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

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0550 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** MEAL SERVICE 1. Based on observation, review of facility policy, and staff interview, the facility failed to provide care in a manner and environment that maintained or enhanced and respected each resident's dignity for 1 of 2 meals observed (noon meal 03/09/20). Failure to sit at the residents level while assisting with meals does not preserve the residents' personal dignity or enhance their quality of life. Findings include: Review of the facility policy, Dining Room Service occurred on 03/11/20. This policy, revised November 2017, stated, . If dining assistance is needed by a resident, employees are to sit next to the resident; do not stand and feed resident. - Observation of the noon meal on 03/09/20 showed the following: * A certified nurse assistant (CNA) (#13) served Resident #28's meal, cut up the pork chop, and encouraged him to eat. When the CNA (#13) noted Resident #28 stopped eating she stood next to the resident and fed him. * A CNA (#11) stood while feeding Resident #241. * A CNA (#13) stood while feeding Resident #3. - During an interview on 03/11/20 at 02:10 p.m., an administrative nurse (#1) confirmed staff should not stand over residents while feeding them. FAILURE TO KNOCK 2. Based on observation, review of facility policy, and staff interview, the facility failed to provide care in a manner and environment that maintained, enhanced, and respected each resident's dignity and individuality for 2 of 10 sampled residents (Residents #12 and #29). Failure to respect residents' personal preferences and announce themselves and wait for permission prior to entering residents' rooms does not preserve the residents' personal dignity or enhance their quality of life and places them at risk of embarrassment and/or emotional harm. Findings include: Review of the facility policy titled Resident Dignity occurred on 03/11/20. This policy, revised February 2013, stated, . to maintain the dignity of all residents . Respecting resident's private space . Knocking on doors and requesting permission to enter . - Observation on 03/09/20 showed the following: * At 2:34 p.m., a certified nurse assistant (CNA) (#15) provided personal cares for Resident #12. A second CNA (#9) knocked on the resident's door and immediately entered the room. The CNA (#9) failed to identify herself and wait for permission to enter the room. * At 10:14 a.m., an unidentified CNA provided personal cares for Resident (#29). A CNA (#14) knocked on the resident's door and immediately entered the room. The CNA (#14) failed to identify herself and wait for permission to enter the room. * At 12:02 p.m., two CNA's (#4 and #14) provided personal cares for Resident (#29). A nurse (#1) knocked on the resident's door and immediately entered the room. The nurse (#1) failed to identify herself and wait for permission to enter the room. -During an interview on 03/11/20 at 02:10 p.m., an administrative nurse (#1) stated she expects staff to knock on resident's door, identify themselves and wait for a response before entering.
F 0623 **Level of harm** - Potential for minimal harm **Residents Affected** - Some	**Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to provide residents or their representatives and the State Long Term Care Ombudsman a written notice of transfer as soon as practicable for 1 of 6 sampled residents (Resident #31) transferred to the hospital from the facility. Failure to provide a notice of transfer does not allow residents to make informed decisions or inform the Ombudsman of the transfer. Findings include: Review of Resident #'31's medical record occurred on all days of survey. The record showed the facility transferred Resident #31 to an acute care hospital on [DATE]. The record lacked evidence the facility completed a transfer form and/or sent a copy to the Ombudsman. During an interview on the afternoon of 0[DATE]1/19 an administrative staff member (#1) confirmed the facility failed to provide a copy of the transfer form.
F 0625 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.** Based on record review and staff interview, the facility failed to provide a bed hold notice upon transfer to the hospital for 1 of 6 sampled residents (Resident #31). Failure to provide a bed hold notice does not allow residents or their legal representatives to make informed choices regarding their readmission rights. Findings include: Review of Resident #31's medical record occurred on all days of survey and identified a hospital admission on 08/13/19. The record lacked evidence the facility completed a bed hold notice and /or provided Resident #31 and or his/her legal representative with the information. During an interview on the afternoon of 03/11/20 an administrative staff member (#1) confirmed the facility failed to provide the bed hold notice.
