STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355080	A. BUILDING _____ B. WING _____	C 12/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNSEITH COM NURSING HOME	15 1ST ST NE DUNSEITH, ND 58329

(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 and complaint survey started on 12/12/21 and concluded 12/15/21.	F 000		
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;	F 584		1/25/22

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

Electronically Signed | 01/13/2022

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F 584	Continued From page 1 §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 §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and resident and staff interview, the facility failed to ensure a safe, clean, comfortable, homelike environment for 4 of 14 sampled residents (Resident #4, #9, #15, and #24) and 1 supplemental resident (#11). Failure to maintain a clean, comfortable, and sanitary environment does not provide a comfortable living area for residents. Findings include: Review of the facility policy titled "Environmental Services Policies and Procedures" occurred on 12/15/21. This policy, dated October 2012, stated, ". . . will maintain the interior and exterior of the facility in a safe, clean and orderly manner . . . Clean window sills . . . Rooms will be cleaned daily . . . Clean floor . . ." - Observation of the resident living area occurred on all days of survey and showed the following: * Resident #11: The window sill soiled with dirt/dust and food on the bathroom floor. * Room #4: The window sill soiled with dirt/dust, the bedside table soiled with food debris and sticky. * Room #15: The window sill soiled with dirt/dust.	F 584	1.The facility policy failed to ensure a safe clean, comfortable, homelike environment for 4 of 14 sampled residents. Failure to maintain a clean, comfortable, and sanitary environment does not provide a comfortable living area for residents. The facility will ensure rooms are cleaned daily per facility policy and maintain a clean, comfortable , and sanitary environment. 2. All residents have the potential to be affected by these deficient practices. 3. All janitorial staff will be in-serviced on proper cleaning of residents room and facility policy. Cleaning list will be provided and check off daily by the janitorial staff. 4. DON/Designee will do a quality monitor on janitorial/housekeeping to ensure proper cleaning of rooms are being done. Quality monitor will be done 3x/week x 16 weeks, then weekly x 16 weeks, followed by monthly for a total of 1 year. The above monitoring will be initiated starting 01/20/22. Results of the monitoring will be reviewed at the Quality Assurance Meeting. 5. 1/25/2022	

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F 584	Continued From page 2 * Room #9: The window sill soiled with dirt/dust. During an interview 12/12/21 at 12:23 p.m., Resident #24 stated, "My room and bathroom is always dirty. I ask them to clean it and they still don't. Last week my toilet didn't get cleaned for 4 days until I finally insisted they cleaned it." - Observation on 12/13/21 at 12:08 p.m., a housekeeper (#8) was noted to be using a heavily soiled frayed cloth. The housekeeper stated she tries to wipe down high touch areas daily. - Observation on 12/15/21 at 9:16 a.m., a housekeeper (#7) was noted to be wiping down a resident's door with a highly soiled rag. When asked what was in the basin he rinsed the rag in the housekeeper stated, "It's some kind of cleaning stuff we use for the door and other areas we clean."	F 584		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced	F 637		1/20/22

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F 637	Continued From page 3 by: Based on record review, staff interview, and review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, the facility failed to complete a significant change in status assessment (SCSA) for 1 of 14 sampled residents (Resident #4). Failure to determine the need for and complete a SCSA in response to a resident's decline limited the facility's ability to accurately assess the resident's status, and identity and implement appropriate care approaches. Findings Include: The Long-Term Care Facility RAI 3.0 User's Manual (Version 1.15), dated October 2017, page 2-22 stated, ". . . A 'significant change' is a major decline or improvement in a resident's status that: 1. Will not normally resolve itself without staff intervention . . . 2. Impacts more than one area of the resident's health status; and 3. Requires interdisciplinary review and/or revision of the care plan. . . ." and page 2-25 stated, "A SCSA is appropriate if there are either two or more areas of decline or two or more areas of improvement. . . . This may include two changes within a particular domain (e.g., [for example] two areas of ADL [Activities of Daily Living] decline or improvement mobility, transfers, walking in corridor and toileting. Review of Resident #4's medical record occurred on all days of survey. An admission Minimum Data Set (MDS), dated 08/02/21, identified the resident independent with locomotion on unit, locomotion off unit and no mood indicators noted. A quarterly MDS, dated 10/26/21, identified the	F 637	1. The facility failed to complete a significant change in status assessment for 1 of the 4 sampled residents. Failure to determine the need for and complete a SCSA in response to a residents decline limited that facility ability to accurately assess the residents status, and identity and implement appropriate care approaches. IDT team will review each resident on MDS schedule for any changes to complete a SCSA. 2.) All residents have the potential to be affected by this deficient practice. 3.) The IDT team will be in-serviced on the definition of significant change and the federal requirements for submission. MDS/DON coordinator will review the information in the RAI 3.0 User's Manual (Version 1.15) regarding significant changes. 4.) MDS Coordinator/Designee will implement a quality monitor starting 01/13/2021 to review each residents MDS assessment to assure the significant change guidelines and/or documentation is being followed. This monitor will be weekly and will include every residents MDS assessment that comes due that week for a for 3 months, than 1x/month for 9 months for a total of one year. The data will be reviewed at the scheduled quality assurance meeting and the process revised as needed. 5.) 1/20/22	

