STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1074	A. BUILDING: _____ B. WING _____	10/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMP HEALTH - MARYHILL	110 HILLCREST DR ENDERLIN, ND 58027

(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) COMPLETE DATE
L1860	33-07-03.2-18,6 PHARMACEUTICAL SERVICES All medications must be administered by individuals authorized to do so in accordance with state laws and regulations governing such acts. Each dose administered must be properly recorded in the resident record. This State Licensing Rule is not met as evidenced by: Based on observation, record review, review of facility job description, and staff interview, the facility failed to comply with the North Dakota Administrative Code (NDAC), Chapter 33-43-01 "Nurse Aide Training, Competency Evaluation, and Registry," for 2 of 2 Medication Aide (MA #5 and #7) observed administering routine and sliding scale insulin. Failure to ensure only authorized staff administered subcutaneous insulin increases the risk for adverse consequences. Findings include: NDAC, Section 33-43-01-17 "Routes or types of medication administration" stated, ". . . Medication assistants I and II may administer medications by the following routes only when specifically delegated by a licensed nurse for a specific client: . . . Subcutaneous . . ." Section 33-43-01-16 "Specific delegation of medication administration" stated, ". . . 2. The individual on the department's nurse aide [registry] is taught by a licensed nurse for each specific client's medication administration which includes verbal and written instruction . . . 3. . . . is observed by a licensed nurse administering the medication to the specific client until competency is demonstrated. 4. . . . has been verified as competent by a licensed nurse . . ." Section	L1860	1. Corrective Action: On October 4th, 2023, communication went out to staff that medication aides are no longer performing any duties related to insulin administration. All insulin administration is performed by the nurse on duty. 2. Identify Other Residents: All residents requiring sliding scale insulin had the potential to be affected by this practice. 3. Measures put in Place: With the job responsibility change on October 4th, medication assignments were adjusted and carts re-organized to fit our change in practice. An in-service education program was conducted by the Director of Nursing Services with all licensed staff (nurses, medication aides, and CNAs) on Thursday, October 26, 2023. 4. Monitoring: Audits will be completed to monitor the administration of insulin are being followed according to updated policy. The nursing department will complete five random observations weekly for two weeks, biweekly for two weeks, monthly for 2 months and as determined by the Quality Assurance program thereafter. All audits will be	11/3/23

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L1860	Continued From page 1 33-43-01-19 "Medication interventions that may not be delegated. The medication assistant I or II . . . may not perform the following acts even if delegated by a license nurse: 1. Conversion or calculation to medication dosage . . ." Review of the facility job description titled "Medication Aide/Resident Assistant" occurred on 10/05/23. This document, dated June 2022, stated, " . . . Administers insulin after specific resident instruction by the nurse. . . ." Observation on 10/03/23 at 11:57 a.m. showed the MA (#7) entered Resident #143's room to check his blood sugar and administed insulin. Observation of medication pass occurred on 10/04/23 at 8:45 a.m. The MA (#5) primed Resident #8's Novolog insulin pen and dialed up eight units. As the Resident #8 ate breakfast, the MA performed a blood glucose check which read 184 milligrams per deciliter. The MA (#5) stated since the resident has a sliding scale order for a and blood sugar between 150-199 "I bump it up one." The MA administered nine units of insulin. Review of Resident #8's medical record occurred on 10/12/23. The physician's orders stated, "Novolog Insulin (may use interchangeably with Aspart): Inject 8 units before meals, plus sliding scale as follows: 150-199= 1 unit . . ." During an interview on 10/04/23 at 11:04 a.m., two administrative staff members (#1 and #9) confirmed MAs administer insulin and sliding scale insulin. During an interview on 10/05/23 at 2:00 p.m., an administrative nurse (#1) stated the facility lacked	L1860	submitted to DON and presented to the Quality Assurance program to ensure compliance. 5. Compliance Date: 11/3/2023	

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L1860	Continued From page 2 documentation to show the facility's MAs received specific resident instruction by the nurse to administer insulin. The facility allowed MA (#5) to perform a calculation of the medication dosage and failed to provide documentation both MAs (#5 and #7) received specific resident instruction by the nurse to administer insulin, a subcutaneous medication.	L1860		

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F 000	INITIAL COMMENTS The standard Medicare/Medicaid recertification survey started on 10/02/23 and concluded 10/05/23.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal	F 550		11/3/23

