STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355033	A. BUILDING _____ B. WING _____	C 06/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CATHERINES LIVING CENTER	1307 N 7TH ST WAHPETON, ND 58075

(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/complaint survey started on 06/13/21 and concluded on 06/16/21.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the	F 578		7/20/21

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

Electronically Signed | 07/01/2021

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F 578	Continued From page 1 individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure the medical record accurately reflected each resident's code level for 1 of 12 sampled residents (Resident #28). Failure to ensure the residents' medical record accurately reflect their wishes prevents staff from following the residents' choice in the event of a medical emergency. Findings include: Review of Resident #28's medical record occurred on all days of survey. An "Advanced Directive/Power of Attorney" form, dated 10/25/02, signed by Resident #28 stated, "I, [resident name], being of sound mind, willfully and voluntarily make known my desire that my dying shall not be artificially prolonged. . . ." The physician's order in the resident's electronic health record dated 01/24/20 stated, "Full code." The banner in the electronic health record stated, "DNR [Do Not Resuscitate]" During an interview on 06/15/21 at 6:15 p.m., an administrative nurse (#2) confirmed the physician's order and the resident's Advance Directive form should match the resident's choice.	F 578	F578 SS=D (Advanced directives) 1. Affected Resident #28: a. Resident #28's medical record was reviewed and changes made to his medical record to reflect the wishes of the resident in all areas of record. The order was changed to match the provider order, residents advanced directive and Matrix banner. 2. Potential Affected Residents: a. All residents have the ability to be affected by the above deficient practice. A facility wide audit on all current in house residents was completed to review their code status in conjunction with their advanced directives, physician order and Matrix banner to ensure all of them accurately reflect the resident's wishes. 3. Measures/Systemic Changes: a. Policy for advanced directives/code status reviewed with Licensed Social Worker (LSW) and licensed staff. b. Audit created for new admissions to ensure order, advanced directive on file, and Matrix banner match. 4. Monitoring: a. The LSW and/or designee will complete weekly audits for 1 month for all	

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F 578	Continued From page 2 The facility failed to ensure Resident #28's medical record reflected resident's code level choice and the signed physician order reflected the resident's choice.	F 578	in house residents and any new admissions upon the day of admit, then every 2 week audits for 3 months to assure all residents code status order, advanced directive, and Matrix banner match. The audits will be reviewed by the Director of Nursing and/or designee and will be compiled monthly and reviewed at the Quality Assurance Committee meeting with ongoing frequency and duration to be determined through analysis and review of results. The Director of Nursing will follow up on further training and process improvements as needed. 5. Completion Date: a. July 20, 2021	
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 record review, review of professional reference, review of facility policy and procedure, and staff interview, the facility failed to provide care in accordance with professional standards for 3 of 5 sampled residents (Resident #1, #2, and #7) who experienced an unwitnessed fall. Failure to complete neurological assessments and/or accurately document the results of the assessments following a fall has the potential for a head injury to go undetected.	F 658	F658 SS=D (Professional Standards) 1. Affected Residents #1, #2, and #7: a. Residents #1, #2, and #7 have been assessed for any neurological deficits in relation to their previously falls and no neurological impairment has been determined. 2. Potential Affected Residents: a. All residents that fall have the potential to be affected by this deficient practice.	7/20/21

