STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355079	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMP HEALTH - ST CATHERINE SOUTH	3102 S UNIVERSITY DR FARGO, ND 58103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The Standard Medicare/Medicaid recertification survey and complaint investigation started 03/14/22 and concluded 03/17/22.	F 000		
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal	F 550		4/20/22

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

Electronically Signed | 04/12/2022

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 550	Continued From page 1 from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. 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 care for 5 of 23 sampled residents (Resident #12, #35, #38, #57, and #60) and 3 supplemental residents (Resident #44, #55, and #72) in a manner and environment that maintained, enhanced, and respected each resident's dignity and individuality. Failure of staff to announce themselves/wait for permission prior to entering residents' rooms and failure to assist with set up of adaptive equipment as care planned 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 policy titled, "Routine Cares" occurred on 03/17/22. This policy, revised September 2019, stated, ". . . Dignity and Privacy . . . Knock and identify yourself upon entering the apartment. Give resident time to respond. . . ." KNOCKING/ENTERING ROOMS Observations showed the following: * 03/14/22 at 3:23 p.m., a staff nurse (#12)	F 550	It is the practice of this facility for staff to knock on the door and announce themselves when entering a resident room. It is also the practice of this facility for staff to assist residents with set up of adaptive equipment for dining. 1. Re-education was provided to staff caring for residents on all units to knock on the resident's door and announce themselves prior to entering a resident room. Re-education was also provided for staff assisting resident #38 and resident #57 to assist the resident with their adaptive equipment for dining. 2. All residents have the potential to be affected when staff do not knock on the resident's door and announce themselves entering a room. All residents with adaptive equipment for dining have the potential to be affected. 3. Re-education was provided to all staff at meetings on 3/22/2022 and 4/6/2022 that in addition to knocking on resident doors, they need to wait for a response from the resident before entering the room and/or announce themselves. Re-education will be provided to all dietary and nursing staff re: assisting	

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F 550	Continued From page 2 entered Resident #44's room, and administered the resident's medications. The nurse (#12) failed to knock and/or announce herself before entering the resident's room. * 03/14/22 at 3:27 p.m., a certified nursing assistant (CNA) (#13) knocked as she entered Resident #60's room. The CNA (#13) failed to announce herself before entering the resident's room. * 03/14/22 at 3:47 p.m., a CNA (#13) knocked as she entered Resident #35's room. The CNA (#13) failed to announce herself before entering the resident's room. * 03/15/22 at 08:34 a.m., a staff nurse (#28) entered Resident #38's room, and provided the resident's wound cares. The nurse (#28) failed to knock and/or announce herself before entering the resident's room. * 03/15/22 at 08:40 a.m., a staff nurse (#28) entered Resident #72's closed bathroom door while the CNA (#30) provided perineal cares. The nurse (#28) failed to knock and/or announce herself before entering the resident's bathroom. * 03/15/22 at 8:57 a.m., while interviewing Resident #12 in his room with the door closed, an unidentified staff member knocked on the room door, opened the door, and stated, "Are you ready to get ready for the day?" The staff member failed to announce herself and wait for permission before entering the resident's room. * 03/15/22 at 09:19 a.m., while observing cares on Resident #55 in her room with the door closed, a CNA (#29) entered the room without knocking and/or introducing himself. During an interview on 03/17/22 at 11:35 a.m., an administrative nurse (#1) reported she expects staff to knock on the resident's door and wait for	F 550	residents with setting up adaptive equipment appropriately for dining. Re-education will be completed at a Skills Fair for all staff to be held on April 12, 13, 14, and 18th. 4. The Quality Nurse or designee will audit 5 staff entering resident rooms on each unit weekly for 4 weeks, monthly for 3 months and quarterly for 1 year for knocking on the door and announcing themselves before entry. The Quality Nurse or designee will audit 5 residents with adaptive equipment for dining weekly for 4 weeks, monthly for 3 months and quarterly for 1 year for proper placement of the adaptive equipment.	

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F 550	Continued From page 3 a response before entering. ADAPTIVE EQUIPMENT REQUIRED FOR MEALS - Observations in the dining room showed the following: * 03/14/22 at 4:20 p.m., an unidentified staff member placed a dinner plate with a plate guard on the left side of the plate, utensils, and three built-up foam handles on the table by Resident #57 without providing set-up assistance. Observation showed food fell on the table and the resident's lap as he attempted to scoop the food. * 03/15/22 at 10:15 a.m., an unidentified staff member placed a breakfast plate with a plate guard positioned at the top of the plate, utensils, and three built-up foam handles on the table by Resident #57 without providing set-up assistance. Observation showed food fell on the table and the resident's lap as he attempted to scoop the food. * 03/15/22 at 4:23 p.m., an unidentified staff member placed a dinner plate with a plate guard positioned at the top of the plate, utensils, and three built-up foam handles on the table by Resident #57 without providing set-up assistance. Observation showed the resident ate pieces of chicken with his fingers and food fell on the table and the resident's lap as he attempted eat the food. Review of Resident #57's medical record occurred on all days of survey and included a diagnoses of Parkinson's disease, and dementia. The current care plan stated, ". . . adaptive equipment: built up foam handled utensils and	F 550		