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F 637	Continued From page 4 resident required extensive assistance with locomotion on the unit, locomotion off the unit, decline with mood, and a significant weight loss. The record lacked evidence the staff identified and/or completed a SCSA following Resident #4's declines in status. During an interview on 12/15/21 at 5:00 p.m., an administrative staff member (#2) confirmed the facility failed to complete a significant change assessment for Resident #4.	F 637		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR	F 656		1/24/22

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F 656	Continued From page 5 recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of the facility policy, and resident and staff interview, the facility failed to develop a comprehensive care plan for 2 of 14 sampled residents (Resident #20 and #24). Failure to develop a comprehensive care plan that includes the services to be provided to the resident may negatively impact the resident's quality of care. Findings Include: Review of the facility policy titled "Comprehensive Care Plans" occurred on 12/15/21. This policy, dated July 2018, stated, ". . . The comprehensive care plan will describe . . . The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being . . ."	F 656	1. The facility failed to develop a comprehensive care plan for 2 of 14 sampled residents. Failure to develop a comprehensive care plan that includes the services to be provided to the resident may negatively impact the residents quality of care. The facility will ensure all care plans are reviewed and updated according to resident care. Resident #20 and #24 have been updated and reviewed. 2. All residents have the potential to be affected by these deficient practices. 3. All facility staff nurses and IDT team will be in-serviced by the DON/Designee on the proper procedure on how to develop and update a proper care plan. Each care plan will be reviewed weekly during their scheduled MDS Assessment	

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F 656	Continued From page 6 - Observation on 12/13/21 at 8:40 a.m. showed Resident #20 with scattered bruises on both hands. When questioned about the bruises Resident #20 stated she did not know what happened. Review of Resident #20's medical record occurred on all days of survey. Diagnoses included a stroke and physician orders included Plavix (a blood thinner). The care plan stated, "I have a history of cerebrovascular accident (stroke) . . . Monitor for signs of bleeding; nosebleed, petechiae, ecchymotic areas, hematoma . . ." Review of Resident #20's skin assessments identified: * 10/21/21 "bruises on hands and arms. Normal for this resident" * 11/10/21 "bruises on arm and hands previously noted" Review of physician documentation, dated 07/22/21, stated, ". . . She is still having some easy bruising to her hands without obvious injury reported. . . . Previous evaluation regarding easy bruising was unremarkable, she remains on Plavix . . ." During an interview on 12/13/21 at 10:32 a.m., a licensed nurse (#6) identified Resident #20's bruises as chronic. The care plan lacked problem, goals and interventions related to the chronic bruising. During an interview on 12/14/21 at 5:28 p.m., an administrative nurse (#2) confirmed staff failed to	F 656	and care plan conference. 4. DON/Designee will do a quality monitor on nursing staff to ensure care plans are developed and updates as needed according to residents care. Quality monitor will de done weekly x 8 weeks, then bi-weekly x 8 weeks, followed by monthly for a total of 1 year. The above monitoring will be initiated starting 1/13/2021. Results of the monitoring will be reviewed at the Quality Assurance Meeting. 5. 1/24/2022.	

