STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355069	A. BUILDING _____ B. WING _____	R-C 10/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVENTIDE HEARTLAND	620 14TH AVE NE DEVILS LAKE, ND 58301

(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
{E 000}	Initial Comments A COVID-19 Emergency Preparedness Survey was completed by the Centers for Medicare and Medicaid Services (CMS) on August 15-17, 2022. The facility was found in compliance with 42 CFR §483.73 related to E-0024(b)(6).	{E 000}		
{F 000}	INITIAL COMMENTS An on-site revisit survey and complaint investigation, started on 10/11/22 and concluded 10/12/22, was conducted to determine compliance with deficiencies identified during the complaint survey completed on 08/22/22.	{F 000}		
F 557 SS=E	Respect, Dignity/Right to have Prsnl Property CFR(s): 483.10(e)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. This REQUIREMENT is not met as evidenced by: Based on information provided by the complainant, observation, record review, and staff interview, the facility failed to promote care in a manner that maintained or enhanced the residents' dignity for 5 of 12 sampled residents (Resident #1, #2, #5, #12, and #15) who required assistance with dressing. Failure to ensure residents the residents wore clean, unsoiled clothing does not promote mental well-being and may lead to a resident's loss of dignity.	F 557	1. Social Service staff have gone through the clothing belonging to residents 1, 2, and 5 and have removed stained clothing from their room. Resident 15: the emesis was cleaned from the floor and blanket was placed in the laundry as soon as the administrative nurse was made aware of the situation on 10/11/2022. Resident 12: a urinary drainage bag	11/16/22

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

Electronically Signed | 11/02/2022

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F 557	Continued From page 1 Findings included: The complainant indicated the facility failed to change residents' soiled clothing. - Review of Resident #15's medical record occurred on all days of survey. A quarterly Minimum Data Set (MDS), dated 08/15/22, identified cognitive impairment and required extensive assistance with dressing and self care. Observations on 10/11/22 showed the following: * 2:27 p.m., Resident #15 lying in bed with emesis on the blanket beside the resident's head and on the floor beside the bed. A certified nursing assistant (CNA) (#26) entered the room and provided perineal cares. Before exiting the room, the CNA failed to clean the emesis from the floor and place the blanket in the laundry. * 5:24 p.m., An unidentified staff member assisted Resident #15 to transfer from the bed to the wheelchair and transported the resident to the dining room for the evening meal. The staff member failed to clean the emesis from the floor or change the bedding. Observation showed the emesis and soiled bedding remained in the residents' room from 2:27 p.m. until 5:28 p.m. During an interview on 10/11/22 at 05:29 p.m., an administrative nurse (#1) confirmed the facility staff failed to clean up the emesis in Resident #15's room in a timely manner. - Review of Resident #1's medical record occurred on all days of survey. A comprehensive MDS, dated 09/19/22, identified extensive assistance required with dressing. Observation	F 557	cover has been placed in resident's room and is being utilized. 2. All residents have the potential to be affected. 3. Standards of Care policy and Catheters – Indwelling policies were reviewed and no changes are required. Education will be provided on 11/03/2022 to all staff that we are responsible for promoting dignity for our residents and this includes ensuring that they are wearing clean, unsoiled clothing and keeping urinary drainage bags covered. 4. Audits will be completed to ensure that residents clothing is clean and unsoiled and urinary drainage bags are covered both inside and outside of rooms. The DON or designee will observe ten residents weekly for one month, then 10 residents monthly for three months, and then 10 audits will be completed at least quarterly for one year with additional audits as recommended by the QA committee. If concerns are identified, immediate corrective action will be implemented. The results of the audits will be reported to the QA committee for further review and recommendation. Upon this review system revisions and/or staff education will be implemented.	

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F 557	Continued From page 2	F 557		

on 10/11/22 at 2:00 p.m., showed Resident #1 visiting in her room visiting with guest and the front of her blouse visibly soiled with food stains. At 5:25 p.m., observation showed Resident #1 in the dining room wearing the same blouse.

- Review of Resident #2's medical record occurred on all days of survey. A quarterly MDS, dated 07/08/22, identified extensive assistance required with dressing. Observation on 10/11/22 at 7:00 p.m., showed Resident #2 in his room and his pants visibly soiled food/spillage.

