STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355050	A. BUILDING _____ B. WING _____	C 05/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE MANOR CARE CENTER	1116 9TH AVE LANGDON, ND 58249

(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 and complaint survey started on 05/09/22 and concluded 05/12/22.	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of	F 561	1. Resident Rights were reviewed with all	6/30/22

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

Electronically Signed | 06/08/2022

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F 561	Continued From page 1 professional reference, and resident and staff interview, the facility failed to honor resident choices for 1 of 1 sampled resident (Resident #20) who felt he was not allowed to refuse his medication. Failure to honor Resident #20's choice to refuse his medication does not respect his autonomy or right to determine what is significant to his care and well-being. Findings include: A Guide to Your Rights as a Resident of a Nursing Facility In North Dakota, from the Long Term Care Ombudsman, updated 08/01/2019, page 8, stated, ". . . You can request, refuse or discontinue treatment to include medications. When doing so you should be notified by your doctor of any medical consequences of your decisions. . . ." During an interview on 05/09/22 at 3:05 p.m., Resident #20 stated, "I just got back from a doctor's appointment and I had to change my pants. I asked them not to give me any 'bladder' pills but they did it anyway, so I had to pee in the van and my pants were all wet. I just came to my room to change them." During an interview on 05/10/22 at 5:05 p.m., Resident #20 identified he left the facility at 9:00 a.m. on 05/09/22 to go to his doctor's appointment in Grand Forks. He again stated, "I told them not to give me a bladder pill, but they didn't listen." Review of Resident #20's medical record occurred on all days of survey and included a diagnosis of urine retention and a physician's	F 561	staff on 5/17/22 and residents on 5/31/22. Resident #20 was reeducated and given a copy of the resident rights on 6/8/22 2. The facility has determined that all residents have the potential to be affected. 3. Resident rights will be addressed with all current residents quarterly, all residents upon admission and Social Services Designee will ask to attend resident council meetings 2 times a year. Staff are educated on resident rights yearly. 4. The Social Services designee will perform resident rights audits immediately with all residents and then quarterly thereafter. Results of the audits will be discussed quarterly with the QA meeting. Human Resources will maintain documentation of staff who have completed yearly resident rights education and new staff need to complete it prior to starting on the floor.	

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F 561	Continued From page 2 order for Bumex (diuretic) 1 milligram (mg) by mouth daily. Resident # 20's care plan stated, ". . . I have bladder incontinence r/t [related to] use of lasix [similar to Bumex] and Bowel Incontinence at times as well. . . . Toileting: Independent. . . ." Resident #20's medication administration record (MAR) for 05/09/2022 showed Bumex 1 mg administered orally at 8:00 a.m. During an interview on 05/12/22 at 8:35 a.m., two administrative staff members (#1 and #6) agreed it is the resident's right to refuse a medication.	F 561		
F 578 SS=E	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the	F 578		6/30/22

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F 578	Continued From page 3 facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to ensure the residents' right to request, refuse, and/or discontinue treatment for 5 of 15 sampled residents (Resident #9, #10, #17, #21, and #95) reviewed for advance directives. Failure to discuss the residents' resuscitation status with the resident and/or the resident's representative and ensure the medical record accurately reflected each resident's code level limited the facility's ability to communicate to direct care staff and emergency personnel the residents' choice in the event of a medical emergency. Findings include: Review of the facility policy titled "Code Status	F 578	1. The code status of resident #9, 10, 17, 21, and 95 along with all other resident□s code statuses were verified with physician signatures and updated in medical records. 2. Determining the code status or presence/absence of Advance Directives is required for all residents. Therefore, all residents have the potential to be affected. 3. The Director of Nursing educated all staff including Social Services Designee and licensed nurses regarding the documentation procedures for Advance Directives/code status on 5/17/22. A chart audit of all residents was completed on 5/19/22. Discrepant findings were	

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F 578	Continued From page 4 Procedure" occurred on 05/10/22. This undated policy stated, ". . . The circumstances surrounding the Code Level . . . will be documented . . . The orders must be reviewed monthly or more often if medically indicated. . . ." - Review of Residents #9's medical record occurred all days of survey. The record lacked a physician's order regarding code status and documentation the facility staff discussed with the resident or resident representative, their choice to receive cardiopulmonary resuscitation (CPR) or do not resuscitate (DNR) and obtain signed documentation of their choice. - Review of Resident #17's medical record occurred all days of survey. The record lacked a physician's order regarding code status and documentation the facility staff discussed with the resident or resident representative, their choice to receive CPR or DNR and obtain signed documentation of their choice. During an interview on 05/10/22 at 5:55 p.m., a social services staff member (#3) and administrative nurse (#4) confirmed the staff failed to add the code level order to the order summary of the residents' medical records and failed to communicate the residents' wishes. -Review of Resident #21's medical record occurred on all days of survey and identified the resident as cognitively intact. A physician's order stated, ". . . DNR: Do Not Resuscitate. . ." The medical record identified a progress note, dated 03/24/22, which indicated Resident #21 and his guardian discussed changing his code status from DNR to CPR.	F 578	addressed immediately, and all needed actions were completed on 5/19/22. 4. The Social Services designee will perform weekly medical record audits of all residents on the MDS assessment schedule for consistent documentation for 1 month, two times a month for 3 months and after that a random medical record audit of at least 10 records for consistent documentation. Results of the audits will be discussed monthly with the QA meeting until such time it is determined that substantial compliance is maintained.	

