87's medical record occurred on all days of survey. Diagnoses include dementia, visual loss, syncope, muscle weakness, lack of coordination, abnormal gait/mobility. The care plan, dated, 07/21/2021, identified, ". . . I have a fall history . . ." The progress notes identified the following: *04/27/21 at 08:15 p.m., ". . . Resident [#87] was found sitting on the floor by bed . . . leaning on her right side . . ." Review of Resident #87's medical record identified facility staff failed to complete and document neurological assessments at the time frame and frquency required. During an interview on 08/18/21 at 9:48 a.m., a supervisory nurse (#4) agreed staff failed to complete and document the neurological assessments at the time frame and frequency required. BLOOD GLUCOSE LEVEL 2. Based on record review, review of facility policy, and staff interview, the facility failed to ensure staff followed standards of practice for 1 of 1 sampled resident (Resident #102) who received insulin. Failure to reassess blood glucose for residents with abnormal levels may result in adverse effects related to hypoglycemia or hyperglycemia (low or high blood sugar levels).	F 658		

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F 658	Continued From page 24 Findings include: Review of the facility policy titled "Hyperglycemia/Hypoglycemia" occurred on 08/19/21. This policy, revised May 2013, stated, ". . . Blood Sugar less than 70 [mg (milligrams)/dl (deciliter)] . . . As per physician order for hypoglycemic reaction or administration of concentrated carbohydrate (4-6 oz [ounces] Gatorade, orange juice, milk, glucose gel) as per sliding scale insulin protocol. . . . Document any incident of either hyper or hypoglycemia in the progress notes section of the electronic medical record. . . ." Review of Resident #102's medical record occurred on all days of survey. Diagnoses included Type 2 diabetes mellitus and long term use of insulin. The annual Minimum Data Set (MDS), dated 07/19/21, identified Resident #102 required insulin injections for all seven days of the assessment period. The care plan, revised 08/24/18, identified ". . . I have Diabetes Mellitus and I use insulin. . . . " The physician's orders identified, ". . . if 50-60 [mg/dl] blood sugar give 8 ounces of carbohydrate. Recheck finger stick blood sugar in 15 to 30 minutes. Repeat treatment and finger stick blood sugar as necessary according to policy . . . 60-70 [mg/dl] blood sugar give 4-6 ounces concentrated carbohydrates. Recheck finger stick blood sugar in 15 to 30 minutes. Repeat treatment and finger stick blood sugar as necessary according to policy . . ." The electronic medication administration record	F 658		

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F 658	Continued From page 25 notes [eMAR]," dated January-June 2021, showed facility staff failed to follow the physician's order and perform 15 to 30 minute blood glucose rechecks on 5 out of 6 occasions when Resident #102's blood sugar levels measured less than 70 mg/dl. During an interview on 08/18/21 at 9:48 a.m., a supervisory nurse (#4) confirmed staff failed to complete the required blood glucose rechecks for Resident #102 per physician's order and facility policy.	F 658		
F 659 SS=D	Qualified Persons CFR(s): 483.21(b)(3)(ii) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to ensure qualified persons provided care, in accordance with the resident's written plan of care, for 1 of 1 sampled resident (#81) observed during a colostomy appliance change. Allowing unlicensed, untrained staff members to provide colostomy appliance changes has the potential to endanger the health and safety of this resident. Findings include: Review of the facility policy titled "Nursing Practice Guidelines - Nursing Service	F 659	1. Staff caring for resident #81 have been educated on the Nurse Practice Act that excludes unlicensed staff from changing colostomy appliances. 2. Any resident with a colostomy has the potential to be affected. 3. Mandatory "All Staff Meetings" were held on September 15th & 16th, 2021 to provide education on the scope of practice for licensed and unlicensed staff, the policy of Bethel Lutheran Nursing & Rehabilitation Center that states changing a colostomy appliance is the responsibility of the nurse and a certified nursing	9/23/21

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F 659	Continued From page 26 Department" occurred on 08/19/21. This policy, revised February 2020, stated, ". . . Ostomy bag - applied, cleaned and changes as needed. . . ." Observation on 08/17/21 at 11:48 a.m. showed a certified nursing assistant (CNA) (#9) and a CNA in orientation (#21) responded to Resident #81's call light. The resident stated, "It [colostomy appliance] exploded." The CNA (#9) obtained a skin prep pad, ostomy pouch, and scissors out of the resident's top drawer. The CNA (#9) removed the ostomy wafer and pouch and discarded them in the garbage. The CNA (#9) asked the other CNA (#12) to ask the nurse for a new appliance. The CNA (#9) cleansed the stoma and peristomal skin with a wet washcloth, then wiped the peristomal skin with the skin prep pad. The other CNA (#12) arrived with the ostomy wafer. The CNA (#9) cut the wafer and told the other CNA (#12), "We cut this at the second line for Resident #81." The CNA (#9) removed the backing and applied the wafer to the skin, then applied the pouch. CNA (#9) told CNA (#12), "We just change this when it needs to be changed." Resident #81 responded, "Yeah it has been about a week since it was changed." During an interview on 08/19/21 at 9:48 a.m., an administrative nurse (#8) and two supervisory nurses (#4 and #5) confirmed the CNAs lack qualifications and training to change an ostomy appliance. "Their role is to empty the bag and record the output."	F 659	assistant may empty and document output only. 4. The Director of Nursing Services (DON) (or designee) will monitor that only licensed staff are changing colostomy appliances. The monitoring will be conducted weekly for 4 weeks, every two weeks for two months, monthly for three months, then quarterly. If concerns are identified, immediate corrective action will be implemented. The DON (or designee) will report results of monitoring to the QA committee on a quarterly basis. 5. September 23rd, 2021.	
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that	F 684		9/23/21

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F 684	Continued From page 27 applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: DIET CONSISTENCY 1. Based on observation, record review, review of professional reference, and staff interview, the facility failed to ensure 5 of 6 sampled residents (Resident #24, #29, #40, #55, and #89) received the care and services necessary to attain the highest degree of safety possible while consuming a modified diet and/or thickened liquids. Failure to provide the appropriate thickened liquid consistency placed these residents at risk for aspiration and dehydration/weight loss. Findings include: Staff failed to provide a copy of the policy addressing feeding assistance. Swigert's "The Source for Dysphagia," 3rd ed., Pro-Ed, Inc., Texas, 2007, pages 9, 10, 125, and educational handouts, identified, ". . . Signs and Symptoms of Dysphagia . . . coughing . . . during a meal . . Some patients cough and choke when they aspirate . . . Thickened liquids are easier to keep together as a cohesive bolus. Thickened liquids also move more slowly through the pharynx [throat], giving the larynx [throat] more time to close and protect the airway. . . . During	F 684	1. Staff involved in preparing food of resident #24 were educated on diet types, consistency, and process of preparing ordered diet. Staff involved in the care of resident #40 were educated on adding thickening to fluids to get appropriate thickness as ordered and where to find instructions based on ordered consistency for hot or cold fluids. Staff involved with the care of resident #29 were educated on proper height of head and position a resident should be in to decrease risk of swallowing problems. Staff involved with the preparation of resident #55 meals were educated on mechanical soft diet and finger foods. Staff involved in care of resident #89 were educated on appropriate diet ordered and for the need to assist with eating per order. Staff also educated on recognizing signs resident and others may be having difficulty with feeding self (picking up foods normally eaten with utensils, mixing foods inappropriately, not knowing what to do with food, etc.). Staff caring for resident #15 were educated to provide (or assist as needed) with oral cares. 2. Any resident with altered consistency diet ordered, declining status, consuming	