- Review of Resident #5's medical record occurred on all days of survey. A quarterly MDS dated 10/03/22, identified extensive assistance required with dressing. Observation on 10/11/2022 at 2:40 p.m., showed Resident #5 wearing a T-shirt visibly soiled with food stains.

- Review of Resident #12's medical record occurred on all days of survey. A quarterly MDS, dated 08/06/22, identified the resident required extensive assistance with dressing. Observation on 10/11/22 at 7:00 p.m., showed Resident #12 lying in bed with door open, his shirt pulled up exposing the lower half of his abdomen, and the uncovered urine collection bag hung from the bed frame. Observation on 10/12/22 at 7:14 a.m. showed Resident #12 lying in bed with the door open. The resident lacked a shirt or covering over his upper body with his brief exposed, and the uncovered urine collection bag hung from the bed frame.

During an interview on 10/12/22 at 5:25 p.m., an administrative nurse (#1) stated staff are expected to change residents' clothing if soiled.

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F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and	F 584		11/16/22

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F 584	Continued From page 4 §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on information provided by the complainant, observation, review of facility policy, and resident and staff interviews, the facility failed to ensure a safe, clean, comfortable, and homelike environment for 10 of 62 resident rooms (Room #3, #10, #13, #15, #16, #32, #48, #49, #58, and #59) observed during the survey. Failure to maintain a clean, comfortable, and sanitary environment does not provide a homelike living area for residents. Findings include: Information provided by the complainant indicated the facility failed to provide a clean and sanitary environment in the resident ' s rooms. Review of the facility policy titled "Proper Cleaning of a Room" occurred on 10/12/22. This policy, dated April 2017, stated, ". . . Policy: It is the policy of Eventide to ensure that all rooms are infection free . . . Place all disposables in the approved receptacles . . ." - Observations in resident's rooms on 10/11/22 showed the following: * 1:46 p.m. Room #59: Paper towels on the floor and several disposable cups observed on the floor and beside the sink. * 1:57 p.m. Room #49: Three large gray water mugs on the resident's bedside table. The resident stated, "I don't know why all those are there. I don't even drink that much water and it	F 584	1. Housekeeping staff have completed a deep clean of rooms 3, 10, 13, 15, 16, 32, 48, 49, 58, and 59. Room 3: jar labeled “spicy pickles” and extra personal care items have been disposed of. Room 49: Extra water mugs have been removed. 2. All residents have the potential to be affected. 3. Education will be provided to all staff on 11/03/2022 that we are responsible for promoting ensure a safe, clean, and homelike environment. This includes disposing of trash appropriately, stocking appropriate amounts of personal care items/storing personal care items in appropriate locations, and removing extra water mugs. 4. Audits will be completed to ensure that resident rooms are clean, trash is disposed of properly, only the necessary amount of personal care items are stocked and are stored in the appropriate location, and only one water mug is present. The DON or designee will observe ten resident rooms weekly for one month, then 10 resident rooms monthly for three months, and then 10 audits will be completed at least quarterly for one year with additional audits as recommended by the QA committee. If concerns are	

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F 584	Continued From page 5 doesn't leave me much room on my table either." * 2:00 p.m. Room #48: Paper towels and medication cups on the floor. * 2:05 p.m. Room #13: Used gloves on the floor next to the waste basket. * 2:34 p.m. Room #10: Used gauze pad on the floor. * 2:40 p.m. Room #3: Seven containers of cleansing cream, four bottles of lotion, and a jar dated 08/10/22 labeled "spicy pickles" dated 08/10/22 on the overbed table. During an interview, Resident #5 stated, "Those aren't any good, I have asked them [the staff] to get rid of them a while ago." * 4:55 p.m. Room #16: Used glove on floor next to the waste basket. * 4:55 p.m. Room #15: Two paper wrappers and a gauze pad on the floor beside the waste basket next to the resident's bed. The top two dresser drawers appear broken and failed to close completely. * 5:25 p.m. Room #58: Used gloves and disposable cups on the floor. * 6:14 p.m. Room #32: Used paper towel on floor near bathroom door. - Observations in resident's rooms on 10/12/22 showed the following: * 7:27 a.m. Room #59: Gauze pads, paper towels and plastic wrap observed on the floor. During an interview on 10/12/22 at 7:10 a.m., a housekeeping staff (#7) reported the housekeeping department has "struggled lately" with staffing.	F 584	identified, immediate corrective action will be implemented. The results of the audits will be reported to the QA committee for further review and recommendation. Upon this review system revisions and/or staff education will be implemented.	
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689		11/16/22

