STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355063	A. BUILDING _____ B. WING _____	02/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKES HOME	242 10TH ST W DICKINSON, ND 58601

(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 started on 02/06/23 and concluded 02/09/23.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or	F 580		3/14/23

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

Electronically Signed | 03/07/2023

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F 580	Continued From page 1 State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and resident and staff interviews, the facility failed to notify the resident's physician of a change in condition for 1 of 1 resident (Resident #33) who experienced low blood pressure, weakness and shortness of breath. Failure to notify the physician of these changes may have prevented the physician from altering the treatment/care provided to the resident. Findings include: Review of the facility policy titled "Notify of Changes" occurred on 02/09/23. This policy, dated 04/21/22, stated, ". . . The purpose of this policy is to ensure the facility promptly . . . consults the resident's physician; . . . when there is a change requiring notification. . . . Compliance Guidelines: The facility must . . . consult with the resident's physician when there is a change	F 580	1. The employees that failed to document physician notification were counseled on proper facility protocol by 3/10/2023. 2. All residents in the facility have the potential to be affected. 3. An in-service education program will be conducted by Nursing Leadership with all licensed nursing staff addressing circumstances that require notification of the residents physician, legal representative or family member of change in status, falls, any incident, significant alteration in treatment, change in room or plan for transfer or discharge to another facility on 3/7/2023 and 3/8/2023. All Healthcare Acadademy associated with with notification of	

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F 580	Continued From page 2 requiring such notification. . . . Circumstances requiring notification include: . . . 2. Significant change in the resident's physical . . . condition such as deterioration in health . . ." During an interview on 02/08/23 at 3:38 p.m. Resident #33 indicated about two weeks ago a nurse gave her the wrong medications. The resident stated, "Now I am very anxious about taking any medications." The resident stated, "After about 1 hour after they gave me the wrong medications I started having trouble breathing, became weak and when they checked my blood pressure it was very low, like 77 or 75 over 44. It was very scary and I don't want to ever experience that again or anyone else to experience it." Review of Resident #33's medical record occurred on all days of survey. The medical record showed a blood pressure of 75/44 on 01/24/23 at 8:57 a.m. Review of the facility's incident report, dated 01/24/23, showed on 01/24/23 at 8:00 a.m. staff administered the wrong medications to Resident #33. Incorrect medications included the following: * Venlafaxine 150 milligrams (mg) (antidepressant) * Keflex 250 mg (antibiotic) * Carvedilol 25 mg (high blood pressure medication) * Isosorbide 24 hours [extended release] 30 mg (heart medication/high blood pressure medication) * Losartan 100 mg (high blood pressure medication) * Pantoprazole 40 mg (anti-reflux medication)	F 580	provider will be completed by all nurses on 3/14/2023. 4. Nursing Leadership will complete random weekly audits for 12 weeks on all units for a total of 10 random residents selected. Residents will be newly assessed to ensure that any declines in condition have been identified, properly evaluated, and communicated to the appropriate people. Audits showing non-compliance will have ad hoc education provided to involved staff member. 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 not be discontinued until the facility completes three consecutive rounds of monthly monitoring that demonstrates sustained compliance as approved by the QAPI committee and medical director. 5. Date completion 3/14/2023	

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F 580	Continued From page 3 The medical record lacked evidence facility staff notified the physician of Resident #33's low blood pressure, weakness and trouble breathing as a result of receiving the wrong medications on 01/24/23. During an interview on 02/09/23 at 9:25 a.m., an administrative nurse (#2) confirmed staff failed to notify the physician of Resident #33's low blood blood pressure and decline in physical health conditions. See F-760	F 580		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 09/02/21 Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.17.1), and staff interview, the facility failed to complete Minimum Data Sets (MDSs) that accurately reflected the residents' status for 2 of 18 sampled residents (Resident #34, and #63). Failure to accurately code the MDS may negatively affect the development of comprehensive care plans and the care provided to the residents. Findings include: Section A: Identification Information	F 641	Section A: Identification Information 1. Resident #34's annual MDS date of 09/16/2022 failed to identify schizoaffective disorder. Record was corrected on 02/21/2022. 2. Any resident that has a comprehensive MDS assessment, which includes admission, annual and significant change of condition, and considered by the the state level II PASRR process to have a serious mental illness and/or intellectual disability or a related condition has the potential to be affected.	3/14/23