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F 550	Continued From page 4 plate guard to aid in feeding . . . I am able to feed myself after set up assistance . . ." The Resident's meal card stated, ". . . red foam handles to utensils . . . plate guard . . ." - Observation in the dining room showed the following: * 03/15/22 at 4:15 p.m., an unidentified staff member delivered a dinner plate with a plate guard positioned at the top of the plate to Resident #38, and walked away. The resident asked an unidentified dietary aide to turn her plate/plate guard to the left so she could scoop her food. Review of Resident #38's medical record occurred on all days of survey and included a diagnoses of quadriplegia, and impaired functional range of motion. The current care plan stated, ". . . Adaptive equipment: left side plate guard, long built up handles for silverware . . . I am able to eat independently after set up . . ." The meal card label states, ". . . left side plate guard . . ." During an interview on 03/16/22 at 10:33 a.m., a dietary manager (#31) reported she expects staff to follow the resident's required adaptive equipment and set up needs per meal card and careplan.	F 550		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)	F 561		4/20/22

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F 561	Continued From page 5 (1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of professional reference, resident and staff interview, the facility failed to honor resident choices for 1 of 1 sampled resident (Resident #65) who felt she was not allowed to leave her room. Failure to honor Resident #65's choice related to time out of her room does not respect her autonomy or right to determine what is significant to her life. Findings include: A Guide to Your Rights as a Resident of a	F 561	It is the practice of this facility to promote and facilitate resident self-determination and choice re: how they want to spend their time. 1. Re-education was provided to staff to encourage and assist resident #65 to participate in activities or individual pursuits of her choice and facilitate her choice to leave her room. Activity interests reassessed for resident #65 and careplan revised to assist her to attend activities of her choice and assist her to leave her room as she chooses.	

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F 561	Continued From page 6 Nursing Facility In North Dakota, from the Long Term Care Ombudsman, updated 08/01/2019, page 12, stated, "You can make choices about how you want to live your life that are significant to you. This includes deciding how you want to spend your time, what you would like your daily schedule and routine to be . . ." During an interview on 03/14/22 at 3:06 p.m. Resident #65 identified she does not get to choose how to spend the day. During a care observation on 03/15/22 at 3:58 p.m. Resident #65 again stated she does not have a choice to leave her room. Resident #65's care plan stated, ". . . My family and I choose that I be up for specific activities that may result in being up in my w/c [wheelchair] for prolonged periods of time. . . . I need staff reminders and assist to act [activities] . . . Goal I will participate in bingo . . . Interventions . . . Act of interest include: Special events, Bingo, Reminisce. . . ." Observation showed the facility held Bingo and special music during the survey and Resident #65 did not attend these activities. Resident #65's activity report for March 2022 showed facility staff offered activities four of 16 days. During an interview on 03/17/22 at 11:02 a.m., two administrative staff members (#1 and #10) felt activities staff invited the resident to activities, but Resident #65 refused to attend and stated they could provide information to show refusals.	F 561	2. Care Managers have identified other residents who do not attend activities or leave their room often and have the potential to be affected. 3. Care Management will re-assess the activity interests of those residents identified to have the potential to be affected. Careplans will be reviewed and revised to assist those residents identified to attend activities of their choice and leave their room when they choose. 4. The Quality Nurse or designee will audit 3 resident weekly for 4 weeks, monthly for 3 months and quarterly for 1 year for attendance at activities of their choosing and ability to be out of their room when they choose.	

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F 561	Continued From page 7 Staff failed to provide this information.	F 561		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.	F 580		4/20/22

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F 580	Continued From page 8 (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to notify the physician of a change in condition for 2 of 2 sampled residents (Resident #35 and #60) who experienced high blood sugars. Failure to notify the physician of blood sugar results above the ordered parameters may result in complications to the resident and prevent the physician from evaluating/prescribing an appropriate treatment plan. Findings include: Review of the facility policy titled "Diabetic Protocol" occurred on 03/17/22. This policy, revised February 2019, stated, ". . . All residents with Diabetes will be monitored and treated as ordered by the physician/NP [nurse practitioner]/PA [physician's assistant]. Follow diabetic protocol if there are not specific orders. . . . Treating Hyperglycemic episodes . . . If blood sugar is greater than 400 call the Dr.	F 580	It is the practice of this facility to notify the residents provider of any change in condition of the resident. 1. The providers caring for residents # 35 and #60 were notified of their blood sugar levels on 3/15/22 and 3/16/22. 2. All diabetic residents have the potential to be affected. 3. Re-education was provided to nurses and medication aides regarding reporting blood sugar levels outside of normal range according to the diabetic protocol or specified physician orders to the resident's provider. Physician order was added to the EMAR for all diabetic residents with their blood sugar parameters that require physician notification. 4. The Quality Nurse or designee will audit 5 diabetic residents weekly for 4 weeks, monthly for 3 months and quarterly for 1 year for reporting of blood	