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

Electronically Signed | 10/27/2023

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F 550	Continued From page 1 from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and resident, family, and staff interviews, the facility failed to assess, develop, and implement interventions to promote dignity for 1 of 1 sampled resident (Resident #3) with concerns regarding toileting/incontinence. Failure to determine appropriate toileting methods caused Resident #3 embarrassment and/or psychosocial harm. Findings include: Review of the facility policy titled "Standard of Care Policy" occurred on 10/05/23. This policy, dated August 2023, stated, ". . . Each resident is treated with dignity and respect. . . ." During an interview on 10/02/23 at 4:02 p.m., Resident #3 verbalized frustration when staff utilized "that sling thing [full body lift] to get up and down. They [staff] told me to go to the bathroom in my pants." During an interview on 10/02/23 at 4:03 p.m., a family member (A) reported Resident #3 has been upset since staff started utilizing the Hoyer lift (full body mechanical lift) and stopped toileting the resident in the bathroom. A current physician	F 550	1. Corrective Action: Per Resident's wishes, #3 goal is to use a standing lift to transfer and therapy did a PT eval on 10-6-23 for improved strength with a goal to return to pal-lift. Plan of care is to be seen 2-3 times a week by PT. Oct 6th, education was provided to staff that Res #3 based on therapy eval will remain a Hoyer transfer, but alternative methods will continue to be utilized to ensure safety/privacy/dignity. Resident did not have interest in using the bed pan per his wishes. Resident #3 made improvements working with PT and on 10-25-23 was cleared to use a pal-lift for transfers to the bathroom. 2. Identify other Residents: All residents have the potential to be affected by this practice. 3. Measures put in Place: An in-service education program was conducted by the Director of Nursing Services with all licensed staff (nurses, medication aides, and CNAs) on Thursday, October 26, 2023. Education included the expectation relating to toileting and the importance of	

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F 550	Continued From page 2 ordered medication caused several loose stools per day. The resident "is upset" when unable to utilize the bathroom and is incontinent even when attempting to "hold it." Review of Resident #3's medical record occurred on all days of survey and showed a physician's order, dated 06/02/23 for lactulose (a medication known to cause loose stools) to be administered three times per day. The current care plan stated, ". . . TOILET USE: I require assistance to use toilet. . . ." The current certified nurse aide (CNA) Activities of Daily Living (ADL) sheet identified staff assist with scheduled toileting every 2-3 hours. Observation on 10/04/23 at 11:55 a.m. showed two CNAs (#2 and #3) completed an incontinence check/change for Resident #3. The CNAs transferred the resident from the bed to the wheelchair utilizing the Hoyer lift. Staff failed to offer the resident any other options for toileting to avoid incontinence. During an interview on 10/05/23 at 9:27 a.m., a CNA (#3) stated, ". . . We just have [Resident #3] go in his pants and check and change him in bed. . . ." The facility failed to toilet Resident #3's according to his abilities/preferences which resulted in a loss of dignity, frustration, and avoidable incontinence. See F690	F 550	respect and dignity specific to toileting, despite transfer ability, and/or offering alternative methods. 4. Monitoring: The nursing department will review 5 random residents to ensure toileting plans are being followed per residents wishes and rights weekly for two weeks, biweekly for two weeks, monthly for 2 months and as determined by the Quality Assurance program thereafter. All audits will be submitted to DON and presented to the Quality Assurance program to ensure compliance. 5. Compliance Date: 11/3/2023	
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15)	F 580		11/3/23

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F 580	Continued From page 3 §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 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).	F 580		

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F 580	Continued From page 4 §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 staff interview, the facility failed to notify the resident's physician of a change in condition for 1 of 1 sampled resident (Resident #3) who experienced a change in bowel status. 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 "Notification of Changes" occurred on 10/05/23. This policy, dated 07/04/23, stated, ". . . The purpose of this policy is to ensure the facility promptly . . . consults the resident's physician . . . Circumstances requiring notification include: . . . 3. Circumstances that require a need to alter treatment. . . ." Review of Resident #3's medical record occurred on all days of survey. Diagnoses included cirrhosis of the liver and metabolic encephalopathy (a brain disease). A physicians order, dated 06/02/23, stated, "Lactulose Solution (a medication known to cause loose stools) 10 GM [grams]/15ML [milliliters] Give 30 ml by	F 580	1. Corrective Action: The provider was notified on 10/5/23 and lactulose was increased to 4 times a day with family/resident consent from previous three times a day order. The provider was updated again after monitoring and wanted no treatment change but to redraw ammonia level which was completed on 10/20/23. Results were normal. On 10-27-23, the provider was updated, and no medication change from the 10-5 order. The provider updated the parameters identifying the appropriate number of bowel movements expected and clarified when to update the provider. 2. Identify Other Residents: All residents of the facility have the potential to be affected by this practice. 3. Measures put in Place: Each morning the interdisciplinary team meets to review 24-hour reports to ensure proper follow-up takes place. Reviewed process/policy on change in condition. An in-service education program was conducted by the Director of Nursing	

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F 580	Continued From page 5 mouth three times a day" Review of a fax sent to the facility from Resident #3's Geriatric Internist on 09/29/23 stated, " . . . With the lactulose, he needs to be having 3 or 4 BM's [bowel movements] per day. . . . follow number of BM's per day and if not having enough we can increase the lactulose dose. . . ." Review of Resident #3's BM record showed the following: * 09/29/23 - Two BMs * 09/30/23 - No BMs * 10/01/23 - One BM * 10/02/23 - No BMs * 10/03/23 - One BM The medical record lacked documentation the facility updated Resident #3's geriatric internist regarding his lack of BMs. During an interview on 10/04/23 at 5:39 p.m., an administrative nurse (#1) confirmed she was not aware of the lack of BMs the resident had since the physician's order on 09/29/23.	F 580	Services with all licensed staff (nurses, medication aides, and CNAs) on Thursday, October 26, 2023. 4. Monitoring: Audits will be completed to monitor notification of change in condition by reviewing five random residents weekly for two weeks, biweekly for two weeks, monthly for 2 months and as determined by the Quality Assurance program thereafter. All audits will be submitted to DON and presented to the Quality Assurance program to ensure compliance. 5. Compliance Date: 11/3/2023	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident.	F 657		11/3/23