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F 578	Continued From page 5 During an interview on 05/10/22 at 10:48 a.m., an administrative staff member (#5) confirmed staff failed to complete the code status change request to accurately reflect Resident #21's code level. - Review of Resident #95's medical record occurred on all days of survey. The record lacked a physician's order regarding code status. On 05/10/22 at 5:00 p.m., a social services staff member (#3) provided a "Do Not Resuscitate (DNR) Request Form." The form showed Resident #95 selected "I do not want to be resuscitated" and was signed by Resident #95, a registered nurse (RN), and the physician on 04/25/22. The facility scanned the DNR form into the electronic health record and added "DNR" to the resident's demographic information on May 10th, 15 days after the order. The physician's order summary lacked the "DNR" order. - Review of Resident #10's medical record occurred on all days of survey and identified the resident as cognitively intact. The record lacked a physician's order regarding the code status or other documentation related to Resident #10's decision regarding a code status. During the morning of 05/10/22, the facility provided a "DNR Request Form" signed by Resident #10 on 11/08/21. The form identified Resident #10 as a full code and lacked a physician's signature.	F 578		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a	F 623		6/30/22

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F 623	Continued From page 6 resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days.	F 623		

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F 623	Continued From page 7 §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon	F 623		

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F 623	Continued From page 8 as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to provide the resident or their representative and/or the State Long Term Care (LTC) Ombudsman a written notice of transfer for 3 of 3 sampled residents (Resident #30, #35, and #96) with a recent hospital transfer. Failure to provide a written copy of the notice of transfer form does not allow the resident and/or their representative to make an informed decision regarding their rights or inform the Ombudsman of the transfer. Findings include: The facility failed to provide a policy regarding notice of transfers upon request. - Review of Resident #30's medical record occurred on all days of survey and identified a hospitalization from March 26-30, 2022. The record contained a Notice of Transfer form noting Resident #30's representative received verbal notification of the transfer on 03/26/22. The	F 623	1. Resident representative of #30, 35, 96 and State Ombudsman were provided the reasons for transfer/discharge in writing by the Social Services Designee on 5/13/22 and understanding was verified and documented. Notice of transfers were mailed to resident representatives. 2. The facility has determined that all residents who have been transferred or discharged have the potential to be affected. 3. Upon transfer to the other facilities including hospitals all Notice of Transfer papers will be given to the Social Service Designee after they are completed by the nurse in charge to make a copy to send to the family or resident representative. A social service note will be placed in the chart to ensure the papers are mailed. The social service designee will also fax the papers to the State Ombudsman monthly to ensure they are properly informed as well.	

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F 623	Continued From page 9 record lacked evidence the facility provided the resident and/or the resident's representative a copy of the notice of transfer for this hospitalization. - Review of Resident #96's medical record occurred on all days of survey and identified a hospitalization from April 20-22, 2022. The record contained a Notice of Transfer form noting Resident #96's representative received verbal notification of the transfer on 04/20/22. The record lacked evidence the facility provided the resident and/or the resident's representative a copy of the notice of transfer for this hospitalization. During an interview on 05/11/22 at 1:25 p.m., an administrative nurse (#1) stated, "Most likely the notice of transfer was not given" to the resident and/or resident's representative. - Review of Resident #35's medical record occurred on all days of survey and identified a hospitalization from March 30 - April 5, 2022. The record lacked evidence the facility completed a Notice of Transfer or provided the State LTC Ombudsman written notice of transfer for this hospitalization. During an interview on 05/11/22 at 10:00 a.m., a social services staff member (#3) agreed the record lacked a Notice of Transfer for Resident #35. During an interview on 05/12/22 at 8:35 a.m., an administrative nurse (#1) agreed the record lacked a Notice of Transfer.	F 623	4. The Social Service Designee will conduct a record audit of all residents who have been transferred or discharged from the facility to ensure the record includes a copy of the transfer/discharge notice. A transfer/discharge notice will be sent to the State Ombudsman Office monthly via fax to prove delivery. This will occur weekly for a period of four weeks, monthly for 2 months and quarterly thereafter. This plan of correction will be monitored at the monthly Quality Assurance meeting until such time consistent substantial compliance has been met.	
F 625	Notice of Bed Hold Policy Before/Upon Trnsfr	F 625		6/30/22

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F 625 SS=D	Continued From page 10 CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, policy review, and staff interview, the facility failed to provide a written copy of the bed hold notice to the resident or their representative for 3 of 3 sampled residents (Resident #30, #35, and #96) with a recent hospital transfer. Failure to provide a written bed	F 625	1. Residents #30, 35, 96 record was reviewed for notification of Bed Hold. The residents and/or legal representatives were immediately notified via mail of the facility□s bed hold policy. 2. The facility has determined that all	

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F 625	Continued From page 11 hold notice does not allow the resident and/or their representative to make an informed decision regarding their rights. Findings include: Review of the facility policy titled "Bed Hold Notice Upon Transfer" occurred on 05/11/22. This policy, dated January 2020, stated, "At the time of transfer for hospitalization or therapeutic leave, the facility will provide to the resident and/or the resident representative written notice which specifies the duration of the bed-hold policy . . ." - Review of Resident #30's medical record occurred on all days of survey and identified a hospitalization from March 26-30, 2022. The record contained a Bed Hold Policy form noting Resident #30's representative provided verbal consent for the bed hold on 03/26/22. The record lacked evidence the facility provided the resident and/or the resident's representative a written copy of the bed hold form. - Review of Resident #96's medical record occurred on all days of survey and identified a hospitalization from April 20-22, 2022. The record contained a Bed Hold Policy form noting Resident #96's representative provided verbal consent for the bed hold on 04/20/22. The record lacked evidence the facility provided the resident and/or the resident's representative a written copy of the bed hold form. During an interview on 05/11/22 at 1:25 p.m., an administrative nurse (#1) stated, "Most likely the bed hold form was not given" to the resident and/or resident's representative.	F 625	residents have the potential to be affected. 3. All resident records were reviewed for notification of bed hold policy. An in-service education program was conducted by the Director of Nursing with all staff including licensed nursing staff addressing the facilities notification of bed hold policy on 5/17/22. Upon transfer to the other facilities including hospitals all bed hold forms will be given to the Social Service Designee after they are completed by the nurse in charge to make a copy to send to the family or resident representative. A social service note will be placed in the chart to ensure the papers are mailed. 4. The Social Service Designee will conduct a record audit of all residents who have been transferred or discharged from the facility to ensure the record includes a copy of the bed hold notice. This will occur weekly for a period of four weeks, monthly for 2 months and quarterly thereafter. This plan of correction will be monitored at the monthly Quality Assurance meeting until such time consistent substantial compliance has been met.	