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F 580	Continued From page 9 [doctor]/practitioner unless orders indicate different level for notification. . . . " - Review of Resident #35's medical record occurred on March 13-17, 2022. Diagnoses included type 2 diabetes mellitus. Medications included "Basaglar KwikPen Solution Pen-injector 100 UNIT/ML [milliliter] (Insulin Glargine) Inject 48 unit subcutaneously at bedtime, Insulin Aspart Solution Inject 13 unit subcutaneously one time a day, Insulin Aspart Solution Inject 15 unit subcutaneously one time a day, and Januvia [medication for diabetes] Tablet (SITagliptin Phosphate) Give 50 mg [milligrams] by mouth one time a day" related to type 2 diabetes mellitus. The physician's orders also identified, "Accu-checks [blood sugar checks]three times a day. . ." Review of the January-March 2022 blood sugar log showed the following results: * 03/09/22, 435 milligrams per deciliter (mg/dL) * 03/11/22, 459 mg/dL Review of the medical record showed the facility failed to notify Resident #35's physician of the high blood sugar readings. - Review of Resident #60's medical record occurred on March 13-17, 2022. Diagnoses included type 2 diabetes mellitus. Medications included "HumaLOG Solution 100 UNIT/ML (Insulin Lispro) Inject 38 unit subcutaneously one time a day, HumaLOG Solution 100 UNIT/ML (Insulin Lispro) Inject 40 unit subcutaneously one time a day, Take with 1600 [calorie] meal, Lantus Solution (Insulin Glargine) Inject 67 unit subcutaneously at bedtime" related to type 2 diabetes mellitus. The physician's orders also	F 580	sugar levels that are above the parameters set forth by the diabetic protocol or physician orders.	

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F 580	Continued From page 10 identified, "Accu-checks three times a day every Tue [Tuesday] Sat [Saturday] . . ." Review of the January-March 2022 blood sugar log showed the following results: * 01/01/22 405 mg/dL * 01/25/22 415 mg/dL and 446 mg/dL * 02/01/22 448 mg/dL * 02/22/22 450 mg/dL and 401 mg/dL Review of the medical record showed the facility failed to notify Resident #60's physician of the high blood sugar readings. During an interview on 03/16/22 at 4:00 p.m., an administrative nurse (#1) confirmed facility staff failed to notify the physicians of Resident #35 and #60's high blood sugar readings.	F 580		
F 584 SS=C	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.	F 584		4/20/22

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F 584	Continued From page 11 §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of maintenance records, and staff interview, the facility failed to provide housekeeping/maintenance services necessary to maintain a safe, clean, and comfortable environment in 2 of 3 units (Residents #12, #29, #69 and #276's rooms) and in 1 of 1 dining room. Failure to maintain a safe, clean, and comfortable living environment placed the residents at increased risk for illness. Findings include: Random observations on March 14-15, 2022, showed dust/grime in the following resident	F 584	It is the practice of this facility to provide a safe, clean, comfortable living environment for residents. 1. Ceiling vents in all areas noted in the 2567 have been cleaned. 2. All room vents have the potential to be affected. 3. Re-education provided to environmental services staff to dust room vents when doing room cleaning each week and with each terminal clean at resident discharge. 4. The Quality Nurse or designee will audit 10 vents throughout the facility weekly for 4 weeks, monthly for 3 months	

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	355079	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 584	Continued From page 12 rooms: * Resident #12, on the ceiling vent cover, the air flow deflector attached to the vent, and the ceiling above the vent. * Resident #29, on an upper wall/beam vent cover and the wall surrounding the vent. * Resident #69, on the ceiling above a vent. * Resident #276, on an upper wall/beam vent cover and top of the adjacent sprinkler head. * Main dining room, on most of the upper wall/beam vent covers. Resident #12, #29, #69, and #276's diagnoses included asthma (a lung disorder that causes shortness of breath, wheezing and cough), acute and chronic respiratory failure (poor exchange of oxygen and carbon dioxide by the respiratory system) with hypoxia (low oxygen levels in the blood), chronic obstructive pulmonary disorder (COPD) (constricted airways in the lungs causing difficulty in breathing), and dependence on supplemental oxygen. During an interview on 03/17/22 at 10:28 a.m., a maintenance supervisor (#27) stated the vents in the facility are "blown out" every 30 days around the third week of the month." Review of the vent maintenance/cleaning records indicated the vents in Resident #12's room were "blown out" on 01/07/22 and Resident #29, #69 and #276's rooms and the main dining room were "blown out" on 01/11/22 (approximately 60 days ago). During an interview on 03/17/22 at 11:56 a.m., the maintenance supervisor (#27) agreed the vents in the resident rooms and the main dining	F 584	and quarterly for 1 year for cleanliness.	

