STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355046	A. BUILDING _____ B. WING _____	C 01/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN ACRES MANOR	1 E MAIN ST CARRINGTON, ND 58421

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The Standard Medicare/Medicaid recertification and complaint survey started on 01/23/22 and concluded 01/26/22.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff and resident interview, the facility failed to ensure the interdisciplinary team assessed the appropriateness to self-administer medications (SAM) for 1 of 2 sampled residents (Resident #27) with medications observed at the bedside. Failure to determine whether SAM is a safe practice has the potential to result in a medication error and/or harm to a resident. Findings include: Review of the facility policy titled "SELF ADMINISTRATION OF MEDICATIONS WITH ASSISTANCE (SAMA)" occurred on 01/25/22. This undated policy, stated, "Each resident who desires to self-administer medications with assistance (SAMA) is permitted to do so if the facility's interdisciplinary has determined the practice would be safe. . . If the resident demonstrated the ability to SAMA, the MAR [medication administration record] is appropriately labeled and the care plan will reflect that the resident is competent to SAMA. . . ."	F 554	1. Address how corrective action will be accomplished for those residents found to have been affected by deficient practice. a. Staff will receive education regarding the SAM assessment policy and procedures including but not limited to: Medications are not able to be left with any resident(s) that do not qualify for self-administration of medication; the Nurse/Med Aide must remain with the resident(s) until medications are swallowed. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice a. All residents have the potential to be affected. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. a. All licensed nurses and CMAs will be educated on or before February 10,	3/2/22

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

Electronically Signed | 02/11/2022

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F 554	Continued From page 1 Observation on 01/23/22 at 11:30 a.m. showed a medication cup located on Resident #27's bedside table contained 2 pills and one half of a pill. The resident stated, "I will take those with my noon meal." Review of Resident #27's medical record occurred on all days of survey. The record lacked a SAM assessment, a provider order, an appropriate label on the MAR, and documentation on the care plan indicating Resident #27 may self-administer medications. During an interview on 01/25/22 at 2:29 p.m., a licensed nurse (#2) identified Resident #27 as unable to SAM. During an interview on 01/26/22 at 12:01 p.m., an administrative nurse (#3) confirmed staff should not leave Resident #27's medications in the room.	F 554	2022, regarding medication administration procedure, specifically, not leaving medications unattended with the resident. All staff educated about notifying nurse if any medications are found in a resident room on or before February 10, 2022. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. a. The DON or designee will monitor all new admissions for self-administration assessment completion if appropriate. An environmental rounding tool was implemented, it includes checking the residents rooms for any medications that should be secured. DON or designee will conduct this audit at random weekly x 4, then bi-weekly x 2, and then monthly x 1. All findings of concern will be immediately addressed and reported to the QA/QAPI committee monthly for further review. Compliance Date: March 2, 2022	
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.	F 583		3/2/22

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F 583	Continued From page 2 §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to provide personal privacy for 1 of 2 sampled residents (Resident #31) observed during insulin administration. Failure to provide privacy in a manner/environment that maintained bodily privacy does not preserve the resident's right to privacy or enhance their quality of life. Findings include: Review of the facility's policy titled "Personal & Privacy Rights" occurred on 01/26/22. This policy, revised 08/01/19, stated, ". . . The facility	F 583	1. Address how corrective action will be accomplished for those residents found to have been affected by deficient practice. a. Residents # 31 and all residents requiring glucose monitoring and insulin administration will be given their Glucoscans and insulin in a discrete and private area. Re-Education provided to staff at time of incident. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice a. All residents who receive insulin	

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F 583	Continued From page 3 must treat you . . . with dignity. . . You should have privacy in medical treatment and personal care . . ." Observations on 01/25/22 showed a nurse (#1) performed the following for Resident #31 in view of other residents and staff in the dining room and/or two adjacent hallways: * 8:47 a.m., performed a blood sugar check on the resident's finger. * 8:52 a.m., prepared an insulin pen, pulled the resident's pant leg up exposing the right lower leg/partial thigh and administered the insulin into the resident's right lower thigh. * 8:54 a.m., prepared another insulin pen and administered the insulin into a different area of the resident's right lower thigh. During an interview on 01/26/22 at 1:45 p.m., an administrative nurse (#3) stated she expected staff to perform resident blood sugar checks and administer insulin in private areas.	F 583	have the potential to be affected by this practice. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. a. Insulin Administration policy will be reviewed. This policy, as well as the policy Quality of Life -Dignity will be reviewed. All staff will be in-serviced on both policies. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. a. QA coordinator, DON or designee will utilize the Glucoscans and Insulin Administration QA Tool will monitor for insulin administration weekly times one-month, monthly times two months and quarterly times three. Compliance Date: March 2, 2022	
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:	F 684		3/2/22