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F 658	Continued From page 3 Findings include: Walters and Kluwar, "Lippincott's Nursing Procedures," 5th Edition, 2009, pages 66-67 stated, "Managing Falls . . . Provide first aid for minor injuries as needed. Monitor the patient's status for the next 24 hours. Even if the patient shows no signs of distress or has sustained only minor injuries, monitor vital signs every 15 minutes for 1 hour, then every 30 minutes for 1 hour, then every 1 hour for 2 hours, or until his condition stabilizes. Monitor neurological assessments with vital signs . . ." Review of the facility policy titled "Neurological Assessment" occurred on 06/16/21. This undated policy stated, ". . . Neurological observation and assessment is completed with a change in physical function, with an acute change of condition, upon physician order or following an unwitnessed fall and/or subsequent to a fall with a suspected head injury . . ." - Review of Resident #1's medical record occurred on all days of survey. The record identified Resident #1 had severe cognitive deficits and had an unwitnessed fall on 05/06/21. Facility staff failed to complete neurological checks following this fall. - Review of Resident #2's medical record occurred on all days of survey. The record identified Resident #2 had severe cognitive deficits and had six unwitnessed falls on 03/02/21, 03/03/21, 04/19/21, 05/30/21, and (two falls on) 06/06/21. Facility staff failed to complete neurological checks following each of these falls.	F 658	3. Measures/Systemic Changes: a. Falls Protocol/Policy for neurological assessment reviewed with licensed staff on June 22, 2021 b. Algorithm created for indications of neurological assessment to be completed c. Falls Protocol/Policy for neurological assessment updated to include algorithm,reviewed with licensed staff on June 22, 2021. Licensed Nurses not in attendance will be given the documents to review with RN Csre Coordinator. 4. Monitoring: b. The RN Care Coordinator and/or designee will complete an audit on each fall for 2 weeks, then monthly random audits of 2 per week (if indicated) for 3 months to assure neurological assessments are completed as indicated and accurately documented. The audits will be reviewed by the Director of Nursing/designee and will be compiled monthly and reviewed at the Quality Assurance Committee meeting with ongoing frequency and duration to be determined through analysis and review of results. The Director of Nursing will follow up on further training and process improvements as needed. 5. Completion Date: a. July 20, 2021	

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F 658	Continued From page 4 - Review of Resident #7's medical record occurred on all days of survey. The record identified Resident #7 had severe cognitive deficits and had seven unwitnessed falls on 12/28/20, 01/15/21, 01/26/21, 02/05/21, 02/13/21, 04/01/21, and 05/09/21. Facility staff failed to complete neurological checks following each of these falls. During two interviews on 06/15/21 at 10:25 a..m. and 11:35 a.m., an administrative nurse (#2) reported, "Nurses do neuro checks during the fall assessment, taking vitals, checking range of motion, looking for an injury. They would do full neuro checks, if there was an obvious head injury or the person reported they hit their head or there was a concern with the previous neuro check. Even if the first neuro check was within normal limits, they should continue with full neuro checks unless indicated by the provider,"	F 658		
F 689 SS=D	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: Based on observation, record review, and staff interview, the facility failed to provide adequate supervision necessary to prevent accidents for 1 of 1 sampled residents (Resident #28) who required supervision in the bathroom. Failure to	F 689	F689 SS=D (Free of Accident Hazards/Supervision/Devices) 1. Affected Resident #28: a. Resident #28□s care plan has been reviewed and revised to reflect proper	7/20/21

