STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255091	A. BUILDING _____ B. WING _____	12/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEXINGTON MANOR SENIOR CARE, LLC	56 ROCKPORT ROAD LEXINGTON, MS 39095

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F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey at the facility from 11/29/2021 through 12/2/2021. During the survey, the SA determined that the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited regulatory deficiencies F677, F695, F812, and F880. The facility's census at the time of the survey was 53 with a bed capacity of 60.	F 000		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview, record review and facility policy review the facility failed to provide nail care for a resident who was dependent for her Activities of Daily Living (ADLs) as evidenced by a brown substance on top of and underneath all fingernails for one (1) of eight (8) residents observed for ADL care. Resident #26 Findings include: Review of the facilities policy titled, "Shower-Tub Bath Policy" dated 04/2017 revealed "Policy It is the policy of this facility to promote cleanliness and comfort, to relax the resident, to stimulate circulation, and to observe the condition of the resident's skin ... Procedure ... 8. Wash hands properly."	F 677	1. On 12/01/21, the Infection Control Perventionist assessed resident # 26 for nail care needs. On 12/01/21, the Infection Control Nurse trimmed and filed Resident # 26 fingernails. 2. On 12/01/21, the Director of Nurses, Charge Nurse, Treatment Nurse, and the Infection Control Preventionsit completed an assessment of all Fifty-one (51) remaining residents for long jagged nails and any substance underneath the nails. No other residents were identified that required nail care. 3. On 12/02/21, the Infection Control Preventionist did a one: one in-service (education) program with the Certified Nursing Assistant assigned to Whirlpool	1/14/22

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

Electronically Signed | 12/23/2021

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F 677	Continued From page 1 Review of the facilities policy titled, "Care of Fingernails for the Certified Nursing Assistant" dated 5/2019 revealed "Policy: It is the purpose of this procedure to provide appropriate care according to current standards of practice. Care of fingernails will be provided by the Certified Nursing Assistant for all no-Diabetic residents ...Procedure: ... 4. Place the basin of warm water on the over -bed table. 5. Ask the resident to soak their hands in the basin 3-5 minutes. 6. Leaving one hand in the water, wash and rinse the resident's other hand. Dry the hand and place it on a dry towel. 7. Clean under the nails with the orange wood stick. 8 ... Repeat with the other hand and 10. Trim the resident's nails using the nail clipper. Clip nails straight across. Shape and remove any rough edges using an emery board or nail file." An observation on 11/29/21 at 11:45 AM, revealed Resident # 26's fingernails were covered in a brown substance both on top of the nails and underneath the nails. An interview on 12/1/21 at 8:27 AM, with Licensed Practical Nurse (LPN) # 3 revealed that residents get a bath or whirlpool bath every day. LPN # 3 revealed that the residents get foot and nail care along with their baths unless they are diabetic and then the nurse does the nail and foot care. An interview on 12/1/21 at 8:30 AM, with Certified Nurse Assistant (CNA) # 1 revealed that residents get a bath every day with nail care. CNA # 1 revealed that the residents get a whirlpool bath three (3) days per week and on the other days they get a bed bath. CNA # 1 revealed that nail care is also done as needed.	F 677	on providing nail care for Residents focusing on substances underneath the nails, and ensuring nails are not jagged. On 12/02/21 -12/10/21, the Infection Control Preventionist did an in-service (education) program with all direct care staff on providing nail care for Residents focusing on substances underneath the nails and ensuring nails are not jagged. On 12/06/21, the Quality Assurance Performance Improvement Committee reviewed the “Nail Care” policy with no recommended change to the procedure. 4. Starting 12/03/21, the Infection Control Preventionist or Director of Nursing will assess three (3) residents per day, three (3) days a week for five (5) weeks for long jagged nails or any substance underneath the nails. After (5) five weeks, the Infection Control Preventionist or Director of Nurses will continue to monitor monthly (Beginning 1/10/22) to ensure nail care is provided per policy and procedure. On 12/29/21, the results of the monitoring will be taken to the Quality Assurance Committee X’s (3) three months (including 12/29/21) to evaluate the process and effectiveness and make changes as found necessary to ensure substantial compliance.	

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F 677	Continued From page 2	F 677		

An observation and interview on 12/1/21 at 8:32 AM, revealed Resident #26 had a thick brown substance under her fingernails. Her fingernails were long and two of the fingernails had jagged edges. Resident # 26 stated, "I want them cut but not to the bone. I scratch so I need some nails."

