STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355039	A. BUILDING _____ B. WING _____	04/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRIGGS COUNTY CARE CENTER	1200 ROBERTS AVE NE COOPERSTOWN, ND 58425

(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 was started on 04/18/21 and concluded on 04/21/21.	F 000		
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 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;	F 880		5/13/21

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

Electronically Signed | 05/13/2021

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 880	Continued From page 1 (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 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 review of facility policy, observation, record review and staff interview, the facility	F 880	1. Corrective Action	

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F 880	Continued From page 2 failed to ensure staff followed appropriate infection control practices for 1 of 1 sampled resident (Resident #9) observed with pressure ulcers. Failure to follow appropriate infection control practices for pressure ulcer care may result in an infection or worsening of the affected area which could cause a delay in healing for the resident. Finding include: Review of the facility policy titled "Skin Care Protocol" occurred on 04/21/21. This policy, revised February 2021 stated, "The facility must ensure . . . a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing . . .1. Dress chronic wounds using clean technique. 2. Cleanse wounds using a non-toxic agent prior to making wound assessment and applying new dressing . . ." Observation on 04/19/21 at 10:45 a.m., showed two certified nurse assistants (CNAs) (#3 and #4) removed dressings from Resident #9's left hip, right and left buttocks, right knee, left shin and sacrum. One CNA (#4) called the nurse to the resident's room to change his colostomy bag that was leaking. A licensed nurse (#5) removed the resident's colostomy bag, cleansed the stoma and surrounding area, and applied the new colostomy bag. The CNAs (#3 and #4) then slid the mesh full body sling under the resident's bare buttocks, sacrum and hips without any dressings or protective undergarments between the resident's open, draining, bleeding pressure ulcers and transferred him into the wheelchair via	F 880	The facility will immediately implement an appropriate infection prevention and intervention plan consistent with the requirements of §483.80 for the affected resident 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: A. Ensuring appropriate infection control practices when caring for Resident #9's pressure ulcers. B. Ensuring the staff consistently change Resident #9's dressings per physician orders. C. Ensure staff review Resident #9's current plan of care for whirlpool bath days to include bath immediately after dressing are removed and re-applied immediately after whirlpool bath. Ensuring Resident #9's pressure ulcers are unprotected at any time while up in wheelchair. The DON, staff IP or designee, in conjunction with applicable ITD members, will: A. Educate staff on appropriate infection control practices when changing Resident #9's dressings. B. Educate staff on appropriate assistance for Resident #9's whirlpool bath that does not consist of him being in his wheelchair without any dressings on for any amount of time. C. Educate staff on the importance of general infection control practices. 2. Identification of others The IP and DON, in conjunction with the applicable the interdisciplinary team (IDT)	

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F 880	Continued From page 3 the lift. The cushion of the wheelchair was covered with a disposable pad. The CNAs failed to provide necessary treatment and services to prevent infection to Resident #9. The CNA (#3) stated on Resident #9's bath days the CNAs always remove the old dressings and get the resident up in the wheelchair before lunch. After lunch, staff bathe the resident, lay him back down and then the nurse applies the new dressings. Observation on 04/19/21 at 1:23 p.m., showed Resident #9 lying in bed on his right side. A licensed nurse (#5) applied collagen powder to the resident's left hip and left buttock covering the ulcers with a protective dressing. The nurse (#5) stated she did not need to clean the wounds prior to applying Resident #9's sterile dressings "because they are clean from the whirlpool bath." The nurse (#5) confirmed staff used the same mesh full body sling when they transferred Resident #9 from the bed to the wheelchair, wheelchair to the whirlpool tub and whirlpool back to the bed. A CNA (#6) assisted the nurse (#5) with repositioning the resident onto his left side. The nurse (#5) applied new gloves washing hands in between. She then applied disinfectant spray to his right buttock and sacrum and patted in the collagen powder to the ulcers with both hands. With her soiled gloves the nurse touched several sterile unopened dressings, searching for the appropriate dressing. The nurse (#5) then opened a protective dressing and applied it to the resident's sacrum and right buttock ulcers. With the same soiled gloves the nurse again touched several unopened sterile dressings located in a bucket, pulled out several dressings, opened them, and proceeded to dress Resident #9's left shin and right knee. The nurse then removed the	F 880	members, will review all residents plan of care with dressings on bath days or any day ensuring appropriate infection control practices are utilized. The IP, DON and applicable IDT members will evaluate the facility's compliance with the dressing changes and infection control practices and develop action plans to address any newly identified non-compliance. 3. System Changes On or before 05/19/2021 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 implement appropriate infection control practices with dressing changes. B. Failure to follow physician orders with dressing changes cleansing pressure ulcers prior to applying new dressings, ointments, etc. 2. The DON, IP or suitable designee will ensure the following: A. Educate all nursing staff (nurses and CNA's) on appropriate infection control practices when completing dressing changes. B. Educate all nursing staff on following physician orders for cleaning pressure ulcers prior to new dressings, ointments, etc. 4.Monitoring Weekly for no less than 12 weeks the DON, IP or a designee will conduct	

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F 880	Continued From page 4 soiled gloves and washed her hands. Per facility policy and physician orders the nurse failed to cleanse Resident #9's left hip and left buttock pressure ulcers before applying prescribed powder and new dressings. The nurse failed to sanitize or wash her hands and don clean gloves prior to sorting through unopened sterile dressings and prior to dressing different pressure ulcer sites. Review of Resident #9's medical record occurred on all days of survey and included the diagnosis of multiple sclerosis. The medical record included the following physician orders: - ". . . SACRUM. CLEANSE WOUND BED, APPLY COLLEGEN [sic] POWDER TO WOUND BED, . . . then utilize ABD [abdominal gauze pad] pad . . ." - ". . . LEFT BUTTOCK. CLEANSE WITH SKIN INTEGRITY WOUND CLEANSER . . . cover with abd pad . . ." - ". . . LEFT HIP. CLEANSE WITH SKIN INTEGRITY WOUND CLEANER . . . and cover with foam dressing or abd pad . . ." During an interview on 04/20/21 at 4:15 p.m., an administrative nurse (#2) stated she expected staff to change gloves and sanitize or wash hands prior to touching unopened dressings and in between different pressure ulcers. During an interview on 04/21/21 at 5:00 p.m., an administrative nurse (#1) stated she expected staff to apply the appropriate protective dressing between Resident #9's open pressure ulcers and the mesh sling to prevent infection and follow facility policy related to infection control and hand	F 880	on-going monitoring to ensure, via observation, the approaches to correct deficient practices related to infection control and prevention are consistently implemented and effective. Such monitoring will include: A. Observing of all nursing staff completing dressing changes on Resident #9 and any other residents with dressing changes to ensure infection control practices are followed and physician orders are followed. Ensuring appropriate hand hygiene is completed and B. Observing all nursing staff to ensure resident #9 is not in his wheelchair with open wounds not being protected. C. Observation of all staff types to ensure performance of proper handwashing and hand hygiene, when indicated, in the course of their routine duties. 5. Correction Date 05/19/2021	

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