STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355053	A. Building B. Wing	12/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Knife River Care Center	118 22nd St NE Beulah, ND 58523

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 46477 Based on record review, review of the facility policy, and resident and staff interview, the facility failed to report a incident of potential neglect immediately to the State Survey Agency (SSA), for 1 of 1 sampled resident (Resident #32) who experienced injuries. Failure to report the potential neglect and the results of the facility's investigation to the SSA, placed Resident #32 and other residents at risk for possible neglect and/or further injury. Findings include: Review of the facility policy titled Abuse Prohibition Policy, occurred on 12/01/22. This policy, dated August 2022, stated, . Neglect shall mean failure to provide goods and services necessary to avoid physical harm . All alleged acts or suspected acts of abuse, neglect . shall be immediately and thoroughly investigated and reported . in accordance with state law (including to the state survey and certification agency) . a report shall be made to the State Survey & Certification Agency State Licensure within five (5) days of the reporting of the alleged incident . During an interview on 11/28/22 at 2:10 p.m., Resident #32 stated, I was being taken for a bath and my feet were dragging on the ground causing carpet burns to my toes, I did not have my blue boots on or pedals for the wheelchair. Review of the investigation completed by the facility occurred on the morning of 11/30/22, it stated, 10/27/2022 [Nurse's name], UM [unit manager], asked resident, [name of resident], what happened to his right great and right second toe. [Name of resident] reported that injury happened when a CNA's [certified nursing aid] were pushing him to his bath and his toe drug on the ground. [Nurse's name] educated staff to make sure his blue boots are on when on the way to the bath house. During an interview on 12/01/22 at 9:20 a.m., two administrative staff members (#1 and #4) confirmed the facility failed to report resident #32's injury to the SSA. Refer to F689.

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40489 THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 08/23/21 Based on record review, staff interview, and review of the Long-Term Care Facility Assessment Instrument (RAI) 3.0 User's Manual, the facility failed to complete a significant change in status assessment (SCSA) for 1 of 20 sampled residents (Resident #20). Failure to identify the need for and complete a SCSA may limit the facility's ability to accurately assess the resident's status and develop an appropriate care plan. Findings include: The Long-Term Care Facility RAI 3.0 User's Manual (Version 1.15), dated October 2019, page 2-22 stated, . A 'significant change' is a major decline or improvement in a resident's status that: 1. Will not normally resolve itself without staff intervention . 2. Impacts more than one area of the resident's health status; and 3. Requires interdisciplinary review and/or revision of the care plan. and page 2-25 stated, A SCSA is appropriate if there are either two or more areas of decline or two or more areas of improvement. This may include two changes within a particular domain (e.g., [for example] two areas of ADL [Activities of Daily Living] decline or improvement mobility, transfers, walking in corridor and toileting. Review of Resident #20's medical record occurred on all days of survey. An annual Minimum Data Set (MDS), dated [DATE], identified the resident required limited staff assist with walking in the room, walking in the corridor, locomotion on the unit, and physical behaviors. The next scheduled quarterly MDS, dated [DATE], identified Resident #20 required extensive staff assistance with walking in the room, walking in the corridor, locomotion on the unit and physical and verbal behaviors. The record lacked evidence the staff identified and/or completed a SCSA following Resident #20's declines in activities of daily living. During an interview on 12/01/22 at 8:27 a.m., a staff member (#9) confirmed the facility staff failed to complete a significant change in status assessment for Resident #20.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46477 THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 08/23/21. Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.17.1), and staff interview, the facility failed to ensure accurate coding of the Minimum Data Set (MDS) for 1 of 20 sampled residents (Resident #32). Failure to accurately complete the MDS does not allow each resident's assessment to reflect their current status/needs and may affect the accurate development of a comprehensive care plan and the care provided to the residents. Findings include: The Long-Term Care Facility RAI User's Manual, revised October 2019, page N-6 stated, . Coding Instructions N0410A-H: Code medications according to the pharmacological classification, not how they are being used. N0410B, Antianxiety: Record the number of days an anxiolytic medication was received by the resident at any time during the 7-day look-back period (or since admission/entry or reentry if less than 7 days). Review of Resident #32's medical record occurred on all days of survey. A physician order dated 08/19/21 showed an order for hydroxyzine HCl Tablet (antihistamine) Give 25 mg [milligrams] by mouth at bedtime for Insomnia. Review of the quarterly MDS, dated [DATE], identified N0410B coded for the use of an antianxiety medication seven of seven days during the look-back period. During an interview on the morning of 12/01/22, the MDS coordinator (#2) confirmed the facility inaccurately coded hydroxyzine as an antianxiety medication.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46477 Based on observation, record review, review of facility policy, and resident and staff interview, the facility failed to review and revise comprehensive care plans to reflect the residents' current status for 3 of 20 sampled residents (Resident #20, #57, and #65). Failure to review/revise the care plans to reflect residents' current status limited the staff's ability to communicate needs and ensure continuity of care for each resident. Findings include: Review of the facility policy titled Care Plan Policy occurred on 12/01/22. This policy, dated February 2022, stated, Review of care plans . on an ongoing basis as the resident's condition changes so that additions or deletions can be made to assure that: a. They reflect the resident's medical and nursing assessment by incorporating identified problem areas. - Review of Resident #20's medical record occurred on all days of survey and included the diagnosis of Post Traumatic Stress Disorder (PTSD). The care plan stated, . Res [Resident] is able to ambulate independently . Observations showed the following: * 11/29/22 at 4:38 p.m., a certified nursing assistant (CNA) (#8) ambulated Resident #20 with hands on assistance. * 11/30/22 at 8:23 a.m., a CNA (#10) ambulated Resident #20 with hands on assistance. Fall risk assessments dated, 08/29/22 and 10/18/22 stated, . Cannot walk unassisted . Progress notes included the following: * 8/09/22 at 4:45 p.m., stated, . Annual MDS [minimum data set] review completed . [Resident #20's name] walks to all destinations with her FWW [front wheeled walker] with staff assist . * 10/18/22 6:28 p.m., stated, . Quarterly MDS review completed. [Resident #20's name] walks to all destinations with her FWW [front wheeled walker] with staff assist . The facility failed to review and revise Resident #20's care plan to update increased assistance with ambulation. A quarterly MDS, dated , 10/18/22, identified a diagnosis of PTSD. The facility failed to address Resident #20's diagnosis of PTSD on the care plan and lacked specific interventions to avoid triggers for the resident's PTSD. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/01/22 at 8:19 a.m., an administrative nurse (#1) confirmed the facility failed to update Resident #20's care plan regarding ambulation and included a diagnosis PTSD. - Review of Resident #57's medical record occurred on all days of survey. The current care plan, stated, . The resident has an ADL [activities of daily living] self-care performance deficit r/t [related to] Limited Mobility. LOCOMOTION: Resident uses a power w/c [wheelchair] for locomotion in facility and requires set-up assistance. A Therapy Daily Encounter note dated 10/28/22 stated . Res. [resident] has had incidents with power wc since this am reported by nsg. [nursing] staff . it was decided due to several incidents with power wc the Res. is not able to use it at this time. Last power wheelchair assessment was completed on 07/19/2022. During an interview on 12/01/2022 at 09:20 a.m., an administrative staff member (#1) agreed staff failed to update the care plan to the current locomotion needs. - Review of Resident #65's medical record occurred on all days. The care plan stated, . The resident has an ADL self-care performance deficit r/t dementia . The quarterly MDS, dated [DATE], indicated the resident required extensive assist with toileting. The facility failed to address Resident #65's toileting needs on the care plan. During an interview on 12/01/22 at 8:19 a.m., an administrative nurse (#1) verified the facility failed to address toileting for Resident #65's care plan. 40489