An observation and interview on 12/1/21 at 8:37 AM, with Registered Nurse (RN) # 1, the Infection Control Nurse confirmed that Resident # 26's fingernails had dirt under them and they were jagged.

An interview on 12/1/21 at 8:40 AM, with the Director of Nurses (DON) revealed that nail care should be done on whirlpool days and as needed, but if they are a diabetic then the nurse must do the trimming. The DON revealed that every shift there should be cleaning up and providing nail care as needed. The DON revealed that according to documentation the resident had not refused any care since 11/18/21. The DON revealed that it is the facility policy to provide nail care as needed and on whirlpool days.

An interview on 12/1/21 at 8:53 AM, with CNA # 2 revealed that Resident # 26 received a whirlpool bath on 11/18/21, 11/22/21, and 11/29/21. CNA # 2 revealed that Resident # 26 gets a whirlpool bath on Mondays and Thursday and gets a bed bath on the other days and she has no documentation of refusals of bath or nail care by Resident # 26. She reported that the CNA that completes the whirlpool bath initials beside the resident's name indicating they completed the bath and if the resident refuses, then the CNA will write refused beside the resident's name.

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F 677	Continued From page 3	F 677		

Review of the facility bath schedule documentation titled "Monday/Thursday Baths **DO BEFORE LUNCH** Nail care must be done with each bath" revealed that Resident # 26 received a whirlpool bath on Mondays and Thursdays. Resident # 26's name was listed on the Monday/Thursday Bath schedule documentation with a CNA's initials beside her name. CNA # 2 had signed and dated the document that Resident # 26 had received a whirlpool bath on 11/18/21, 11/22/21 and 11/29/21.

Review of the facilities in-service conducted by the DON on 9/21/21 revealed TITLED AND DETAILED CONTENT OF INSERVICE: Nail care: See policy, Care of fingernails will be provided by the CNA for all non-diabetic residents. Report to the nurse any redness, irritation, broken skin, or loose skin or swelling. Nurse will perform cut and trim nails of diabetics."

Record review of the CNA care guide for Resident # 26 revealed that the resident was to receive total assistance with ADL's.

Record review of Resident # 26's "Admission Record" revealed she was admitted to the facility on 7/8/21 with diagnoses of Hemiplegia and Hemiparesis following Cerebral Infarction affecting left non-dominant side, Aphasia, Essential (primary) Hypertension, Gout, Hyperlipidemia, Hypoxemia, and Unspecified Dementia without behavioral disturbances.

Record review of the Minimum Data Set (MDS) for Resident #26, with an Assessment Reference Date (ARD) of 10/7/21, Section C had a Brief Interview for Mental Status (BIMS) score of 03,

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F 677	Continued From page 4 which indicated that the resident had severe cognitive impairment.	F 677		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning 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: Based on observation, staff and resident interview, record review and facility policy review, the facility failed to ensure the proper labeling of oxygen tubing and humidifier bottles and failed to place signage on resident doors indicating oxygen was in use for 4 (four) of 6 (six) residents receiving oxygen therapy. Residents #2, #26, #28 and #36. Findings include: Review of the facility policy "Oxygen Concentrator" reviewed 2021 revealed, " ... Policy Explanation and Compliance Guidelines: ...h. Place an oxygen warning sign on the resident's door." Review of the facility's policy titled, "Nebulizer and Oxygen Tubing Storage Policy" with a review date of 2021 revealed, "POLICY It is the policy of this facility to decrease the risk of potential and/or direct exposure to infection diseases, air	F 695	This plan of correction is submitted to meet requirments established by state and federal law. Please accept this plan as our credible allegation of compliance. 1. On 12/01/2021, the Director of Nurses assessed all rooms in the facility, removed oxygen concentrators that were not in use, and ensured all elders receiving Oxygen therapy had the appropriate signage on the door, tubing and humidifiers were labeled and dated. 2. On 12/01/2021, the Director of Nurses reviewed and printed all Oxygen orders and assessed elders' rooms with Oxygen to ensure compliance with signage on the door, tubing, and humidifiers labeled and dated. 3. On 12/02/2021-12/09/2021, the Director of Nurses and Infection Control Preventionist performed in-service training	1/14/22