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F 684	Continued From page 28 the oral intake of medicines, foods and/or liquids, it is optimal for a patient to be seated at a 90-degree angle, whether in bed or in a chair. . . . The 90 [degree] position allows the patient to control material in the oral cavity [mouth] with a minimal impact of gravity. . . . Even a slightly reclined position while eating greatly increases the risk of premature loss of food over the back of the tongue. . . ." - Review of Resident #24's medical record occurred on all days of survey. Diagnoses include dementia, Parkinson's disease, and dysphagia (swallowing disorder). The current care plan identified, ". . . I am coughing with food and fluid . . . Monitor/document/report to doctor as needed for signs/symptoms of dysphagia: Pocketing, Choking, Coughing, Drooling, Holding food in mouth, Several attempts at swallowing, Refusing to eat, Appears concerned during meals. . . ." During an interview on 08/19/21 at 11:50 a.m., a managerial nurse (#5) reported Resident #24's physician's orders, dated 03/02/21, identified "pureed diet with honey thickened liquids." A progress note, dated 03/08/21 at 4:27 p.m., identified, "Resident eating Lunch in dinning [sic] room. Resident began choking CNA [certified nursing assistant] applied abd [sic] thrust and a chunk of ground meat was dislodged from the resident's throat. The resident continued to cough but no other difficulty breathing. Resident suctioned with small amount yellow phlegm removed from back of mouth. Resident continues to cough occasionally but breath sounds are clear and no other signs of resp. [respiratory]	F 684	food or drink in bed or reclining chair, or experiencing a change in dentation has the potential to be affected. Any resident who receives nothing by mouth has the potential to be affected with oral cares. 3. Mandatory All Staff Meetings were held on September 15th & 16th, 2021. Staff were educated on appropriate diet consistency, preparation, how to thicken liquids and where to find instructions to do so, recognizing difficulty feeding self, proper positioning while eating or drinking, and where to find the ordered diet on tray cards. Staff were educated on providing (or assisting as needed) oral cares to residents who are receiving nothing by mouth. 4. The Director of Nursing Services (or designee) will monitor diet consistency served matches ordered diet, staff thickening liquids for residents, residents for receiving proper assistance during meals, oral cares given to residents who are not receiving food or drink by mouth. Monitoring will be conducted weekly for four weeks, every two weeks for two months, monthly for three months, then quarterly x3. If concerns are identified, immediate corrective action will be implemented. The Director of Nursing Services(or designee) will report results of monitoring to the QA committee on a quarterly basis. 5. September 23, 2021	

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distress. . . ." Staff failed to serve Resident #24 pureed foods as per physician's order.

- Review of Resident #29's medical record occurred on all days of survey. Diagnoses include cerebral infarction (stroke) and dysphagia. The care plan identified, ". . . I have problem or potential nutritional problem related to . . . dehydration . . . I have oral-pharyngeal dysphagia w/SLP [speech language pathologist] Swallow evaluation 6/16/21. . . ."

Observation on 08/16/21 at 9:14 a.m., showed a nurse (#29) raised the head of Resident #29's bed to an approximate forty-degree angle before administering his medications and encouraging him to drink a glass of water. The medications were cut in half and placed in pudding. Staff failed to raise the head of Resident #29's bed to an approximate ninety-degree angle prior to offering him the medications in pudding and a glass of water.

- Review of Resident #40's medical record occurred on all days of survey. Diagnoses include dysphagia following cerebral infarction (stroke) and pneumonitis (lung infection) due to inhalation of food/vomit. The quarterly Minimum Data Set (MDS), dated 06/07/21, identified coughing or choking during meals or when swallowing medications.

The current physician's orders identified, ". . . Regular (General/DAT [diet as tolerated]) diet Mechanical Soft texture, Nectar consistency [liquids] . . ."

The care plan identified ". . . I have a swallowing

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problem r/t [related to] Coughing or choking during meals or swallowing med [medication], difficulty with thin liquids. Mech [mechanical] Soft diet with Nectar thick liquids was ordered. . . . I requires [sic] assistance with meals. Cue me and feed me with all meals. . . ."

Observations showed the following:
* 08/17/21 at 5:54 p.m., a managerial activity staff member (#3) added one pump of Simply Thick Easy Mix to Resident #40's eight-ounce cup of hot chocolate. According to the mixing instructions on the label, hot chocolate required two pumps to obtain a nectar thick consistency.
* 08/17/21 at 5:54 p.m., a dietary staff member (#7) added two pumps of Simply Thick Easy Mix to Resident #40's four-ounce glass of juice. According to the mixing instructions on the label, juice required one pump to obtain a nectar thick consistency.
* 08/17/21 at 5:54 p.m., a managerial activity staff member (#3) served Resident #40's tray. Staff failed to assist/cue Resident #20 during the supper meal. Observation showed Resident #40 coughed occasionally during the meal.

During an interview on 08/18/21 at 12:38 p.m., a managerial dietary staff member (#2) reported the facility trains all staff to use Simply Thick Easy Mix and confirmed both staff members (#3 and #7) failed to add the correct amount of thickener to Resident #40's liquids.

- Review of Resident #55's medical record occurred on all days of survey. Diagnoses include dementia, weakness, and dehydration. The quarterly MDS, dated 06/19/21, identified loss of 5% or more in the last month and not on a

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physician-prescribed weight-loss regimen. Review of "Weight Change Note", dated 07/12/21, identified, ". . . Resident triggers for significant unplanned weight loss of -12.2% in 30 days from 5/19/21 238# to 209# 6/30/21. . . ."

The physician's orders identified, ". . . Finger Food Diet, Mechanical Soft texture, Thin consistency, Finger foods per OT [occupational therapy] 6/18/21. . . ."

The care plan identified, ". . . I have problem or potential nutritional problems . . . I have poor po [by mouth] intake at meals . . . Significant wt [weight] loss in last 30 days . . ." The kardex report [CNA care plan] identified, ". . . I require (1) staff participation to eat. I am able to feed myself finger foods. . . . Trial small portions 7/12/21. . . ."