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F 625	Continued From page 12 - Review of Resident #35's medical record occurred on all days of survey and identified a hospitalization from March 30 - April 5, 2022. The record contained a Bed Hold Policy form noting Resident #35's representative provided verbal consent for the bed hold on 03/30/22. The record lacked evidence the facility provided the resident and/or the resident's representative a written copy of the bed hold form. During an interview on 05/11/22 at 10:00 a.m., a social services staff member (#3) agreed the record lacked evidence the family received the bed hold form. During an interview on 5/12/22 at 8:35 a.m., an administrative nurse (#1) agreed the record lacked evidence the facility gave a bed hold form to the resident and/or resident's representative.	F 625		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s).	F 657		6/30/22

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F 657	Continued From page 13 An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review, policy review, and staff interview, the facility failed to ensure staff reviewed and revised comprehensive care plans to reflect the residents' current status for 3 of 15 sampled residents (Resident #9, #30, and #33). Failure to review and revise the care plans limited staffs' ability to communicate needs and ensure continuity of care. Findings include: Review of the facility policy titled "Comprehensive Care Plans" occurred on 05/11/22. This policy, revised 01/29/21, stated, "The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. . . . Other factors identified by the interdisciplinary team, or in accordance with the resident's preferences, will also be addressed in the plan of care. . ." - Review of Resident #9's medical record	F 657	1. The oxygen order was reviewed for Resident #9 and update in care to reflect physician order. Resident #33□s care plan was updated to reflect current transfer needs. Resident #30□s care plan was revised to reflect her current weight. Weights have been completed and will continue to weigh weekly. 2. All residents of the facility have the potential to be affected by this practice. 3. We as a interdisciplinary team will plan to meet every Tuesday before individual resident□s quarterly care conference to assess and revise care plan and discuss any significant changes. Any changes made to care plan will be discussed during care conference with resident representative and resident if present. 4. Interdisciplinary Team will perform care plan audits once a week for four weeks following quarterly care conferences. Then twice a month for two month and	

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F 657	Continued From page 14 occurred on all days of survey. Diagnoses included centrilobular emphysema (lung disorder). A physician's order, dated 01/24/22, stated, "O2 [oxygen] continuous 2L [liters]/min [minute] Nasal Cannula . . ." Resident #9's current care plan stated, "I have a diagnosis of centrilobular emphysema. . . My [oxygen] level is 3L per my Doctors orders but I will change it to 2L via nasal cannula. . . Remind me to leave my oxygen at 3L per doctors orders. . ." During an interview on 05/11/22 at 5:49 p.m., an administrative staff member (#11) confirmed staff should have revised Resident #9's care plan. - Review of Resident #33's medical record occurred on all days of survey. Diagnoses included hemiplegia affecting left nondominant side and pain in unspecified joint. The resident's current care plan stated, "TRANSFER: I need assist of 2 staff and gait belt." Observations on 05/10/22 at 11:08 a.m. showed Resident #33 used a cane and transferred independently from a motorized scooter to the bed. A while later, the resident stood from the bed and completed a self transfer back to the motorized scooter without staff assistance or use of a gait belt. During an interview on 05/12/22 at 8:50 a.m., an administrative nurse (#1) confirmed staff should have revised Resident #33's care plan. - Review of Resident #30's medical record occurred on all days of survey. A physician's	F 657	quarterly thereafter to assure the review and revision of care plans are completed. Results will be reviewed by the Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee.	

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F 657	Continued From page 15 order, dated 12/29/21, stated, "Regular diet, Ground texture, Regular consistency. Small portions per resident request." The quarterly Minimum Data Set (MDS), dated 04/06/22, listed a weight of 110 pounds, a loss of 5% or more in the last month or a loss of 10% or more in the last six months, and not on a physician-prescribed weight loss program. Review of Resident #30's weights showed a greater than 10% loss over six months on 04/04/22 and a greater than 5% loss over one month on 04/21/22. See F692. The staff failed to revise Resident #30's care plan to include a problem, goal, and interventions related to a significant weight loss.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: PHYSICIAN'S ORDERS 1. Based on record review, policy review, and staff interview, the facility failed to follow professional standards of practice regarding physicians' orders for 2 of 15 sampled residents (Resident #14 and #21). Failure to ensure staff followed physicians' orders may result in adverse harm to residents. Findings include:	F 658	1. Reviewed Resident #14□s TAR and educated all staff including nursing on the importance of documentation on 5/17/22. Reviewed current wound documentation to ensure accurate measurements and wound care. Reviewed Resident #21□s and educated all staff including nursing to update physician order regarding blood sugar glucose results and record	6/30/22