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F 641	Continued From page 4 The Long-Term Care Facility RAI Manual, revised October 2019, pages A-21 to A-23, stated, ". . . Section A1500: Preadmission Screening and Resident Review (PASRR) . . . Coding instructions: Code 0, no, and skip to A1550 . . . Code 1, yes: if PASRR Level II screening determined that the resident has a serious mental illness . . . and continue to A1510 . . . " - Review of Resident #34's medical record occurred on all days of survey. Diagnoses included schizoaffective disorder. The record showed a PASRR Level I completed on 09/21/21, followed by the referral and a completed Level II screening. The annual MDS, dated 09/16/22, showed section A1500 coded 0, as No, which resulted in the staff member failing to code section A1510. During an interview on 02/08/23 at 11:20 a.m., a social services staff member (#4) confirmed staff failed to correctly code A1500. Section N: Medication The Long-Term Care Facility RAI Manual, revised October 2019, pages N-6 to N-7 stated, ". . . Steps for Assessment . . . Review the resident's medical record for documentation that any of these medications were received by the resident during the 7-day look-back period . . . N0410F, Antibiotic: Record the number of days an antibiotic medication was received by the resident at any time during the 7-day look-back period . . . "	F 641	3. Electronic Education through Healthcare Academy was provided individually to the two social services personnel for Section A. Healthcare Academy module will be completed by 3/10/2023 by social services personnel. 4. All resident who have a comprehensive MDS assesment, which includes admission, annual and significant change of condition, will be audited weekly for accuracy for 12 weeks by social services staff. If non-compliance is noted with audits, ad hoc education will be completed with social services staff and record will be corrected. 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 not be discontinued until the facility completes three consecutive rounds of monthly monitoring that demonstrates sustained compliance as approved by the QAPI committee and medical director. 5. Date of completion 3/14/2023 Section N: Medication 1. Resident #63's quarterly MDS date 12/02/2022 identified seven days of antibiotic use in section N0410F and was missed coded. Record was corrected on 02/24/2023 by MDS nurse.	

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F 641	Continued From page 5 - Review of Resident #63's medical record occurred on all days of survey. Diagnoses included open wound left foot and diabetes. A physician's order dated, 09/16/22, stated, "Mupirocin ointment [a topical antibiotic ointment] 2 % Once a day, PRN [as needed] Amount to Administer - Apply Mupirocin ointment with dressing on left foot callous as needed." The quarterly MDS dated 12/02/22, identified seven days of antibiotic use in section N0410F. The medication administration record (MAR) dated 11/26/22-12/02/22 lacked documentation of administration of an antibiotic during the 7-day look back period. During an interview on 02/09/23 at 8:54 a.m., an administrative nurse (#3) agreed the MAR lacked documentation of an antibiotic administration and staff failed to correctly code N0410F.	F 641	2. Any resident that has a comprehenisve or quarterly MDS assessment has the potential to be affected. 3. Education will be provided individually to the two MDS nursing personal for section N0410F through electronic educatino provided by HealthCare Academy. Eduation will be completed by 3/10/2023. 4. Random audits of 10 residents having a comprehensive or quarterly MDS will be completed weekly for accuracy of section N for 12 weeks by MDS Staff. If non-compliance is noted with audits, ad hoc education will be completed with MDS staff and record will be corrected. Audits started the week of 2/20/2023 and will cotinue. After four 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 not be discontinued until the facility completes three consecutive rounds of monthly monitoring that demonstrates sustained compliance as approved by the QAPI committee and medical director. 5. Date of COmpletion 3/14/2023	
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors.	F 759		3/14/23

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F 759	Continued From page 6 The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to ensure a medication error rate of less than five percent for 2 of 6 residents (Resident #22 and #46) observed during medication pass. Three medication errors occurred during staff administration of 28 medications, resulting in a 10% error rate. Failure to ensure medications are administered correctly may result in an adverse side effects. Findings include: Review of the facility policy titled "Use Of Insulin Pens" occurred on 02/09/23. This policy, dated 12/14/16, stated, ". . . Insulin pens will be prepared and primed prior to actual dose administration to ensure expelling of air and accuracy of dosage . . . After needle is in place, do an air shot before injection . . . To perform air shot do the following . . . Dial two units . . . Hold syringe with needle pointing up and tap reservoir gently to remove air bubbles to tip of needle . . . Press the push button on syringe . . . until a drop of insulin appears. . . ." - Observation on 02/09/23 at 6:53 a.m. showed a licensed nurse (#1) prepared Resident #46's Lantus insulin pen for injection. The nurse (#1) secured the needle on the insulin pen, and failed to perform an air shot to expel air from the pen prior to injection.	F 759	1. The Nurse who failed to properly prime insulin pens before administering insulin to residents #22 and #46 was educated on 02/09/2023. The nurse demonstrated proper priming of the insulin pen and administration on 2/14/23 and 2/23/23 by evaluation of nurse manager. 2. All residents receiving insulin injections have the potential to be affected. 3. Nursing Leadership staff provided written education to all nursing staff on 2/10/2023. Skills in-service will be completed on 3/6/23 and 3/8/23 for all nursing staff by nursing leadership. 4. Random nurses will be audited by Nursing Leadership for proper insulin pen preparation and administration weekly for 12 weeks with a a minimum of 5 total insulin preparations and administrations. On-the-spot education will be completed for non-compliance with proper insulin pen preparation and administration. Weekly audits started the week of 2/10/2023. After twelve weeks of monitoring, provided that such monitoring demonstrates expectations are consistently met, monitoring may be	