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 46477 Based on observation, record review, and resident interview, the facility failed to ensure staff provided appropriate interventions to prevent new ulcers from developing for 1 of 4 sampled residents (Residents #32) with physician orders for pressure ulcer treatment/prevention. Failure to implement ordered interventions has the potential for the development of new pressure ulcers that can result in pain and/or infection for residents. Findings include: During an observation and interview on 11/28/22 at 2:10 p.m., and 11/30/22 at 4:11 p.m., it was observed that Resident #32 did not have on pressure relieving boots and Resident #32 stated, no one has offered to put on my boots Review of Resident #32's medical record occurred on all days of survey. The Physician orders stated: * Dated 12/05/18, Resident to wear foam boots daily unless resident refuses. * Dated 06/15/22, Ensure Blue Boots (to relieve pressure) are on @ (at) ALL times - even when in W/C (wheelchair) * Dated 07/21/22, L) (left) heel: Aquaphor (gauze dressing) to heel. Wear blue boots at ALL TIMES. The care plan, revised on 04/28/21, stated, The resident has paraplegia, limited mobility and needs assistance with his Activities of Daily Living.The resident will remain free of complications related to immobility, including contractures, thrombus (blood clot) formation, skin-breakdown. Heel flotation boots to be on at all times while in bed. Observations completed on 11/28/22, 11/29/22, and 11/30/22 showed facility staff failed to apply Resident #32's pressure relieving boots. Review of Resident #32's November Treatment Administration Record (TAR) staff signed that pressure relieving boots were applied daily. During an interview on 12/01/22 at 9:20 a.m., with administrative staff members (#1 and #4) confirmed staff failed to apply pressure relieving boots as ordered and failed to document any refusals from the resident.

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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** 46477 1. Based on information provided by the complainant, observation, record review, review of facility policy, and staff and resident interviews, the facility failed to provide appropriate supervision and devices to prevent an accident for 1 of 1 resident (Resident #32) who received an injury when transported by staff to the bathing area. Failure to ensure staff utilized bilateral foam boots and/or wheelchair foot pedals caused an injury to Resident #32's toes. Findings include: Information provided by the complainant indicated the resident was not in his chair properly and staff let his feet drag on the floor which caused open wounds. Review of the facility policy titled Incidents and Accidents occurred on 12/01/22. This policy, revised October 2022, stated, Accident refers to any unexpected or unintentional incident, which results or may result in injury or illness to a resident.The following incidents/accidents require to be reported .Observed accidents/incidents . resident injuries due to staff handling. Review of Resident #32's medical record occurred on all days of survey. Resident #32 has medical diagnosis of diabetes, diabetic neuropathy, paraplegia, and history of pressure ulcers. Current Physician orders stated, Cleanse R) [right] big toe, and second right toe with NS [normal saline] then cover with bandaid every day and prn [as needed]. Monitor for any s/s [signs or symptoms] of infection. Observation on the morning of 11/28/22 showed, black scabs to Resident's #32's right big toe and right second toe. During an interview on 11/28/22 at 2:10 p.m., Resident #32 stated, I was being taken for a bath and my feet were dragging on the ground causing carpet burns to my toes, I did not have my blue boots on or pedals for the wheelchair. During an interview on 12/01/22 at 9:20 a.m., administrative staff members (#1 and #4) stated, staff failed to properly transport the resident with blue boots on and/or pedals on the wheelchair causing injury to toes. 40489 2. Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide adequate supervision and assistive devices necessary to prevent accidents for 1 of 3 sampled residents (Resident #20) observed during a gait belt transfer. Failure to utilize the gait belt during transfers placed Resident #20 at risk of an accident and/or injury. Findings include: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled AMBULATING/TRANSFERRING A RESIDENT WITH A GAIT BELT occurred on 12/01/22. This policy, revised February 2022, stated, Purpose: To ensure staff will use gait belts when assisting with ambulation/transfers for residents who are care planned as unsafe to ambulate/transfer independently. Review of Resident #20's medical record occurred on all days of survey and