Observations showed the following:
* 08/16/21 at 6:37 p.m., staff failed to serve Resident #55 a meal tray. Staff served Resident #55's meal 40 minutes after the start of the dining service as kitchen staff had already left the service area.
* 08/18/21 at 12:02 p.m., staff served Resident #55 a mechanical soft tray without finger foods.

During an interview on 08/18/21 at 12:38 p.m., a managerial dietary staff member (#2) confirmed staff failed to serve Resident #55 mechanical soft finger foods.

- Record review for Resident #89 occurred on all days of survey. Medical diagnoses included adult failure to thrive and dementia. The physician orders identified, ". . . Mechanical Soft [textured foods], Thin consistency [liquids] . . ." The care

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F 684	Continued From page 32 plan identified, ". . . I have problem or potential nutritional problem . . . Potential insufficient fluid intake [at] meals/ med [medication] pass . . . [History of] significant unplanned weight loss . . ." Observations of the dining room showed the following: * 08/16/21 at 5:40 p.m., Resident #89 fed herself following tray set-up. Her tray contained both mechanical soft chopped and pureed consistency food items and thin liquids. An unidentified staff member encouraged Resident #89 to eat as she walked past the table. Observation showed Resident #89 picked up sliced carrots with her fingers and three carrots floating in her juice. Staff failed to serve Resident #89 mechanical soft foods as per physician's order and failed to assist as needed throughout the meal. * 08/17/21 at 11:50 p.m., Resident #89 took a bite of her ground turkey following tray set-up. Her tray contained both mechanical soft ground and pureed consistency food items and thin liquids. A certified nursing assistant (CNA) (#13) walked by Resident #89's table, and stated, "Are you gonna swallow? You've been chewing on that meat forever. Try to swallow." Staff failed to serve Resident #89 mechanical soft foods as per physician's order and failed to assist as needed throughout the meal. * 08/18/21 at 12:10 p.m., Resident #89 sat in her low wheelchair next to the dining room table with her meal untouched. Staff failed to assist as needed throughout the meal. During an interview on 08/19/21 at 1:21 p.m., a managerial staff member (#28) reported, "[Resident #89] is on a mechanical soft diet with finger foods. I don't know why she would	F 684		

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get puree foods. [Resident #89] doesn't eat well if she's alone."

ORAL CARES

2. Based on observation, record review, review of facility policy, review of professional reference, and resident/staff interviews, the facility failed to ensure 1 of 1 sampled resident (Resident #15) who consumes nothing by mouth (NPO) received the care and services necessary to attain the highest degree of safety possible. Failure to provide oral cares placed the resident at risk for oral and respiratory infection.

Findings include:

Review of the facility policy titled "Oral Hygiene" occurred on 08/19/21. This policy, revised April 2020, stated, ". . . Certain residents (example gastrostomy tube) may be more prone to oral problem and may require oral cares on a more frequent basis. The residents will have individual care plans on how often to complete the oral cares . . ."

Berman, Snyder, and Frandsen's "Kozier & Erb's Fundamentals of Nursing: Concepts, Process, and Practice," 10th ed., Pearson Education, Inc., Massachusetts, page 758, states, ". . . Provide special oral care . . . To prevent oral infections and potential respiratory infections . . . to clean and moisten the membranes of the mouth and lips . . ."

Review of Resident #15's medical record occurred on all days of survey. Diagnoses include right hemiplegia/hemiparesis [paralysis

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	355070	A. BUILDING _____ B. WING _____	08/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHEL LUTHERAN NURSING & REHABILITATION CENTER	1515 2ND AVE WEST WILLISTON, ND 58801

(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 684	Continued From page 34	F 684		

on one side of the body] following cerebral infarction [stroke] and gastrostomy. The significant change Minimum Data Set (MDS), dated 05/16/21, identified Resident #15 received 51% or more of his total calories through a feeding tube. The physician's order identified, ". . . Check self-admin [administration] nightly (biotene) [mouthwash] every night shift . . ."

Resident #15's care plan identified ". . . I require tube feeding related to Dysphagia [swallowing disorder]. . . . I am NPO - nothing by mouth. . . . I am able to suction myself. . . . I am able to brush my own teeth with set up. . . ." The kardex report [CNA care plan] identified, ". . . Assist me with my oral cares by providing ice water and mouth swabs at sink while sitting up and staff to supervised [sic], set up and assist as needed. . . . Swab mouth with moist toothettes . . ."

Observations on 08/17/21 at 10:05 a.m., 08/18/21 at 10:43 a.m., 11:13 a.m., and 1:15 p.m., showed staff (#9 and #10) provided cares and failed to offer oral hygiene.

During an interview on 08/18/21 at 8:45 a.m., Resident #15 confirmed staff do not offer him moist toothettes with cares and do not consistently offer him his Biotene mouth rinses at night. Resident #15 reported he is unable to open the Biotene bottle.

During an interview on 08/19/21 at 9:48 a.m., an administrative nurse (#8) and two managerial nurses (#4 and #5) confirmed the nursing staff should offer Resident #15 oral hygiene cares after assisting him with other cares at a minimum of every two hours.

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F 692 SS=E	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and review of professional reference, the facility failed to provide/offer fluids to 10 of 17 sampled residents (Resident #2, #16, #22, #24, #45, #49, #61, #72, #97, #103) observed during cares and/or required staff assistance for fluid intake. Failure to provide fluids and/or assistance with fluid intake may result in dehydration, constipation, and urinary tract infections (UTIs). Findings include:	F 692	1. Resident #2, #16, #22, #24, #45, #49, #61, #72, #97, & #103 will be placed on intake monitoring daily beginning 9/20/21. These residents will be assessed for adequate intake as evidenced by signs and symptoms of dehydration. Staff involved with the care of these residents were educated on the importance of offering fluids following all cares. 2. All residents, that are dependent on staff for activities of daily living (ADL), have the potential to be affected. 3 Mandatory "All Staff Meetings" were	9/23/21