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F 759	Continued From page 7 - Observation on 02/09/23 at 7:07 a.m. showed a licensed nurse (#1) prepared Resident #22's Lyumjev and Toujeo insulin pens for injection. The nurse (#1) secured the needle on the insulin pens and failed to perform an air shot to expel air from the pens prior to injection. During an interview on 02/09/23 at 7:45 a.m., an administrative nurse (#2) stated she would expect the nurse to perform an air shot prior to administering the insulin.	F 759	reduced to monthly. Monthly monitoring will continue for no less than three months. All monitoring will not be discontinued until the facility completes three consecutive rounds of monthly monitoring that demonstrates sustained compliance as approved by the QAPI committee and medical director. 5. Date of completion 3/14/2023	
F 760 SS=G	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, review of professional reference, review of facility policy, and resident and staff interviews, the facility failed to follow professional standards for medication administration for 1 of 1 sampled resident (Resident #33) who experienced adverse side effects as a result of a significant medication error. Failure of staff to administer medications utilizing safe administration practices resulted in an adverse reaction to Resident #33's physical health/safety, and affected the resident's psychosocial well being. Findings include: Berman, Snyder, Kozier, and Erb's, "Fundamentals of Nursing Concepts, Process, and Practice", 10th Edition, Copyright 2016 by	F 760	1. The nurses who failed to properly administer medication to resident #33 were counselled and educated promptly on 01/24/2023 Audits were completed on 2/22/2023 on this specific nurse for proper administration of medications. 2. All residents receiving medications are at risk. 3. Nursing Leadership staff will provided education to all nursing staff and certifed mediation aides (cma's) through policy review and written education on 02/10/2023. Healthcare Academy Modules related to medication administration was assigned on 2/1/2023 for all nurse and cma's to have it	3/14/23

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F 760	Continued From page 8 Pearson Education, Inc., New Jersey, page 769-771, stated, ". . . Before administering a medication, identify the client correctly using the appropriate means of identification . . . Errors can and do occur, usually because one client gets a drug intended for another. . . ." Review of the facility policy titled "Administering Oral Medications" occurred on 02/09/23. This policy, revised October 2010, stated, ". . . Purpose: The purpose of this procedure is to provide guidelines for the safe administration of oral medications. . . . 6. Check the label on the medication and confirm the medication name and dose with the MAR [medication administration record]. . . . 10. Confirm the identity of the resident. . . ." During an interview on 02/08/23 at 3:38 p.m., Resident #33 stated, "About two weeks ago a nurse gave me the wrong medications and after about an hour I started feeling sick to my stomach, having trouble breathing, became very weak and when they checked my blood pressure it was very low, like 77 or 75 over 44. One nurse (#13) kept saying we need to get her to the ER [emergency room] and another nurse (#15) said we need to get her laid down in bed." The resident told the nurses she did not want to go to the ER. "I was very scared and I don't want to ever experience that again or want anyone else to experience it." The resident indicated she had to stay in bed the day of the incident and the day after "because I was very weak and felt fuzzy." She admitted feeling very anxious now when taking her medications. Review of Resident #33's medical record	F 760	completed by 3/10/2023. Skills Inservice to discuss the 6 rights and reneforce proper medication administation will be completed with CMA's and Nurses on 3/7/2023 and 3/9/2023. 4. 5 random nurses or cma's will be audited by Nursing Leadership for proper medication preparation and administration weekly for 12 weeks. On the spot education will be completed for non-compliance of proper medication preparation and administration. 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 not be discontinued until the facility completes three consecutive rounds of monthly monitoring that demonstrates sustained compliance as approved by the QAPI committee and medical director. 5. Completion date of 3/14/2023	

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F 760	Continued From page 9	F 760		

occurred on all days of survey and showed a blood pressure of 75/44 on 01/24/23 at 8:57 a.m. A quarterly Minimum Data Set, dated 11/04/22, identified the resident as cognitively intact.

Review of the facility's incident report, dated 01/24/23, showed on 01/24/23 at 8:00 a.m. staff administered the wrong medications to Resident #33.
Incorrect medications included the following:
* Venlafaxine 150 milligrams (mg) (antidepressant)
* Keflex 250 mg (antibiotic)
* Carvedilol 25 mg (high blood pressure medication)
* Isosorbide 24 hours [extended release] 30 mg (heart medication/high blood pressure medication)
* Losartan 100 mg (high blood pressure medication)
* Pantoprazole 40 mg (anti-reflux medication)

The incident report stated a nurse (#13) ". . . grabbed the . . . medications (sic) were sitting in (sic) side table, handed resident her medication cup, once she handed it back I noted the cup had a different resident and room # [number] written on the side. . . ." The incident report identified another nurse (#14) pre-dished the medications and left the wrong medications in Resident #33's room on the bedside table.