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F 657	Continued From page 6 (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to review and revise comprehensive care plans to reflect the residents' current status for 3 of 15 sampled residents (Resident #9, #12, and #35). Failure to review and revise the care plan limited staffs' ability to communicate needs and ensure continuity of care. Findings include: Review of the facility policy titled "Comprehensive Care Plans" occurred on 10/05/23. This policy, revised August 2022, stated, ". . . It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident . . . the care planning process will begin upon admission and ongoing with changes. . ."	F 657	1. Corrective Action: a. #12 care plan was created on 9-15-22 for Diabetes Mellitus. On October 5th, ensured the care plan was updated appropriately. b. #35 care plan was updated on 10-25-2023. c. #9 care plan was updated on 10-25-2023. 2. Identify Other Residents: All diabetic residents have the potential to be affected by this practice. Reviewed all diabetic residents in facility and assured that care plan is up to date. 3. Measures put in Place: Facility wide communication on October 6th, 2023, related to care planning. On October	

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F 657	Continued From page 7 - Review of Resident #9's medical record occurred on all days of survey. Diagnoses included type 2 diabetes mellitus. The physician's orders included short-acting insulin with blood glucose monitoring three times a day. Resident #9's care plan lacked problem, goals, and interventions related to diabetes mellitus. - Review of Resident #12's medical record occurred on all days of survey. Diagnoses included type 2 diabetes mellitus. The physician's orders included long-acting insulin with blood glucose monitoring twice a week and as needed. Resident #12's care plan lacked problem, goals, and interventions related to diabetes mellitus. - Review of Resident #35's medical record occurred on all days of survey. Diagnoses included type 2 diabetes mellitus. The physician's orders included blood glucose monitoring daily. Resident #35's care plan lacked problem, goals, and interventions related to diabetes mellitus. During an interview on 10/05/23 at 2:00 p.m., an administrative nurse (#1) stated she expected staff to update the care plans to include diabetes mellitus and interventions.	F 657	25th, education about care planning was provided to the IDT team and completed a facility wide review related to diabetes on the care plan to ensure diabetes was identified as a problem. An in-service education program was conducted by the Director of Nursing Services with all licensed staff (nurses, medication aides, and CNAs) on Thursday, October 26, 2023. 4. Monitoring: Audits will be completed on care plans specific to all diabetic residents by reviewing five random residents weekly for two weeks, biweekly for two weeks, monthly for 2 months and as determined by the Quality Assurance program thereafter. All audits will be submitted to DON and presented to the Quality Assurance program to ensure compliance. 5. Compliance Date: 11/3/2023	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by:	F 658		11/3/23

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F 658	Continued From page 8 Based on observation, review of facility policy, review of professional reference, and staff interview, the facility failed to follow professional standards of practice regarding medication administration and monitoring blood sugars for 1 of 2 sampled residents (Resident #143) and 1 supplemental resident (Resident #8) observed during medication pass. Failure to ensure the resident eats within 5-10 minutes of receiving a rapid acting insulin and failure to monitor blood sugars per physician orders may result in a hypoglycemic reaction (low blood sugar), diabetic coma and/death and failure to ensure residents receive the correct medications may result in serious adverse health effects. Findings include: Review of the facility policy titled "Insulin" occurred on 10/05/23. This policy, dated February 2022, stated, " . . . Policy: It is the policy of this facility . . .to prevent adverse effects on a resident's condition. . . . short acting insulin's should be administered at the start of the meal. (10 minutes max [maximum] prior to the start of eating). . . . If a resident doesn't eat after getting insulin the charge nurse should be notified and proper, follow up and monitoring completed. . . ." Kozier & Erb's "Fundamentals of Nursing, Concepts, Process and Practice," 11th Edition eText, 2021, Pearson, Boston, Massachusetts, pages 831-832, stated, ". . . Administer only medications personally prepared . . ." pages 838-840 stated, ". . . Administering Oral Medications . . . Gather the MAR(s) [medication administration records] for each client together so that medications can be prepared for one client	F 658	1. Corrective Action: a. Short Acting Insulin Administration: On Oct 3rd, all medication aides and nurses had a meeting with the Director of Nursing going over short-acting insulin practices, proper administration, signs of hyper and hypoglycemia. On October 4th, 2023, communication went out to staff that medication aides are no longer performing any duties related to insulin administration. All insulin administration is performed by the nurse on duty. b. Medication Pass: On October 6th, communication provided facility wide along with direct education to medication aides and nurses on the 6 rights of Medication Administration. Specific one on one coaching with medication aide #5 and nurse #6 happened on October 6th directly on dishing up medications. On October 4th, medication assignments were adjusted and carts re-organized to fit our change in practice. c. Blood Sugars: For Res #143 insulin was not administered on Oct 2nd, at 8pm, Oct 3rd, at 8pm, and Oct 4th, at 8am due to provider order. Res did not receive Insulin at any of the above times. 2. Identify Other Residents: All residents	

