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 02/10/2021

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 and complaint survey started on 02/08/21 and concluded 02/10/21.	F 000		
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: Based on observation, record review, review of facility policy, and review of manufacturer instructions, the facility failed to follow professional standards of practice for 1 of 2 observations of insulin pen preparation and administration (Resident #18). Failure to prepare insulin per policy/manufacturer recommendation may result in the resident receiving an inaccurate dose of insulin and failure to offer food within 5 to10 minutes after the administration of a rapid acting insulin may result in hypoglycemia (low blood sugar). Findings include: Review of the facility policy titled "Insulin Pen" occurred on 02/10/21. This policy, reviewed/revised 05/06/20, stated, "Procedure . . . Prime the insulin pen: Dial 2 units by turning the dose selector clockwise. With the needle pointing up, push the plunger, and watch to see that at least one drop of insulin appears on the tip of the needle. If not, repeat until at last one drop appears. . . . Fully depress plunger until the	F 658	1) Nursing staff were in serviced on the facilities policy titled Insulin Pen for proper insulin pen usage. 2) The facility has determined that all residents receiving insulin for diabetes have the potential to be affected. 3) All Licensed nursing staff will be in-serviced on the facility insulin pen policy. In-service training included observation of each nurse administering insulin by insulin pen. A skill checklist was completed for each nurse to ensure proper administration of insulin using insulin pen. Findings were reviewed with each nurse. Corrective action was provided as needed. 4) The Director of Nursing Services or designee will complete random skill checklist of nurses administering insulin by insulin pen for six consecutive weeks to ensure nurses are administering insulin in accordance with our facilities policy titled Insulin Pen.	3/17/21

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

Electronically Signed | 03/12/2021

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F 658	Continued From page 1 dosing numbers count back to zero. While still pressing the plunger, keep the needle in the skin for up to 6-10 seconds and then remove the needle from the skin. . . ." The manufacturer's instructions for the NovoLog Flex Pen found at www.novomedlink.com stated, ". . . prime your pen: turn the dose selector to select 2 units. Press and hold the dose button. Make sure a drop appears. . . . Give your injection: Insert the needle. Press and hold the dose button. After the dose counter reaches 0, slowly count to 6. . . ." Observation on 02/09/21 at 11:31 a.m. showed a licensed nurse (#1) attached a needle to Resident #18's Novolog (rapid acting) insulin pen, without priming the insulin pen, selected 6 units of insulin, entered the resident's room, administered the insulin, and immediately removed the insulin pen after injection. The licensed nurse (#1) failed to prime the insulin pen prior to administration and failed to hold the dose button for the count of 6. The facility staff failed to prime the insulin pen, wait an appropriate time after insulin injection, and failed to offer food within 10 to15 minutes after rapid acting insulin administered.	F 658	Skill checklist will be reviewed by quality assurance until consistent substantial compliance has been achieved.	
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent	F 686		3/17/21

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F 686	Continued From page 2 pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide appropriate treatment and services to prevent the deterioration of pressure ulcer for 1 of 3 sampled residents (Resident #26) with pressure ulcers. Failure to routinely assess, monitor, and measure Resident #26's pressure ulcer and ensure consistent implementation of ordered interventions may result in delayed healing of the pressure ulcer. Findings include: Review of the facility policy titled "Skin Assessment" occurred on 02/10/21. This policy, revised January 2021, stated, ". . . skin assessment as part of our systemic approach to pressure injury prevention and management. . . . skin assessment will be conducted by a licensed or registered nurse upon admission/re-admission and weekly thereafter. The assessment may also be performed after a change of condition or after any newly identified pressure injury. . . .7. Documentation of skin assessment: a. Include date and time of the assessment, your name and position title. b. Document observations (e.g. skin conditions, how the resident tolerated the procedure, etc.). c. Document type of wound. d.	F 686	1) Appropriate revisions were made to the pressure sore policy to reflect cause, prevention and treatment. The DON reviewed the revised policy with all staff involved in care of resident #26 on 2-11-2021. 2) Chart Audits were completed for all residents with pressure related wounds or for those residents followed by the clinical nurse specialist. All orders were reviewed. 3) One nurse will be assigned to ensure that measurements and documentation on pressure related wounds or for those residents followed by clinical nurse specialist. A validation checklist will be used to ensure pressure related wounds are being measured and evaluated weekly. 4) The Director of Nursing services or designee will review physician orders of all residents that are followed by consultation. Validation checklist will be completed for six consecutive weeks to ensure treatment is as ordered and is care planned. Audits will be reviewed by quality assurance and reviewed at the quarterly QA meetings until substantial	