Staff failed to administer medications utilizing safe administration practices and resulted in Resident #33 experiencing a hypotensive reaction (low blood pressure), weakness and trouble breathing. Resident #33 reported experiencing increased anxiety since the

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F 760	Continued From page 10 incident. During an interview on 02/09/23 at 7:51 a.m., an administrative nurse (#2) confirmed Resident #33 as cognitively intact, and stated, "The resident recalls the events of the incident/medication error accurately." The nurse (#2) confirmed only the two nurses who were involved in the medication error received verbal education at the time.	F 760		
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,	F 880		3/10/23

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F 880	Continued From page 11 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. §483.80(f) Annual review. The facility will conduct an annual review of its	F 880		

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	355063	A. BUILDING _____ B. WING _____	02/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 12 IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to follow standards of infection control for 2 of 10 sampled residents (Residents #11 and #68) observed during perineal cares and/or dressing change. Failure to follow infection control standards has the potential for transmission of communicable diseases and infections to residents, staff, and visitors. Findings include: DRESSING CHANGE Review of the facility policy titled "Wound Care Dressing Change" occurred on 02/13/23. This policy, dated October 2022, stated, ". . . remove soiled dressing. . . . Remove soiled gloves. Perform hand hygiene. . . . Put on clean gloves. . . ." Observation on 02/07/23 at 8:15 a.m. showed a nurse (#5) removed Resident #11's right foam heel protector and a blue absorbent pad, and without changing gloves, measured the pressure ulcer, opened the promogram prism (wound treatment), used gloved hands to form it to the open area, and then replaced the absorbed pad and the foam heel cushion. The nurse (#5) failed to remove her gloves and perform hand hygiene after removing the foam heel pad and absorbent dressing. PERINEAL CARE	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)/unit(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 perform hand hygiene or handwashing after removing gloves during/after performing perineal care and during wound dressing change 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 correctly completing hand hygiene after removing gloves, and before touching items that potentially contaminate surfaces. To verify this/these staff understands hand hygiene and handwashing, this/these staff will perform a successful return demonstration of identifying the need and correct procedure for performing hand hygiene and handwashing. 2. Identification of Others	

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F 880	Continued From page 13 Review of the facility policy titled "Hand Hygiene" occurred on 02/13/23. This policy, dated October 2022, stated, ". . . Staff will perform hand hygiene when indicated . . . Before applying and after removing personal protective equipment (PPE), including gloves . . . after assistance with personal body functions . . . " - Observation on 02/07/23 at 8:30 a.m. showed a certified nurse assistant (CNA) (#6) donned gloves and provided perineal care for Resident #11. The CNA (#6) cleansed the rectal area of stool using a wet wipe. The CNA (#6) washed, rinsed, and dried the buttocks area with a washcloth and towel and the CNA (#6) placed the washcloth and towel directly onto the floor along with the resident's pajamas. The CNA (#6) removed her gloves and without performing hand hygiene, the CNA (#6) assisted in applying a clean brief, applied the right heel bootie, adjusted the resident's clothing, assisted with transferring the resident into the wheelchair, placed the foley catheter bag into a dignity bag, and performed hand hygiene. - Observation on 02/07/23 at 8:50 a.m. showed two CNA's (#7 and #8) assisted Resident #68 on and off the bedpan. The resident voided in the bedpan and the CNA (#7) completed perineal cares, removed her gloves, adjusted the resident's clothing, raised the head of bed, put a pillow under the resident's legs, gave her a drink of water, closed the blinds, and then performed hand hygiene. During an interview on 02/09/23 at 9:05 a.m., two administrative nurses (#2 and #5) confirmed they	F 880	The IP and DON, in conjunction with the applicable interdisciplinary team (IDT) members, will review current nursing facility guidelines for hand hygiene 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 03/14/23 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 complete handwashing or hand hygiene in accordance with CDC guidelines. Information about root cause analysis can be found at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/GuidanceforRCA.pdf (2) The DON, SDC, IP or suitable designee will ensure the following: a. All staff will receive education regarding keeping hands clean between tasks, and contacts with objects/persons that has the potential for cross contamination. 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	

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F 880	Continued From page 14 expect staff to remove gloves and perform hand hygiene after perineal cares before doing other tasks and to change gloves and perform hand hygiene after removing foam heel protector before applying wound treatment.	F 880	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 all staff types to ensure performance of proper handwashing and hand hygiene, when indicated, in the course of their routine duties. Observations will be made across all shifts and 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	

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F 880	Continued From page 15	F 880	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 03/14/23	