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F 684	Continued From page 4 Based on observation, record review, and resident and staff interview, the facility failed to ensure appropriate care and services for 1 of 1 sampled resident (Resident #199) reviewed for edema (fluid retention). Failure to ensure timely and consistent implementation of support stockings may result in worsening edema. Findings include: The facility failed to provide a policy regarding edema/support stockings. Review of Resident #199's medical record occurred on all days of survey and identified diagnoses of heart failure and right femur fracture aftercare. A physician's order, dated 01/13/22, stated, "Weekly edema check to right lower extremity. . . ." The care plan smart charting interventions (identified by the facility as a nurse/certified nurse aide (CNA) task list) included an approach/task stating, ". . . Right leg, knee high ted hose [support stocking], on in AM [morning], off in PM [evening]. . . ." A progress note, dated 01/24/22 at 2:05 a.m., stated, ". . . does have right foot edema. wears ted hose for this. . . ." Observations on 01/24/22 at 10:05 a.m., 1:54 p.m. and 3:59 p.m. and on 01/25/22 at 9:25 a.m. showed Resident #199 resting in a recliner in his room and lacked a support stocking to the right leg. The stocking sat on a table beside the resident's recliner. During an interview on 01/25/22 at 9:25 a.m., Resident #199 stated, "They [facility staff] took it [support stocking] off the other day and they	F 684	1. Address how corrective action will be accomplished for those residents found to have been affected by deficient practice. a. Resident #199 is no longer residing in this facility. All nursing staff involved were re-educated on making sure to follow physician orders as prescribed including implications of possible worsening effects. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice a. All residents have the potential to be affected. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. a. All direct care staff including licensed nurse(s) and certified nurse aide(s) will be re-education on following physician orders for the implementation of support stockings including importance of preventing and monitoring edema. Education will occur monthly for 3 months and as needed to ensure understanding. All nursing staff will receive education with assistive documents regarding inputting orders into the EHR correctly on or before February 24th, 2022. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. a. QA Audits monitoring correct order input will be completed on 3 residents	

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F 684	Continued From page 5 [staff] never put it [stocking] back on." During an interview on 01/25/22 at 11:43 a.m., administrative nurses (#6 and #7) stated the facility staff incorrectly input Resident #199's support stocking task into the computer, therefore, the CNAs were not triggered to apply the stocking to Resident #199's right leg.	F 684	each week for 3 months who require support stockings to ensure physician orders are being followed and placement is in correct position. The audits will be completed by the Unit Manager or designee and the results will be presented to the DON at the weekly QA/QAPI meeting for 3 months. Completion Date: March 2, 2022	
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, record review, review of facility policy, and staff interview, the facility failed to follow professional standards of practice related to respiratory care for 2 of 2 sampled residents (Resident #27 and #28) receiving oxygen. Failure to ensure maintenance of oxygen tubing and humidifiers has the potential to spread infection to residents. Findings include: Review of the facility policy titled "Golden Acres Manor Respiratory Equipment Cleaning & Disinfection Policy" occurred on 01/26/22. This	F 695	1. Address how corrective action will be accomplished for those residents found to have been affected by deficient practice. a. All nursing staff involved were re-educated on making sure to follow maintenance orders as indicated including implications of possible effects on all residents requiring respiratory equipment. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice a. All residents have the potential to be affected.	3/2/22