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F 658	Continued From page 9 at a time. Rationale . . . reduces the chance of errors. . ." - Review of Resident #143's medical record occurred on all days of survey and included a diagnosis of diabetes mellitus. A physician's order, dated 09/28/23, stated, ". . . Novolog 20 units subcutaneous four times a day . . ." - Observations on 10/03/23 showed the following: * 11:57 a.m. a medication aide (MA) (#7) entered Resident #143's room to check the resident's blood sugar and administer insulin. The MA (#7) said the resident's name and he would open his eyes and fall back asleep. The MA attempted to wake the resident by rubbing his arms and cheek with no response from the resident. The MA then checked the resident's blood sugar, obtained a result of 174, administered 20 units of Novolog insulin [a rapid acting insulin], and exited the room. The resident failed to arouse during the finger stick or the injection. * 1:04 p.m. a certified nurse aide (CNA) (#4) entered Resident #143's room to bring him his dinner tray, 59 minutes after the MA administered his insulin. When the CNA stated the resident's name, the resident responded by opening his eyes and immediately went back to sleep. The CNA attempted to awaken the resident without success stating his name repeatedly, rubbing his arms and hands. The CNA took the resident's dinner to the MA (#7) and stated, "[Resident #143's name] is zonked, could you take his dinner tray to the kitchen to keep it warm." The MA took the resident's tray to the kitchen and failed to notify the nurse of the situation. The facility failed to ensure the resident ate after	F 658	of the facility have the potential to be affected. 3. Measures put in Place: An in-service education program was conducted by the Director of Nursing Services with all licensed staff (nurses, medication aides, and CNAs) on Thursday, October 26, 2023. 4. Monitoring: Audits will be completed to monitor blood sugar/insulin administration and medication administration. a. The nursing department will review five random residents regarding blood sugars/insulin administration weekly for two weeks, biweekly for two weeks, monthly for 2 months and as determined by the Quality Assurance program thereafter. b. The nursing department will review medication administration on 5 random staff (med aides/nurses) weekly for two weeks, biweekly for two weeks, monthly for 2 months and as determined by the Quality Assurance program thereafter. All audits will be submitted to DON and presented to the Quality Assurance program to ensure compliance. 5. Compliance Date: 11/3/2023	

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F 658	Continued From page 10	F 658		

administering rapid acting insulin, and notify the nurse about being unable to arouse Resident #143.

Refer to F726

- Observation of medication pass occurred on 10/04/23 at 8:45 a.m. with a MA (#5). The MA prepared Resident #8's medication as a licensed nurse (#6) entered the medication room and stated, she needed "[Resident #24's] medications." The MA (#5) stopped preparing the medications for Resident #8 and prepared Resident #24's medications, while the nurse (#6) stood on the opposite side of the medication cart. The MA (#5) crushed the medications, added pudding to the cup and handed the medications to the nurse. The nurse (#6) administered medications prepared by the MA (#5).

During an interview on 10/05/23 at 2:00 p.m. an administrative nurse (#1) stated she expected staff to administer medications they had prepared.

BLOOD SUGARS

Review of the facility policy titled "Diabetic Blood Glucose Checks" occurred on 10/05/23. This policy, dated August 2023, stated, ". . . PURPOSE Any resident with diabetes will have his/her blood glucose monitored as ordered by the physician. . . ."

- Review of Resident #143's medical record occurred on all days of survey and included a diagnosis of diabetes mellitus. A physician's order, dated 09/28/23, stated, " . . . Novolog [a

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F 658	Continued From page 11 rapid acting insulin] 20 units subcutaneous four times a day for Diabetes If BS [blood sugar] is under 150 do not give Novolog . . ." The staff administered rapid acting insulin without verifying Resident #143's blood sugar was over 150 on the following dates and times: * 10/02/23 at 8:00 p.m. * 10/03/23 at 8:00 p.m. * 10/04/23 at 8:00 a.m. During an interview on 10/05/23 at 2:32 p.m., an administrative nurse (#1) stated she expected staff to check blood sugars before administering the insulin.	F 658		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §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 staff interview, the facility failed to provide adequate supervision and assistive devices necessary to prevent accidents for 2 of 6 sampled residents (Resident #12 and #143) observed during a gait belt transfers. Failure to use a gait belt during transfers placed the residents at risk of accidents and injury. Findings include:	F 689	1. Corrective Action: On October 6th, communication was provided via our staff communication system (when to work) and by the charge nurse prior to each shift for a week to capture all working staff on proper gait belt use. The IDT team completed an audit on gait belts being available throughout the facility. 2. Identify other Residents: All residents	11/3/23