F 0644 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of the [ST] Provider Manual for Preadmission Screening and Resident Review (PASRR), review of facility policy, and staff interview, the facility failed to complete a status change assessment for 1 of 1 sampled resident (Resident #26) with a newly diagnosed mental illness. Failure to complete a change in status assessment may result in the delivery of care and services inconsistent with residents' needs. Findings include: The [ST] PASRR Provider Manual states, . Change in Status Process . Whenever the following events occur, nursing facility staff must contact [MED] to update the Level I screen for determination of whether a first time or updated Level II evaluation must be performed. These situations suggest that a significant change in status has occurred: . If an individual with MI, ID, and/or RC (Mental illness, intellectual disability, and conditions related to intellectual disability (referred to in a regulatory language as related conditions or RC)) was not identified at the Level I screen process, and that condition later emerged or was discovered. Review of the facility policy titled PASARR occurred on 03/12/20. This policy revised, September 2017, stated, . If the resident is diagnosed with [REDACTED]. Review of Resident #26's medical record occurred on all days of survey. An initial PASARR, dated on 09/09/19 identified no major mental illnesses (MMI) and no PASARR II needed. A

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

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

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F 0644 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) physician's order, dated 10/25/19, showed, . New diagnosis . MAJOR [MEDICAL CONDITION], RECURRENT SEVERE WITHOUT PSYCHOTIC FEATURES . During an interview on 0[DATE] at 4:02 p.m., a social services staff member (#12) confirmed the staff failed to complete the required Level I screening after the new diagnoses.
F 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure services provided by the nursing facility meet professional standards of quality.** Based on observation, review of facility policy, review of facility skill checklist, and staff interview, the facility failed to follow professional standards of practice in priming of [MED] pens for 2 of 3 observations (morning of 03/11/20) of [MED] administration. Failure to correctly prime the [MED] pen may result in residents to receiving an inaccurate dose of [MED]. Findings include: Review of the facility policy and procedure titled [MED] Pens occurred on 03/11/20. This policy, revised March 2018, stated, . Turn the dosage knob to '2'units to prime the pen. Holding the pen with the needle pointing upwards, press the button until at least a drop of [MED] appears. Review of the facility skill checklist titled, [MED] Pens Clinical Skill Checklist occurred on 03/11/20. This checklist dated, March 2018, stated, . Holding the pen with the needle pointing upwards, press the button until at least a drop of [MED] appears. Observation on 03/11/20 at 8:05 a.m., showed a licensed nurse (#2) prepared an [MED] pen for injection for Resident #141. The nurse removed the needle cover and primed the [MED] pen in a horizontal position. Observation on 03/11/20 at 11:31 a.m., showed a licensed nurse (#2) prepared an [MED] pen for injection for Resident #10. The nurse removed the needle cover and primed the [MED] pen in a horizontal position. During an interview on 03/11/20 at 2:17 p.m., an administrative nurse (#1) confirmed the staff did not follow faciltiy policy, and failed to correctly prime the [MED] pen.