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F 584	Continued From page 13 room needed washing.	F 584		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to provide care and services to ensure proper skin care for 1 of 1 sampled resident (Resident #10) with a skin condition (rash). Failure to complete skin assessments and notify the provider of worsening skin conditions may cause continued pain, worsening skin conditions, and delay changes in treatment. Findings include: Review of Resident #10's medical record occurred all days of survey. A physician order, dated 02/08/22, stated, "Calmoseptine Ointment [a barrier cream] 0.44-20.6 % (Menthol-Zinc Oxide) Apply to Groin/penis topically two times a day for Excoriation After cleansing and patting dry apply calmoseptine BID [twice a day] and with brief changes till clear then go back to tena with zinc tx [treatment]. ok to use Aquaphor also. AND Apply to Groin/penis topically as needed for excoriation With brief changes." The care plan	F 684	It is the practice of this facility to provide care and ensure proper skin care for all residents. 1. Skin assessments were completed and documented for resident #10 on 2/10/22, 2/14/22, 2/17/22, 2/21/22, 2/24/22, 2/28/22, 3/3/22, 3/7/22, 3/10/22, 3/14/22, and 3/17/22. Notification completed to resident #10's provider of rash and excoriation on buttocks and thighs, provider assessed on 3/22/22. 2. All residents with a skin condition have the potential to be affected. 3. Re-education provided to all nursing staff at Nurses meeting on 4/6/2022 re: skin assessment and notification of provider for worsening skin conditions. 4. The Quality Nurse or designee will audit 5 residents with a skin condition weekly for 4 weeks, monthly for 3 months and quarterly for 1 year for documentation of weekly skin assessment and notification to provider if skin condition	4/20/22

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F 684	Continued From page 14 stated, ". . . I have potential for pain related to: Impaired mobility, inability to communicate needs . . . Intervention . . . Monitor/record/report to Nurse any s/sx [signs/symptoms] of non-verbal pain: Changes in breathing (noisy, deep/shallow, labored, fast/slow); . . . I have an alteration in my skin integrity of . . . excoriation [a stripping or removal of skin] to bilateral groin and underside of penis . . . I am at risk for alterations in my skin integrity related to: disease process, Impaired Mobility, Incontinence . . . nonverbal. . . Interventions . . . Skin assessment as scheduled, update provider if indicated; Administer treatments as ordered and monitor for effectiveness. . . ." Observation on 03/15/22 at 10:06 a.m. showed three certified nurse aides (CNAs) (#4, #5, and #9) assisted Resident #10 with morning cares. The CNAs opened the resident's brief and turned him to his side. Observation showed a red, excoriated rash on the resident's buttocks which extended down his thighs. As the CNA (#5) cleansed and dried the area, two dry lesions fell off. The CNA (#5) failed to apply calmoseptine to the resident's buttocks/thighs. The CNAs (#4, #5, and #9) returned the resident to his back and two CNAs (#4 and #9) cleansed the groin and genitalia. As they patted the area dry, bloody areas appeared on the resident's skin. The CNA (#9) applied calmoseptine to the resident's groin and genitalia area. The nurse (#6) entered, provided care, and examined the placement of the calmoseptine and added more to the pubic area. Observation showed the location of Resident #10's rash matched the location where the brief encountered his skin.	F 684	has worsened.	

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F 684	Continued From page 15 Facility staff completed weekly skin assessments for Resident #10 from 11/18/21 through 02/07/22. A nursing skin assessment note, dated 02/07/22 identified the following ". . . Bilateral groin areas are excoriated and underside of penis is excoriated. . . . Current Skin Interventions in Place: Note placed on PAC [practitioner communication] folder updating regarding skin on groin and penis. Skin was lotioned [sic]. . . . Plan: Continue with current plan of care" This assessment failed to identify Resident #10's rash on his buttocks and thighs. The medical record lacked another skin assessment after 02/07/22. During an interview on 03/17/22 at 11:02 a.m., with administrative staff members (#1 and #10), staff member (#1) stated she talked with the nurse who completed the skin assessment on 02/07/22 and communicated with the practitioner and the nurse felt the rash had improved. Facility staff failed to notify Resident #10's provider when the rash/excoriation worsened and spread to his buttocks and thighs and failed to complete skin assessments after 02/07/22.	F 684		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 689		4/20/22