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F 689	Continued From page 6 §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, review of facility policy and procedure, and staff interview, the facility failed to provide adequate supervision and assistive devices necessary to prevent accidents for 1 of 5 sampled residents (Resident #2) observed during a gait belt transfer. Failure to utilize the gait belt during transfers placed Resident #2 at risk of an accident and/or injury. Findings include: Review of the facility policy titled "Standards of Care" occurred on 10/12/22. This policy, revised March 2022, stated, "PURPOSE: These standards will help guide the staff at Eventide in providing quality, safe care to our residents. PROCEDURE: SAFETY 1. A gait belt will be used for all assisted transfers . . ." Review of Resident #2's medical record occurred on all days of survey. The care plan stated, ". . . ADL [Activities of Daily Living]/MOBILITY DEFICIT. . . TRANSFER: Walker, gait belt, assist x 1. . . ." Observation on 10/12/22 at 7:27 a.m., showed a certified nursing assistant (CNA) (#3) transferred Resident #2 from the bed to the wheelchair using	F 689	1. Facility is unable to correct the incident from 10/12/2022 where the gait belt was not used. Facility staff have completed a gait belt/transfers competency with CNA #3. 2. All residents that require assistance with transfers have the potential to be affected. 3. Standards of Care policy was reviewed and no changes are required. Education will be provided on 11/03/2022 to all nursing staff that gait belts must be used with all assisted transfers. Staff should not lift residents under their arms or pull on resident pants during transfers. 4. Audits will be completed to ensure that gait belts are being utilized with all assisted transfers and that staff are not lifting resident under their arms or pulling their pants. The DON or designee will observe ten resident transfers weekly for one month, then 10 resident transfers monthly for three months, and then 10 resident transfers will be completed at least quarterly for one year with additional audits as recommended by the QA committee. If concerns are identified,	

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F 689	Continued From page 7 the resident's walker. The CNA (#3) lifted Resident #2 under the right arm to stand, pulled on the back of the resident's pants to pivoted him into the wheelchair. The CNA (#3) failed to use the gait belt when transferring Resident #2. During an interview on 10/12/22 at 11:30 a.m., an occupational therapist (#2) stated, "Staff are to always use the gait belt when transferring [Resident #2's name] as he is a very high fall risk." During an interview on 10/12/22 at 5:15 p.m., an administrative nurse (#1) stated staff are expected to use the gait belt during all assisted transfers and should not lift under the resident's arm or pull on their pants.	F 689	immediate corrective action will be implemented. The results of the audits will be reported to the QA committee for further review and recommendation. Upon this review system revisions and/or staff education will be implemented.	
{F 725} SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:	{F 725}		11/16/22

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{F 725}	Continued From page 8 (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: During the onsite revisit completed on October 12, 2022, evidence showed the facility failed to achieve compliance with this requirement. Refer to 08/22/22 CMS2567. Based on information from the complainant, observation, resident and staff interviews, and review of facility Alarm Response Report, the facility failed to ensure sufficient nursing staff to meet resident needs for 4 of 4 confidential residents (Residents A, B, C, and D) who required staff assistance. Failure to provide sufficient staffing and answer call lights in a timely manner does not promote a resident's right to physical, mental, and psychosocial well-being. Findings include: The complainant indicated long call light wait times. The facility failed to provide a call light policy. Resident interviews on 10/11/22 identified the following: * At 2:03 p.m., Resident A indicated he/she has often waited 30-45 minutes for staff to answer the	{F 725}	1. The facility is unable to provide follow up with Residents A, B, C, and D as their identities are confidential. 2. All residents have the potential to be affected. 3. Nursing leadership and staffing coordinator will continue to meet daily to ensure that a staffing plan is in place that ensures sufficient nursing staff. On 11/03/2022 all staff will be re-educated on the expectation that it is everyone's responsibility to answer call lights and that call lights should remain on until the residents need has been met. The leadership team will continue to complete daily rounds on all residents. As part of daily leadership rounds the residents will be asked for their feedback on call light response times. On 11/03/2022 all staff will be educated on the expectation that they reply that when calls for assistance are made via the walkie talkie. Nurses will be educated that they are also responsible to carry pagers and must respond to the call light when their pager sounds/ensure that the resident's need is met. Call Response Time Reports will be	

