STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355100	A. BUILDING _____ B. WING _____	11/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVENTIDE DEVILS LAKE CARE CENTER	**302 7TH AVE NE DEVILS LAKE, ND 58301**

(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
E 000	Initial Comments A COVID-19 Emergency Preparedness Survey was completed by the Centers for Medicare and Medicaid Services (CMS) on 11/17/2020. The facility was found in compliance with 42 CFR §483.73 related to E-0024(b)(6).	E 000		
F 000	INITIAL COMMENTS A COVID-19 Focused Infection Control Survey was conducted on 11/17/20. The facility was found to not be in compliance with 42 CFR 483.80 infection control regulations and will be cited at F880. The facility had 3 COVID-19 positive residents.	F 000		
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	F 880		12/21/20

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

Electronically Signed | 12/11/2020

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F 880	Continued From page 1 facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (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.	F 880		

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F 880	Continued From page 2 Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to follow infection control standards for one of one days (11/17/20) of observation. Failure to practice infection control related to hand hygiene and/or glove use has the potential to spread infection to other residents, personnel, and visitors. Findings include: Review of the facility policy titled "Coronavirus (2019-nCoV)", occurred 11/17/20. This policy, revised May 2020, stated, ". . . e. Hand hygiene is a necessary component of preventing the transmission with alcohol based hand rubs being the preferred method of hand hygiene. . . g. Educate resident, families, and staff in regards to covering their coughs, sneezes, and proper hand hygiene. . . ." Review of the facility policy titled "Hand Hygiene", occurred 11/17/20. This policy, revised November 2019, stated, ". . . Hand Hygiene will be done . . . Before and after resident contact (before you leave the room). Before every clean procedure. After every dirty procedure. As needed. . . ."	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)/unit(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 hand hygiene or handwashing when donning PPE, moving between tasks, residents, and after touching potentially contaminated surfaces, in accordance with CDC guidelines. (2) Educate all staff on correctly completing hand hygiene after changing tasks, moving between residents, doffing/donning PPE, changing gloves, and touching potentially contaminated surfaces. To verify all staff understands hand hygiene and handwashing, all staff will perform a successful return demonstration of identifying the need and correct procedure for performing hand	

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F 880	Continued From page 3 - During an interview on 11/17/2020 at 2:35 p.m. with staff member (#6), the staff reached under her face shield and adjusted her surgical mask to wipe her nose and cough on two separate occasions, and then placed the tissue into her pocket. Without performing hand hygiene, reached into a laundry basket containing clean linen and placed the clean linen into a storage closet. The staff member failed to properly dispose of the contaminated tissue or perform hand hygiene at appropriate times. - Observation on 11/17/20 at 2:42 p.m., showed a droplet precaution sign on the door frame of Resident #2's room. A certified nursing assistant (CNA) (#3) wearing a N95 respirator [a respiratory protective device designed to achieve a very close facial fit] and a face shield exited the room, removed the face shield and N95 respirator, and without performing hand hygiene, applied a surgical mask and failed to disinfect the face shield before re-applying. Review of Resident #2's medical record occurred on 11/17/20. A physician's order, dated 11/16/20, identified, "Droplet precautions r/t [related to] COVID symptoms. . . N95 to be removed outside of room and face shield to be cleaned." - Observation on 11/17/2020 at 3:05 p.m., showed a staff member (#8) touched several snack bars with bare hands, cut the bars in smaller pieces, and placed them onto a different plate. The staff member failed to perform hand hygiene and/or use gloves to complete the task. - Observation on 11/17/20 at 3:15 p.m., showed a CNA (#2) removed their gown, gloves and face	F 880	hygiene and handwashing. 2. Identification of Others The IP and DON, in conjunction with the applicable the interdisciplinary team (IDT) 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 12/21/2020 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. (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, or a designee will conduct on-going monitoring to ensure, via	

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F 880	Continued From page 4 shield, exited the designated COVID-19 unit, removed their N95 respirator, placed it in a labeled brown paper bag, and without performing hand hygiene applied a surgical mask. During an interview on 11/17/20 at 5:00 p.m., an administrative nurse (#1) stated she expected staff to disinfect face shields after exiting an isolation room, perform hand hygiene after removing personal protective equipment (PPE) and before applying PPE, after contact with their face shield, surgical mask, or face, and expected glove usage with food handling. The facility failed to ensure the staff performed hand hygiene and/or glove usage appropriately to reduce the risk of infection transmission to resident, staff, and visitors.	F 880	observation, the approaches to correct deficient practice related to infection control and prevention are consistently implemented and effective. Such monitoring will include: (1) Observations of all staff types to ensure correct donning and doffing of PPE when entering and exiting droplet precaution isolation/quarantine rooms. (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 units. Observations of noncompliance with the above will result in ad hoc education for the involved staff. Such education will be documented on monitoring forms. After twelve weeks of monitoring, provided that such monitoring demonstrates expectations are consistently met, monitoring may be reduced to monthly. Monthly monitoring will continue for no less than three months. All monitoring will be reported to the quality assurance process improvement (QAPI) committee as part of QAPI activities. Monitoring will not be discontinued until the facility completes three consecutive rounds of monthly monitoring that demonstrate sustained compliance as approved by the QAPI committee and medical director. 5. Correction Date 12/21/2020	

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F 880	Continued From page 5	F 880	1.Corrective Action: a.Facility determined no residents identified were affected by the deficient practice. b.An audit tool has been developed to monitor infection prevention practices; both hand hygiene and PPE. The audit tool will be completed by the Director of Nursing or designee 4X a week for 1 month, 2X a week for two months, 1X a week 3 months and then quarterly for a year. c.All staff meeting held on 12/9/2020 to formally address the concern and correction required. Additional team meetings will be held on 12/16/20 and 12/17/20 to reach staff not able to attend the first one and individual education will be provided prior to 12/21/20 for those not in attendance. I. Meetings include viewing of CDC's lesson on cleans hands as well as donning and doffing PPE. d.All staff to perform return hand hygiene demonstrations– both soap and water and alcohol-based hand rub (ABHR) prior to compliance date of 12/21/20. 2.Identification of Others:	

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F 880	Continued From page 6	F 880	a.Facility identified that all residents have the potential to be affected by this practice. 3.System changes: a.A root-cause analysis has been conducted to identify and address the failure to complete handwashing or hand hygiene in accordance with CDC guidelines. A copy of this analysis is available upon request. b.All staff meeting held on 12/9/2020 to formally address the concern and correction required. Additional team meetings will be held on 12/16/20 and 12/17/20 to reach staff not able to attend the first one and individual education will be provided prior to 12/21/20 for those not in attendance. I. Meetings include viewing of CDC's lesson on cleans hands as well as donning and doffing PPE. 4.Monitoring: All staff members will adhere to infection prevention practices. a.An audit tool has been developed to monitor infection prevention practices; both hand hygiene and PPE. The audit tool will be completed by the Director of Nursing or designee 4X a week for 1 month, 2X a week for two months, 1X a week 3 months and then quarterly for a year.	

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F 880	Continued From page 7	F 880	b.See above c.Noncompliance will result in education to involved staff. 5.Compliance will occur on or before 12/21/2020.	