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F 692	Continued From page 36 Review of the facility policy titled "Hydration Management" occurred on 08/19/21. This policy, revised May 2017, stated, ". . . Fluids readily available in resident rooms and offered to resident at appropriate intervals during cares. . . ." Swigert's "The Source for Dysphasia," 3rd ed., Pro-Ed, Inc., Texas, 2007, page 137, identified, ". . . One of the most difficult challenges when working with patients is getting them to take enough thickened liquids to meet their fluid needs. . . ." - Review of Resident #2's medical record occurred on all days of survey. Diagnoses included dementia, dysphasia (swallowing disorder), constipation, and history of urinary tract infections. The physician's orders identified, ". . . thin [liquid] consistency . . ." The current Kardex report (CNA care card) identified, ". . . Encourage fluids . . ." Observations showed no water/fluids available in Resident #2's room on 08/16/21 at 1:20 p.m. and 08/17/21 at 5:27 p.m. - Review of Resident #16's medical record occurred on all days of survey. Diagnoses included cerebrovascular accident (CVA), dementia, dysphasia, constipation, and history of urinary tract infections. The physician's orders identified, ". . . nectar [thickened liquid] consistency . . ." The current Kardex report identified, ". . . Offer fluids throughout the day, fluids with medication pass and meals. NECTAR THICK . . ."	F 692	held on September 15th & 16th, 2021 to educate staff on the importance of offering fluids following all ADL cares and signs & symptoms of fluid deficit. 4. The Director of Nursing Services (DON) (or designee) will evaluate intake record after 1 week of monitoring to identify those at continued risk. At risk residents will remain on intake monitoring until deemed appropriate to remove. Staff will also be monitored for offering fluids following cares by DON (or designee). Monitoring will be completed weekly for four weeks, biweekly for two months, monthly for three months, then quarterly. The results of the monitoring will be reported to the QA committee on a quarterly basis by the DON (or designee). 5. September 23rd, 2021	

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F 692	Continued From page 37 Observations showed the following: * 08/16/21 at 1:20 p.m., No water/fluids available in Resident #16's room. * 08/17/21 at 9:37 a.m., Two certified nursing assistants (CNAs) (#12 and #13) provided Resident #16's cares without offering water. - Review of Resident #22's medical record occurred on all days of survey. Diagnoses included dementia, dysphagia, and constipation. The physician's orders identified, ". . . nectar [thickened liquid] consistency . . ." The current Kardex report identified, ". . . Offer fluids throughout the day, fluids with medication pass and meals. NECTAR THICK . . ." Observation on 08/16/21 at 3:05 p.m. showed no water/fluids available in Resident #22's room, and the CNAs (#31 and #32) offered no fluids after cares. - Review of Resident #24's medical record occurred on all days of survey. Diagnoses included dementia, Parkinson's disease, dysphasia, constipation, and history of urinary tract infections. The physician's orders identified, ". . . nectar consistency . . ." Observations showed the following: * 08/16/21 at 1:20 p.m., no water/fluids available in Resident #24's room. * 08/17/21 at 9:19 a.m., CNAs (#12 and #13) provided Resident #24's cares without offering water. - Review of Resident #45's medical record occurred on all days of survey. The quarterly Minimum Data Set (MDS), dated 06/05/21,	F 692		

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F 692	Continued From page 38	F 692		

identified extensive assist of one person for eating. The current care plan identified, ". . . Encourage good nutrition and hydration . . ." The current Kardex report identified, ". . . Encourage fluids during the day . . ."

Observation on 08/17/21 at 8:59 a.m. showed CNAs (#21 and #24) provided Resident #45's cares without offering water.

- Review of Resident #49's medical record occurred on all days of survey. Diagnoses included history of traumatic brain injury, unspecified dementia with behavioral disturbance, and cognitive communication deficit. The current care plan and Kardex report identified, ". . . Encourage fluids during the day . . ."

Observation on 08/17/21 at 11:10 a.m. showed CNAs (#21 and #23) transferred Resident #49 into the wheelchair and exited the room without offering water.

- Review of Resident #61's medical record occurred on 08/19/21. The current care plan identified, ". . . Encourage . . . hydration . . ." The Kardex report identified, ". . . Encourage fluids during the day . . ."

Observation on 08/17/21 at 11:16 a.m. showed CNAs (#21 and #23) transferred Resident #61 into the wheelchair and exited room without offering water.

- Review of Resident #72's medical record occurred on all days of survey. Diagnoses included dysphasia, constipation, and history of

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F 692	Continued From page 39 urinary tract infections. The physician's orders identified, ". . . thin [liquid] consistency . . ." The current Kardex report identified, ". . . Encourage fluids . . ." Observation on 08/17/21 at 9:47 a.m. showed the CNAs (#12 and #15) provided Resident #72's cares without offering water. - Review of Resident #97's medical record occurred on all days of survey. Diagnoses included CVA, dementia, constipation, and history of urinary tract infections. The physician's orders identified, ". . . thin [liquid] consistency . . ." The current Kardex report identified, ". . . Encourage fluids . . ." Observation on 08/16/21 at 9:54 a.m. showed a CNA (#19) provided Resident #97's cares without offering water. - Review of Resident #103's medical record occurred on 08/19/21. The current care plan identified, ". . . Encourage . . . hydration . . ." The current Kardex report identified, ". . . Encourage fluids . . ." Observation on 08/16/21 at 2:57 p.m. showed a CNA (#23) provided Resident #103 cares without offering water. Facility staff failed to ensure Resident #2, #16, and #24 had water in their rooms and assist Resident #16, #22, #24, #45, #49, #61, #72, #97, and #103 with fluid intake.	F 692		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5)	F 693		9/23/21

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F 693	Continued From page 40 §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, review of professional reference, and staff interview, the facility failed to provide the care and services to prevent potential complications for 1 of 1 sampled resident (Resident #15) receiving medication and nutrition by a gastrostomy tube. Failure to check gastric residual volume, dissolve medications in water prior to administration, and flush the gastrostomy tube after interrupting the feeding has the potential to result in adverse events. Findings include:	F 693	1. Staff member caring for resident #15 was educated to check gastric residual volume, dissolve medication in 30 ml water prior to administration, and to flush the gastrostomy tube with 30 ml□s of water after interrupting the feeding. 2. Any resident, who has a gastrostomy tube, has the potential to be affected. 3. "All Staff Meetings" were held on September 15th & 16th, 2021 to educate staff to check gastric residual volume prior to use of gastrostomy tube, dissolve medication in 30 ml□s of water, and to flush gastrostomy tube with 30 mls of	