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F 686	Continued From page 3 Describe wound (measurements, color, type of tissue in wound bed, drainage, odor, pain). . . ." The facility did not have a specific policy on pressure ulcers. Review of Resident #26's medical record occurred on all days of survey. Diagnoses include dementia, type 2 diabetes mellitus, vitamin B deficiency and an unstageable pressure ulcer of left heel. The annual Minimum Data Set (MDS), dated 12/26/20, identified severely impaired cognition, extensive assistance of one staff member for bed mobility, transfers, dressing, and toileting. The MDS also identified one unstageable pressure ulcer and the risk for developing pressure ulcers. The care plan lacked a problem, goal, and approaches for preventing and/or healing Resident #26's pressure ulcer. A physician order, dated 05/23/20, stated, "Heel boots to bilateral heels AAT [at all times] every day and night shift for pressure relief". Observation on 02/08/21 at 3:04 p.m., showed Resident #26 sitting in her room in a recliner with the footrest elevated, wearing gripper socks and hard sole slippers with her heels resting on the footrest. No heel boots noted in the room. Observation on 02/09/21 at 8:04 a.m., showed Resident #26 sitting in a wheelchair at the table with feet flat on the floor wearing gripper socks and hard sole slippers. Observation on 02/09/21 at 3:02 p.m., showed Resident #26 sleeping in the recliner with the footrest elevated, wearing gripper socks and hard sole slippers with her heels resting on the	F 686	compliance has been achieved.	

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F 686	Continued From page 4	F 686		

footrest. A staff nurse (#6) performed the scheduled dressing change to Resident #26's left heel. Observation showed the wound on the left heel to have a moderate amount of purulent [containing pus] drainage, and macerated [soft] edges, and measured 1 centimeter (cm) x 2 cm x 0.2 cm. The staff nurse (#6) cleansed the wound and performed the dressing change as ordered. No heel boots noted in the room.

Observation on 02/10/21 at 10:03 a.m., showed Resident #26 sleeping in the recliner with the footrest elevated, resident wearing gripper socks and hard sole slippers with her heels resting on the footrest. Heel boots noted to be sitting on the floor by the dresser.

The progress notes identified the following:
*11/11/20 11:55 a.m., ". . . Scant amount of serosanguineous drainage noted. Area measures 0.3 cm x 0.4 cm x 0.1 cm w/ pink granulated tissue present. Edged are well defined and blanchable . . . "
*11/23/20 1:20 p.m., "Wound to left lateral heel measures 0.7 cm X 0.8 cm X 0.1 cm. 100% eschar noted to wound bed. Peri wound area is blanchable with no erythemic skin noted . . . "
*12/29/20 3:49 p.m., ". . . Scant amount of serosanguinous drainage noted on previous dressing. No odor noted. Wound has well defined edges. Wound bed has approximately 90% slough and 10% granulation tissue to wound bed. Granulation tissue is pink in color. Periwound is pink in color. No pain report by resident. Measured 1.0 cm x 1.0 cm x 0.1 cm."
*01/12/21 6:15 p.m., ". . . Wound measures were 1 x 0.7 mm . . . "
*01/19/21 10:47 a.m., "Dressing change

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F 686	Continued From page 5 completed to left heel, unable to observed drainage as dressing was removed due to bathing. Wound measurements are 1cm x 1 cm x 0.3 cm. Wound bed is 60% pale granulation tissue with 40% thin yellow adherent slough. Peri-wound is calloused skin of normal skin tones; which when debrided off the wound edges are not defined, they appear to have an epibole [curled under] appearance. . . ." *01/26/21 4:01 p.m., ". . . Wound measurements are 0.7 cm x 1 cm x 0.3 cm. Wound bed is 60% beefy red with granulation tissue with 40% thin yellow slough. Peri-wound is macerated with defined edges." *02/02/21 3:12 p.m., "Wound measurements are 1 cm x 1 cm x 0.2 cm. Wound bed is 80% pale granulation tissue with 20% thin yellow adherent slough. Peri-wound is calloused skin of normal skin tones . . . " During an interview on 02/09/21 at 3:02 p.m., a staff nurse (#6) confirmed that heel boots were ordered at all times for Resident #26 when not ambulating and that the heel boots were not present in Resident #26's room. The facility failed to provide consistent monitoring of Resident #26's pressure ulcer, including measuring the area which limited the facility's ability to identify improvement or worsening of the pressure ulcer. The facility also failed to care plan and implement goals and interventions for prevention and healing of Resident #26's pressure ulcer.	F 686		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including	F 695		3/17/21