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{F 725}	Continued From page 9 call light. * At 4:25 p.m., Resident B reported he/she has often waited up to 30-45 minutes for staff to answer the call light. * At 4:35 p.m., Resident C reported he/she waited 30-40 minutes for staff to answer the call light, and stated, "I wet the bed waiting for them." * At 5:15 p.m., Resident D reported he/she waited up to an hour for staff to answer the call light. Observations on 10/12/22 showed the following: * 6:59 a.m., the call light in Resident A's room answered by a certified nursing assistant (CNA) (#4). The CNA turned off the resident's call light, exited the room, and messaged into the walkie talkie for assistance and received no response. The CNA (#4) stated, "And no one is going to answer me back." * 7:02 a.m., Resident #A turned the call light back on. * 7:12 a.m., an administrative staff member (#5) answered the resident's call light. The resident requested to get up and ready for the day. The administrative staff member exited the room, approached CNA (#4) in the hallway and asked the CNA, Are you caring for Resident A today? The CNA stated, "No". The administrative staff member (#5) messaged into the walkie talkie for assistance and received no response. * 7:19 a.m., a CNA (#6) answered the resident's call light and assisted the resident. Review of the facility Alarm Response Reports for Resident A, B,C, and D's rooms identified the following: * 10/01/22 through 10/07/22.: Assist/Nurse Call Response time of 10-20	{F 725}	reviewed daily Monday-Friday with Saturday and Sunday reports reviewed on Monday. For any call light response times greater than 15 minutes a member of the leadership team will follow up with the resident and the employee responsible for caring for the resident at that time. 4. Audits will be completed to ensure that call lights are being answered in a timely manner and resident's needs are being met in a timely manner. The DON or designee will complete 10 call light audits weekly for one month, 10 call light audits for one month, then 10 call light audits for three months, and then 10 call light audits will be completed at least quarterly for one year with additional audits are recommended by the QA committee. If concerns are identified, immediate corrective action will be implemented. The results of the audits will be reported to the QA committee for further review and recommendation. Upon this review system revisions and/or staff education will be implemented if needed.	

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{F 725}	Continued From page 10 minutes occurred 21 times Assist/Nurse Call Response time of 21-30 minutes occurred 10 times Assist/Nurse Call Response time of 31-60 minutes occurred 4 times Assist/Nurse Call Response time of greater than one hour occurred 2 times. During an interview on 10/12/22 at 5:26 p.m., an administrative nurse (#1) stated staff are expected to answer a call light "within 5 minutes or less".	{F 725}		
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;	F 880		11/10/22

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(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 §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 infection.	F 880		

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	355069	A. BUILDING _____ B. WING _____	R-C 10/12/2022

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F 880	Continued From page 12 §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, and staff interview the facility failed to follow infection control practices for 3 of 8 sampled residents (#15, #16 and #17) observed during personal cares. Failure to practice infection control related to urinary catheters, and personal cares has the potential to spread infection within the facility. Findings include: * Observation on 10/12/22 at 7:27 a.m., showed a certified nursing assistant (CNA) (#3) assisted Resident #2 with morning cares. The CNA performed peri-cares and catheter cares with a wet washcloth and then placed the dirty/soiled washcloth on the resident's bedside table. When the CNA completed morning cares she placed the washcloth in the soiled linen bag and failed to disinfect the resident's bedside table. - Review of Resident #15's medical record occurred on all days of survey. A quarterly Minimum Data Set (MDS), dated 08/15/22, identified a diagnoses of traumatic brain injury with cognitive impairment and required extensive assistance with dressing and self care. Observations of Resident #15 on 10/11/22 showed: * 2:27 p.m., Resident #15 lying in bed with emesis on the blanket beside the resident's head and on the floor beside the bed. A certified	F 880	DPOC 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) 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 have adequate knowledge of hygienic cleaning practices and the facility's cleaning/disinfecting product(s) in order to utilize them correctly for disinfection and cleaning purposes. (2) Ensuring staff hand hygiene or handwashing when moving between tasks, residents, and after touching or placing resident equipment/items on 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 all staff on hygienic cleaning technique to prevent cross contamination	