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F 693	Continued From page 41 Review of the facility policy titled "Enteral Tube Feeding" occurred on 08/19/21. The policy, revised August 2019, stated, ". . . Assessment of gastric residual volume. . . . return aspirate to the stomach (via tube). . . . Flushing the gastrostomy tube. . . . Flush whenever feeding is interrupted. . . ." Berman, Snyder, and Frandsen's "Kozier & Erb's Fundamentals of Nursing: Concepts, Process, and Practice," 10th ed., Pearson Education, Inc., Massachusetts, page 843, states, ". . . Crush a tablet into a fine powder and dissolve in 30 to 60 mL [milliliters] of warm purified water. . . . Do not administer whole or undissolved medications because they will clog the tube. . . ." Review of Resident #15's medical record occurred on all days of survey. Diagnoses include dysphagia following unspecified cerebrovascular disease and gastrostomy. The significant change in status Minimum Data Set (MDS), dated 05/16/21, identified Resident #15 receives 51% or more of the total calories through a feeding tube. Resident #15's current care plan identified ". . . I require tube feeding related to Dysphagia. . . . Check for tube placement and gastric contents/residual volume per facility protocol and record. . . ." The current physician's orders identified, ". . . Check GA [gastric] tube for placement/residual before administration of medications follow with flushing GA tube with 30 ml of water . . . three times a day. . . ." Observations showed the following: * 08/18/21 at 10:43 a.m., a nurse (#10)	F 693	water after interrupting the feeding. Competency checklist has been completed for all direct care licensed staff. 4. The Director of Nursing Services (DON) (or designee) will monitor licensed nursing staff for medications administered through a gastrostomy tube, will be diluted in 30 ml□s of water, given individually, flushed before and after each medication, as well as gastric residual volume check prior to use of gastrostomy tube, and a water flush of 30 ml□s anytime the gastrostomy feeding is interrupted. The monitoring will be conducted weekly for 4 weeks, every two weeks for two months, monthly for three months, then quarterly. If concerns are identified, immediate corrective action will be implemented. The DON (or designee) will report results of monitoring to the QA committee on a quarterly basis. 5. September 23rd, 2021.	

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F 693	Continued From page 42 administered crushed medications and Jevity (tube feeding formula) feeding per Resident #15's gastrostomy tube. The nurse failed to check the gastric residual volume prior to the administration. The nurse (#10) failed to dissolve medications in water prior to administration. * 08/18/21 at 1:15 p.m., a nurse (#10) interrupted Resident #15's tube feeding to check gastric residual volume and failed to flush the tube. During an interview, on 08/19/21 at 9:48 a.m., an administrative nurse (#8) and two managerial nurses (#4 and #5) confirmed they expected the nursing staff to check gastric residual volume prior to using the gastrostomy tube, to dissolve medications in water prior to administration to prevent clogging, and flush the gastrostomy tube after interrupting the feeding.	F 693		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility	F 755		9/23/21

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F 755	Continued From page 43 must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to ensure the availability of emergency medications to meet the needs of residents in 1 of 1 emergency medication box. Failure to remove and replace expired medication has the potential for residents to go untreated in the event of an emergency. Findings include: Review of the facility policy titled "Emergency and After Hour Drug Supply" occurred on 8/18/21. This policy, dated February 2020, stated, " . . . The emergency drug kit contains drugs . . . essential in providing treatment . . ." Observation of the medication room (The Towers) occurred on 8/18/21 at 11:09 a.m. with an administrative staff member (#8). A list of mediations for the emergency medication box identified Doxycycline (an antibiotic) with an	F 755	1. The doxycycline, haloperidol, and nitroglycerin were removed from the emergency kit on August 19th, 2021 and replaced. 2. Any resident requiring an emergency medication has the potential to be affected. 3. Mandatory "All Staff Meetings" were held on September 15th & 16th, 2021 to educate staff to check the emergency medication kit and remove/replace all expired medications. The policy & procedure "Emergency & After Hour Drug Supply" was reviewed and staff educated. Consultant pharmacist notified and educated to check emergency kit for expired medications monthly and replace if required. 4. The Director of Nursing Service (DON) (or designee) will monitor the emergency kit for any expired	

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F 755	Continued From page 44 expiration date of June 2021, Haloperidol (an antipsychotic) with an expiration date of June 2021, Nitroglycerin (used for chest pain) with an expiration date of June 2021. During an interview on 8/19/21 at 11:09 a.m., an administrative nurse (#8) confirmed staff should remove/replace the expired medications in the emergency kit.	F 755	medications. Monitoring will be done weekly for four weeks, then every two weeks for two months, then quarterly. If concerns are identified immediate corrective action will be implemented. The DON (or designee) will report to the QA committee on a quarterly basis. 5. September 23rd, 2021.	
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, review of a professional reference, and staff interview, the facility failed to	F 757	1. Staff involved in the care of resident #24 have been educated to obtain urine	9/23/21

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F 757	Continued From page 45 ensure a regimen free of unnecessary medications for 1 of 10 sampled residents (Resident #24) with a history of urinary tract infections (UTIs). Failure to discontinue an antibiotic or include documentation regarding the clinical justification for continued use of the antibiotic placed Resident #24 at risk of experiencing adverse effects related to its continued use. Findings include: Kozier & Erb's "Fundamentals of Nursing, Concepts, Process and Practice," 11th Edition eText, 2021, Pearson, Boston, Massachusetts, page 675, stated, ". . . Certain medications also increase susceptibility to infection. . . . Even some antibiotics used to treat infections can have adverse effects. Antibiotics may kill resident flora, allowing the proliferation of strains that would not grow and multiply in the body under normal conditions. . . ." - Review of Resident #24's medical record occurred on all days of survey and identified diagnoses of urinary urgency and history of 12 UTIs in 11 months. The progress notes identified the following: * 02/12/21 at 1:37 p.m., ". . . Cephalexin and Macrobid for UTI. . . . Resident continues to have urges to go and asks to go about every half hour or so. No other symptoms at this time." * 02/12/21 at 5:08 p.m., "[Physician's] nurse called to inform us of ordering Bactrim 2 x [times] daily for UTI asked the nurse if we were to continue the Nitrofurantoin Macrocrystal Capsule 25 MG [milligrams] PO [by mouth] at bedtime or if	F 757	culture microbiology report when completed to check prescribed antibiotics are not resistant. 2. Any resident, who has a urine culture ordered has the potential to be affected. 3. Mandatory “All Staff Meetings” were held on September 15th & 16th, 2021 to educate staff that when a urine culture is ordered to obtain the urine culture microbiology report, when completed, and to check prescribed antibiotics are not resistant. Neighborhood Nurse Managers/Infection Control Nurse have developed a spread sheet to identify when urine cultures have been ordered, and when, lurine culture microbiology reports have been received. 4. The Director of Nursing Services (DON) (or designee) will monitor all residents, who have a urine culture completed, for a urine culture microbiology report to check prescribed antibiotics are not resistant. Monitoring will be conducted weekly for four weeks, every two weeks for two months, then monthly for three months, then quarterly. The DON (or designee) will report to the QA committee on a quarterly basis. 5. September 23rd, 2021.	