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F 658	Continued From page 16 Review of facility policy titled "Pressure Sore Policy" occurred on 05/12/22. This policy, dated 01/22/20, stated, ". . . Assess and measure pressure ulcer by inputting wound measurements in TAR [treatment administration record] . . . INTERVENTION 1. Contact physician/nurse practitioner and obtain order for treatment. . ." - Review of Resident #14's medical record occurred on all days of survey. A physician's order, dated 12/06/21, stated, "Cleanse wound to right lateral heel with NS [normal saline] and gauze. Apply Aquacel [type of wound dressing] cut to fit or slightly larger than area to wound, cover with Mipilex or Allevyn [types of wound dressings]. Change every Monday, Wednesday and Friday. . ." Review of Resident #14's TAR from January through April 2022 showed staff failed to document dressing changes as completed on the following dates: *01/05/22, 01/14/22, 01/21/22, 01/28/22, 01/31/22 *02/02/22, 02/07/22, 02/09/22 *03/18/22, 03/21/22, 03/23/22, 03/25/22 *04/01/22, 04/11/22, 04/18/22 A physician's order, dated 12/07/21, stated, "Nursing Order - Measure wound every Monday until healed. . . every day shift every Mon [Monday] . . ." Review of Resident #14's TAR from January through April 2022 showed staff failed to measure the wound on the following dates: 01/31/22 and 02/07/22	F 658	communication with physician in medical record. Built policy on altering medical records for all residents in response to Resident□s #26 struck out weights. Reviewed altering medical record policy with dietary manager and nursing staff. Resident #21 and #96□s update insulin pens were discarded, and new insulin pens were updated with open and discard date. Educated all nurses and CMAs on the importance of properly dating new insulin pens. 2. The facility has determined that all residents have the potential to be affected. 3. DON is checking all wound documentation daily and reeducating staff as needed. Nurses will check with the physician to update the physician order to reflect when they want to be notified on blood sugar levels. Will educate all new staff on altering medical records policy upon hire and yearly. Will post a sign to remind nursing staff to date all new insulin pens with open and discard date. Nurses/CMA will sign off all insulin pen dates on the sheet located in narcotic count binder. 4. The Director of Nursing or designee will	

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F 658	Continued From page 17 During an interview on 05/12/22 at 8:50 a.m., an administrative nurse (#1) confirmed staff failed to follow physician's orders regarding dressing changes and wound measurements. - Review of Resident #21's medical record occurred on all days of survey. Diagnoses included Type 2 Diabetes Mellitus. A physician's order, dated 05/28/21, stated, "NovoLOG FlexPen Solution [insulin] . . . Inject as per sliding scale: . . . Notify Provider if [blood glucose] over 400. . ." Review of Resident #21's blood glucose readings from January through May 2022 showed the following: *01/19/22 a blood glucose of 450 milligrams per deciliter (mg/dl) *01/21/22 a blood glucose of 455 mg/dl *05/01/22 a blood glucose of 402 mg/dl Resident #21's medical record lacked documentation staff notified the provider of the blood glucose levels above 400. During an interview on 05/12/22 at 8:50 a.m., an administrative nurse (#1) confirmed staff failed to follow physician's order for Resident #21. ALTERING A MEDICAL RECORD 2. Based on observation, record review, professional reference, and staff interview, the facility failed to follow professional standards of practice for 1 of 1 resident (Resident #26) whose medical record had been altered. Failure to ensure medical record documentation remains	F 658	monitor wound documentation against physician orders, blood sugar glucose results and reporting to physician, and dating of insulin pens every week for one (1) month then every two (2) weeks for two (2) months and then randomly thereafter. Medical records will monitor and update the altering medical records policy and will have staff acknowledge their review of policy. This plan of correction will be monitored at the monthly Quality Assurance meeting until such time consistent substantial compliance has been met.	

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F 658	Continued From page 18	F 658		

intact may result in an inability to accurately assess resident needs.

Findings include:

The facility failed to provide a policy or procedure regarding staff changing entries in a resident's medical record.

Kozier & Erb's "Fundamentals of Nursing, Concepts, Process and Practice," 11th Edition eText, 2021, Pearson, Boston, Massachusetts, "Chapter 14: Documenting and Reporting" page 247-248, and page 250 stated, ". . . Accuracy . . . Notations on records must be accurate and correct. . . . When using computerized charting, the nurse needs to be aware of the agency's policy and process for correcting documentation mistakes. . . . Care that is omitted because of the client's condition or refusal of treatment must also be recorded. Document what was omitted, why it was omitted, and who was notified. . . . Don't . . . Alter a record even if requested by a superior or a primary care provider. . . ."

- Review of Resident #26's medical record occurred on 05/10/22. Weight records from 10/28/21 through 03/30/22 showed weekly weights with strikethrough markings indicating "incorrect." Progress notes lacked documentation of a reason for the weights being eliminated and if new weights were obtained.