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F 695	Continued From page 6 tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy review, and staff interview, the facility failed to provide respiratory care consistent with standards of practice and physician orders for 3 of 5 sampled residents (Resident #12, #16, and #19) receiving oxygen. Failure to administer, assess, and monitor oxygen as ordered may complicate a resident's respiratory status and result in inappropriate use of oxygen. Findings include: Review of the facility policy titled "Oxygen Administration" occurred on 02/09/2021. The policy, updated 01/29/21, stated, ". . . Oxygen is used conservatively in residents with chronic lung disease because high levels of oxygen may suppress breathing stimuli. . . . Obtain orders from physician or nurse practitioner, a. type of oxygen therapy, b. administration device and liter flow rate or concentration. . . ." - Review of Resident #12's medical record occurred on all days of the survey. Physician's order, dated 11/27/2020, stated, "APPLY OXYGEN AT 2L [two liters] VIA NC [nasal canula] FOR O2 [Oxygen] saturation BELOW 92% ON RA [room air] every day and night shift related to	F 695	1) All Licensed nurses were in-serviced on the facility policy titled oxygen administration for administration of oxygen to residents. 2) The facility has determined that all residents using oxygen have the potential to be affected. 3) An in-service education program was conducted by the Director of Nursing Services with all licensed nurses addressing the significance of providing oxygen to all residents who need oxygen and to have oxygen applied per Doctor□s order. Also licensed nurses are reminded to educate residents with oxygen not to adjust the oxygen per self and what could happen if oxygen is too high or too low. Also licensed nurses are reminded to chart the education in residents progress notes. Signs of too much Oxygen: Signs of low oxygen " Visual changes * SOB " Ringing in the ears * HA " Nausea * Restless " Irritability * Chest	

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F 695	Continued From page 7 DYSPNEA." The current care plan identified "problem . . . I have Emphysema/COPD [Chronic obstructive pulmonary disease] history of pneumonia. . . Interventions . . . Monitor for s/sx [signs and symptoms] of acute respiratory insufficiency: Anxiety, Confusion, Restlessness, SOB [Shortness of breath] at rest, Cyanosis,[bluish discoloraztion of the skin], Somnolence [sleep walking] . . . Monitor for s/sx of acute respiratory insufficiency. . . chest pain, increased difficulty breathing (Dyspnea), increased coughing and wheezing." A nursing progress note dated 12/20/2020, stated, ". . . Note Text: Resident is on oxygen at 3 LPM [liters per minute] per NC [nasal canula] . . . " Observations of resident #12 showed: * 02/10/21 at 8:32 a.m., Resident is in her room, sitting in a recliner, with oxygen concentrator set at 3 liters. * 02/10/21 at 12:22 p.m., Resident at lunch with oxygen tank on wheelchair, oxygen set at 3 liters. During an interview on 02/10/21 at 12:30 p.m., a nurse (#6), identified Resident #12 had an order for oxygen at 2 liters. An observation made with the nurse (#6) of Resident #12's oxygen tank, the nurse (#6) confirmed the oxygen setting at 3 liters. When asked, the nurse (#6) stated "oxygen doses cannot be changed without a physician's order," and the staff nurses monitor residents' oxygen settings. The nurse confirmed staff set the oxygen incorrectly and adjusted Resident #12 oxygen setting to 2 liters.	F 695	Pain " Anxiety * Confusion " Confusion " Dizziness " Quit Breathing 4) The Director of Nursing Services and or designee will review each resident oxygen and assure oxygen is set to proper order. The Director of Nursing Services (DON), or designee, will complete random weekly oxygen use audits for four (4) consecutive weeks to ensure that oxygen is being used as directed by the Doctor. Audits will assure that care plans remain updated to reflect these interventions. Audited records will be reviewed by the Risk Management/Quality Assurance Committee at the monthly QA meeting until such time consistent substantial compliance has been achieved as determined by the committee. Findings of this audit will be discussed with the Resident Council.	