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F 689	Continued From page 5 follow specific supervision instructions for Resident #28 placed the resident at risk of an accident and/or injury. Findings include: Review of Resident #28's medical record occurred all days of survey. A fall risk completed on 04/21/21 identified Resident #28 as having a fall risk assessment score of 15 or high risk. Resident #28's care plan stated, ". . . at risk for falling r/t [related to] decreased mobility requiring staff assistance with transfer and ambulation and decreased safety awareness and cognitive status and diminished eyesight . . . to be supervised when in the bathroom. . . . " Observation on 06/14/21 showed: * 3:51 p.m.: Resident #28 rested in bed, a nursing assistant (NA) (#7) assisted Resident #28 to ambulate to the bathroom, assisted the resident to sit on the toilet and gave the resident the call light. The NA (#7) waited in the hallway for the resident to pull the call light. * 4:08 p.m.: The NA (#7) checked on Resident #28, in the bathroom. Resident #28 stated he/she was not done toileting. The NA (#7) showed the resident the call light again. The NA (#7) stepped into the hallway. During an interview on 06/14/21 at 4:55 p.m., a staff nurse (#8) stated Resident #28 had fallen. Resident #28 the NA (#7) reported he/she asked Resident #28 numerous times about if they were finished in the bathroom. The NA (#7) then went to assist with cares in another resident room leaving Resident #28 alone in the bathroom.	F 689	supervision needed in the bathroom. 2. Potential Affected Residents: a. All residents that fall have the potential to be affected by this deficient practice. 3. Measures/Systemic Changes: a. An audit was completed for all in house residents to assure that group sheet and ADL/falls care plan reflect most up to date plan of care for each resident and match. b. Education provided to all nursing staff regarding group sheets and how to ensure residents plan of care is being followed in regards to assistance and supervision in the bathroom on 6/22/2021, 6/29/2021 and on 7/6/2021 weekly All-Staff meetings. Those that haven't went to All-Staff meetings were given the document to review and sign. 4. Monitoring: a. The RN Care Coordinator and/or designee will complete audits weekly for 1 month for residents with a fall risk score 10 or higher (indicating high risk for falls), then monthly for 3 months to assure that those at high risk for falls group sheet and ADL/falls care plan reflect most up to date plan of care for each resident and match. The audits will be reviewed by the Director of Nursing and/or designee and will be compiled monthly and reviewed at the Quality Assurance Committee meeting with ongoing frequency and duration to be determined through analysis and review of results. The Director of Nursing will follow up on further training and process	

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F 689	Continued From page 6 Nursing Progress Notes identified: * 06/14/21 5:34 p.m., "Resident suffered a fall in [the] bathroom after utilizing the toilet. Bump noted to head at occipital [back of skull]. Resident reports mild pain to the area. No open skin noted. Neuro checks in place with no concerns at this time. No further injuries. SBAR [situation background assessment recommendation form] to provider. Resident's daughter informed. . . ." * 06/14/21 10:08 p.m., "Resident complained of mild pain to occipital area post fall. PRN [as needed] Tylenol 650 mg [milligrams] PO [per oral] per standing order and applied ice pack to the area; resident verbalized interventions to be effective. Continues with neuro checks; no neuro deficits noted. Resident able to consume 100% of supper per self post set up. Resting in bed at this time; call light within reach." * 06/15/21 09:16 a.m., "IDT [Inter Disciplinary Team] met to review fall from 6/14. Resident was in the bathroom when [resident] had a fall last evening. Bump to head, no major injuries noted. Continues with neuro checks. Daughter notified. Ice placed to bump on head, tylenol given. Resident has difficulty explaining what happened due to cognitive impairment. Continue to monitor, plan of care reviewed." * 06/15/21 01:30 p.m., "Resident has no c/o [complaints of] pain following fall. Neuro checks done and WDL [within defined limits], VSS [vital signs stable], will continue to monitor. During an interview on 06/16/21 at 08:45 a.m., an administrative nurse (#2) agreed the facility failed to provide adequate supervision and follow the care plan for Resident #28.	F 689	improvements as needed. 5. Completion Date: a. July 20, 2021	
F 695	Respiratory/Tracheostomy Care and Suctioning	F 695		7/20/21

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F 695 SS=D	Continued From page 7 CFR(s): 483.25(i) § 483.25(i) Respiratory care, including 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: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 07/17/19. Based on observation, record review, review of the facility policy, and staff interview, the facility failed to ensure proper respiratory care for 1 of 3 sampled residents (Resident #10) with orders for oxygen (O2) therapy. Failure to provide oxygen as ordered may complicate the resident's respiratory status. Findings included: Review of the facility policy titled "Oxygen Therapy" occurred on 06/16/21. This undated policy, stated, ". . . Obtain physician orders for specifics regarding administration . . . Document assessment of resident oxygen status, tolerance, vital signs, and respiratory status in medical record as necessary . . ." Review of Resident #10's medical record occurred on all days of survey. Diagnoses included acute respiratory disease. Current physician's order identified continuous oxygen at	F 695	F695 SS=D (Respiratory/Tracheostomy Care and Suctioning) 1. Affected Resident #10: a. Resident #10 was assessed following notification of oxygen tank being empty and there were no abnormal assessment findings, an SBAR was sent to the provider to request review of residents need for oxygen therapy due to stable respiratory status. Physician orders received to change resident□s oxygen to PRN and to monitor oxygen saturations for 10 days and then update with findings. 2. Potential Affected Residents: a. Any resident with orders for continuous oxygen that utilize an e-cylinder, portable oxygen tank have the potential for being affected by this deficient practice. 3. Measures/Systemic Changes: a. Nurse delegated by Director of Nursing will review provider□s orders to identify all residents that use oxygen and require portable tanks when outside of room.	