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F 757	Continued From page 46	F 757		

they wanted that on hold his nurse was going to verify with him and get back to us."
* 02/12/21 at 5:22 p.m., "PCP [primary care provider] nurse called back stop the Nitrofurantoin Macrocrystal Capsule 25 MG as it is not stopping her UTIs and just take the Bactrim DS BID [twice daily] x 7 days. . . ."
* 02/12/21 at 10:58 p.m., ". . . Resident has Macrobid D/c'd [discontinued] today on day shift, and Bactrim DS ordered for UTI. Resident exhibits no s/s [signs/symptoms] on evening shift other than needing to go to bathroom all the time. Even after going 5 minutes before, we have her on an hourly toileting schedule. She has not c/o [complained of] burning or flank pain. . . ."
* 02/13/21 at 10:48 a.m., ". . . No s/s of UTI, no increase in bathroom behavior. No adverse reaction at this time. Vital signs stable see flow sheet. . . ."
* 02/14/21 at 10:26 a.m., ". . . No s/s of UTI. No increase in bathroom behavior. Vital signs stable see flow sheet. . . . No adverse reaction."

Resident #24's urine culture microbiology report, dated 02/15/21, identified a resistance to Nitrofurantoin (Macrodantin) and Trimethoprim/Sulfamethoxazole (Bactrim).

The progress notes identified the following:
* 02/15/21 at 12:10 a.m., ". . . Resident's 2nd day on Bactrim DS this evening for UTI. Resident exhibits no s/s on evening shift other than needing to go to bathroom as usual on this shift. Res [Resident] is on an hourly toileting schedule after dinner. She has no c/o [complaints of] burning or flank pain. . . ."
* 02/16/21 at 2:45 a.m., ". . . No adverse effect of ABX [antibiotic] noted. No s/s noted as res

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F 757	Continued From page 47 denied/unable to express urinary discomfort. . . ." * 02/16/21 at 3:22 p.m., ". . . No adverse reaction to Bactrim observed or reported. No urgency/frequency, burning sensation or discomfort when voiding observed or reported. Denies abdominal or flank pain. . . ." * 02/17/21 at 3:13 p.m., ". . . Resident continues on Bactrim ds no s/s of adverse reactions, no urinary symptoms other than resident continues to want to use the restroom about every half hour. Resident is reassured but states she hasn't used the RR [restroom] when reminded." During an interview on 08/19/21 at 1:09 p.m., a managerial nurse (#5) acknowledged the facility failed to obtain a copy of Resident #24's urine culture microbiology report which indicated a resistance to both of the prescribed antibiotics.	F 757		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §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	F 761		9/23/21

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F 761	Continued From page 48 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 ensure accurate labeling, storage, and recording of medication administration in 2 of 5 medication storage areas (Harmony and Legacy) observed. Failure to correctly label, store, and record medication administration may result in medication errors and harm to the residents. Finding include: MEDICATION LABELING Review of the facility's policy titled "Labeling of Medications" occurred on 8/19/21. This policy, revised February 2020, stated, ". . . Labels for individual drug containers must include . . . The resident's name . . . the prescribing physician's name . . . The name, address, and telephone number of the issuing pharmacy . . . The name, strength, and quantity of the drug . . . The prescription number . . . The date the drug dispensed . . . labels for each single unit package include . . . The expiration date or discard date when applicable . . . Directions for use . . . The expiration date or discard date when applicable . . . Contents of one container may not be transferred to another container . . . "	F 761	1. Nitroglycerin bottle was sent back to pharmacy on August 18th, 2021. Licensed Nurse caring for resident #110 was educated to record the date, time, and dosage of narcotic medication on the narcotic record at time of administration. The medication fridge on Legacy Neighborhood was cleaned and defrosted on August 19th, 2021. The medication fridge on Harmony Neighborhood was cleaned and defrosted on August 22nd, 2021. 2. All residents have the potential to be affected. 3. Mandatory "All Staff Meetings" were held on September 15th & 16th, 2021 to educate licensed nursing staff to check both bottles of medication, when a medication is stored inside of a second bottle, to ensure label is the same. If a discrepancy is identified the dispensing pharmacy is to be contacted. In addition, education was provided to sign narcotic medication (date, time, and dosage)out on the narcotic form at the time of administration. Licensed Nurses were also educated to clean and defrost medication fridges on a monthly basis.	

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F 761	Continued From page 49 Review of the facility's policy titled "Controlled Medications Administration" occurred on 08/19/21. This policy, revised September 2020, stated, ". . . when a controlled medication is administered, the licensed nurse . . . administering the medication immediately enters all the following information on the MAR [Medication Administration Record] . . . Date and time of administration . . . Amount administered . . . Signature of the nurse administering the dose, completed after the medication is actually administered . . . amount of medication left after administration . . ." Observation of the Legacy Unit medication cart on 08/18/21 at 8:35 a.m. showed a medication container with an expired medication label. The medication label identified Nitroglycerin tablets 0.4 mg (milligrams), take sublingual every 5 minutes x 3, for chest pain, six tablets. The fill date on the label read 05/25/20 with an expiration date of 02/09/21. The Nitroglycerin bottle inside the container showed 20 tablets with an expiration/discard date of February 2022. During an interview on 08/18/21 at 8:35 a.m., an administrative nurse (#8) indicated staff should have contacted the pharmacy regarding the incorrect Nitroglycerin label. MEDICATION RECORDING Review of the narcotic administration book identified the medication cart on Legacy Unit contained 27 tablets of Percocet for Resident #110. The book identified Resident #110 received his last dose of Percocet on 08/17/21 at 7:00	F 761	Monthly cleaning log was adjusted to include defrosting. 4. The Director of Nursing Services (DON) (or designee) will monitor the medication carts for same labeling of medication products that are stored in two containers, narcotic medications are signed out in narcotic book at time of administration, and cleaning/defrosting of medication fridges. Monitoring will be conducted weekly for four weeks, then every two weeks for 2 months, then monthly for three months, then quarterly. If concerns are identified immediate correction action will be implemented. The DON (or designee) will report to the QA committee on a quarterly basis. 5. September 23rd, 2021.	

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F 761	Continued From page 50 p.m. The nurse (#22) counted Resident #110 Percocet tablets and discovered 26 versus 27 tablets. During an interview on 08/18/21 at 9:15 a.m., a nurse (#22) indicated she gave a dose of Percocet to Resident #110 at 7:30 a.m., recorded the medication on his MAR, but failed to record the medication administration or date/time in the narcotic administration book. During an interview on the morning of 08/18/21, an administrative nurse (#8) stated staff should document medication administration in a timely manner. MEDICATION STORAGE Observation on 08/18/21 at 9:50 a.m. of the Harmony and Legacy Units' medication storage rooms showed the freezers in the medication refrigerators with excessive ice buildup. Observation showed damp Insulin pen boxes in the refrigerator and towels placed in the freezer to collect dripping water. During an interview on 08/18/21 at 11:09 a.m., an administrative nurse (#8) agreed freezers should be defrosted to ensure no excessive ice buildup.	F 761		
F 812 SS=E	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.	F 812		9/23/21