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F 689	Continued From page 12 Review of the policy titled "Use of Gait Belt" occurred on 10/04/23. This policy, dated May 2023, stated, "It is the policy of this facility to use gate belts with residents that require hands on extensive assist to ambulate or transfer for the purpose of safety. . . ." Observations showed the following: * 10/03/23 at 9:49 a.m., a certified nurse aide (CNA) (#4) transferred Resident #143 from the wheelchair to the recliner without a gait belt. The CNA (#4) lifted under both of the resident's arms while the resident held onto the CNA's elbows. * 10/03/23 at 11:45 a.m., a CNA (#2) transferred Resident #12 from the toilet to the wheelchair without a gait belt. The CNA (#2) pushed upward on the resident's back and held onto the waist band of the resident's pants during the transfer. The CNA (#2) transferred the Resident #12 to the recliner by holding the resident's hands and pulling the resident up to a standing position. During an interview on 10/05/23 at 2:00 p.m., an administrative nurse (#1) stated she expected staff to use a gait belt with transfers.	F 689	requiring the use of a gait belt (requiring extensive assistance for transfers) have the potential to be affected by this practice. 3. Measures put in Place: An in-service education program was conducted by the Director of Nursing Services with all licensed staff (nurses, medication aides, and CNAs) on Thursday, October 26, 2023. This included a demonstration to ensure understanding proper gait belt use and the importance of safe transferring. 4. Monitoring: The nursing department will review staff completing gait belt transfers on 5 random certified/nursing staff weekly for two weeks, biweekly for two weeks, monthly for 2 months and as determined by the Quality Assurance program thereafter. All audits will be submitted to DON and presented to the Quality Assurance program to ensure compliance. 5. Compliance Date: 11/3/2023	
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary	F 690		11/3/23

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F 690	Continued From page 13 incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident, family, and staff interviews, the facility failed to provide appropriate services and assistance to maintain bowel/bladder continence for 1 of 6 sampled residents (Resident #3) observed during toileting/incontinence care. Failure to provide toileting assistance may result in unnecessary incontinence, a loss of dignity, and avoidable skin issues. Findings include:	F 690	1. Corrective Action: Res #3 continues to receive lactulose 4-times per day since Oct 4th due to having liver cirrhosis. On Oct 20th, the provider ordered ammonia level which was completed on 10/20/23 with normal levels. Therapy did a PT eval on 10-6-23 for improved strength with a goal on returning to a pal-lift to try to improve continence. Plan of care is to be seen 2-3 times a week by PT. Oct 6th, education was provided to staff that Res	

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F 690	Continued From page 14 Review of the facility policy titled "Bowel and Bladder Program" occurred on 10/05/23. This policy, dated April 2023, stated, ". . . PURPOSE: [Facility Name] will provide appropriate programs and treatments for our residents . . . to restore and maintain as much normal bowel and bladder function as possible. . . ." During an interview on 10/02/23 at 4:02 p.m., Resident #3 verbalized frustration when staff utilized "that sling thing [full body lift] to get up and down. They [staff] told me to go to the bathroom in my pants." During an interview on 10/02/23 at 4:03 p.m., a family member (A) reported Resident #3 has been upset since staff started utilizing the Hoyer lift (full body mechanical lift) and stopped toileting the resident in the bathroom. A current physician ordered medication caused several loose stools per day. The resident "is upset" when unable to utilize the bathroom and is incontinent even when he has tried to "hold it." Review of Resident #3's medical record occurred on all days of survey. The care plan stated, ". . . TOILET USE: I require assistance to use toilet. . . ." The certified nurse aide (CNA) Activities of Daily Living (ADL) sheet identified staff assist with scheduled toileting every 2-3 hours for Resident #3. Progress notes included the following: * 08/15/23 at 2:26 p.m., ". . . Discharge: Physical Therapy . . . Patient finished therapy with the current transfer status of Pivot transfer into his chair, bed, and bathroom ModA [moderate assist]	F 690	#3 based on therapy eval will remain a Hoyer transfer, but alternative methods will continue to be offered to ensure safety/privacy/dignity when Res #3 needs to use the bathroom. Resident #3 made improvements and on 10-25-23 was cleared to use a pal-lift for transfers to the bathroom. Per his request will ask staff to assist him to the toilet when he needs to go. 2. Identify other Residents: All residents have the potential to be affected by this practice. 3. Measures put in Place: An in-service education program was conducted by the Director of Nursing Services with all licensed staff (nurses, medication aides, and CNAs) on Thursday, October 26, 2023. Education included the expectation relating to toileting. 4. Monitoring: The nursing department will review 5 random residents to ensure toileting plans are being followed per residents wishes/comprehensive assessment weekly for two weeks, biweekly for two weeks, monthly for 2 months and as determined by the Quality Assurance program thereafter. All audits will be submitted to DON and presented to the Quality Assurance program to ensure compliance. 5. Compliance Date: 11/3/2023	