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F 656	Continued From page 7 care plan Resident #20's chronic bruising. - Review of Resident #24's medical record occurred on all days of survey. Diagnoses included knee pain and diabetic neuropathy. The current physician orders stated Gabapentin (nerve pain medication) 300 mg (milligrams) twice a day, Tylenol extra strength 500 mg twice a day, and Tylenol extra strength 500 mg every 4 hours PRN (as needed) for knee or other pain. The quarterly Minimum Data Set (MDS), dated 08/24/21, identified Resident #24 has pain almost constantly and received scheduled pain medications. During an interview on 12/12/21 at 3:32 p.m., Resident #24 stated she has pain almost all the time, especially in her lower extremities. The care plan lacked problem, goals and interventions related to chronic pain. During an interview on 12/14/21 at 3:08 p.m., an administrative nurse (#2) confirmed staff failed to care plan Resident #24's chronic pain.	F 656		
F 685 SS=D	Treatment/Devices to Maintain Hearing/Vision CFR(s): 483.25(a)(1)(2) §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in	F 685		1/24/22

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F 685	Continued From page 8 the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and resident and staff interviews, the facility failed to ensure 1 of 1 resident (Resident #24) who didn't receive glasses as ordered. Failure to assist a resident with vision needs/obtaining glasses may result in the inability to carry out activities of daily living (ADLs) and instrumental activities of daily living (IADLs). Findings include: During an interview on 12/12/21 at 3:25 p.m., Resident #24 stated she could not see the activity calendar on the wall in her room because she had not received her new glasses the eye doctor ordered several months ago. The resident stated, "Even if I get right up there to it, I can't read it." The resident went on to say she experiences blurred and double vision without wearing glasses. She stated she had reader glasses and they disappeared soon after admission to the facility, stating, "I think they fell into the garbage accidentally by a nurse." Review of Resident #24's medical record ocurred on all days of survey. The medical record included an "Appointments/Physician orders/Progress Notes" form, dated 03/24/21, the form identified Resident #24's eye appointment and a physician's order: "New Glasses. Bifocals, Trifocals or Progressives. . . ." Nursing progress notes included the following:	F 685	1. The facility failed to ensure 1 of 1 residents who didn't receive glasses as ordered. Failure to assist a resident with vision needs/obtaining glasses may result in the inability to carry out activities of daily living (ADLs)and instrumental activities of daily living. The facility will ensure all residents have the proper devices needed to carry out daily activities of daily living. Resident #24 was set up with another appointment to get new glasses. Staff will provided resident with magnifying glass to help assist with reading until resident receives glasses. Proper documentation has been documented in residents chart. Staff will notify resident #24 daily with daily activity calendar or assist with resident reading until resident receives new glasses. 2. All residents have the potential to be affected by these deficient practices. 3. IDT team and nursing staff will be in-serviced on follow-up procedures and resident documentation to ensure all resident receive proper treatment/devices in a timely manner. 4. DON/Designee will do a quality monitor on all residents to ensure all residents receive ordered treatment/devices. Quality Monitor will be done weekly for a total of one year. The above monitoring will be initiated starting 01/13/2022. 5. 1/24/2022	

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F 685	Continued From page 9 * "03/24/21 5:10 PM Resident left facility at 2:05 pm for eye appt [appointment] . . . Returned 5 pm. . . . New glasses ordered. . . ." * "05/28/21 6:25 PM Resident had reported to writer that they were feeling dizzy while sitting and their vision was blurry. . . ." * "08/24/2021 06:39 AM . . . Client wears glasses. . . ." * "11/24/21 4:05 PM Annual Assessment . . . Resident . . . stated that she needs a magnifying glass so she can read regular print . . . Resident likes; bingo, . . . reading, . . . keeping up with the news . . ." Observations throughout the survey showed Resident #24 did not wear glasses. During an interview on 12/14/21 at 11:06 a.m., a nurse (#6) confirmed Resident #24 went to the eye doctor at Indian Health Services (IHS) in March and had not received her new glasses. "I know it's a long time, I called IHS and spoke to whoever answered the phone and when I asked about the resident's glasses they told me they were having trouble getting any glasses." The nurse (#6) stated, "Upon admit the resident had some reader glasses from a retail store I think." The nurse (#6)confirmed the facility failed to look at other options for Resident #24 obtain glasses.	F 685		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:	F 758		1/24/22

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F 758	Continued From page 10 (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or	F 758		