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F 695	Continued From page 5 contaminants, and bacterial exposure. We will provide our residents with the proper storage and cleaning of respiratory equipment. PROCEDURE The facility will replace all respiratory tubing's weekly. These tubing's will be dated and stored in a dated plastic bag when not in use. The plastic bags will also be changed out weekly. The equipment will be cleaned at the time of tubing change out and PRN (as needed). Documentation will be placed on the resident's record weekly." Resident #2 An observation on 11/29/21 at 12:07 PM, revealed Resident #2 had no oxygen (O2) in use sign posted on the door. Record review revealed Resident #2 had a Physician's Order, dated 11/5/21, for O2 at 2 Liters (L), via Nasal Cannulas (NC), while awake. Resident #26: An observation on 11/29/21 at 12:24 PM, revealed Resident # 26 receiving O2 via NC at 2 liters with no O2 in use sign outside the resident's door. Record review of Resident # 26's Physician's Orders dated 7/29/21 revealed "Change oxygen order to O2 at 2L per NC PRN (as needed) SOB (shortness of breath)." Record review of Resident # 26's "Admission Record" revealed she was admitted to the facility on 7/8/21 with diagnoses of Hemiplegia and Hemiparesis following Cerebral Infarction affecting left non-dominant side, Aphasia, Essential (primary) Hypertension, Gout, Hyperlipidemia, Hypoxemia and Unspecified	F 695	to all nurses regarding signage on the door, tubing, and humidifiers labeled and dated. On 12/06/2021, the Quality Assurance/Performance Improvement Committee reviewed the "Oxygen Concentrator" policy with no recommended change to the procedure. 4. The Director of Nurses or Infection Control Preventionist will observe for accurate date and initials are present on all in use Oxygen tubing and humidifier bottles and "Oxygen in use" signage present on doors of residents with Oxygen concentrators (Beginning on 12/03/21), (1) time a week for six (6) weeks. The Charge Nurse, Director of Nurses, or Infection Control Preventionist will continue to monitor monthly (beginning 1/17/22) during compliance rounds. On 12/29/21, the results of the observation/monitoring will be taken to the Quality Assurance Committee X's (3) three months (including 12/29/21) to evaluate the process and effectiveness and make changes as found necessary to ensure substantial compliance.	

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F 695	Continued From page 6	F 695		

Dementia without behavioral disturbances.

Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/7/21, revealed Resident #26 had a Brief Interview for Mental Status (BIMS) score of 03 which indicated Resident #26 had severe cognitive impairment.

Resident # 28

An observation on 11/29/21 at 11:19 AM, revealed Resident # 28 receiving O2 via nasal cannula at 3 liters with no date or label on the O2 tubing and no O2 in use sign outside the resident's door.

An interview on 11/29/21 at 11:20 AM, with Resident # 28 revealed, "I don't know if they put a date on the tubing or not."

Record review of Resident # 28's Physicians Orders revealed ..."Continue Admission orders... 19. O2 @ (at) 3L (liters) per NC (nasal cannula) continuous. Dx: (diagnosis) Chronic Obstructive Pulmonary Disease (COPD)."

Record review of Resident # 28's "Admission Record" revealed Resident #28 was admitted to the facility on 4/15/21 with diagnoses of Type 2 Diabetes Mellitus, Hypertension, COPD with acute exacerbation, Personal history of other diseases of the Respiratory system, End Stage Renal Disease, and Obstructive Sleep Apnea.

Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/9/21, revealed Resident #28 had a Brief Interview for Mental Status (BIMS) score of 15

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F 695	Continued From page 7	F 695		

which indicated Resident #28 was cognitively intact.

Resident #36:
An observation on 11/29/21 at 11:58 AM, of Resident #36's oxygen concentrator revealed there was no date on the O2 humidifier bottle or the O2 tubing to indicate when it was last changed. There was no O2 in use sign posted on Resident #36's door.

Record review, of the Electronic Health Record (EHR) revealed Resident #36 had a Physician's Order, dated 11/25/21, for O2 at 2L via NC as needed for shortness of breath.

On 11/30/21 at 3:30 PM, an interview with Licensed Practical Nurse (LPN) # 2 revealed that it is the responsibility of the nurse starting the O2 on the resident for the first time to put the O2 in use sign outside the resident's door.

On 12/1/21 at 8:27 AM, an interview with LPN # 3 revealed that it is the responsibility of the nurse admitting the resident on O2 or starting O2 to put the O2 in use sign on the resident's door.

On 12/2/21 at 9:12 AM, an interview with the Director of Nurses (DON) revealed it is the responsibility of the nurse starting the residents O2 for the first time to put the O2 in use sign on the resident's room door. The DON revealed the O2 tubing should be dated and labeled weekly. The DON revealed that the need to change the O2 tubing is on the Treatment Administration Records (TARS) and usually triggers for night shift to complete.