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F 689	Continued From page 16 THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 03/13/20. Based on observation, record review, review of the manufacturer's instruction manual, and resident/staff interviews, the facility failed to provide adequate assistance for 4 of 7 sampled residents (Resident #3, #35, #61, and #377) observed during a sit-to-stand mechanical lift transfer. Failure to ensure proper use of the stand lift caused Resident #3 pain/discomfort and placed Resident #35, #61, and #377 at risk for pain and/or injury. Findings include: Review of the "[brand name] Sit-to-Stand Lift" manufacturer's instruction manual occurred on 03/17/22. The manual identified, ". . . Caution . . . Before the product is used, adequately qualified nursing staff must assess the physical and mental condition of the patient/resident. . . . Caution . . . The patient/resident must have sufficient core stability (capability of sitting autonomously [independently] on the edge of the bed is an indicator for a sufficient core stability). Furthermore, he/she must be able to bear his/her body weight with one leg. . . ." Review of the facility policy titled "Mechanical Lifts" occurred on 3/17/22. This policy, dated July 2018, stated, "Resident's at St. Catherine will be transferred in the safest, easiest manner possible that promotes independence. . . . A standing lift is available for resident that require more than one person to assist with a transfer and is used for residents capable of bearing weight. . . . 3. A standing lift transfer may be done with only one	F 689	It is the practice of this facility to provide adequate assistance to residents using the standing lift and to properly use the standing lift per manufacturer's instructions. 1. Residents #3, #35, #61 and #377 were changed to a full body lift until OT could observe and assess transfers using the sit to stand lift. Each resident was assessed and changes made to their careplan regarding their transfer status as appropriate for safety. 2. All residents using a sit to stand lift have the potential to be affected. 3. PTA provided re-education to CNA's on appropriate use of the standing lift and notification of nurse if resident is unable to transfer according to manufacturer's recommendation on 3/23/2022. Re-education also provided on locking wheelchair brakes during the transfer. 4. The Quality Nurse or designee will audit 5 residents using the standing lift weekly for 4 weeks, monthly for 3 months and quarterly for 1 year for safe transfer and locked wheelchair brakes.	

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F 689	Continued From page 17 caregiver present unless otherwise care planned. . . ." - Review of Resident #3's medical record occurred on all days of survey and included a diagnoses of anxiety, osteoarthritis, and polyneuropathy. The current care plan stated, ". . . I require assist of one utilizing a standing lift for transfers with a large sling . . ." Observations showed the following: * On 03/15/22 at 12:25 p.m., a CNA (#13) transferred Resident #3 onto the toilet and later into her wheelchair utilizing a sit-to-stand lift. During the transfer, Resident #3 did not bear weight and hung from the harness in a semi-seated position. As the harness straps pulled upward into Resident #3's axillae, her shoulders raised to ear level and her elbows extended horizontally or higher. As the CNA (#13) lowered Resident #3 into her wheelchair, she asked, "Are you okay?" Resident #3 responded, "I have a sore shoulder." * On 03/15/22 at 3:16 p.m., a CNA (#13) transferred Resident #3 onto the toilet and later into her wheelchair utilizing a sit-to-stand lift. During the transfer, Resident #3 did not bear weight and hung from the harness in a semi-seated position. As the harness straps pulled upward into Resident #3's axillae, her shoulders raised to ear level and her elbows extended horizontally. * 03/15/22 at 3:50 p.m., a CNA (#16) transferred Resident #3 into her wheelchair utilizing a sit-to-stand lift. During the transfer, Resident #3 did not bear her weight and hung from the harness in a semi-seated position. As the harness straps pulled upward into Resident #3's	F 689		

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F 689	Continued From page 18	F 689		

axillae, her shoulders raised to ear level and her elbows extended horizontally or higher. Resident #3 grunted as she lowered into the wheelchair.

- Review of Resident #35's medical record occurred on all days of survey and included a diagnoses of anxiety, ataxia [movement disorder], osteoarthritis, and chronic pain. The current care plan stated, ". . . I require 1 staff assistance with transfers . . ."

Observation on 03/15/22 at 10:32 a.m., showed a CNA (#17) transferred Resident #35 onto the toilet utilizing a sit-to-stand lift. Resident #35 did not bear weight. While in the harness, she bent at the waist with her toes braced against the foot plate and knees locked. As the harness straps pulled upward into Resident #35's axillae, her shoulders raised.

During an interview on 03/17/22 at 11:35 a.m., an administrative nurse (#1) reported she "expects people who are using a stand lift to bear their weight." She added, "We usually have physical therapy evaluate them."

- Review of Resident #61's medical record occurred on all days of survey and included diagnoses of history of stroke, bilateral leg weakness, and chronic pain. The current care plan stated, ". . . Transfer: I require 1 staff assistance with transfers . . . I require Mechanical aid standing lift for transfers . . ."

During an observation on 03/15/22 at 10:15 a.m., A CNA (#32) transferred Resident (#61) in a sit-to-stand lift from the wheelchair to the bathroom to perform toileting cares. The CNA

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fastened the transfer sling around the resident and to the lift, but failed to apply the lower leg strap behind the resident's calf. During the transfer, Resident #61's legs slipped forward and to the side and her upper body becaame loose in the sling. The CNA continued to transfer the resident to the toilet. The CNA (#32) stated she was "in a hurry" and needed to get the resident to an appointment.

- Review of Resident #377's medical record occurred on all days of survey. The care plan stated, ". . . TRANSFER: I require 1 staff assistance with transfers. . . . I require Mechanical Aid standing lift for transfers. . . ."

During an observation on 3/15/22 at 9:12 a.m., a certified nursing assistant (CNA) (#24) transferred Resident #377 from the commode with a stand lift. While in a standing position the CNA (#24) adjusted the resident's clothing and Resident #377 stated her arms were getting tired and she was ready to sit down. The CNA (#24) moved the lift toward the wheelchair, which then rolled away. The CNA (#24) backed up the lift, re-positioned the wheelchair, and only locked the left brake. As the CNA (#24) positioned the lift one of the legs became tangled with the overbed table. The CNA (#24) positioned the lift in front of the wheelchair and lowered the resident into the wheelchair. Because the CNA (#24) failed to lock the right brake on the wheelchair, it swung to the right and hit the wall when the CNA (#24) lowered the resident.