During an interview on 05/10/22 at 1:44 p.m., a dietary manager (#7) stated he struck out the weights and noted them as "incorrect, because they aren't correct, I think they [referring to staff] were just writing something in." When asked if

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F 658	Continued From page 19 new weights were obtained, the dietary manager (#7) replied "no." During an interview on 05/10/22 at 2:37 p.m., an administrative nurse (#1) agreed Resident #26's weights should not be marked as incorrect without the appropriate documentation. The nurse (#1) confirmed the facility lacked a policy or procedure for making changes to a medical record. INSULIN PENS 3. Based on observation, review of facility policy, and staff interview, the facility failed to follow professional standards of practice for 2 of 2 sampled residents (Resident #21 and #96) receiving insulin. Failure to date insulin pens increases the risk of residents receiving medication with reduced efficacy. Findings include: Review of the facility policy titled "Insulin Pen" occurred on 05/11/22. This policy, revised February 2021, stated, ". . . Insulin pens should be disposed of after 28 days or according to manufacturer's recommendations. . . ." Observation of medication pass occurred on 05/10/22 at 10:15 a.m. with a licensed nurse (#2). Review of insulin pens showed the following: * Resident #21's Novolog insulin flex pen failed to have an open date or a discard date. * Resident #21's Lantus insulin pen failed to have a discard date. * Resident #96's Basaglar insulin pen failed to	F 658		

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F 658	Continued From page 20 have a discard date. During an interview on 05/11/22 at 11:15 a.m., an administrative nurse (#1) stated she expected insulin pens to have an opened and discard date.	F 658		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, the facility failed to provide adequate assistance for 3 of 9 sampled residents (Residents #10, #26, and #35) observed during repositioning and/or transfers. Failure to use proper transfer and repositioning techniques places residents at risk for pain and/or injury. Findings include: The facility failed to provide a policy for resident transfers upon request. - Review of Resident #10's medical record occurred on all days of survey. Diagnoses included right above the knee amputation. The current care plan stated, ". . . I require assist of two staff for all ADL's [activities of daily living] . . . I use a hoyer lift [mechanical lift] with assist of two staff for all transfers."	F 689	1. Transfer for resident policy was made and staff were educated on 5/17/2022. CNAs were reeducated on proper lifting techniques including not lifting residents under their arms and importance of locking wheelchair brakes. 2. The facility has determined that all residents have the potential to be affected. 3. All staff will be inserviced yearly on the facility transfer policy. All new employees will be educated on facility transfer policy and signed off on orientation checklist. 4. DON or Resident Care Coordinator will observe two CNAs during transfers once a week for a month, then twice a month for two months and then yearly. Transfer	6/30/22

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F 689	Continued From page 21 Observation on 05/10/22 at 1:45 p.m. showed two certified nursing assistants (CNAs) (#9 and #10) transferred Resident #10 from the bed to the wheelchair. Resident #10 required repositioning in the wheelchair and both CNAs (#9 and #10) lifted the resident under the arms to reposition. During an interview on 05/11/22 at 10:00 a.m., an administrative nurse (#1) stated, "We do not promote lifting under the arms." - Review of Resident #26's medical record occurred on all days of survey. The current care plan stated, ". . . I need extensive assistance of one staff with the following: Transfers . . . Walking: I have a front wheeled walker that I use for transfers. I use the W/C [wheelchair] for mobility. I need someone to take me to/from where I want/need to be. . . . I am able to transfer with assist of one staff and my walker." During an observation on 05/10/22 at 8:44 a.m., a CNA (#8) entered Resident #26's room. The CNA applied a gait belt, placed the resident's walker in front of the wheelchair, and cued the resident to hold onto walker. The CNA lifted on the gait belt to assist Resident #26 to a standing position. As the resident started to stand, the wheelchair rolled backwards and lodged on a bookshelf. The CNA acknowledged that the wheelchair brakes should have been locked. - Review of Resident #35's medical record occurred on all days of survey. The care plan stated, ". . . ADL/Mobility: I require assist of 1 for most ADL's r/t [related to] impaired balance. I am	F 689	audits will be reviewed during the Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee.	

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F 689	Continued From page 22 nervous about falling. . . . Safety: I need a lot [sic] of queuing to help with tasks. . . . Transfer: I need extensive assist of one staff member to assist with stand pivot transfer." During an observation on 05/10/22 at 8:30 a.m., a CNA (#8) entered Resident #35's room to transfer the resident from a wheelchair to a recliner. The CNA applied a gait belt, placed the resident's walker in front of the wheelchair, cued the resident to hold onto the walker, and lifted on the gait belt to assist the resident to stand. As the resident started to stand, the wheelchair rolled backwards and lodged against the bed. The CNA (#8) failed to lock the wheelchair brakes during a resident transfer. During an interview on 05/12/22 at 8:35 a.m. two administrative nurses (#1 and #6), when asked if they expected the wheelchair brakes to be locked, responded "yes" and acknowledged the facility does not have a policy for transfers.	F 689		
F 692 SS=D	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	F 692		6/30/22

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F 692	Continued From page 23 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, and staff interview, the facility failed to ensure acceptable parameters of nutritional status for 2 of 3 sampled residents (Resident #26 and #30) with weight loss. Failure to adequately monitor and evaluate weights, complete nutritional assessments, assess the effectiveness of existing interventions, and re-evaluate the need for updated or additional interventions may result in weight loss, inadequate nutrition, and/or delayed wound healing. Findings include: The facility failed to provide a nutrition or weight loss policy upon request. - Review of Resident #30's medical record occurred on all days of survey. Diagnoses included unspecified anemia, vitamin B12 deficiency anemia, and history of colon cancer. A physician's order, dated 12/29/21, stated, "Regular diet, Ground texture, Regular consistency. Small portions per resident request." The quarterly Minimum Data Set (MDS), dated 04/06/22, identified a weight of 110 pounds (lbs), a loss of 5 percent (%) or more in the last month	F 692	1. Facility created a nutrition/weight loss policy and educated all staff on new policy. Nurses are now monitoring and inputting weights. Resident #30 significant change is completed. Resident #26□s care plan was updated to reflect changes. Weekly weights on Monday. Nurses are monitoring and inputting weights. 2. The facility has determined that all residents have the potential to be affected. 3. An in-service education program was conducted by the Director of Nursing and the Dietary Manager with all direct care staff addressing nutritional interventions including weight documentation and monitoring. 4. MDS and Dietary Manager will audit all weights and report any changes during morning huddle every weekday. Quality Assurance completed for all residents once a week for eight weeks, then twice a month for two months and every quarter. Care plans will be reviewed for updated information to reflect these interventions. Audited records will be reviewed by the	