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F 695	Continued From page 8 two liters (2L)/minute per nasal cannula. The care plan stated, " RESPIRATORY: Resident at risk for respiratory distress/obstructed airway secondary to reports of shortness of breath when lying flat and with exertion and diagnosis of Obstructive sleep apnea, COVID 19 . . . Administer medications/treatments as ordered and monitor effects . . ." Observations on 06/13/21 at 5:28 p.m. and 06/14/21 at 8:12 a.m. showed Resident #10 sitting in his/her wheelchair in the dining room with an empty oxygen tank. During an interview on 06/14/21 at 8:18 a.m., a nursing staff member (#1) confirmed Resident #10's oxygen flow rate is ordered at 2L continuously and confirmed an empty oxygen tank on the back of the resident's wheelchair.	F 695	b. Education provided to staff regarding how to read portable oxygen tank gauge to ensure oxygen is in tank prior to disconnecting from concentrator on 6/22/21, 6/29/21, 7/6/21 at weekly All-Staff meeting. Those that didn't attend were given the document shared to review and sign. c. Nursing orders placed in EMAR for residents utilizing oxygen for nursing staff to ensure adequate level of oxygen present in portable tank each shift while awake. 4. Monitoring: a. The RN Care Coordinator and/or designee will complete audits weekly for 1 month for residents utilizing oxygen, then monthly for 3 months on all residents who use oxygen. The audits will be reviewed by the Director of Nursing and/or designee and will be compiled monthly and reviewed at the Quality Assurance Committee meeting with ongoing frequency and duration to be determined through analysis and review of results. The Director of Nursing will follow up on further training and process improvements as needed. 5. Completion Date: a. July 20, 2021	
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name.	F 732		6/16/21

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F 732	Continued From page 9 (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to post nursing staff data in a prominent place accessible to residents, families, and visitors for 4 of 4 days of the survey (June 13-16, 2021). Failure to post staffing data in an	F 732	F732 SS=C (Posted Nurse Staffing Information) 1. Affected Resident/deficient practice: a. The facility failed to post nursing staff data in a prominent place accessible to	

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F 732	Continued From page 10 accessible place does not allow residents, families, and visitors to be aware of the numbers of licensed and unlicensed staff on duty for each shift. Findings include: Observation on 06/13/21 at 2:00 p.m., 06/14/21 at 8:00 a.m., 06/15/21 at 8:00 a.m., and 06/16/21 at 8:00 a.m. showed the daily staff data posted outside of the DON's (Director of Nursing) office, by the administrative offices. The location of the posted data made it difficult for residents, families, and visitors to read the staffing information. During an interview on 06/16/21 at 10:40 a.m., an administrative nurse (#2) stated, "she/he was not aware of the correct placement of the posting and will place it in the correct spot where residents and families can view it." The facility failed to post the staff data in an accessible place for residents, families and visitors to view.	F 732	residents, families, and visitors. Failure to post staffing data in an accessible place does not allow residents, families, and visitors to be aware to the numbers of licensed and Deficient Practice unlicensed staff on duty each shift. 2. Potential Affected Residents: a. All residents have the ability to be affected by this deficient practice if they are unable to access the data. 3. Measures/Systemic Changes: a. The posting of staffing hours document has been relocated in a more visible, accessible place to allow residents, families and visitors to view the current daily staffing. 4. Monitoring: b. The posting of daily staffing hours will be audited monthly for 3 months to ensure visibility and accessibility remain in place. The audits will be reviewed by the Director of Nursing and/or designee and will be compiled monthly and reviewed at the Quality Assurance Committee meeting with ongoing frequency and duration to be determined through analysis and review of results. The Director of Nursing will follow up on further training and process improvements as needed. 5. Completion Date: a. 06/16/2021	
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	F 880		7/9/21