During an interview on 03/17/22 at 11:00 a.m. two administrative nurses (#1 and #10), when asked if they expected the wheelchair brakes to

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F 689	Continued From page 20 be locked, responded "yes."	F 689		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and resident and staff interviews, the facility failed to provide care and services to control pain for 3 of 23 sampled residents (Residents #12, #31 and #40). Failure to offer pharmacological and/or non-pharmacological pain interventions may result in unresolved/increased pain and decreased quality of life for all residents. Findings include: Review of the facility policy titled "Pain Management" occurred on 03/17/22. This policy, dated December 2015, stated, ". . . Pain in residents will be assessed and treated promptly and consistently to help assure the highest level of pain relief possible. . . . Assess for possible non-pharmacological parameters which may include: Behavioral . . . Physical Agents (application of heat or cold), Massage, Exercise, Repositioning, Distraction Techniques. Assess for possible pharmacological interventions; administer medication as ordered. . . . Enter pain problem and interventions on care plan. . . .	F 697	It is the practice of this facility to provide care and services to control pain for residents who require such services. 1. Pain management reviewed for resident #12, #31, and #40. Changes made to careplan to address pain to the highest level of pain relief possible including use of non-pharmacological approaches that are effective for that resident. 2. All residents with pain would have the potential to be affected. 3. Re-education provided to CNA□s and nurses on 3/23/2022 and 4/6/2022 about pain management programs and utilization of careplanned interventions for residents. Non-pharmacological interventions reviewed for residents with careplanned interventions, revisions made to include only those applicable to that resident. Nurse re-education completed to document in the progress notes and/or MAR both pharmacological and non-pharmacological pain management interventions and the	4/20/22

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F 697	Continued From page 21 Reassess resident as necessary. . . ." - Review of Resident #40's medical record occurred all days of survey. The record identified the resident experienced an unwitnessed fall on 03/13/22 at 5:10 a.m., which resulted in a right hip/pelvis injury. Physician's orders included Morphine oral solution 4 mg [milligrams] every one hour prn [as needed]. Resident #40's care plan stated, "Focus . . . pain . . . Interventions: Provide me with medications/treatments as ordered. . . . Anticipate my need for pain relief . . . Evaluate the effectiveness of pain interventions . . ." Review of Resident #40's medication administration record (MAR) indicated staff administered 4 mg of morphine on 03/15/22 at 3:48 p.m. (one hour 27 minutes before care). An observation on 03/15/22 at 5:05 p.m. through 5:37 p.m. showed two CNAs (#18 and #19) provided care to Resident #40. Before turning the resident, a CNA (#19) told the resident it would hurt. The CNAs (#18 and #19) rolled the resident from side to side three times and each time the resident grimaced and yelled. During an interview on 03/17/21 at 11:02 a.m., two administrative staff members (#1 and #10) agreed the goal is to keep Resident #40 as comfortable as possible, and if able, give pain medication before a care task that may increase the resident's pain. - Review of Resident #31's medical record occurred on all days of survey and identified	F 697	effectiveness to relieve the residents pain. 4. The Quality Nurse or designee will audit 10 residents with pain weekly for 4 weeks, monthly for 3 months and quarterly for 1 year to review relief of pain with documented pharmacologic and non-pharmacologic interventions.	

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diagnoses of age-related osteoporosis, other chronic pain, and pain in thoracic spine. The care plan stated, ". . . Provide me with medications/treatments as ordered. Encourage me to try different pain-relieving methods i.e. positioning, relaxation therapy, bathing, heat and cold application. Observe and report changes in usual routine, sleep patterns, decrease in functional abilities, decrease [sic] ROM [range of motion], withdrawal or resistance to care. . . ."

During an interview on 03/15/22 at 8:55 a.m., Resident #31 stated she has pain in her back, "so bad that when I'm standing at my sink, I have to sit down to finish brushing my teeth." Resident #31 explained she took hydrocodone at home four times a day. Resident #31 stated she no longer gets pain medication as her nurse practitioner discontinued the Hydrocodone.

During an interview with Resident #31 on 03/17/22 at 8:30 a.m., Resident #31 stated, "not right now," when asked if she has pain. If Resident #31 reports pain, "they ask if I want Tylenol, but I can't have that." Resident #31 responded "no" when asked if staff offer other interventions.

A physician's order, dated 01/17/22, stated, "Pain level: assess pain level BID [twice a day] and follow up as necessary, every day and evening shift for pain level."