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F 758	Continued From page 11 prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review, facility policy review, and staff interview, the facility failed to ensure orders for as needed (PRN) psychotropic drugs were limited to 14 days for 1 of 1 sampled resident (Resident #8) receiving a PRN antipsychotic medication. Failure to ensure the physician renewed the PRN order after 14 days may result in the resident receiving an unnecessary medication. Findings include: Review of the facility's policy titled "Use of Psychotropic Drugs" occurred on 12/14/21. This policy, revised March 2019, stated, ". . . PRN orders for antipsychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. . . ." Review of Resident #8's medical record occurred on all days of survey. Diagnoses included dementia and anxiety. The physician's orders, dated 09/28/21, included Seroquel (antipsychotic) 12.5 milligrams by mouth as needed for behaviors. The record lacked evidence the attending physician or prescribing practitioner evaluated the resident for the appropriateness of the medication after 14 days. During an interview on 12/14/21 at 5:28 p.m., an administrative nurse (#2) confirmed the provider failed to review the PRN medication every 14	F 758	1.The facility failed to ensure orders for as needed (PRN) psychotropic drugs were limited to 14 days for 1 of 1 sampled resident receiving a PRN antipsychotic medication. The facility will ensure that the physician renewed the PRN order after 14 days if needed and a end date will be provided on EMAR for each PRN antipsychotic medication. The medication will automatically be deleted from electronic MAR after the 14 day. Resident #8 PRN antipsychotic medication was discontinued from MAR for non-usage. 2. All residents have the potential to be affected by these deficient practices. 3. All facility nursing staff will be in-serviced by DON/Designee on facility policy and proper charting/documentation of PRN antipsychotic medications. 4. DON/Designee will do a quality monitor on nursing staff on PRN antipsychotic medications are put in EMAR system correctly with automatic end date after the 14 days, medication order properly documented, and followed up with physician. Quality monitor will be done weekly for a total of one year. The above monitoring will be initiated starting 01/13/2022. Results of the monitoring will be reviewed at the quality assurance meeting. 5. 01/24/2022	

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F 758	Continued From page 12 days.	F 758		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to prepare and serve food under sanitary conditions in 1 of 1 kitchen. Failure to discard expired chlorine test strips, test and document chlorine sanitizer concentration results, and ensure adequate wash temperatures may result in inadequate cleaning and sanitizing of dishes and utensils and has the potential to spread illness and/or foodborne illness to residents. Findings include:	F 812	1. The facility failed to prepare and serve food under sanitary conditions in 1 of 1 kitchen. The facility will ensure that kitchen staff will test and document chlorine sanitizer concentration results, and ensure wash temperatures are adequate for cleaning and sanitizing of dishes and utensils to prevent the potential spread of illness/and or foodborne illness to residents. 2.All residents and staff have the potential to be affected by these deficient	1/24/22

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F 812	Continued From page 13 Review of the facility policy titled "Dishwasher Temperature" occurred on 12/12/21. This policy, revised 11/29/21, stated, ". . . For low temperature dishwashers (chemical sanitization): a.) The wash temperature shall be 120 [degrees Fahrenheit] b.) The sanitizing solution shall be 50 ppm (parts per million) hypochlorite (chlorine) on dish surface in final rinse. 5.) Chemical solutions shall be maintained at the correct concentrations, based on periodic testing, at least once per shift . . . Results of concentration checks shall be recorded. 6.) Water temperatures shall be measured and recorded prior to each meal and/or after the dishwasher has been emptied or refilled for cleaning purposes. Observations showed the following: * 12/12/21 at 12:10 p.m. the dietary aide (#4) stated the dishwasher is a chemical machine. "We use strips (pointed to strips) to check the chemicals and the gauge to check the temperature. The temperature should be 115 [degrees]." He further stated, he had not checked the chemicals today and could not remember the last time he checked it, although he "tries to check it daily." The chlorine test strips in use showed an expiration date of February 2019. The dietary aide checked the chlorine rinse cycle level and it measured a concentration of approximately 100 ppm. Review of the December 2021 daily temperature and chlorine log, placed on a wall near the dishwasher, showed staff failed to document the chlorine concentration level or wash temperature for the first 12 days of December. 12/12/21 at 1:50 p.m. the dietary manager (#3)	F 812	practices. 3.All kitchen staff will be in-serviced on facility policy for testing of the chlorine sanitizer concentrations results and documentation of dish washer temps to prevent the potential spread of illness/and or foodborne illness to residents/staff. 4. DON/Designee will do a quality monitor on kitchen staff to ensure staff is following policy/procedure on chlorine sanitizer concentration results and dishwasher temps are properly documented according to facility policy. Quality monitor will be done 3x weekly x 16 weeks, then weekly x 16 weeks, followed by monthly for a total of one year. The above monitoring will be initiated starting 01/13/2021. Results of the monitoring will be reviewed at the Quality Assurance Meeting. 5. 01/24/2022	

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F 812	Continued From page 14	F 812		

stated the facility only had the expired strips and she would obtain some from a local restaurant. The manager stated the facility will stop using the dishwasher until they can locate new chlorine strips. Review of the daily temperature and chlorine concentration logs from October 1 through November 30, 2021 showed the facility staff recorded the daily temperature and chlorine concentration six out of 61 days.