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F 812	Continued From page 51 (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 standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to ensure staff stored, prepared, and served food under sanitary conditions in 1 of 1 kitchen used to prepare food for all residents, staff, and visitors. Failure to properly thaw foods, store foods off the floor and away from the ceiling, and label food taken out of the original container has the potential for foodborne illness to residents, staff, and visitors. Findings include: Review of the facility policy titled "Thawing Foods" occurred on 08/17/21. This policy, dated October 2017, stated, ". . . All foods are thawed using appropriate practices to ensure food safety . . . Never thaw foods at room temperature . . ." Review of the facility policy titled "Food Storage" occurred on 08/17/21. This policy, dated October 2017, stated, ". . . Plastic containers with	F 812	1) The frozen soup was disposed of in the garbage. The food boxes that were stored within 18 inches of the ceiling and on the floor in the walk-in freezer were moved. The vegetable box that was stored on the floor in the second freezer was moved. The bulk containers (brown sugar, chow mien noodles, pasta, and crackers) were labeled with product and date. 2) Any resident, staff, or visitor has the potential to be affected. 3) Mandatory "All Staff Meetings" were held on September 15th & 16th, 2021 to provide education to not thaw food at room temperature, to keep all boxes in the freezer 18 inches from the ceiling and off floor, and to label and date bulk containers (brown sugar, crackers, chow mien noodles, and pasta) after removal from original container. Staff were also educated on policy & procedures titled	

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F 812	Continued From page 52 tight-fitting covers or zip lock bags must be used for storing cereals, cereal products, flour, sugar . . . and broken lots of bulk foods. All containers must be legible and accurately labeled . . . Food is stored a minimum of 6 inches above the floor and 18 inches from the ceiling . . . Perishable foods such as . . . frozen products must be refrigerated immediately . . . meat, fish and poultry should be stored on lower shelves . . ." Observation on 08/16/21 at 1:40 p.m., showed: * Frozen soup thawing on a counter. * Walk-in freezer with food boxes stored less than 18 inches to the ceiling and food boxes placed directly on the floor. * Second freezer with vegetable box placed directly on the floor. * Food storage room with bulk containers unlabeled or dated (brown sugar, chow mien noodles, pasta, and crackers) after removed from original packages. During an interview on 08/16/21 at 1:55 p.m., a dietary staff member (#30) stated, "I took it [frozen soup] out of the freezer an hour ago . . . I'll leave it out 5-6 hours to thaw . . ." During an interview on 08/18/21 at 1:20 p.m., a dietary manager (#30) stated she expected food stored off the floor, food containers labeled and dated, and frozen food thawed in the fridge.	F 812	"Thawing Foods & Food Storage." 4) Dietary Service Manager (or designee) will monitor how food is thawed, that no boxes are stored within 18 inches of the ceiling or on freezer floor, and labeling of bulk containers of what product is stored, with date, after removal from original package. Monitoring will be done weekly for one month, every two weeks for two months, then quarterly. If concerns are identified, immediate corrective action will be implemented. Dietary Service Manager (or designee) will report to the QA committee quarterly. 5) September 23rd, 2021.	
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	F 880		9/21/21

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F 880	Continued From page 53 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, 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	F 880		

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F 880	Continued From page 54 (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, review of the staff orientation checklist, and staff interview, the facility failed to follow infection control practices for 6 of 41 sampled residents (Resident #24, #29, #30, #55, #64 and #72). Failure to follow infection control practices during personal cares and in the kitchen/dining room has the potential to transmit infections to other residents, staff, and visitors. Finding include: BARE HAND CONTACT WITH FOOD	F 880	1. Staff members involved in the care of resident #24, #29, #30, & #72 were educated on Hand Hygiene. Staff members involved in the care of resident #24, #55, & #64 were educated on the sanitation of equipment, mechanical lifts, between resident use. Staff members involved with Bare Hand Contact with Food were educated on proper Plastic Glove use. 2. All residents have the potential to be affected. 3. Mandatory "All Staff Meetings" were	

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F 880	Continued From page 55 Review of the facility policy titled "Use of Plastic Gloves" occurred on 08/19/21. This policy, dated October 2017, stated, ". . . Plastic gloves are to be worn whenever handling the food directly with hands when . . . handling ready-to-eat foods . . . During food preparations, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks . . ." Observation in the Legacy Unit kitchen on 08/16/21 at 5:40 p.m. showed a dietary staff member (#21) preparing sandwiches. The dietary staff member (#21) touched trays, dishes, the refrigerator, and cabinets multiple times with ungloved hands and then touched bread, sandwich meat, and lettuce. A certified nursing assistant (CNA) (#23) picked up an unidentified resident's slice of bread and applied mayonnaise to the bread with bare hands. HAND HYGIENE Review of the facility policy titled "Hand Hygiene" occurred on 08/19/21. This policy, dated September 2017, stated, ". . . Hand hygiene is required in the below situations . . . before and after direct resident contact . . ." Observations showed the following: * 08/16/21 at 9:26 a.m., CNAs (#12 and #13) assisted Resident #30 onto the toilet utilizing a sit-to-stand lift. One CNA (#13) performed perineal cares, adjusted the resident's clothing, removed her soiled gloves, and without sanitizing her hands transferred the resident into his wheelchair. The other CNA (#12) failed to sanitize her hands after removing her gloves and	F 880	held on September 15th & 16th, 2021 to provide education on: Hygienic cleaning technique to prevent cross contamination when using equipment shared between residents. To use the proper disinfecting products along with the appropriate dwell time. Education on the importance of and techniques for hand hygiene prior to meals and snacks. Education on completing hand hygiene after changing tasks, moving between residents, changing gloves, and touching potentially contaminated surfaces. All viewed CDC□s lessons on "Clean hands" and "Sparkling Surfaces." On September 14th & 17th, 2021 HH/Handwashing Session was held for staff to perform a Competency checklist with successful return demonstration to educator. 4. The Director of Nursing Services (DON) (or designee) will conduct weekly on-going monitoring for no less than 12 weeks to ensure, via observation, the approaches to correct practice related to infection control and prevention are consistently implemented and effective. Such monitoring will include: a. Observations of staff engaged in cleaning activities to ensure cleaning and disinfection is completed in a hygienic manner and cleaning products are used in accordance with manufacturer instructions to achieve disinfection. b. Observations of meal service across breakfast, lunch, and dinner meals each neighborhood to ensure staff consistently perform proper hand hygiene prior to the meal.	