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide adequate assistive devices necessary to prevent accidents for 3 of 5 sampled residents (Resident #14, #20, #140) and one supplemental resident (Resident #142) observed during transfers. Failure to use a gait belt appropriately during transfers (Resident #14, #20, and #142), and failure to cue a resident (Resident #140) to use minimal weight bearing per care plan has the potential to result in avoidable accidents and injury. Findings include: Review of the facility policy titled Gait (Transfer) Belt occurred on 3/12/20. This policy dated, October 2017, stated, . Place the belt around the resident's waist over clothing. Make sure the belt is securely buckled so it does not slide. Do no use the pants/slacks. as a gait (transfer) belt. - Observation on 0[DATE] at 1:00 p.m. showed two certified nursing assistant's (CNAs) (#3 and #4) applied a gait belt to Resident #14 and assisted him to the toilet. During the transfer, both CNA's (#3 and #4) reached under the resident's arms and lifted him to a standing position. The CNA's (#3 and #4) failed to utilize the gait belt during the transfer. - Observation on 0[DATE] at 10:18 a.m. showed two CNAs (#5 and #6) applied a gait belt to Resident #142 and trasnferred him from the bed to the wheelchair. During the transfer, the CNA (#5) reached under the resident's arm and lifted him to a standing position. The CNA (#5) failed to utilize the gait belt during the transfer. -Review of Resident #20's medical record occurred on all days of survey. [DIAGNOSES REDACTED]. Resident #20's care plan stated Assist of 1 for transfers with gaitbelt and front wheel walker or assist bar/rail. - Observation on 03/09/20 at 10:49 a.m. showed a CNA (#4) transferred Resident #20 into the tub room to use the commode. The CNA (#4) assisted Resident #20 to stand and transferred him/her on and off the commode. The CNA failed to utilize a gaitblet during the transfer. Observation on 03/09/20 at 3:50 p.m. showed a CNA (#9) transferred Resident #20 into the tub room to use the commode. The CNA pulled the resident's brief and pants up while holding onto the resident's waistband and attempting to move the commode. Resident #20 became unsteady and had to sit on the edge of the commode. The CNA (#9) failed to utilize a gait belt during the transfer. Observation on 0[DATE] at 8:51 a.m. showed a CNA (#10) guided Resident #20's hands to the hand rail and assisted him/her stand. The CNA had Resident #20 take a few steps, turn, and sit in the wheelchair. The CNA (#10) failed to use a gait belt during the transfer. Observation on 0[DATE] at 1:40 p.m. showed a CNA (#10) placed a gait belt around Resident #20's waist and instructed him/her to use the assist rail on the bed and stand. The CNA pulled the resident up by the waistband of his/her pants. The CNA (#10) failed to use the gait belt during the transfer. During an interview on 03/11/20 at 2:30 p.m. an administrative nurse (#1) stated she expected staff to use gait belts for non-mechanical lift transfers and gait belt application/use is part of yearly staff competencies. - Review of Resident #140's medical record occurred on all days of survey and showed the resident experienced fractured left fibula. Resident #140's current CNA card, stated, Partial weight bearing to left leg. Observation on 0[DATE] at 11:50 a.m. showed two CNAs (#4 and #5) assisted Resident #140 to transfer to and from a wheelchair to a commode. During the transfers Resident #140 lifted his/her right leg and put full weight on the left leg. Failure of the CNAs (#4 and #5) to cue the resident to partial weight bearing has the potential to aggravate the injury to Resident #140's left leg.
F 0758 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of facility policy, and staff interview, the facility failed to ensure each resident's medication regimen was free from unnecessary medications for 1 of 5 sampled residents (Resident #29) reviewed for unnecessary meds. Failure to include documentation regarding the clinical justification/specific circumstances for continued use of as needed (PRN) [MEDICAL CONDITION] medication beyond 14 days and failure to establish a specific start and stop date may result in the resident receiving a medication for an excessive duration and/or experiencing adverse side effects related to its use. Findings include: Review of the facility policy titled [MEDICAL CONDITION] Medications occurred on 03/11/20. This policy, revised June 2017, stated . PRN orders for [MEDICAL CONDITION] drugs are limited to 14 days. If the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. Review of Resident #29's medical record occurred on all days of survey. [DIAGNOSES REDACTED]. A physician's order for [MEDICATION NAME] (antianxiety medication), dated 10/24/2019, stated, . [MEDICATION NAME] Tablet 0.5 MG (milligram) by mouth as needed for anxiety at least 4 hours between doses AND Give 0.5 mg by mouth one time a day related to OTHER SPECIFIED ANXIETY DISORDERS . The record lacked documentation regarding the provider's rationale for extending the PRN [MEDICATION NAME]. During an interview on 03/11/20 at 2:07p.m., an administrative nurse (#1) confirmed the staff failed to ensure the provider indicated the rationale for extending the duration for the PRN [MEDICATION NAME] for Resident #29.