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	355033	A. BUILDING _____ B. WING _____	C 06/16/2021

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F 880	Continued From page 11 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 §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	F 880		

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F 880	Continued From page 12 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 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 12/03/20. Based on observation, review of facility policy/procedure, and staff interview, the facility failed to follow infection control practices for 5 of 14 sampled residents (Resident #7, #9, #11, #28 and #94) and 2 supplemental residents (Resident #31 and #38). Failure to practice infection control related to hand hygiene and glove use during cares (Resident #7, #9, #11, #28, #31, and #94), and during meal service/feeding (Resident #38)	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	

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F 880	Continued From page 13 has the potential for transmission of communicable diseases and infections to residents and staff. Findings include: Review of the facility policy titled "Hand Hygiene" occurred on 06/16/21. This policy, dated, June 2017, stated, ". . .all associates will be trained and competent in following proper hand hygiene practices . . . Times to perform hand hygiene are, but not limited to: . . . before and after direct resident contact . . . before and after eating or handling food . . . before and after assisting a resident with meals . . . before and after assisting a resident with personal cares . . . before and after assisting a resident with toileting . . . after contact with a resident's mucous membranes and body fluids or excretions . . . after handling soiled or used linens . . . after removing gloves. . . ." Observations showed the following: * 06/13/21 at 4:00 p.m., Resident #94 laid in bed as two certified nursing assistants (CNAs) (#9 and #11) donned gloves prior to providing cares. One of the CNAs (#11) performed perineal care, removed his gloves, and donned new gloves without sanitizing/washing his hands. Both CNAs (#9 and #11) put a clean brief on Resident #94, pulled up her pants, and placed blue boots on her feet. * 06/13/21 at 5:00 p.m., a dietary staff member (#5) wore gloves while plating food during meal service and handled ready-to-eat food while wearing the same pair of gloves. * 06/13/21 at 5:29 p.m., a CNA (#9) assisted Resident #38 to drink fluids. The CNA (#9)	F 880	consistent system for ensuring a system for: (1) Ensuring staff glove usage when moving between tasks in accordance with CDC guidelines. (2) Ensuring staff hand hygiene or handwashing when moving between tasks, residents, after removing gloves, and after touching potentially contaminated surfaces, in accordance with CDC guidelines. The DON, staff development coordinator (SDC), IP or designee, in conjunction with applicable IDT members, will: (1) Educate on the importance of proper glove usage. (2) Educate on correctly completing hand hygiene after changing tasks, moving between residents, changing gloves, and touching potentially contaminated surfaces. To verify this/these staff understands hand hygiene and handwashing, this/these staff will perform a successful return demonstration of identifying the need and correct procedure for performing hand 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	