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F 880	Continued From page 56 prior to exiting the room and transporting the resident to an activity. * 08/17/21 at 9:19 a.m., CNAs (#12 and #13) toileted Resident #24. One CNA (#13) performed perineal cares, and with soiled gloves, adjusted the resident's clothing. The other CNA (#12) failed to sanitize her hands after removing her gloves and prior to exiting the resident's room. * 08/17/21 at 9:47 a.m., CNAs (#12 and #15) changed Resident #72's brief, and with soiled gloves, covered the resident with a blanket. One CNA (#15) failed to sanitize her hands after removing her gloves and prior to exiting the room. * 08/17/21 at 11:20 a.m., CNA (#12) changed Resident #29's soiled (bowel movement) brief, removed her gloves, and without sanitizing her hands, donned new gloves and performed catheter cares. * 08/17/21 at 2:30 p.m., a managerial nurse (#5) started Resident #29's intravenous therapy (IV) and failed to sanitize her hands after removing her gloves and prior to exiting the resident's room. SANITATION OF EQUIPMENT Review of the "Certified Nursing Assistant Orientation Checklist" occurred on 08/19/21. The undated orientation checklist, stated, ". . . Use of mechanical lifts: 1) Full Assist Lift, 2) Partial Assist Lift . . . Reviewed cleaning of the frequently touched surfaces of the lift in between resident use. . . ." Observations showed the following infection control breaches: * On 08/16/21 at 3:18 p.m., CNAs (#22 and #23)	F 880	c. Observations of all staff types to ensure performance of proper handwashing and hand hygiene, in the course of their routine duties. Observations will be made across all shifts and neighborhoods/units. Observations of noncompliance with the above will result in ad hoc education for the involved staff. Such education will be documented on monitoring forms. After 12 weeks of monitoring, provided that such demonstrates expectations are consistently met, monitoring may be reduced to monthly. Monthly monitoring will continue for no less than 3 months. All monitoring will be reported to the QAPI committee. Monitoring will not be discontinued until the facility completes 3 consecutive rounds of monthly monitoring that demonstrates sustained compliance as approved by the QAPI committee and medical director. 5. September 21, 2021 1. Corrective Action The facility will immediately implement an appropriate infection prevention and intervention plan consistent with the requirements of ¿483.80 for the affected resident(s)/neighborhood(s) identified in the deficiency. The infection preventionist (IP), director of nursing (DON), in conjunction with applicable interdisciplinary team (IDT)	

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	355070	A. BUILDING _____ B. WING _____	08/19/2021

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F 880	Continued From page 57 toileted Resident #64 prior to transferring him into his wheelchair utilizing a full body lift. One CNA (#22) failed to sanitize the lift prior to exiting the room and using the lift with another resident. * 08/17/21 at 9:19 a.m., CNAs (#12 and #13) transferred Resident #24 into the bathroom utilizing a sit-to-stand lift. One CNA (#12) failed to sanitize the lift prior to exiting the room and using the lift with another resident. * 08/17/21 at 12:23 p.m., CNAs (#17 and #18) transferred Resident #55 into bed utilizing the Hoyer lift. The CNAs (#17 and #18) failed to sanitize the lift prior to exiting the room and using the lift with another resident. During an interview on 08/18/21 at 5:38 p.m., a supervisory nurse (#6) confirmed she expected the nursing staff to perform appropriate hand hygiene/glove use when handling food and after direct contact with residents and equipment.	F 880	members, shall identify and implement a consistent system for ensuring a system for: (1) Ensuring staff have adequate knowledge of hygienic cleaning practices of equipment used with multiple residents. (2) A staff mealtime hand hygiene program in accordance with current nursing facility guidelines from the CDC. (3) Ensuring staff hand hygiene or handwashing when donning PPE, moving between tasks, residents, and after touching potentially contaminated surfaces, in accordance with CDC guidelines. The DON, staff development coordinator (SDC), IP or designee, in conjunction with applicable IDT members, will: (1) Educate staff on hygienic cleaning technique to prevent cross contamination when using equipment shared between residents. To use the proper disinfecting products. (2) Educate staff on the importance of and techniques for hand hygiene prior to meals and snacks. (3) Educate staff on correctly completing hand hygiene after changing tasks, moving between residents, changing gloves, and touching potentially contaminated surfaces. To verify staff, understand hand hygiene and handwashing, these staff will perform a successful return demonstration of identifying the need and correct procedure for performing hand hygiene and handwashing.	

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F 880	Continued From page 58	F 880	2. System Changes On or before 09/21/2021 the facility shall complete the following actions: (1) DON, IP, and applicable IDT members will conduct root-cause analysis to identify and address the reasons for non-compliance related to: a. Failure to ensure cleaning was completed in a hygienic manner with appropriate dwell times to achieve disinfection in accordance with CDC guidelines and cleaning product manufacturer instructions. b. Failure to ensure each staff member performed hand hygiene and offered an effective hand hygiene method prior to each meal. c. Failure to complete handwashing or hand hygiene in accordance with CDC guidelines. Information about root cause analysis can be found at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/GuidanceforRCA.pdf (2) The DON, SDC, IP or suitable designee will ensure the following: a. Educate all staff whose job duties include cleaning tasks on hygienic cleaning procedures and products used in accordance with manufacturer instructions to achieve disinfection on equipment shared by multiple residents. b. All staff engaged in meal delivery as part of their usual duties will be educated on expectations for proper hand hygiene prior to meal service.	

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F 880	Continued From page 59	F 880	c. All staff will receive education keeping hands clean between tasks, contacts with potentially contaminated surfaces and between residents. This education will include the CDC's lesson on clean hands available at https://youtu.be/xmYMUly7qiE. (3) The facility leadership may contact the [State] Quality Improvement Organization (QIO), to inquire about the assistance and services available from the QIO in improving infection prevention and control within the facility through quality assurance process improvement (QAPI) methods. Contact with the QIO may be made. 4. Monitoring Weekly for no less than 12 weeks, the DON, IP, SDC or a designee will conduct on-going monitoring to ensure, via observation, the approaches to correct deficient practice related to infection control and prevention are consistently implemented and effective. Such monitoring will include: (1) Observations of staff engaged in cleaning activities to ensure cleaning and disinfection is completed in a hygienic manner and cleaning products are used in accordance with manufacturer instructions to achieve disinfection. (2) Observations of meal service across breakfast, lunch, and dinner meals in each neighborhood to ensure staff consistently perform proper hand hygiene prior to the meal. (3) Observations of all staff types to	

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F 880	Continued From page 60	F 880	ensure performance of proper handwashing and hand hygiene, when indicated, in the course of their routine duties. Observations will be made across all shifts and neighborhoods/units. Observations of noncompliance with the above will result in ad hoc education for the involved staff. Such education will be documented on monitoring forms. After twelve weeks of monitoring, provided that such monitoring demonstrates expectations are consistently met, monitoring may be reduced to monthly. Monthly monitoring will continue for no less than three months. All monitoring will be reported to the quality assurance process improvement (QAPI) committee as part of QAPI activities. Monitoring will not be discontinued until the facility completes three consecutive rounds of monthly monitoring that demonstrate sustained compliance as approved by the QAPI committee and medical director. 5. Correction Date 09/21/2021	