included a diagnosis of Alzheimer's disease. A quarterly Minimum Data Set (MDS), dated [DATE], identified the resident required limited assist with ambulation and extensive assist with transfers. Review of fall risk assessments dated, 08/29/22 and 10/18/22 identified, . Cannot walk unassisted . Observations of staff assistance with Resident #20 showed the following: * 11/29/22 at 4:38 p.m., showed a certified nursing assistant (CNA) (#8) transferred Resident #20 from the recliner using the resident's walker. The CNA lifted under Resident #20's left arm to stand. The resident unable to stand, the CNA again lifted under the resident's left arm and the resident stood. The CNA held onto the back of the resident's pants while the resident ambulated to the bathroom. After the resident finished toileting the CNA again lifted the resident under the left arm to assist to a standing position. The bag on the resident's walker contained a gait belt. * 11/30/22 at 8:23 a.m., showed a CNA (#10) assisted Resident #20 from a dining chair to a standing position. The CNA attempted to use a gait belt and the resident refused. The CNA lifted under the resident's left arm three times until the resident was able to stand up. The CNAs (#8 and #10) failed to use the gait belt when transferring Resident #20. During an interview on 12/01/22 at 8:19 a.m., an administrative nurse (#1) stated staff are expected to use the gait belt during all assisted transfers and should not lift under the resident's arms or pull on their pants even if the resident refuses to use the gait belt.

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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** 46477 Based on observation, facility policy review, and staff interview, the facility failed to ensure the safe and secure storage of drugs and biologicals in 1 of 4 medication carts observed. Failure to lock the medication cart may result in unauthorized access to medications. Findings include: Review of the facility policy titled Medications System Procedure occurred on 12/01/22. This policy, revised July 2022, stated, . J. Keeping med (medication) cart locked at all times unless dispensing medication . - Observation on 11/29/22 from 11:06 a.m. to 11:15 a.m., showed the certified medication aid (CMA) (#5) stepping into a resident room and leaving the medication cart ([NAME] Lane) unlocked. Further observation showed unidentified staff members and residents walking by the unlocked and unattended medication cart. During an interview on 12/01/22 at 9:20 a.m., with administrative staff members (#1 and #4) confirmed that staff failed to lock the unattended medication cart.

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide and implement an infection prevention and control program. 39685 1. Based on observation, review of facility policy, and staff interview, the facility failed to ensure staff followed infection control practices for 1 of 3 sampled residents (Resident #71) on transmission based precautions related to positive COVID-19 status. Failure to provide and properly utilize personal protective equipment (PPE) for residents on transmission based precautions has the potential to spread the COVID-19 virus to other residents, personnel, and visitors. During the on-site survey, the team determined a potential Immediate Jeopardy (IJ) situation existed on 11/28/22 at 4:30 p.m. The IJ potential resulted from observations of improper use of PPE and lack of staff knowledge/education regarding infection control practices and procedures. These findings placed residents in immediate danger due to the potential spread of the COVID-19 virus. * 11/28/22 at 2:25 p.m.-The survey team contacted the management staff at the State Survey Agency (SSA) to report the findings and to discuss a potential IJ situation. * 11/28/22 at 4:30 p.m.- The survey team notified the facility's administrator, director of nursing (DON), of the IJ and requested they develop a plan for removal of the immediate jeopardy.The team provided the facility with the IJ template. * 11/28/22 at 4:55 p.m.- The SSA notified the regional office of the immediate jeopardy situation. * 11/29/22 at 8:25 a.m.- The facility provided a written removal plan (via verbal and e-mail) for the IJ. * 11/29/22 at 9:22 a.m.- The survey team reviewed and accepted the facility's written plan. * 11/29/22 at 10:00 a.m.- The survey team conducted staff observations and interviews. The survey team identified discrepancies in facility staff infection control practices and requested the facility administrator, DON and IP [infection preventionist] develop additional measures for removal of the immediate jeopardy. * 11/29/22 at 10:30 a.m.- The facility provided a revised written plan for the removal for the IJ. * 11/29/22 at 1:30 p.m.