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F 695	Continued From page 6 policy, revised February 2018, stated, ". . . To prevent the risk of infection associated with respiratory equipment among residents . . . Oxygen Concentrators . . . Change oxygen tubing (mask, cannula, and extension tubing) weekly. Change humidifier bottle and connection tubing weekly . . ." Review of Resident #28's medical record occurred on all days of survey and identified a diagnosis of hypoxemia (abnormally low concentration of oxygen in the blood). Physician's orders, dated 01/22/21, stated, "Oxygen at 2 LPM [liters per minute] while in bed . . ." and "Change O2 [oxygen] cannula and humidifier weekly . . ." The resident's January 2022 treatment administration record (TAR) and a nurse progress note dated 01/21/22 at 5:31 a.m. indicated the oxygen tubing and humidifier jar changed on 01/21/22. Observations on 01/23/22 at 4:29 p.m., 01/24/22 at 10:03 a.m., and 01/25/22 at 10:39 a.m. showed Resident #28's oxygen tubing and humidifier jar labeled with a date of 01/14/22 (not 01/21/22 as indicated in the TAR and nurse progress note). During an interview on 01/25/22 at 10:39 a.m., a nurse (#1) confirmed the dates on the oxygen tubing and humidifier jar showed 01/14/22 and stated, "We are to change the jar and tubing out every Thursday. It should have been done." - Review of Resident #27's medical record occurred on all days of survey and identified a diagnosis of idiopathic pulmonary fibrosis (a chronic lung disease). Physician's orders, dated	F 695	3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. a. Residents who require nebulizers, oxygen and CPAP orders will have cleaning schedule, tubing changing schedule, care plans and that all masks/tubing will be audited daily for 2 weeks, weekly for 6 weeks and monthly for 2 months by unit manager(s) or designee(s). 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. a. The DON will report the findings of the audits and observations to the QA/QAPI committee for any additional monitoring and/or modification of this plan monthly for 3 months. The QA/QAPI committee can modify this plan to ensure the facility remains in compliance. Completion Date March 2, 2022	

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F 695	Continued From page 7 06/03/21, stated, "Oxygen at 3 LPM/nasal cannula continuously . . . Change O2 cannula and humidifier weekly . . ." During an interview on 01/25/22 at 10:35 a.m., a licensed nurse (#2) stated staff change all resident's humidifiers and oxygen tubing every Thursday and date the humidifier canister when it is changed. Observation at this time showed Resident #27's humidifier and oxygen tubing without a date. The nurse (#2) confirmed staff failed to date Resident #27's humidifier and oxygen tubing.	F 695		
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. 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	F 880		3/2/22

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F 880	Continued From page 8 standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of	F 880		

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F 880	Continued From page 9 infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, review professional reference, and staff interview, the facility failed to follow infection control practices for 4 of 16 sampled residents (Resident #18, #31, #40, and #200) and one supplemental resident (Resident #42). Failure to follow infection control practices during personal cares, wound care, glove usage, sanitizing of personal protective equipment (PPE) and passing residents' ice water has the potential to transmit infections to other residents, staff, and visitors. Findings include: Review of the facility's policy titled "Golden Acres Manor Transmission-Based Precautions" occurred on 01/26/22. This policy, dated November 2017, stated, ". . . Droplet Precautions - intended to prevent transmission of pathogens spread through close respiratory or mucous membrane contact with respiratory secretions (i.e. respiratory droplets that are generated by a resident who is coughing, sneezing, or talking). . . ." Review of the facility's policy titled "Personal Protective Equipment (PPE)" occurred on 01/26/22. This policy, dated November 2017, stated, ". . . PPE refers to a variety of barriers (gloves, gowns, face protection, masks, and N95	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 entering and exiting a room on droplet precautions donned, doffed, disposed of, and sanitized reusable personal protective equipment (PPE), in accordance with CDC guidelines. (2) Ensuring staff perform hand hygiene or handwashing when donning PPE, moving between tasks, residents, and after touching potentially contaminated surfaces, in accordance with CDC guidelines. (3) Ensure staff who perform water pass do so in a sanitary manner, in accordance with infection control standards. The DON, staff development coordinator	