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F 690	Continued From page 15 x1 [with one staff]. He was able to do this many times and consistently. . . ." * 08/28/23 at 12:55 p.m., " . . . Therapy . . . UPDATE: OTR [Occupational Therapist Registered] has been notified from several staff that pt [patient] is having increased difficulty transferring with 1 person assist consistently and safely. Recommending 2 person assist for all transfers at this time. . . ." * 09/08/23 at 11:16 a.m., ". . . Nurse note . . . Focus: room change/transfer Observation: RA's [restorative therapy aides] reported res [resident] having difficulties with transfers since room change. Action: Will use a pal-lift [sit to stand lift] at this time and have PT/OT [physical therapy/occupational therapy] assess. * 09/08/23 at 12:28 p.m., ". . . Therapy . . . UPDATE: OT completed transfer assessment with restorative. Recommend standing lift at this time for all transfers. . . ." * 09/24/23 at 3:14 p.m., ". . . Nurse note . . . Observation: resident noted to have increased weakness, loss of appetite, and overall decline during shift. resident [sic] currently having difficulty using PAL stand lift; staff requesting to use hoyer lift for resident transfers until resident can be evaluated by therapy. Action: resident switched to 2 person hoyer lift for transfers d/t [due to] increased weakness and decline for safety until evaluation. The record lacked evidence of a PT/OT evaluation since 09/24/23. During an interview on 10/04/23 at 5:39 p.m., an administrative staff member (#1) verified Resident #3 had not received a PT or OT	F 690		

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F 690	Continued From page 16 evaluation for transfer methods since 09/24/23. Observation on 10/04/23 at 11:55 a.m. showed two CNAs (#2 and #3) completed an incontinence check/change for Resident #3. The CNAs transferred the resident from the bed to wheelchair utilizing the Hoyer lift. Staff failed to offer the resident any other options for toileting to avoid incontinence. During an interview on 10/05/23 at 9:25 a.m., a CNA (#4) reported staff have not attempted to utilize a Hoyer toilet sling for Resident #3. During an interview on 10/05/23 9:27 a.m., a CNA (#3) reported no knowledge of a toilet sling and no bathroom toileting since Resident #3 changed to a hoyer lift for all transfers. The CNA stated, " . . . We just have him go in his pants and check and change him in bed. . . ." During an interview on 10/05/23 at 9:29 a.m., a CNA (#5) reported staff have not attempted to toilet Resident #3 with a toilet sling and stated, "[The resident] is a check and change. . . ." Facility staff failed to provide/attempt alternate toileting methods consistent with Resident #3's verbalized needs/requests, which resulted in avoidable incontinence, decreased dignity, and risk of skin breakdown. See F550	F 690		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning.	F 695		11/3/23

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F 695	Continued From page 17 The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interviews, the facility failed to provide respiratory care consistent with professional standards of practice for 2 of 4 sampled residents (Resident #23 and #143) receiving oxygen by nasal cannula. Failure to administer oxygen according to the physician's order may result in complications and compromise the residents' respiratory status. Findings include: Review of the facility policy titled "OXYGEN ADMINISTRATION OF" occurred on 10/05/23. This policy, dated February 2022, stated, "Procedure: 1. Check physician's orders . . . for flow rate . . ." - Review of Resident #23's medical record occurred on all days of survey and identified a physician's order, dated 05/15/23, stated, "Oxygen at 2-4 liters continuous for dyspnea per nasal cannula . . ." Observations showed the following: * 10/04/23 at 10:26 a.m. Resident #23 received oxygen per nasal cannula at 1.5 liters per minute (LPM). * 10/05/23 at 9:29 a.m. Resident #23 received	F 695	1. Corrective Action: Resident's #23 and #143 were addressed by adding that oxygen liters will be checked every 2 hours. 2. Identify other Residents: All residents on oxygen have the potential to be affected by this practice. 3. Measures put in Place: Residents on oxygen will have increased checks (2-hours) added to the mar/tar to assure that oxygen is being delivered at the liters ordered by the provider. An in-service education program was conducted by the Director of Nursing Services with all licensed staff (nurses, medication aides, and CNAs) on Thursday, October 26, 2023. 4. Monitoring: The nursing department will review 5 random residents to ensure oxygen is being administered at the correct ordered level weekly for two weeks, biweekly for two weeks, monthly for 2 months and as determined by the Quality Assurance program thereafter. All audits will be submitted to DON and presented to the Quality Assurance	

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F 695	Continued From page 18 oxygen per nasal cannula at 1.5 LPM. During an interview on 10/05/23 at 9:29 a.m., a medication aide (#5) verified Resident #23's oxygen was set at 1.5 LPM. - Review of Resident #143's medical record occurred on all days of survey and identified a physician's order, dated 9/28/23, stated, "O2 [oxygen] @ [at] 4 LPM per nasal cannula continuous . . ." Observations showed the following: * 10/02/23 at 5:07 p.m. Resident #143 received oxygen per nasal cannula at 3 LPM. * 10/04/23 at 10:38 a.m. Resident #143 received oxygen per nasal cannula at 3.5 LPM. * 10/04/23 at 4:25 p.m. Resident #143 received oxygen per nasal cannula at 3.5 LPM. * 10/05/23 at 12:01 p.m. Resident #143 received oxygen per nasal cannula at 3.5 LPM. During an interview on 10/05/23 at 12:01 p.m., a licensed nurse (#6) verified Resident #143's oxygen per nasal cannula was set at 3.5 LPM and turned the oxygen to 4 LPM. During an interview on 10/05/23 at 2:35 p.m., an administrative staff member (#1) stated she expected staff to administer oxygen at the rate ordered by the physician.	F 695	program to ensure compliance. 5. Compliance Date: 11/3/2023	
F 726 SS=J	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure	F 726		11/3/23