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of facility policy, and staff interview, the facility failed to label two multi-dose [MED] pens in 1 of 1 medication storage room. Failure to label multi-dose pens with the date opened increases the risk of residents receiving outdated medications with reduced medication efficacy. Findings include. Review of the facility policy titled [MED] Pens occurred on 03/11/20. This policy, revised on March 2018, stated, . Verify provider order, the expiration date and the number of days the pen has been open . Observation of the medication storage room occurred on 03/11/20 at 1:40

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F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) p.m. One [MED] Kwik Pen ([MED] pen) and one [MEDICATION NAME] Flex Touch Pen ([MED] pen) label failed to identify an open date or an expiration date. During an interview on 03/11/20 at 2:10 p.m., an administrative nurse (#1) stated she expects staff to date [MED] pens with open and expiration dates.
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of manufacturer's labeling, review of facility policy, and staff interview, the facility failed to properly store fluids/supplements and dishware in a sanitary manner in 1 of 1 kitchen and 1 of 1 nourishment center. Failure to identify the date/time sensitive fluids are opened, dispose of time sensitive fluids that have expired, properly store scoops for liquid supplementation, and clean/handle dishware in a sanitary manner may result in altered consistency of thickened fluids and cause foodborne illnesses from cross contaminated dishware. Findings include: FOOD STORAGE Review of the facility policy/procedure titled Food/Supply Storage occurred on [DATE]. This policy, dated [DATE], stated, . Use By and Freeze by (expiration) dates are checked on a regular basis; foods/fluids that have expired or are otherwise unsafe for use are discarded. The manufacturers' label for the thickened fruit juice stated, Use within seven days of opening. Observations during the dietary tour on [DATE] at 1:38 p.m. with a dietary staff member (#7) showed the following undated, expired items, and improperly stored item: - Kitchen, reach in cooler, one undated/opened cranberry juice, and one opened juice dated ,[DATE] ([DATE]), opened 17 days. - Nutrition Center, container of supplement for thickening liquids with a scoop stored in the product. During the tour, the dietary staff member (#7) reported she expected staff to label thickened beverages when opened, to dispose of the expired thickened juice, and store the scoop in a separate container. DISHWARE Review of the facility policy/procedure titled Ware Washing occurred on [DATE]. This policy, dated [DATE], stated, . Mechanical Ware Washing, 1. Employees wash hands between dirty/clean side of dish machine. Review of the facility policy/procedure titled Hand Hygiene And Handwashing occurred on [DATE]. This policy, dated [DATE], stated, . Sanitizers are not used in food service or dining except immediately after proper handwashing. Observation during the dietary tour on [DATE] at 1:38 p.m. showed a dietary staff member (#8) failed to wear an apron to prevent soiling of her uniform during dishwashing. Two observations showed the dietary staff member (#8) moved from the soiled dishwashing area to handling clean dishes without washing her hands with soap and water. The dietary staff member (#8) rinsed her hands in a bucket of kitchen sanitizer and moved clean dishes from the drying area to the dishware storage area. During the tour, the dietary staff member (#7) reported staff are expected to wear an apron while washing dishes, and to use an alcohol based hand sanitizer between the dirty and clean side of the dish machine. This staff member's expectation is not consistent with facility policy. Failure to clean and store dishware in a sanitary manner placed residents, visitors, and staff at risk for foodborne illness.