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F 695	Continued From page 8 - Resident #16's medical record occurred on all days of survey. Diagnoses included chronic obstructive pulmonary disease. Observations of Resident #16 showed: * 02/08/21 at 12:37 p.m., Resident#16 sitting in a recliner watching television, oxygen in place with concentrator set at 3 liters. * 02/09/21 at 8:08 a.m., Resident #16 resting in the recliner watching television, oxygen in place with concentrator set at 3 liters. * 02/10/21 at 09:30 a.m., showed Resident #16 laying in the recliner sleeping, oxygen in place with concentrator set at 3 liters. A physician's order dated 09/14/20, stated, "Continuous oxygen 2L/MIN [2 liters per minute] via nasal cannula every morning and at bedtime." -Resident #19's medical record occurred on all days of survey. Diagnoses included congestive heart failure. Observations of Resident #19 showed: * 02/08/21 at 1:15 p.m., Resident #19 sitting in the recliner with oxygen in place at 3 liters. * 02/09/21 at 8:12 a.m., Resident #19 sitting in their wheelchair,with oxygen in place at 3 liters . * 02/10/21 at 9:25 a.m., Resident #19 laying in bed watching television,with oxygen in place at 3 liters. A physician's order, dated 9/18/20, stated, "Administer oxygen at 2LPM via NC to keep oxygen saturation at 92% or above." During an interview on 02/10/21 at 4:30 p.m., an administrative staff member (#10) confirmed they expected nursing staff to follow the physician	F 695		

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F 695	Continued From page 9 orders.	F 695		
F 801 SS=E	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e) This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by	F 801		4/14/21

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F 801	Continued From page 10 the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services who- (i) For designations prior to November 28, 2016, meets the following requirements no later than 5 years after November 28, 2016, or no later than 1 year after November 28, 2016 for designations after November 28, 2016, is: (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is not met as evidenced by:	F 801		

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F 801	Continued From page 11 Based on staff interview, the facility failed to ensure the dietary manager received the necessary education to obtain the required qualifications to serve as the director of food and nutrition services for 1 of 1 dietary manager (#5). Failure to ensure qualified staff with the appropriate competencies and skill sets to carry out the functions of the food and nutrition services has the potential to result in adverse outcomes to residents, staff, and visitors. Findings include: During an interview on 02/10/21 at 11:15 a.m., the dietary manager (#5) identified beginning the Certified Dietary Manager (CDM) training in July 2020 and has not completed the course. During an interview on 02/10/21, at 1:01 p.m., an administrative staff member (#10) identified the facility failed to ensure the dietary manager (#5) completed the required education for CDM. The facility failed to provide the necessary training in food and nutrition services to carry out daily operation duties.	F 801	1) No resident was affected by the alleged violation. 2) The facility has determined that all residents may have the potential to be affected. 3) Admin staff met with the Dietary Supervisor and QA on educational requirements for a qualified nutrition professional. The Dietary Supervisor and QA enrolled in the CFM course from IFSEA and passed on 4-14-2021. The Dietary Supervisor has completed the serv-safe course as well. 4) A Registered Dietitian will continue routine visits during which time she will perform consultative duties within the realm of her profession.	
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.	F 812		3/17/21

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F 812	Continued From page 12 (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED JUNE 13, 2019 Based on observation, review of facility policy, and staff interview, the facility failed to prepare and serve food in a sanitary manner in 1 of 1 kitchen. Failure to ensure the concentration of quaternary (Quat) solution is within expected concentration and to perform hand hygiene after handling soiled dishes may result in inadequate sanitization of the kitchen. Finding include: SANITIZING During the dietary tour on 02/10/21 at 10:22 a.m., with the dietary manager (#5), observation showed two buckets of prepared solution for cleaning of the counter tops as needed during food preparation. The cook (#3) identified one of the prepared solutions as sanitizer and the other as soap and water. When requested the dietary manager (#5)	F 812	1) The dietary staff members involved were immediately in-serviced by the QA Coordinator on proper checking of the sanitizing solution. The policy for testing of multi-quat sanitizer was reviewed. 2) The facility has determined that all residents may have the potential to be affected. 3) All dietary staff will be in-serviced on the facility□s testing of multi-quat sanitizer and will be shown how to properly check the sanitizing solution by our consulting Dietician and/or QA Coordinator. In-service training included observation of each employee performing the procedure. A validation checklist will be completed for each dietary employee to determine if the employee was performing the procedure correctly. Findings were reviewed with each employee. Corrective action was provided as needed. 4) The dishwasher will continue to perform and record the PPM daily as well as the expiration date of the strips.	