Review of the facility "In-service Training"

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F 695	Continued From page 8 completed on 8/25/21 by the DON revealed "TITLE AND DETAILED CONTENT OF INSERVICE: ...changing and date of tubing."	F 695		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and facility policy review, the facility failed to prevent the potential of a food borne illness as evidenced by food open and used after the expiration date and food stored with an open lid and past the use by date on one (1) of three (3) kitchen tours. Findings include: The facility policy titled, "Storage of Refrigerated Food" with a revised date of 10/17 revealed	F 812	1. On 11/29/21, the Head Cook immediately discarded the fruit cocktail. On 11/29/21, the Head Cook immediately discarded the buttermilk. On 11/29/21, the Head Cook and Corporate Compliance officer inspected all items in the refrigerator to ensure compliance. No other items were found to be out of date. 2. On 12/3/21, the Director of Nurses	1/14/22

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F 812	Continued From page 9 POLICY: The facility ensures the quality and safety and sanitation of refrigerated foods through accepted storage practices. PROCEDURE: ... 4. Food taken out of original containers is put in a clean sanitized container with a tight-fitting lid. No food is left uncovered. 5. All opened foods are labeled with common name of food, date stored and use-by date." An observation on 11/29/21 at 10:20 AM, of the kitchen revealed in the walk-in refrigerator a half gallon container of buttermilk that was 3/4 (three-fourths) empty. The container had an expiration date of 11/4/21 and an opened date of 11/17/21. An interview on 11/29/21 at 10:20 AM, with Dietary Staff #3 confirmed that the buttermilk had an expiration date of 11/4/21 and an opened date of 11/17/21 and was 3/4 empty. Dietary Staff #3 confirmed that the buttermilk could have been used in cooked recipes or served as a drink for all the residents. Dietary Staff #3 confirmed that serving this out-of-date buttermilk could have caused the residents to be sick. An observation on 11/29/21 at 10:40 AM, of the 4-door refrigerator revealed a metal container with a plastic lid that had one corner opened. The metal container was 1/4 (one-fourth) full of fruit cocktail that had an opened and used by date of 11/8/21. An interview on 11/29/21 at 10:42 AM, with Dietary Staff #1, Dietary Staff #2 and Dietary Staff #3 confirmed that the metal container had a plastic lid with one corner opened, it was 1/4 full of fruit cocktail and had an opened and used by date of 11/8/21. They also revealed that the fruit	F 812	reviewed diet orders and found 47 of the 53 residents receive an oral tray and have the potential to be affected. 3. On 12/1/21, the Registered Dietitian did an in-service (education) program with all Dietary staff on the Policies and Procedures of Food Storage, Labeling, and Dating. On 12/6/21, the Quality Assurance/Performance Improvement Committee reviewed and revised the Food Storage, labeling, and Dating Policy and Procedures to include the position (Head Cook or Cook aide) responsible for monitoring food storage areas. On 12/7/21, the Administrator did an in-service/ education with the dietary staff on the policy changes. 4. The Head Cook or Cook Aide will perform a daily inspection of food storage and document their findings for five (5) weeks (Beginning 12/01/21). Starting 12/03/21, the Dietary Manager or Administrator will observe and monitor three (3) times a week for five (5) weeks. On 12/29/21, the monitoring results will be taken to the Quality Assurance Committee X's (3) three months (including 12/29/21) to evaluate the process and effectiveness and make changes as found necessary to ensure substantial compliance.	

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F 812	Continued From page 10 cocktail could have been served to all residents, including those on a pureed diet. Dietary Staff #2 and Dietary Staff #3 revealed that the facility policy was to discard anything opened in the refrigerator after seven (7) days and if it had been served to the residents after the 7 days in the refrigerator it could have made the residents sick. An interview on 12/1/21 at 11:10 AM, with the Registered Dietician (RD) revealed that if buttermilk was used after the expiration date, then it could have made the residents sick. The RD revealed it is the facility policy to discard food when expired. The RD revealed that food stored in containers in the refrigerator must be covered with no loose lids and used within 7 days. Record review of an in-service dated 1/6/2021, titled "Food Handling and Storage" revealed the in-service was attended by Dietary Staff #1, #2 and #3. The in-service content included, "Went over food handling and storage, to date items when you open, then open date. Make sure all containers have a date on them always first in and last out..."	F 812		
F 880 SS=D	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.	F 880		1/14/22

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LEXINGTON MANOR SENIOR CARE, LLC	56 ROCKPORT ROAD LEXINGTON, MS 39095