Review of the February 2022 MAR showed Resident #31 rated her pain between four and seven (on a 10-point scale), on six days within the month. Review of the March 2022 MAR showed Resident #31 rated her pain as two on

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SMP HEALTH - ST CATHERINE SOUTH	3102 S UNIVERSITY DR FARGO, ND 58103

(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 697	Continued From page 23 March 1st and five on March 10th. The medical record lacked evidence staff offered non-pharmacological interventions for pain. Resident #31's current orders failed to include a scheduled or PRN medication for pain, and the medical record failed to show staff implemented interventions as care planned for pain. In an interview on 03/17/22 at 11:00 a.m., two administrative nurses (#1 and #10) identified their expectation is that staff would document interventions offered for pain in the progress notes. - Review of Resident #12's medical record occurred on all days of survey and identified diagnoses of gout (a type of arthritis that causes inflammation of joints) and Type II diabetes mellitus with polyneuropathy (disease of the nerves caused by high insulin levels). Physician's orders showed the resident received scheduled Tylenol, PRN (as needed) Tylenol, and an analgesic rub for pain. The current care plan stated, ". . . Encourage me to try different pain relieving methods i.e. positioning, relaxation, therapy, bathing, heat and cold application. . . . Evaluate the effectiveness of pain interventions PRN. . . ." Resident #12's medical record lacked evidence staff implemented non-pharmacological pain interventions as care planned.	F 697		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be	F 761		4/20/22

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F 761	Continued From page 24 labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to discard expired suction equipment/supplies in 2 of 2 medical equipment storage areas (North and South). Failure to discard expired suction machine supplies may result in reduced efficacy if/when a resident requires suctioning. Findings include: Observation of the North and South medical equipment storage areas occurred on 03/16/22 at 3:45 p.m. with a licensed staff member (#32).	F 761	It is the practice of this facility to discard expired supplies. 1. All suction supplies have been assessed and expired supplies have been discarded and replaced. 2. All residents requiring suctioning would have the potential to be affected. 3. Re-education completed on 4/6/2022 to nursing staff to discard expired supplies and replace with supplies with current dates. 4. The Quality Nurse or designee will audit suction supplies weekly for 4 weeks,	

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F 761	Continued From page 25 Observations identified the following: South Medication Storage Room: * Two ConMed 66-inch suction tubing expired June 2020 and February 2021. * Three sterile water containers expired June 2020, July 2020, and February 2021 North Medication Storage Room: * Two ConMed 66- inch suction tubing expired January 2020 and October 2021 * One sterile water container expired July 2020 During the observation, the licensed staff member (#32) agreed the expired items needed to be discarded and expected all equipment to be up to date.	F 761	monthly for 3 months and quarterly for 1 year for current dates.	
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,	F 880		4/20/22

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F 880	Continued From page 26 visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §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.	F 880		

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F 880	Continued From page 27 §483.80(e) Linens. 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: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 03/13/20. Based on observation, review of facility policy, review of professional reference, and staff interview, the facility failed to follow infection control practices for 5 of 23 sampled residents (Resident #3, #8, #10, #33, and #65) and 1 supplemental resident (#32) observed during cares. Failure to follow standard infection control practices has the potential for transmission of communicable diseases and infections to residents and staff. Findings include: PROTECTIVE PERSONAL EQUIPMENT Review of the policy titled "Novel Coronavirus Prevention and Response" occurred on 03/17/22. This policy, dated 04/12/21, stated, ". . . Make PPE [personal protective equipment], including facemask, eye protection, gowns, and gloves, available immediately outside of the resident's room . . ." Review of CDC (Centers for Disease Control and	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 are completing hand hygiene when removing gloves, in accordance with CDC guidelines. (2) Ensuring staff are completing thorough and correct perineal care by cleaning front to back to ensure cleanliness and decrease urinary tract infections. (3) Ensuring staff entering and exiting a room requiring PPE don, doff, disinfect, and store or dispose of personal protective equipment (PPE), in accordance with CDC guidelines.	

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F 880	Continued From page 28 Prevention) guidance found at https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/eye-protection.html, updated August 13, 2021, stated, "Reusable eye protection should [sic] cleaned and disinfected after each patient encounter. . . . Ensure appropriate cleaning and disinfection after each use if reusable face shields or goggles are used." During an interview on 03/14/22 at 1:55 p.m., a nurse manager (#2) confirmed staff must wear face shields in unvaccinated resident's rooms, which are identified by "Face Shield Required" signage on the residents' doors. Review of the resident "COVID-19 Vaccine and Declinations" list identified Residents #8, #10, #32, #33, and #65 as unvaccinated. Observations showed the following: * 03/14/22 at 3:32 p.m. a clear tote with lid on a table outside of Resident #10 and #32's room used for both residents. The tote contained face shields and a container of disinfectant wipes. * 03/14/22 at 3:35 p.m., the absence of a PPE cart immediately outside Resident #65's room. Observation showed the nearest PPE tote approximately 75 feet from the resident's room. * 03/16/22 at 2:56 p.m. showed a shared PPE cart approximately 25 feet from Resident #8's room and approximately 50 feet from Resident #33's room. Observations showed the staff failed to follow standard infection control practices during the following times: * 03/14/22 at 12:18 p.m., a therapist (#22) reassessed Resident #33 without a face shield in	F 880	The DON, staff development coordinator (SDC), IP or designee, in conjunction with applicable IDT members, will: (1) Educate all staff when removing gloves, hand hygiene must be performed. (2) Educate all staff on performing correct perineal cares by cleaning front to back. (3) Educate all staff selecting, donning, doffing, and storing or disposing of PPE when entering a room requiring PPE. To verify each staff understands the procedure, each will perform a successful return demonstration of selecting, donning, doffing, and storing or disposing of PPE for providing cares in a room requiring specific PPE. 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 04/20/2022 the facility shall complete the following actions: (1) DON, IP, and applicable IDT members will conduct root-cause analysis to identify and address the reasons for non-compliance related to:	