- The survey team reviewed and accepted the facility's revised written plan of correction for the IJ. * 11/29/22 at 1:50 p.m.- The survey team notified the facility administration and removed and reduced the IJ from a scope and severity of K to a scope and severity of E. * 11/29/22 at 1:50 p.m.- The SSA notified the CMS [Center for Medicare and Medicaid Services] location of the removal of the immediate jeopardy. Findings include: (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the facility policy titled Infection Prevention and Control Program occurred on 12/01/22. this policy, revised August 2022, stated, . Transmission-based precautions [TBP] and Isolation Precautions refer to the actions (precautions) implemented . that are based upon the means of transmission (airborne, contact, and droplet) in order to prevent or control infections . facility staff will apply TBP to residents who are known or suspected to be infected with certain infectious agents requiring additional controls to prevent transmission . Review of the facility policy titled, . Personal Protective Equipment (PPE) Guidance occurred on 12/01/22. This policy, revised November 2022, stated, . PPE when caring for known/suspected COVID-19 residents . a N95 mask, eye protection, gloves, and gown must be worn at all times with every resident interaction . donning and doffing should be done in accordance with current Center for Disease Control [CDC] and Center for Medicare and Medicaid Services [CMS] and the North Dakota Department of Health [NDDOH] guidance, procedure . Review of Resident #71's medical record occurred on 11/28/22. Diagnoses included COVID19 positive on 11/22/22. The current care plan identified Resident #71 on airborne and contact precautions related to COVID 19 infection . Resident infection will be resolved without complications . Keep resident room door closed if possible to maintain resident's safety . Resident to quarantine in room . Staff to wear N95 mask when in room . Staff will donn and doff PPE appropriately when entering resident's room . Observation on 11/28/22 at 11:40 a.m. showed signage stating . Droplet precautions . Stop . everyone must clean their hands with sanitizer before entering and when leaving the room . make sure their eyes, nose and mouth are fully covered before room entry . remove face protection before room exit . Donning PPE full Garb: Gown, N95 respirator, face shield, gloves, bouffant . Doffing PPE full garb: Gown and gloves, bouffant, face shield, N95 respirator . Observation on 11/28/22 at 11:25 a.m. showed a certified nurse aide (CNA) (#5) entered Resident #71's room wearing a surgical mask and failed to donn a N95 mask, gown, face shield or gloves or perform hand hygiene. The CNA (#5) exited the room with the same surgical mask, was not wearing other PPE, failed to perform hand hygiene, and carried a meal tray with dishes (no paper products) down the hall to the kitchen. During an interview on 11/28/22 at 11:40 a.m., a CNA (#5) stated she failed to donn and doff the proper PPE (N95 mask, faceshield or goggles, gown, gloves) or hand sanitize when entering and exiting a COVID19 positive resident room. During an interview on 11/28/22 at 4:30 p.m., an administrative nurse (#1) stated she expected all staff to donn/doff appropriate PPE and perform hand hygiene when entering and exiting a COVID19 positive resident room. 31725 THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 08/23/21. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	2. Based on observation, record review, review of facility policy, and staff interview, the facility failed to follow standards of infection control for 3 of 9 sampled residents (Residents #20, #32, and #50) observed during cares. Failure to follow infection control standards has the potential for transmission of communicable diseases and infections to residents, staff, and visitors. Findings include: SANITATION Review of the facility policy/procedure titled Knife River Care Center Standard Precautions occurred on 12/01/22. This policy, dated September 2022, stated, . Body fluids considered potentially infectious include: . All body fluids, secretions, and excretions except sweat . 