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** Based on observation, review of facility policy, and staff interview, the facility failed to follow standard infection control practices for 4 of 4 sampled residents (Resident #16. #17. #20 and #241) observed during cares, and 1 of 1 meal observed (noon meal on 03/09/20). Failure to follow standard infection control practices may result in the spread of infections within the facility. Findings include: Review of the facility policy titled, Hand Hygiene and Handwashing, occurred on 03/12/20. This policy, dated January 2018, stated, . wash hands with plain soap and water . use and alcohol-based hand rub . before having direct contact with residents . after having contact with another person's skin . After having contact with bodily fluids, wound or broken skin . After removing gloves . During service of meals . Wash hands before meal service begins,whenever visible soiled and whenever hands are contaminated by touching a resident, self, or any surface (eg. table, chair, counter) . Do not touch any food or eating surfaces with bare hands (ie., fork tines, eating surfaces of plates, drinking surfaces of glasses) . - Observation on 03/09/20 at 10:55 a.m., showed Resident #17 seated on the bedside with his catheter bag lying on the bare floor. Observation on 0[DATE] at 11:39 a.m. showed Resident #17 seated on the bedside with the catheter bag lying on the bare floor. A certified nurse assistant (CNA) (#5) picked the catheter bag off the floor, emptied the catheter bag, then returned the catheter bag on to the bare floor. The CNA (#5) failed to hang the catheter on the bed side or place it in a storage bag/cover to prevent contact with the floor surface. Observation on 0[DATE] at 2:08 p.m., showed Resident #17 sitting on the bedside with his catheter bag lying on the bare floor. A CNA (#4) picked the catheter bag off the floor, emptied the catheter bag, then returned the catheter bag on to the bare floor. The CNA (#4) failed to hang the catheter bag on the bed side or place it in a storage bag/cover to prevent contact with the floor surface. During an interview on 03/11/20 at 2:11 p.m., an administrative nurse (#1) stated she would expect staff to store the catheter bag in a storage bag or hang it on the bedside and not allow contact with the floor. - Observation on 03/09/20 at 4:05 p.m. showed a CNA (#9) assisted Resident #16 to the commode. The CNA (#9) donned gloves, removed a soiled brief, and provided pericares. Observation showed stool on the peri-wipe. Without removing his/her gloves the CNA (#9) applied a new incontinence brief, pulled up Resident #16's pants, placed his/her gloved hand on the gait belt around resident's waist and assisted him/her back to the recliner. - Observation on 03/09/20 at 10:49 a.m. showed a CNA (#4) assisted Resident #20 to the commode, provided pericares, and removed his/her gloves. The CNA then pulled Resident #20's pants up and assisted him/her to the wheelchair. The CNA failed to perform hand hygiene before exiting the room. - Observation on 03/09/20 at 3:50 p.m. showed a CNA (#9) donned gloves and assisted Resident #20 to the commode. The CNA removed the soiled brief and, without removing his/her gloves or performing hand hygiene, the CNA applied a clean brief, restocked the garbage bags, opened a new bag of wipes, provided pericares, and assisted Resident #20 to the wheelchair. The CNA (#9) removed his/her gloves, and without performing hand hygiene pushed Resident #20 out of the room. - Observation on 0[DATE] at 2:02 p.m. showed two CNAs (#10 and #11) entered Resident #241's room. Both CNAs donned gloves and CNA (#10) removed the resident's soiled brief and performed pericare. With the same gloves the CNA (#10) applied a new brief and pulled up Resident #241's pants. The CNA (#11) disposed of the soiled brief and, without removing gloves or performing hand hygiene, assisted CNA (#10) to position Resident #241 on the right side and placed a pillow behind his/her back. DINING OBSERVATION: - Observation on 03/09/20 at 12:13 p.m. showed an unidentified CNA wiped Resident #7's face with a napkin and without performing hand hygiene, fed bites of food to another resident (Resident #13). The unidentified CNA periodically wiped Resident #7's face with the same paper napkin and then touched and fed bites of food to Resident #13. The CNA failed to perform hand hygiene between contact with Resident #7 and Resident #13. - Observation on 03/09/20 at 12:28 p.m. showed a CNA (#4) adjusted Resident #20's [MED]gen tubing and then touched the resident's hair. Without performing hand hygiene, the CNA picked up another resident's glass and assisted him/her to drink. During an interview on 03/11/20 at 2:30 p.m. an administrative nurse (#1) stated she expected staff to remove gloves after peri-care/toileting hygiene, perform hand hygiene after glove removal, and perform hand hygiene after touching a resident or resident equipment.