(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 880	Continued From page 11	F 880		

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 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

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F 880	Continued From page 12 (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: Based on observations, staff interviews, facility policy review, the facility failed to prevent the possible spread of infection by failure to clean and disinfect multi-use equipment between resident use for one (1) of four (4) days of survey. Findings include: Review of facility policy titled, "Policy for Cleaning and Disinfection of Resident-Care Equipment," dated 3/31/21, revealed, "Resident-care equipment can be a source of indirect transmission of pathogens. Reusable resident-care equipment will be cleaned and disinfected in accordance with current CDC (Centers for Disease Control) recommendations in order to break the chain of infection ...Policy Explanation and Guidelines, 3b. Each user is responsible for routine cleaning and disinfection of multi-resident items after each use, particularly before use of another resident."	F 880	1. On 12/01/2021, the Director of Nurses performed one on one training with Certified Nursing Assistant #5 regarding cleaning and disinfecting of Rosie V3 Automated Vital Sign Machine per policy to ensure she was able to demonstrate and verbalize compliance to prevent the spread of infection by cleaning and disinfecting the vital sign machine in between use. 2. On 12/01/2021, the Director of Nurses assessed all residents for any possible communicable diseases or infections. All residents are at risk to potentially be affected; however, none were affected. 3. On 12/02/2021-12/13/2021, the Infection Control Preventionist performed in-service training to all personal care staff regarding Cleaning and Disinfection of Resident-Care Items and Equipment. On	

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F 880	Continued From page 13 An observation, on 11/29/21 at 12:15 PM, revealed CNA #5, entered and exited the rooms of Resident #31, Resident #14, and Resident #48 using a Rosie V 3 Automated Vital Sign System to check the residents' blood pressure, without cleaning and disinfecting it between resident use. An interview on 11/29/21 at 12:20 PM, with CNA #5 confirmed that she did not clean the blood pressure machine between use on the residents. She stated that this could cause the residents to catch a cold or virus. She stated that she had in-service education on cleaning equipment and that she should have cleaned it between each resident. An interview, on 12/01/21 at 12:55 PM, with the Director of Nursing, (DON), revealed that not cleaning and sanitizing the blood pressure cuff between residents, could cause a major transfer of several infections from one resident to another. Record Review revealed CNA #5 attended an in-service titled, "Cleaning of Patient Equipment - Including vital sign machine," dated 9/23/21.	F 880	12/06/2021, the Infection Preventionist and Quality Assurance Performance Improvement Committee conducted a root cause analysis with the following findings. The data reviewed was the finding from the survey where the direct observation by the surveyor revealed that Certified Nursing Assistant #5 was not cleaning and disinfecting the vital sign machine in between resident use. The team interviewed Certified Nursing Assistant #5 to determine possible reasons this may have occurred. The interview revealed that Certified Nursing Assistant # 5 was nervous while being observed by the surveyor while she was performing vital signs. Certified Nursing Assistant # 5 wanted to get her vital signs completed in a timely manner because she takes pride in her work. Certified Nursing Assistant # 5 stated that she knew the process for cleaning and disinfecting equipment but didn't perform the process each time due to being nervous as she was being observed. The performance Improvement committee concluded that the root cause of this problem was a lack of attention to cleaning and disinfecting equipment while being observed. All staff is being in-serviced on 12/22/21 through 12/29/21 regarding the policy for cleaning and disinfecting multi-use equipment by completing a pre-test and watching a video https://youtube/RCOQbwZWiQO. The staff is then completing a post-test. The Quality Assurance Performance Improvement Committee reviewed the "Cleaning and disinfection of Resident-Care Items and Equipment"	

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F 880	Continued From page 14	F 880	policy with no recommended change to the policy. 4. The Director of Nurses or Infection Control Preventionist will observe (2) two Certified Nursing Assistants (2) two times a week for (4) weeks while obtaining vital signs using the Rosie V 3 Automated Vital Sign system to ensure they are performing the procedure of cleaning and disinfecting multi-use equipment in between residents while following the facility's policy for "Cleaning and Disinfection of Resident-Care Items and Equipment" (beginning 12/03/21). The Charge Nurse, Director of Nurses, or Infection control Preventionist will continue to monitor by observing during walking rounds weekly (Beginning 1/3/22) for (4) four weeks. On 12/29/21, the results of the monitoring will be taken to the Quality Assurance Committee X's (3) three months (including 12/29/21) to evaluate the process and effectiveness and make changes as found necessary to ensure substantial compliance.	