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F 726	Continued From page 19 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)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, record review, and staff interview, the facility failed to ensure the competency of nursing staff for 1 of 1 nursing staff (#7) observed during insulin administration (#143) . Failure to provide a meal or juice with in 5-10 minutes after administering short acting insulin, administering insulin to a nonarousable resident, and failure to notify a nurse of a resident's altered status may result in harm to facility residents.	F 726	1. Corrective Action: a. DON completed a comprehensive assessment including vitals, attempted to arouse the resident, attempted to offer food and juice, and updated Resident #143's medical provider and family. b. Oct 3rd immediate education on facility policy/procedure for administering	

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F 726	Continued From page 20 During the standard survey, the team determined an Immediate Jeopardy (IJ) situation existed on 10/03/23 at 2:00 p.m. The IJ resulted from a medication aide administering short acting insulin to a resident not alert enough to consume food thus, putting the resident at risk for a reaction from low blood sugar. The staff member who administered the insulin lacked awareness of the side effect of failing to provide food after administration of short acting insulin. The staff also failed to notify the nurse of Resident #143's altered status. * 10/03/23 at 2:34 p.m., The survey team contacted the State Survey Agency (SSA) to report the findings and discuss potential immediate jeopardy (IJ). The survey team was instructed to verify further details. * 10/03/23 at 3:49 p.m., The survey team contacted the SSA again for further discussion regarding the potential IJ situation and verified the presence of IJ. * 10/03/23 at 4:08 p.m., The SSA contacted the survey team after discussion with the CMS (Centers for Medicare & Medicaid Services) location and verified the presence of IJ. * 10/03/23 at 5:15 p.m., The survey team notified the administrator, and the director of nursing (DON), of the IJ situation, provided them with the IJ template, and requested they develop a plan for removal of the immediate jeopardy. * 10/04/23 at 8:55 a.m., The administrator, and the DON presented the IJ removal plan for the	F 726	short acting insulin, appropriate actions/interventions to involve the charge nurse to ensure resident safety, signs of hyper and hypoglycemia, and rights of medication administration for nurses and medication aides was completed. 2. Identify other Residents: All residents requiring short acting insulin have the potential to be affected by this practice. 3. Measures put in Place: Medication aides are no longer giving insulin as of October 4th. An in-service education program was conducted by the Director of Nursing Services with all licensed staff (nurses, medication aides, and CNAs) on Thursday, October 26, 2023. 4. Monitoring: The nursing department will continue to review that short acting insulin is given as ordered and per facility protocol for all residents with short acting insulin weekly for two weeks, biweekly for two weeks, monthly for 2 months and as determined by the Quality Assurance program thereafter. All audits will be submitted to DON and presented to the Quality Assurance program to ensure compliance. 5. Compliance Date: 11/3/2023	

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F 726	Continued From page 21 survey team to review. The removal plan contained the following: * DON completed a comprehensive assessment including vitals, attempted to arouse the resident, attempted to offer food and drink, and updated Resident #143's medical provider. * Inservice and education on facility policy/procedure for administering short acting insulin, appropriate actions/interventions to ensure resident safety with the staff member directly involved in the deficient practice, all nursing staff on duty, and on-coming staff. * Review of facility policies and resources for questions/concerns. * 10/04/23 at 11:16 a.m., The survey team reviewed and accepted the facility's removal plan for the IJ. The survey team verified the implementation of the removal plan as of 10/03/23. The deficient practice remained at an "D" scope and severity following the removal of the IJ. Findings include: Review of the facility policy titled "Insulin" occurred on 10/05/23. This policy, dated February 2022, stated, ". . . Policy: It is the policy of this facility . . .to prevent adverse effects on a resident's condition. . . . short acting insulin should be administered at the start of the meal. (10 minutes max [maximum] prior to the start of eating). . . . If a resident doesn't eat after getting insulin the charge nurse should be notified and proper, follow up and monitoring completed. . . ." Review of Resident #143's medical record	F 726		

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F 726	Continued From page 22	F 726		

occurred on all days of survey and included a diagnosis of diabetes mellitus. A physician's order, dated 09/28/23, stated, ". . . Novolog 20 units subcutaneous four times a day . . ."

Observations on 10/03/23 showed the following:
* 11:57 a.m. a medication aide (#7) entered Resident #143's room to check his blood sugar and administer insulin. The MA (#7) said the resident's name and he would open his eyes and fall back asleep. The medication aide attempted to wake the resident by rubbing his arms and cheek with no response from the resident. The medication aide checked the resident's blood sugar with the results of 174 milligrams per deciliter (mg/dl), administered 20 units of Novolog insulin [a fast acting insulin], and exited the room.
* 1:04 p.m. a Certified Nurse Aide (CNA) (#4) attempted unsuccessfully to awaken Resident #143 to provide the meal. Staff returned the tray to the kitchen.
* 1:12 p.m. This surveyor informed an administrative staff member (#1) of the situation concerning Resident #143. The administrative staff member informed the MA she needed to check Resident #143's blood sugar at this time.
* 1:19 p.m. The administrative staff member (#1) and MA (#7) checked Resident #143's blood sugar with the results of 136 mg/dl.
*1:21 p.m. The administrative staff member (#1) went to the kitchen to get Resident #143 some food.
* 3:07 p.m. a MA (#7) checked Resident #143's blood sugar with a result of 102 mg/dl.
* 3:17 p.m. a MA (#7) stated,"I did not know that [the resident needs to eat with in 5-10 minutes after administering a rapid acting insulin] until