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F 880	Continued From page 14 touched the front of his/her face mask and without performing hand hygiene continued to assist Resident #38 to drink his/her fluids. * 06/13/21 at 6:03 p.m., a CNA (#9) hugged another CNA that entered the dining room while waiting to serve meal trays. The CNA (#9) touched his/her hair, and the sticky side of taped name tag, and without performing hand hygiene, served meal trays and assisted residents with meal set up and eating. * 06/14/21 at 8:05 a.m., two CNAs (#6 and #7) transferred Resident #31 to the toilet for morning cares. The CNA (#6) rinsed his/her hands with water, did not use soap, then donned gloves. The CNA (#7) began morning cares for Resident #31. The CNA (#6) began making the bed. The CNA (#6) touched a soiled sheet, reached into his/her pocket for a bag without removing gloves, placed soiled sheet into bag, continued to straighten the room without removing gloves or performing hand hygiene. * 06/14/21 at 9:48 a.m., a CNA (#6) donned gloves and assisted Resident #7 to the bathroom using a gait belt. The CNA (#6) performed perineal care, pulled up Resident #7's pants, and transferred him/her to the wheelchair. The CNA (#6) wiped the resident's face with a tissue and then removed his/her gloves. The CNA (#6) failed to perform hand hygiene after perineal cares and before completing other tasks. * 06/14/21 at 10:03 a.m., two CNAs (#6 and #7) donned gloves prior to providing Resident #9 cares. A CNA (#6) removed the soiled brief and performed perineal care. Without removing gloves, the CNA (#6) applied a clean brief. Both CNAs adjusted Resident #9's pants and assisted him/her back to the wheelchair with a mechanical lift. The CNA (#6) removed his/her gloves and	F 880	address any newly identified non-compliance. 3. System Changes On or before 07/09/2021 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: a. Failure to ensure proper glove usage. b. Failure to complete handwashing or hand hygiene in accordance with CDC guidelines. Information about root cause analysis can be found at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/GuidanceforRCA.pdf (2) The DON, SDC, IP or suitable designee will ensure the following: a. All staff will receive education on proper glove usage, when to change, and when to perform hand hygiene after removal. b. 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. (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	

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F 880	Continued From page 15 without performing hand hygiene left the room and returned the mechanical lift to the storage room. * 06/14/21 at 10:20 a.m., two CNAs (#12 and #13) provided morning cares prior to transferring Resident #94 into her wheelchair. A CNA (#13) exited the room without sanitizing/washing her hands and transported the resident to hair care. * 06/14/21 at 12:16 p.m., two CNAs (#3 and #4) donned gloves and performed perineal care for Resident #11 while in bed. The CNAs (#3 and #4) applied a clean brief, pulled his/her pants up, repositioned the resident, and removed gloves. The CNAs (#3 and #4) failed to perform hand hygiene after perineal cares before completing other tasks. * 06/14/21 at 4:30 p.m., Resident #94 laid in bed as two CNAs (#9 and #14) donned gloves prior to providing cares. A CNA (#9) performed perineal care, removed her gloves, and donned new gloves without sanitizing/washing her hands. Both CNAs (#9 and #14) put a clean brief on Resident #94 and pulled up her pants. The CNA (#14) exited the room at this time without sanitizing/washing her hands. * 06/15/21 at 9:51 a.m., a CNA (#3) donned gloves and assisted Resident #28 to ambulate to bathroom. The CNA (#3) removed the soiled brief. Without removing his/her gloves the CNA (#3) opened multiple drawers and doors searching for a clean brief and perineal cleansing cloths. The CNA (#3), while wearing the same gloves, performed perineal care, adjusted resident pants, and ambulated resident to the bed. The CNA (#3) then removed his/her gloves, adjusted the head of the bed, and emptied the trash before performing hand hygiene.	F 880	and control within the facility through quality assurance process improvement (QAPI) methods. Zoom Meeting set up on 7/7/2021. 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) Observations of all staff to ensure staff properly wear and remove gloves during resident care. (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	

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F 880	Continued From page 16 During an interview on 06/15/21 at 3:00 p.m., an administrative nurse (#10), confirmed he/she expected staff to perform hand hygiene after glove removal, after exiting rooms, before handling food, before assisting with meals, after touching soiled linen, after performing perineal care, after providing cares to residents, and after touching soiled PPE.	F 880	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 07/09/2021	
F9999	FINAL OBSERVATIONS Based on observation, record review, policy review, and resident, group, family, and staff interviews, the complainant concerns regarding call light response times, resident safety (fall prevention), resident assessment (urinary tract infection), and dignity were unsubstantiated.	F9999		