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F 692	Continued From page 24 or a loss of 10% or more in the last six months, and not on a physician-prescribed weight loss program. Review of Resident #30's weights showed a greater than 5% loss over one month on 01/31/22 and 04/25/22 and a greater than 10% loss over six months on 04/04/22 as shown in the weights below: 10/04/21 (124.0 lbs) 12/28/21 (127.9 lbs) 01/31/22 (119.5 lbs) = 6.6 % loss in one month 03/21/22 (120.0 lbs) 04/04/22 (110.4 lbs) = 11.0 % loss in six months 04/25/22 (107.1 lbs) = 10.7 % loss in one month The current care plan stated, "Nutrition: I have a good appetite and eat independently in my room . . . I will maintain weight and nutritional balance . . . I like small portions. I will ask for more food if I am still hungry . . . weigh weekly . . ." The care plan failed to address Resident #30's significant weight loss. The medical record lacked weekly weights. A quarterly dietary profile assessment, completed on 04/12/22, identified Resident #30's appetite as fair and listed no supplements. The staff failed to document or address Resident #30's weight loss. Observations of Resident #30 throughout the survey showed the resident ate independently. During an interview on 05/11/22 at 2:27 p.m., an administrative nurse (#1) and a dietary manager (#7) stated Resident #30 "will not take supplements and only wants small portions."	F 692	Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee.	

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Both staff failed to explain the facility's system for identifying weight loss to ensure the dietician completed an assessment and implemented interventions. The dietary manager (#7) failed to provide documentation of any discussions or interventions regarding Resident #30's weight loss.

- During an interview on 05/10/22 at 8:15 a.m., Resident #26's family (#1) stated approximately six months ago they requested to have supplements because they felt their family member was losing weight. The facility only started giving the supplements after their meeting last month at which time she weighed 133 pounds. The family stated the resident's usual weight was about 158 pounds.

Review of Resident #26's medical record occurred on all days of survey. Diagnoses included dementia, Type 2 Diabetes Mellitus, deficiency of B group vitamins, and anemia. The quarterly MDS, dated 03/26/22, identified a weight of 133 pounds with weight loss. The annual MDS, dated 12/26/21, identified a weight of 154 pounds. This is a weight loss of 13.6% in three months.

A dietary note, dated 03/24/22, stated, ". . . Resident comes out to the dining room for all Three meals . . . Resident weighs 154 . . ." This progress note showed a discrepancy in the resident's weight recorded two days later (03/26/22) in the quarterly MDS.

Resident #26's care conference note, dated 04/07/22, stated, ". . . Those in attendance were [name of family member] via phone, Dietary

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manager, both resident care coordinators, Social Worker Designee, Activity Coordinator and D.O.N. [director of nursing] . . . Dietary: . . . current weight is 133, three months ago it was 138 and 6 months ago it was 150, which is a 17-pound loss. . . . continues to be on a regular, pureed diet. . . . meal intake ranged from 50% to 75% over the last 30 days. [Family] requested that [resident] receive soft foods such as mashed potatoes, cottage cheese etc. . . . We discussed possible interventions to keep [resident] from continued weight loss such as starting on 4oz of ensure twice a day, providing pudding for her 2pm and 8pm snack, having someone stay with her until her snack is completed . . ."

A physician's order, dated 03/15/22, stated, "Regular diet Ground texture, Regular consistency . . ." A current nursing order stated, "Vitals - Weight on Mondays NO later then [sic] 10am."

Resident #26's care plan, revised 04/09/22, stated, ". . . I am at risk for nutritional problems r/t [related to] cognitive deficits. I need assist of one with meals and snacks. . . . Obtain and record weight daily. I require assist of one staff with meals. I receive 4 oz [ounces] of ensure two times per day. . . ."

The vital sign record identified Resident #26's weight as:
10/27/21 146.8 lbs
03/30/22 133.2 lbs
04/25/22 138 lbs
There is a discrepancy of weights between the dates shown. Subsequent record review showed the dietary manager crossed out the weekly

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F 692	Continued From page 27 weights for the months of November 2021 through March 29, 2022 and noted "incorrect." During an interview on 05/10/22 at 1:44 p.m., the dietary manager (#7) indicated he altered the weight record, crossing off weights he felt were not correct, stating, "I think staff were just writing something in." When asked if staff re-weighed the resident, he said "no." The dietary manager stated he reviewed weights weekly and no weight loss triggered for Resident #26 with the documented weights in the 150's. During an interview on 05/10/22 at 2:37 p.m., an administrative nurse (#1) stated she was unaware staff crossed out the weights in the resident's record and agreed the facility staff failed to accurately monitor Resident #26's weights and provide supplemental interventions. Failure to consistently obtain accurate weights may have contributed to incorrect assessment of weight changes.	F 692		
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	F 757		6/30/22