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F 726	Continued From page 23 they told me [earlier today]." * 4:23 p.m. a MA (#8) checked Resident #143's blood sugar with a result of 86 mg/dl. During an interview on 10/03/23 at 5:27 p.m., an administrative staff member (#1) confirmed she expected staff to administer short acting insulin with a meal, inform the nurse if a resident is not eating after short acting insulin administration, and if a resident is nonarousable.	F 726		
F 732 SS=B	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors.	F 732		11/3/23

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F 732	Continued From page 24 §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to post complete and accurate daily staff information for 3 of 4 days of survey (October 02-04, 2023). Failure to post accurate staffing data does not allow residents and visitors knowledge of the number of licensed and unlicensed staff on duty each shift. Findings include: Observation on October 02-04, 2023, showed the daily staff posting outside of the nurse's station. The posting showed staffing data for the night shift only, and no staffing for the day and evening shift the entire day. During an interview on 10/05/23 at 2:00 p.m., an administrative nurse (#1) stated she expected night shift to complete the staffing form and staff to make changes if needed.	F 732	1. Corrective Action: The census sheet was checked immediately on Oct 5th, 2023, and updated to ensure accuracy. One-on-one coaching provided to the night nurse on filling the census sheet out appropriately per our facility policy. 2. Identify other Residents: All residents have the potential to be affected by this practice. 3. Measures put in Place: An in-service education program was conducted by the Director of Nursing Services with all licensed staff (nurses, medication aides, and CNAs) on Thursday, October 26, 2023. Education to all nurses on the expectation on updating the census sheet ongoing and reviewing the policy. 4. Monitoring: The nursing department will check/review the census sheet to ensure it is posted weekly for two weeks, biweekly for two weeks, monthly for 2 months and as determined by the Quality	

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F 732	Continued From page 25	F 732	Assurance program thereafter. All audits will be submitted to DON and presented to the Quality Assurance program to ensure compliance. 5. Compliance Date: 11/3/2023	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or	F 880		11/3/23

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F 880	Continued From page 26 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 IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:	F 880		

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F 880	Continued From page 27 Based on observation, review of facility policy, and staff interview, the facility failed to follow standards of infection control for 2 of 6 sampled residents (Resident #3 and #18) observed during personal cares. Failure to practice infection control standards related to hand hygiene has the potential to spread infection throughout the facility. Findings include: Review of the policy titled "Infection Prevention and Control Program" occurred on 10/04/23. This policy, dated May 2023, stated, ". . . Glove Hygiene (Always make sure that resident is safe prior to glove removal and washing hands) . . . Perform hand hygiene immediately after removal of gloves . . ." - Observation on 10/04/23 at 11:55 a.m. showed two certified nurse aides (CNAs) (#2 and #3) assisted Resident #3 with a check and change. One CNA (#3) donned gloves and performed incontinence care as the other CNA (#2) assisted with turning the resident. After removing her gloves the CNA (#3) repositioned the resident's bedside table, opened the curtain, repositioned the resident's call light, placed a pillow behind the resident's head and right arm, touched the resident's headset and remote, moved the wheelchair, and covered the resident with a blanket before performing hand hygiene. - Observation on 10/04/23 at 4:00 p.m. showed two CNAs (#2 and #3) transferred Resident #18 onto the toilet. One CNA (#3) performed perineal care as the resident stood near the toilet. With visible stool on the wipe, the CNA (#3) completed	F 880	1. Corrective Action: On Oct 6th, education was sent out via our messaging system (when to work) for all staff on infection prevention regarding hand hygiene. Completed audits and education related to donning/doffing and hand washing to ensure staff understand the expectations. 2. Identify other Residents: All residents have the potential to be affected by this practice. 3. Measures put in Place: An in-service education program was conducted by the Director of Nursing Services with all licensed staff (nurses, medication aides, and CNAs) on Thursday, October 26, 2023. 4. Monitoring: The nursing department will review 5 random staff on hand washing practices weekly for two weeks, biweekly for two weeks, monthly for 2 months and as determined by the Quality Assurance program thereafter. All audits will be submitted to DON and presented to the Quality Assurance program to ensure compliance. 5. Compliance Date: 11/3/2023	

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F 880	Continued From page 28 perineal cares and assisted the resident into the wheelchair. After removing her gloves the CNA (#3) positioned the wheel chair at the sink, obtained a hand towel for the resident, repositioned the wheelchair, assisted the resident into the recliner, moved the resident's fluids closer to the resident, and covered the resident with a blanket before performing hand hygiene. The CNA (#3) failed to perform hand hygiene after glove removal and before completing other tasks. During an interview on 10/05/23 at 2:00 p.m., an administrative nurse (#1) stated she expected staff to perform hand hygiene after glove removal after the resident is in a safe position.	F 880		