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F 880	Continued From page 10 particulate respirators). . . . The use of PPE does not replace the need to follow basic infection control measures such as hand hygiene . . . Golden Acres Manor will refer to CDC [Center for Disease Control] for updated guidance and direction for proper donning [putting on] and doffing [taking off] of PPE. . . ." Review of the CDC guidance found at: https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/eye-protection.html, updated September 13, 2021, stated, ". . . If a disposable face shield or goggles is cleaned and disinfected, it should be dedicated to one HCP [health care professional] and cleaned and disinfected whenever it is visibly soiled or removed (e.g., when leaving the isolation area) . . ." Review of the CDC guidance found at: https://www.cdc.gov/niosh/npptl/pdfs/PPE-Sequence-508.pdf, stated " . . . . HOW TO SAFELY REMOVE PERSONAL PROTECTIVE EQUIPMENT (PPE) . . . Remove all PPE before exiting the patient room except a respirator, if worn. . . . Remove PPE in the following sequence: 1. GOWN AND GLOVES . . . 2. GOGGLES OR FACE SHIELD . . . If the item is reusable, place in designated receptacle for reprocessing. Otherwise, discard in a waste container. 3. MASK OR RESPIRATOR . . . 4. WASH HANDS OR USE AN ALCOHOL-BASED HAND SANITIZER IMMEDIATELY AFTER REMOVING ALL PPE . . ." TRANSMISSION-BASED PRECAUTIONS (TBP)/PPE USE - Review of Resident #200's medical record	F 880	(SDC), IP or designee, in conjunction with applicable IDT members, will: (1) Educate staff on selecting, donning, doffing, disposing of, and sanitizing reusable PPE when entering a room on droplet precaution isolation/quarantine procedures. To verify each of these staff understands the procedure, then each will perform a successful return demonstration of selecting, donning, doffing, disposing of, and sanitizing reusable PPE for providing cares in a droplet precaution room. (2) Educate staff on correctly completing hand hygiene after changing tasks, moving between residents, changing gloves, and touching potentially contaminated surfaces. To verify these staff understands hand hygiene and handwashing, these staff will perform a successful return demonstration of identifying the need and correct procedure for performing hand hygiene and handwashing. (3) Educate staff on utilizing proper infection control procedures during water pass. To verify each of these staff understands the water pass procedure, these staff will perform successful return demonstration of water pass utilizing effective infection control standards. 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	

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	355046	A. BUILDING _____ B. WING _____	C 01/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN ACRES MANOR	1 E MAIN ST CARRINGTON, ND 58421

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F 880	Continued From page 11 occurred on all days of survey and identified TBP and droplet precautions implemented on 01/21/22 due to a positive COVID-19 test result. Observations of Resident #200 showed the following: * 01/25/22 at 9:00 a.m., a certified nurse aid (CNA) (#8) donned PPE, entered the resident's room to deliver breakfast, doffed his PPE, and placed his face shield onto the isolation cart. The CNA then performed hand hygiene, obtained a sanitizing wipe, sanitized the face shield, and failed to sanitize the areas on the isolation cart the contaminated face shield touched. * 01/25/22 at 5:35 p.m., a CNA (#11) donned PPE, entered Resident #200's room to deliver the evening meal, doffed his PPE, performed hand hygiene, and without sanitizing the face shield, the CNA put the shield back on and went to the dining room to assist another resident with their evening meal. - Review of Resident #42's medical record occurred on all days of survey and identified TBP and droplet precautions implemented on 01/23/22 due to a positive COVID-19 test result. Observation on 01/25/22 at 5:35 p.m. showed a CNA (#10) donned a gown, an N95 mask, and a face shield. Without gloves, the CNA entered Resident #42's room with a few items from the evening meal tray located outside the resident's room. The CNA (#10) exited the resident's room to retrieve a few more items off the meal tray, reentered the resident's room, and repeated this process two more times, until all meal items were delivered to the resident. The CNA (#10) then	F 880	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 02/19/2022 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: a. Failure to select, don, utilize, doff, and sanitize reusable PPE necessary for droplet precautions isolation/quarantine room access, in accordance with CDC guidelines. b. Failure to complete handwashing or hand hygiene in accordance with CDC guidelines. c. Failure to complete water pass in accordance with effective infection control standards. 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. Educate all staff whose normal duties include entering resident rooms on the correct procedure for selecting, donning, using, doffing, and sanitizing reusable PPE when entering a droplet	