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F 880	Continued From page 13 nursing assistant (CNA) (#26) entered the room and provided perineal cares. The resident stated to staff he did not feel very well. Before exiting the room, the CNA failed to clean the emesis from the floor and place the blanket in the laundry. * 5:24 p.m., an unidentified staff member assisted the resident to transfer from the bed to the wheelchair and transported the resident to the dining room for the evening meal. The staff member failed to clean the emesis from the floor or change the bedding. Observation showed the emesis and soiled bedding remained in the residents' room from 2:27 p.m. until 5:28 p.m. During an interview on 10/11/22 at 5:29 p.m., an administrative nurse (#1) stated facility staff failed to clean up the emesis in Resident #15 room in a timely manner. - Review of Resident #16's medical record occurred on all days of survey. Diagnoses included kidney disease and urinary incontinence. The current physician's orders, dated 10/11/22 identified a Foley catheter. Observations showed the following: * 10/11/22 at 2:29 p.m., Resident #16 in her room with a urine catheter bag hanging on the garbage can filled with soiled wipes and gloves. - Review of Resident #17's medical record occurred on all days of survey. Diagnoses included neurogenic bladder and retention of urine. The current physician's orders dated 10/05/22 identified a Foley catheter.	F 880	when cleaning resident items in resident rooms, on correct dwell times and cleaning product use to achieve desired disinfection in resident rooms. To verify these/this staff understands the training, the staff will complete a return demonstration of cleaning resident items in a hygienic manner using proper dwell times to achieve disinfection. (2) Educate all staff on correctly completing hand hygiene after changing tasks, moving between residents, placement of urine collection devices and contaminated towels/linen, 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/handwashing, perineal cares, and placement of urine collection devices/items. 2. Identification of Others The IP and DON, in conjunction with the applicable the interdisciplinary team (IDT) members, will review current guidelines from CDC and CMS. The IP, DON and applicable IDT members will evaluate the facility's compliance with the guidelines. The facility will develop action plans to address any newly identified non-compliance. 3. System Changes On or before 11/10/2022 the facility shall complete the following actions:	

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F 880	Continued From page 14 Observation showed the following: * 10/11/12 at 2:31 p.m., showed Resident #17 in her room recliner with a catheter bag laying on the floor. A (CNA) (#26) entered the room to answer the call light, and failed to remove the catheter bag from the floor before leaving the room. * 10/12/22 at 9:05 a.m., Resident #17 in her room sitting in the recliner with a urine catheter bag hanging on the garbage can filled with soiled gloves and wipes.	F 880	(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 cleaning of surfaces/resident items was completed in a hygienic manner with appropriate dwell times to achieve disinfection in accordance with CDC guidelines and cleaning product manufacturer instructions. b. Failure to complete handwashing/hand hygiene, perineal cares, and care of urine collection devices/items 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. Educate all staff whose job duties include cleaning tasks on hygienic cleaning procedures including effective contact or dwell times for disinfectants used in the cleaning process. This education will include the CDC's lesson on cleaning available at https://youtu.be/t7OH8ORr5Ig. b. All staff will receive education keeping hands clean between tasks, placement of soiled towels/linen, and urine collection devices/items when in contact with contaminated surfaces and between	

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F 880	Continued From page 15	F 880	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 and control within the facility through quality assurance process improvement (QAPI) methods. 4. Monitoring Weekly for no less than 12 weeks, the DON, IP, SDC or a designee will conduct on-going monitoring to ensure, via observation, the approaches to correct deficient practice related to infection control and prevention are consistently implemented and effective. Such monitoring will include: (1) Observations of staff engaged in resident care, cleaning surfaces and urine collection devices/items to ensure cleaning and disinfection is completed in a hygienic manner and cleaning products are used in accordance with manufacturer instructions to achieve disinfection. (2) Observations of all staff types to ensure performance of proper handwashing/hand hygiene, placement of clean and soiled resident items 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	

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F 880	Continued From page 16	F 880	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 11/10/2022	