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F 812	Continued From page 13 measured the concentration of the sanitizer. The test strip measured less than 100 parts per million (ppm). When asked, the cook (#3) identified he prepared the bucket of sanitizer an hour ago. The dietary manager (#5) emptied the sanitizer bucket and prepared a new one using the automatic dispensing system. When tested the sanitizer measured less than 100 ppm. The dietary manager (#5) emptied the bucket, ran the dispenser, then filled the bucket again; this time the sanitizer measured 200 ppm. The dietary manager (#5) identified the sanitizing solution should measure 200 - 300 ppm. WARE WASHING Review of the facility policy titled, "Hand Hygiene" occurred on 02/10/21. This policy, dated January 2021, stated, "Hand hygiene is a general term that applies to either handwashing or the use of an antiseptic hand rub . . . Hand hygiene is indicated and will be performed under the conditions listed in, but not limited to, the attached hand hygiene table. . . . HAND HYGIENE TABLE: Condition . . . After handling contaminated objects . . ." - Observation of dishwashing occurred on 02/10/21 at 1:15 p.m. The dietary staff member (#4) rinsed/scraped the dirty dishes/kitchen supplies, placed them in the dish washing rack, put the rack into the dishwasher, prepared another rack of dishes for the dishwasher, without hand washing moved to the cleaned dishes, unloaded clean items from a rack, put them away, removed the clean dishes from the dishwasher for drying, and moved the dirty rack	F 812	Dishwasher will notify the Dietary Manager and/or Maintenance if PPM is not within the designated 150-400 PPM as listed in our policy. Dietary Manger will do a QA of the sanitization log once a week for a month then once a month for 5 months and randomly thereafter to ensure that proper charting is being done and PPM□s are within the proper range. Audit results will be reviewed monthly at the QAPI meeting.	

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F 812	Continued From page 14 into the dishwasher for washing. During the observation the staff member (#4) worked between placing soiled items into racks to removing clean items, three times without performing hand hygiene. During an interview on 02/10/21 at 2:10 p.m., the dietary staff member (#4), when asked about the observations of hand hygiene, indicated she did not know she should have washed her hands when moving from dirty to clean. Continued interview with the dietary management staff member (#5) confirmed they failed to educate staff on proper hand hygiene.	F 812		
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	F 880		3/17/21

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F 880	Continued From page 15 §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (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	F 880		

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F 880	Continued From page 16 transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to ensure staff followed standard infection control practices for 5 of 10 sampled residents (Resident #5, #12, #16, #19, and #29) and 1 supplemental resident (#40) observed during cares. Failure to follow standard infection control practices related to hand hygiene and glove use may result in the spread of infections within the facility. Findings include: Review of the facility policy titled "Hand Hygiene" occurred on 02/10/21. This policy, revised January 2021, stated, "Hand hygiene is a general term that applies to either handwashing or the use of an antiseptic hand rub . . . Hand hygiene is indicated and will be performed under the conditions listed in, but not limited to, the attached hand hygiene table. . . . HAND HYGIENE TABLE: Condition . . . Between resident contacts . . . After handling contaminated objects . . . Before applying and after removing personal protective equipment (PPE), including gloves . . . Before performing resident care procedures . . . after assistance with personal body functions (e.g., elimination, hair grooming, smoking) . . . " Review of the facility policy titled "Infection	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 adequate knowledge of hygienic cleaning practices and the facility's cleaning/disinfecting product(s) in order to utilize them correctly for disinfection and cleaning purposes of shared equipment. 2. Ensuring staff hand hygiene or handwashing when donning PPE, moving between tasks, residents, and after touching potentially contaminated surfaces, in accordance with CDC guidelines. 2. Identification of Others The IP and DON, in conjunction with the applicable the interdisciplinary team (IDT)	