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F 880	Continued From page 29 place. * 03/14/22 at 3:42 p.m., two CNAs (#7 and #14) exited Resident #10's room without face shields in place. * 03/15/22 at 9:11 a.m., a CNA (#17) dressed Resident #33 and then exited the room without a face shield in place. * 03/15/22 at 9:34 a.m., a CNA (#5) and a nurse (#6) exited Resident #65's room and failed to clean and disinfect their face shields. Both staff entered other resident's rooms. * 03/15/22 at 9:50 a.m., two CNAs (#8 and #9) exited Resident #32's room and failed to clean and disinfect their face shields. The CNA (#8) continued down the hall and interacted with staff and the CNA (#9) entered another resident's room. * 03/15/22 at 9:52 a.m., a CNA (#5) exited Resident #65's room and failed to clean and disinfect the face shield. * 03/15/22 at 10:03 a.m., two CNAs (#4 and #5) and a nurse (#6) exited Resident #10's room and failed to clean and disinfect their face shields. The CNA (#4) assisted another resident in the hallway, the CNA (#5) and nurse (#6) entered other resident's rooms. * 03/15/22 at 10:05 a.m., a CNA (#21) sat next Resident #8 and assisted her as she ate brunch in the lounge. The CNA (#21) failed to wear a face shield. During an interview on 03/16/22 at 2:56 p.m., a nurse (#3) confirmed the facility did not follow the facility policy, failed to place a PPE cart immediately outside of unvaccinated residents' rooms, and failed to clean and disinfect face shields between use with residents.	F 880	a. Failure to complete hand hygiene and changing gloves when necessary. b. Failure to perform perineal cares correctly. c. Failure to wear and store or dispose of PPE appropriately. (2) The DON, SDC, IP or suitable designee will ensure the following: a. Educate all staff on the importance of hand hygiene and changing gloves and when both tasks must be performed. b. Educate all staff on the importance of performing correct perineal cares by cleaning front to back. c. Educate all staff on the importance of following PPE procedures when doffing required PPE. (3) The facility leadership will contact the North Dakota Quality Improvement Organization (QIO), to inquire about the assistance and services available from the QIO in improving infection prevention and control within the facility through quality assurance process improvement (QAPI) methods. 4. Monitoring Weekly for no less than 12 weeks, the DON, IP, SDC or a designee will conduct on-going monitoring to ensure, via observation, the approaches to correct deficient practice related to infection control and prevention are consistently implemented and effective. Such monitoring will include: (1) Observation of all staff performing	

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F 880	Continued From page 30 PERINEAL CARES Berman, Snyder, and Frandsen's "Kozier & Erb's Fundamentals of Nursing: Concepts, Process, and Practice," 11th ed., Pearson Education, Inc., Massachusetts, pages 743-744, stated, ". . . Clean the labia majora and perineum from front to back, from pubis to the rectum . . ." Observations showed the following: * 03/15/22 at 10:37 a.m., a CNA (#23) donned gloves, assisted Resident #8 to stand utilizing a sit-to-stand lift, and then provided perineal cares. The CNA (#23) failed to clean the perineal area from front to back. * 03/15/22 at 3:16 p.m., a CNA (#13) donned gloves, raised Resident #3 in a sit-to-stand lift, and then provided perineal cares. Resident #3 knees were bent in a semi-seated position in the lift, and the CNA (#13) failed to clean the front perineal area. During an interview on 03/16/22 at 2:56 p.m., an infection control nurse (#3) agreed staff should thoroughly clean the perineal area and must clean front to back when performing perineal cares to prevent urinary tract infections.	F 880	hand hygiene and changing gloves when necessary. (2) Observation of all staff performing correct perineal cares by cleaning front to back. (3) Observation of all staff following PPE procedures when entering and exiting an isolation room. Observations will be made across all shifts and neighborhoods/units. Observations of noncompliance with the above will result in ad hoc education for the involved staff. Such education will be documented on monitoring forms. After twelve weeks of monitoring, provided that such monitoring demonstrates expectations are consistently met, monitoring may be reduced to monthly. Monthly monitoring will continue for no less than three months. All monitoring will be reported to the quality assurance process improvement (QAPI) committee as part of QAPI activities. Monitoring will not be discontinued until the facility completes three consecutive rounds of monthly monitoring that demonstrate sustained compliance as approved by the QAPI committee and medical director. 5. Correction Date 04/20/2022	