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F 757	Continued From page 28 §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 facility policy, and staff interview, the facility failed to ensure the resident's medication regimen remained free of unnecessary medications for 3 of 3 sampled residents (Resident #16, #19, and #33) receiving antipsychotic medications. Failure to establish a baseline by assessing for abnormal involuntary movements before starting an antipsychotic and to monitor periodically while on the medication may result in the resident experiencing adverse consequences related to the antipsychotic medication. Findings include: Review of facility policy titled "DISCUS [Dykinesia Identification System Condensed User Scale - an assessment used to identify side effects of antipsychotic medications] Item Definitions" occurred on 05/12/22. This policy, dated 01/22/20, stated, ". . . The rater using the DISCUS should be completely familiar with these terms and definitions in order to properly assess residents on antipsychotic therapy. . . HOW OFTEN ARE THEY DONE. . . Base line and every 6 months or other wise [sic] specified by	F 757	1. Completed AIMS on Residents # 16, 19, and 33 on 5/24/2022. MDS coordinator was educated and policy created. A review of all medication orders to determine if an AIMS evaluation is warranted was completed on 5/24/2022. 2. The facility has determined that all residents receiving the prescribed drugs have the potential to be affected. 3. MDS Coordinator will have baseline AIMS completed before starting new medications per policy. MDS Coordinator will have baseline AIMS completed for all residents on medications per policy. Every six months routine evaluation of AIMS will be completed for all residents on medications per policy. Provider round nurse will inform MDS coordinator of any new medications that have been ordered. 4. MDS coordinator will audit once a week for eight weeks, then every two weeks for two months and then quarterly thereafter for period of one year and then every six months to coordinate with resident□s MDS assessment of medication orders to	

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F 757	Continued From page 29 the Doctor." The facility staff failed to provide an Abnormal Involuntary Movement Scale (AIMS) assessment policy. - Review of Resident #16's medical record occurred on all days of survey. The electronic medication administration record (EMAR) and physician's orders identified the resident received risperidone (antipsychotic medication) 0.5 milligrams (mg) twice a day with a start date of May 2021. Resident #16's medical record identified an AIMS assessment completed on 6/03/21 and lacked any further AIMS assessments. During an interview on 05/11/22 at 3:56 p.m., an administrative nurse (#1) confirmed staff failed to complete any further AIMS assessments for Resident #16 and stated she expected staff to complete an assessment every six months. - Review of Resident #19's record occurred on all days of survey. A physician's order, dated 01/13/22, stated, "Abilify [antipsychotic medication] Tablet 5 MG . . . Give 1 tablet by mouth one time a day related to unspecified mood disorder." Resident #19's medical record lacked documentation of a completed DISCUS assessment per policy. During an interview on 05/12/22 at 9:17 a.m., an administrative nurse (#1) confirmed staff failed to complete a DISCUS assessment on Resident #19. - Review of Resident #33's medical record	F 757	ensure that appropriate indications for use of any drugs are clearly documented in the medical record. MDS Coordinator will report all finding to Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee.	

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F 757	Continued From page 30 occurred on all days of survey. A physician's order, dated 01/19/22, stated, "Aripiprazole [antipsychotic medication] Tablet 2 MG. Give 2 mg by mouth one time a day for Mood/Behavior." Resident #33's medical record lacked documentation of a completed DISCUS assessment per policy. During an interview on 05/12/22 at 9:32 a.m., an administrative nurse (#1) confirmed staff failed to complete a DISCUS assessment for Resident #33.	F 757		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;	F 880		6/15/22

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F 880	Continued From page 31 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under 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.	F 880		

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F 880	Continued From page 32 §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, and staff interview, the facility failed to follow infection control practices for 5 of 15 sampled residents (Resident #10, #14, #25, #33, and #96). Failure to follow infection control practices during a dressing change (Resident #14), foley catheter cares (Resident #10 and #25), medication administration (Resident #33), and when performing a blood glucose check (Resident #96) has the potential to spread infection to other residents, staff, and visitors. Findings Include: FOLEY CATHETER CARE Review of the facility policy titled "Catheter Bag Emptying Policy" occurred on 05/11/22. This undated policy stated, ". . . Empty catheter into graduate cylinder 5.) Before closing the foley bag, clean with an alcohol swab . . ." - Observation on 05/09/22 at 2:43 p.m. showed a certified nursing assistant (CNA) (#9) emptied Resident #10's urinary catheter bag into a graduate cylinder. While emptying the catheter bag, the CNA allowed the urine drainage port to touch the sides of the graduate and failed to clean the drainage port with an alcohol swab. The CNA (#9) dumped the urine into the toilet, obtained water directly from the sink faucet to rinse the graduate, and emptied the rinse water	F 880	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) members, shall identify and implement a consistent system for ensuring a system for: (1) Ensuring staff have a clean surface or barrier for dressing change supplies. (2) Ensuring staff emptying a foley catheter bag do not allow the urine port to touch the graduate cylinder, use alcohol swabs to clean the urine port, and rinse the graduate with the handheld sprayer. (3) Ensuring staff performing blood glucose checks do not contaminate the container of strips used for the blood glucose monitoring machine. (4) Ensuring staff administering medications discard any medication dropped on the medication cart. The DON, staff development coordinator (SDC), IP or designee, in conjunction with applicable IDT members, will:	