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F 880	Continued From page 17 Prevention and Control Program" occurred on 02/10/21. This policy, revised January 2021, stated, ". . . 8. Equipment protocol: a. All reusable items and equipment . . . shall be cleaned in accordance with our current procedures . . ." - Observation on 02/08/21 at 12:42 p.m., showed a certified nursing assistant (CNA) (#9) assisted Resident #16 to the bathroom. The CNA donned gloves, removed Resident #16's incontinence product which contained bowel movement (BM), assisted Resident #16 to sit on the toilet, doffed her gloves, and without performing hand hygiene shut the bathroom door, adjusted the recliner in the room with the remote control, and straightened the items on the side table. - Observation on 02/09/21 at 8:17 a.m., showed a CNA (#8) entered Resident #40's room without performing hand hygiene, obtained Resident #40's temperature and oxygen saturation, and exited the room without performing hand hygiene or disinfecting the thermometer or oxygen saturation monitor. The CNA then entered Resident #5's room, obtained Resident #5's temperature and oxygen saturation, and exited the room without performing hand hygiene or disinfecting the thermometer or oxygen saturation monitor. The CNA next entered Resident #19's room, and obtained Resident #19's temperature and oxygen saturation, and exited the room without disinfecting the thermometer or oxygen saturation monitor or performing hand hygiene. - Observation on 02/09/21 at 9:28 a.m. showed a CNA (#3) assisted Resident #12 to the toilet, provided peri cares, and removed her gloves.	F 880	members, will review current COVID-19 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 03/17/2021 the facility shall complete the following actions: 1. DON, IP, and applicable IDT members will conduct root-cause analysis to identify and address the reasons for non-compliance related to: Failure to complete handwashing or hand hygiene in accordance with CDC guidelines. Failure to complete disinfection of shared equipment in accordance with CDC guidelines. 2. The DON, IP or suitable designee will ensure the following: All staff will receive education keeping hands clean between tasks, contacts with potentially contaminated surfaces and between residents. This education will include the CDC's lesson on clean hands available at https://youtu.be/xmYMUly7qiE. 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	

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F 880	Continued From page 18 Without performing hand hygiene, the CNA (#3) donned a new pair of gloves, cleaned the resident's dentures, and handed them to the resident with her gloved hand. The CNA (#3) removed her gloves, without hand hygiene, donned a new pair of gloves, and continued to wash and dress the resident. The CNA (#3) removed her gloves, without hand hygiene, assisted the resident to her recliner, and left the room. The CNA (#3) failed to perform hand hygiene between glove changes and before exiting the room. - Observation on 02/09/21 at 10:41 a.m., showed two CNAs (#8 and #11) transferred Resident #29 to the bed using a mechanical lift. Both CNAs donned gloves, then removed the lift sheet, the resident's pants, and soiled incontinence product. The CNA (#11) performed perineal cares while the other CNA (#8) assisted Resident #29 to turn. The CNA (#8) also assisted to remove the soiled incontinence product. The CNA (#8) wore the same gloves during the entire encounter, removed the garbage and exited the room without removing her gloves or performing hand hygiene. The CNA (#8) removed her gloves in the hallway while still holding the garbage and failed to perform hand hygiene prior to entering the soiled utility room. - Observation on 02/09/21 at 12:55 p.m., showed two CNA's (#8 and #11) transferred Resident #19 with a mechanical lift to bed and changed the resident's incontinence product. The CNA (#8) performed perineal care and applied a protective cream to the buttocks. The CNA (#8) removed her gloves, and without performing hand hygiene held Resident #19's hand to assist the resident in	F 880	control and prevention are consistently implemented and effective. Such monitoring will include: 1. Observations of staff engaged in cleaning activities to ensure cleaning and disinfection is completed in a hygienic manner and cleaning products are used in accordance with manufacturer instructions to achieve disinfection of shared equipment. 2. Observations of all staff types to ensure performance of proper handwashing and hand hygiene, when indicated, in the course of their routine duties. Observations will be made across all shifts and neighborhoods/units. Observations of noncompliance with the above will result in ad hoc education for the involved staff. Such education will be documented on monitoring forms. After twelve weeks of monitoring, provided that such monitoring demonstrates expectations are consistently met, monitoring may be reduced to monthly. Monthly monitoring will continue for no less than three months. All monitoring will be reported to the quality assurance process improvement (QAPI) committee as part of QAPI activities. Monitoring will not be discontinued until the facility completes three consecutive rounds of monthly monitoring that demonstrate sustained compliance as approved by the QAPI committee and medical director.	

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F 880	Continued From page 19 rolling. The CNA (#8) later placed the oxygen cannula in Resident #19's nose still without performing hand hygiene. During an interview on the afternoon of 02/10/21, an administrative nurse (#7) stated she expected staff to perform hand hygiene upon entry/exit of resident rooms, after removing gloves, and between resident contacts. The administrative nurse also confirmed staff failed to disinfect the thermometer and oxygen saturation monitor per protocol.	F 880	5. Correction Date 03/17/2021	
F9999	FINAL OBSERVATIONS Based on record review, staff interview, and resident and family interview, the complaint issues investigated in conjunction with the standard Medicare/Medicaid survey were not substantiated.	F9999		