12/12/21 at 3:50 p.m. the dietary manager (#3) received chlorine strips from the local restaurant and the dishwasher rinse cycle showed a chlorine concentration at approximately 100 ppm and the wash temperature at the gauge showed 115 degrees Fahrenheit (F). Using a maximum registering thermometer in the dishwasher (plate level measurement) the wash cycle showed 103.5 degrees F. The unit manager stated the facility would contact maintenance, use paper products, and the three-compartment sink to wash dishes instead of the dishwasher.

12/13/21 at 8:20 a.m. the maintenance manager (#5) stated he turned up the water heater for the kitchen area and contacted the local plumber to check on the water booster in the kitchen.

12/13/21 at 9:00 a.m. the facility received a new bottle of chlorine test strips with an expiration date of March of 2023. The unit manager (#3) checked the chlorine in the rinse cycle and the concentration measured 50 ppm and the temperature gauge showed 142 degrees F with a plate temperature of 150.3 degrees F.

During an interview on 12/14/21 at 1:30 p.m., the dietary manager (#3) confirmed she expected

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F 812	Continued From page 15 staff to check the water temperature of the wash cycle and the chlorine concentration of the rinse cycle at least daily and record this information.	F 812		
F 880 SS=E	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; (ii) When and to whom possible incidents of	F 880		1/18/22

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F 880	Continued From page 16 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 observation, professional reference, Centers for Disease Control, and Prevention (CDC) guidance, and staff interview, the facility	F 880	1. Corrective Action The facility will immediately implement an appropriate infection prevention and	

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F 880	Continued From page 17 failed to follow standard infection control practices on 3 of 4 days of survey (December 12, 13, and 15, 2021). Failure to follow infection control practices related to proper procedure for mask usage may result in the spread of infection to residents, staff and/or visitors. Findings include: PERSONAL PROTECTIVE EQUIPMENT Review of CDC guidance found at: https://www.cdc.gov, updated August 13, 2021, stated, "Your guide to masks . . .Wear one that covers your nose and mouth . . . How not to wear a mask . . . under your nose . . ." Review of CDC guidance found at: https://www.cdc.gov, updated September 10, 2021, stated, "Implement Source Control Measures. . . . Cloth mask: . . . They are not personal protective equipment (PPE) appropriate for use by healthcare personnel. . . . Facemask: Occupational Safety and Health administration (OSHA) defines facemasks as a surgical, medical procedure, dental or isolation mask. . . ." Upon entry to the facility on 12/12/21 the survey team observed the following: * 12:04 p.m., showed a charge nurse (#2) wore a cloth mask. * 12:24 p.m., showed a certified nurse aide (CNA) (#10) wore a cloth mask. * 12:35 p.m., showed a housekeeper (#7) wore a cloth mask while cleaning resident rooms 114 and 116. The residents were present in their rooms. * 12:56 p.m. showed a CNA (#1) wore a cloth	F 880	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) Ensure staff continuously wear a surgical face mask, covering both nose and mouth in accordance with guidelines from the CDC. 2. Identification of Others The IP and DON, in conjunction with the applicable the interdisciplinary team (IDT) members, will review current nursing facility 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 01/18/2022 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 wear surgical mask covering nose and mouth	

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F 880	Continued From page 18 mask which rested on her top lip. As the CNA ambulated with Resident #18 in the hall to the activity room, the CNA repeatedly moved the mask to cover her nose as the mask continued to slide down to her lip. - Observation on 12/13/21 at 10:19 a.m., showed a nurse (#9) entered Resident #1's room with a surgical mask resting on her upper lip and below her nose. The nurse proceeded to provide Resident #1 with wound care. - Observation on the morning of 12/15/21, showed a nurse (#9) entered Resident #15's room with a surgical mask resting on her upper lip and below her nose. The facility failed to ensure staff wore proper PPE and wore it correctly. During an interview on 12/14/21 at 4:11 p.m., an administrative nurse (#2) identified staff purchased their own masks online. The administrative nurse was unsure if all staff wore surgical masks at all times.	F 880	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, IP or suitable designee will ensure the following: a. All staff will receive education on the proper use of a surgical mask. 4. Monitoring Weekly for no less than 12 weeks, the DON, IP, 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) Observation of all staff wearing surgical mask in accordance with guidelines for the CDC. 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	

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F 880	Continued From page 19	F 880	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 01/18/2022	
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		