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F 880	Continued From page 33 into the toilet. - Observation on 05/10/22 at 2:10 p.m. showed a CNA (#8) emptied Resident #25's urinary catheter bag into a graduate cylinder. The CNA (#8) dumped the urine into the toilet, obtained water directly from the sink faucet to rinse the graduate, and emptied the rinse water into the toilet. During an interview on 05/11/22 at 1:29 p.m., an administrative nurse (#1) stated she expected staff to use the handheld sprayer in the resident's bathroom to rinse a graduate cylinder and not obtain water directly from the sink faucet. MEDICATION ADMINISTRATION The facility failed to provide a Medication Administration policy upon request. Observation during medication pass on 05/11/22 at 8:05 a.m. showed a licensed nurse (#12) obtained Resident #33's medications and dropped one of the pills on top of the medication cart. The nurse (#12) picked up the pill, using bare hand contact, placed it into the medication cup, and administered the medications to Resident #33. During an interview on 05/11/22 at 11:15 a.m., an administrative nurse (#1) stated she expected staff to discard a pill if dropped on the medication cart. BLOOD GLUCOSE MONITORING Observation on 05/11/22 at 11:47 a.m. showed a	F 880	(1) Educate staff to provide a clean surface or protective barrier for dressing change supplies (2) Educate staff on emptying a foley catheter per infection control guidelines (3) Educate staff to performing a blood glucose check without contamination (4) Educate staff administering medications to discard a dropped medication 2. Identification of Others The IP and DON, in conjunction with the applicable the interdisciplinary team (IDT) members, will review current nursing facility guidelines from CDC and CMS. The IP, DON and applicable IDT members will evaluate the facility's compliance with the guidelines. The facility will develop action plans to address any newly identified non-compliance. 3. System Changes On or before 06/15/2022 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 provide a clean surface/ barrier for dressing change supplies b. Failure to empty a foley catheter using infection control guidelines c. Failure to perform a blood glucose check without contamination of the strips d. Failure to discard a dropped	

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F 880	Continued From page 34 nurse (#13) performed a blood glucose monitoring check on Resident #96. The nurse used a lancet needle to obtain blood from the resident's finger and failed to obtain enough blood for the blood glucose machine to provide a result. Without changing gloves, the nurse (#13) obtained another glucose monitoring strip from the container and performed the test. The nurse (#13) failed to remove her gloves and perform hand hygiene before obtaining a new blood glucose monitoring strip from the container used for multiple residents. During an interview on 5/11/22 at 12:15 p.m., an administrative nurse (#1) confirmed the nurse may have contaminated the bottle of glucose monitoring strips and confirmed the nurse (#13) discarded the bottle of strips. DRESSING CHANGE Observation on 05/11/22 at 2:04 p.m. showed a nurse (#13) entered Resident #14's room to perform a dressing change to a pressure ulcer on the right heel. The nurse placed the supplies (scissors, skin prep wipes, packaged dressing, gauze, and saline solution) on the bedside table, sanitized hands, and began the dressing change. The nurse (#13) failed to provide a clean surface/barrier for the supplies prior to performing wound care. During an interview on 05/12/22 at 9:32 a.m., an administrative nurse (#6) confirmed she expected staff to provide a clean surface or sanitize the area for supplies when performing a dressing change.	F 880	medication (2) The DON, SDC, IP or suitable designee will ensure the following: a. Staff provide a clean area/barrier for dressing supplies, empty a foley catheter bag using infection control guidelines, perform a blood glucose check without contamination and discard dropped medications. (3) The facility leadership will contact the North Dakota 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. 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 providing a clean surface/barrier for dressing change supplies (2) Observations of staff emptying a foley catheter bag using IC guidelines (3) Observation of staff performing a blood glucose check without contamination of the strips	

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F 880	Continued From page 35	F 880	(4) Observation of medication pass and ensuring staff know procedure for any dropped medications 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 06/15/2022	
F 881 SS=F	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §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:	F 881		6/30/22

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F 881	Continued From page 36 §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on review of facility guideline/pre-antibiotic checklist and staff interview, the facility failed to consistently implement ongoing review for an antibiotic stewardship program. Failure to implement a system of antibiotic monitoring to ensure the correct indication, dose, and duration may result in adverse outcomes, the unnecessary use of antibiotics, and the development of antibiotic-resistant organisms. Findings include: Review of the facility guideline/pre-antibiotic checklist titled "Agency for Healthcare Research and Quality: Four Moments of Antibiotic Decision Making Form" occurred on 05/12/22. This guideline, dated June 2021, stated, ". . . form is to help team incorporate the four moments of antibiotic decision making into daily practice in your facility . . . help identify opportunities to make changes that improve systems around antibiotic use . . . directions: use form when a complete blood count (CBC), urinalysis/urine culture, or antibiotic is ordered for a resident in your facility . . . review cases once or twice weekly . . . name of antibiotic, diagnosis, symptom onset . . . recurring issue . . . what measures have been into place prior to calling physician . . . does resident have a catheter . . . vitals . . . increased fluids . . . cough, diarrhea, stomach cramps . . . care-planned . . . when was last time this antibiotic taken . . . diagnostic	F 881	1. Initiated an infection and prevention control program including antibiotic stewardship program and system to monitor antibiotic use. ADON completed infection preventionist program training offered by CDC. 2. All residents have the potential to be affected. 3. Nurses will be educated at an inservice regarding new policy for antibiotic stewardship created by the Infection Preventionist. Nurses will be educated to inform infection preventionist when new antibiotics are ordered for residents. Infection preventionist will monitor electronic records for any new antibiotics started. 4. The Infection Preventionist will complete chart audits will residents with UA, CBC, and/or new antibiotic ordered every week. A antibiotic decision making form will be completed for all resident with orders for UA, CBC, and/or new antibiotic and will be reported at monthly Quality Assurance meetings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355050	A. BUILDING _____ B. WING _____	C 05/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 881	Continued From page 37 testing done . . . labs, xrays, urine analysis . . . family notified, resident education given, staff education given . . ." During an interview the morning of 05/12/2022, two administrative nurses (#1 and #6) when asked to provide information about the facility antibiotic stewardship process, failed to provide documentation or logs. The administrative nurses confirmed the facility failed to consistently implement a protocol to monitor for antibiotic stewardship for residents on antibiotics.	F 881		
F9999	FINAL OBSERVATIONS The complaints investigated in conjunction with the standard Medicare/Medicaid survey were unsubstantiated.	F9999		