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F 880	Continued From page 12 doffed his gown, face shield, and N95 mask, performed hand hygiene, and without sanitizing the face shield, the CNA put the shield back on and went to the dining room to assist another resident with their evening meal. During an interview at this time, when informed about lack of glove use in Resident #42's room, the CNA (#10) stated, "I have gloves" and reached into his right scrub top pocket, presented a handful of gloves, and placed those gloves back into his pocket. During an interview on 01/25/22 at 6:00 p.m., an administrative nurse (#6) stated staff are expected to sanitize their face shield after leaving a TBP room, wear gloves at all times in TBP rooms, and have a staff member outside the TBP room hand items from the meal trays to the staff member in the TBP room. During an interview on 01/26/22 at 12:26 p.m., an administrative nurse (#12) stated the facility educated staff to sanitize face shields after leaving TBP rooms and not to carry extra gloves in their scrub top pockets. HAND HYGIENE/GLOVE USE Review of the facility's policy titled "Golden Acres Manor Infection Prevention and Control Program" occurred on 01/26/22. This policy, revised May 2021, stated, ". . . Hand Hygiene Protocol: All staff shall wash their hands . . . between resident contacts, after handling contaminated objects, after PPE removal . . . Staff shall wash their hands before and after performing resident care procedures. . . ."	F 880	isolation/quarantine precaution room. This education will include the CDC's lesson on personal protective equipment developed for nursing home staff available at https://youtu.be/YYTATw9yav4. 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. c. Educate all staff who perform water pass do so utilizing effective infection control standards. 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 types to ensure correct selection, donning, use, doffing, and sanitizing reusable PPE when entering and exiting droplet precaution isolation/quarantine rooms. (2) Observations of all staff types to ensure performance of proper handwashing and hand hygiene, when indicated, in the course of their routine duties. (3) Observations of all staff types to ensure a sanitary water pass.	

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F 880	Continued From page 13 - Observation on 01/24/22 at 1:10 p.m., showed a CNA (#8) assisted Resident #18 with perineal cares, removed his gloves, and assisted the resident to a recliner. Without performing hand hygiene, the CNA (#8) offered the resident water while touching the straw. - Observation on 01/24/22 at 1:30 p.m. showed two CNAs (#8 and #9) transferred Resident #40 from a wheelchair to the bathroom via a mechanical lift. The CNA (#8) performed perineal cares, applied a clean brief, removed his gloves, and assisted the other CNA (#9) to transfer the resident back into a wheelchair. Without performing hand hygiene, the CNA (#8) arranged the resident's clothing, offered water while touching the straw, pushed the resident's wheelchair to the doorway, and then sanitized his hands prior to exiting the resident's room. - Observation on 01/25/22 at 8:22 a.m. showed a nurse (#1) performed wound care while Resident #31 rested in bed. The nurse applied ostomy powder and barrier cream to Resident #31's pressure ulcer on the buttocks area, removed gloves, and without performing hand hygiene assisted with applying Resident #31's brief. The nurse (#1) donned new gloves and applied skin prep to the resident's heel ulcers. The nurse (#1) failed to perform hand hygiene after removing gloves and before doing other tasks and wound care. During an interview on the afternoon on 01/26/22, an administrative nurse (#3) confirmed she expected staff to perform hand hygiene after removing gloves, before applying new gloves and	F 880	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 02/19/2022	

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F 880	Continued From page 14 after toileting cares before doing other resident tasks. WATER PASS Observations on 01/24/22 at 2:24 p.m. and 2:26 p.m. showed two CNAs (#4 and #5) passed ice water to residents in the 100 and 200 wings. Both CNAs retrieved water mugs from the residents' rooms and filled the mugs with ice while holding the mugs over the clean ice container on a cart. Observation showed ice fly out of the residents' mugs into the clean ice container. The CNAs continued this process as they passed ice water down the 100 and 200 wings. During an interview on 01/26/22 at 12:01 p.m., an administrative nurse (#3) agreed staff failed to pass ice water in a sanitary manner.	F 880		
F9999	FINAL OBSERVATIONS Based on observation, record review, policy review, and resident, family, and staff interview, the complaint investigated in conjunction with the standard Medicare/Medicaid survey was not substantiated.	F9999		