9. Clean up spills of blood or other infectious material in the following manner . b. disinfect the surface with a tuberculocide/germicide supplied by the facility . Observation on 11/28/22 at 4:16 p.m. showed a certified nurse assistant (CNA) (#7) donned gloves and emptied a urinary catheter bag for Resident #32, in the process of emptying the bag, the CNA (#7) spilled urine on the floor. The CNA (#7) wiped up the urine with a paper towel after finishing emptying the bag, completed hand hygiene and left the room without disinfecting the floor. Record review of facility Infection Log dated October 2022 occurred on 11/29/22. This log shows Resident #32 having a urinary infection and was on contact precautions. During an interview on the afternoon of 12/01/22, an administrative nurse (#1) confirmed the floor should have been disinfected according to facility policy. PERINEAL CARE Review of the facility policy titled Perineal Care occurred on 12/01/22. This policy, dated January 2022, stated, . It is the practice of this facility to provide perineal care to all incontinent residents . to . prevent infection . front to back . Review of Resident #20's medical record occurred on all days of survey. The care plan stated, .The resident has an ADL [activities of daily living] self-care deficit . Requires extensive assist from 1 staff to assist resident with routine toileting . provide peri cares . During an observation on 11/29/22 at 4:38 p.m., a CNA (#8) assisted Resident #20 to the bathroom. The resident was incontinent of urine and while performing perineal cares the CNA wiped, the resident's perineum from the back to the front, right groin, back to front again and left groin. The CNA failed to provide proper perineal cares to prevent risk of infection. During an interview on 12/01/22 at 8:09 a.m., an administrative staff nurse (#1) stated she expected staff to use proper infection control practices when providing perineal cares. HAND HYGIENE (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355053	A. Building B. Wing	12/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Knife River Care Center	118 22nd St NE Beulah, ND 58523

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the facility policy/procedure titled Knife River Care Center Employee Handwashing Procedure occurred on 12/01/22. This policy, dated 6/22/22, stated, . Wash Hands (at a minimum) . Before and after each resident contact . After contact with any body fluids, After handling any contaminated items (linens, soiled briefs, garbage, etc.) . Observation on 11/30/22 at 11:00 a.m. showed a CNA (#3) donned gloves and provided perineal care for Resident #50. The CNA (#3) cleansed the rectal area of stool, removed her gloves, donned clean gloves, applied a brief, and removed her gloves. Without performing hand hygiene, the CNA (#3) positioned the resident's pillows, blankets, call light and applied heel booties. During an interview on the afternoon of 12/01/22, an administrative nurse (#1) stated she expected staff to remove gloves and perform hand hygiene after perineal care before continuing other resident cares. 40489 46477

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355053	A. Building B. Wing	12/01/2022

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0888 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure staff are vaccinated for COVID-19 **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39685 Based on record review, facility policy review, review of professional reference, and staff interview, the facility failed to ensure staff completed the primary COVID19 vaccination series for 2 of 2 staff member (Staff A and B) reviewed who were partially vaccinated. Failure to ensure staff completed all recommended doses of the vaccination series for a multi-dose COVID19 vaccine placed residents and staff at risk for COVID19 infection. Findings include: Review of the facility policy titled Covid19 Vaccination occurred on 12/01/22. This policy, dated 12/20/21, stated, . staff documentation related to the COVID19 vaccine includes at a minimum: the offering of the COVID19 vaccine or information on obtaining the COVID19 vaccine; and the COVID19 vaccine status of staff and related information as indicated by the National Health Care Safety Network (NHSN) . effective March 15, 2022, all Knife River Care Center (KRCC) employees are required to be fully vaccinated against the coronavirus unless exemption has been granted . Review of the Centers for Disease Control and Prevention (CDC) guidelines for Pfizer COVID19 Vaccine found at www.cdc.gov/coronavirus.[NAME].gov.au stated, . Pfizer-BioTech COVID-19 Vaccine . Number of shots: 2 doses in primary series, second dose given 3 weeks (or 21 days) after first dose . may be given up to 42 days (6 weeks) after first dose . Review of staff COVID19 vacination records showed Staff A and Staff B received the first dose of Pfizer COVID19 vaccine on 08/15/22. The records lacked a date for Staff A and Staff B's second dose of Pfizer COVID-19. During an interview in the afternoon on 12/01/22, an infection control nurse (#6) confirmed Staff A and B did not complete the second dose of Pfizer COVID19 vaccine and were not fully vaccinated. The facility failed to ensure all staff are fully vaccinated for COVID19.