STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355064	A. BUILDING _____ B. WING _____	07/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING CENTER OF GARRISON	609 4TH AVE NE GARRISON, ND 58540

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F 000	INITIAL COMMENTS The standard Medicare/Medicaid recertification survey started on 07/16/18 and concluded 07/19/18.	F 000		
F 640 SS=B	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment.	F 640		8/1/18

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

Electronically Signed | 08/02/2018

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F 640	Continued From page 1 (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.15), and staff interview, the facility failed to complete and submit an Omnibus Budget Reconciliation Act of 1987 (OBRA) required tracking record for 1 of 2 residents (Resident #1) reviewed who died in the facility. Findings include: The Long-Term Care Facility RAI Manual, pages 2-10, 2-15, and 2-36, stated, ". . . Death In Facility refers to when the resident dies . . . The facility must complete a Death in Facility tracking record. . . . OBRA-Required Tracking Records and Assessments are federally mandated, and therefore, must be performed for all residents of Medicare and/or Medicaid certified nursing homes. These assessments are coded on the	F 640	A death in facility was completed and transmitted on July 19, 2018. All deaths in facility from 06/01/2017 to current have been verified that the transmission was completed. DON or designee will ensure and monitor compliance. Audits will be conducted 1 x month for 3 months; than quarterly for 3 quarters. Audits will consist of the verifying transmissions were completed for all deaths. Audits began 08/01/2018. Analysis of the observations and facility's compliance will be presented to our Quality Assurance team beginning 08/23/2018 who will recommend changes and ongoing monitoring/auditing after analysis if needed.	

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F 640	Continued From page 2 MDS [Minimum Data Set] 3.0 in Items A0310A (Federal OBRA Reason for Assessment) and A0310F (Entry/discharge reporting). They include: Tracking records - Entry - Death in facility . . . Death in Facility Tracking Record (A0310F=12) - Must be completed when the resident dies in the facility or when on LOA. Must be completed within 7 days after the resident's death, . . . Must be submitted within 14 days after the resident's death . . ." Review of Resident #1's medical record occurred on July 18-19, 2018. The medical record identified the resident died in the facility on 03/07/18. Review of the MDS records completed for Resident #1 showed the facility failed to complete a Death in Facility Tracking Record by 03/15/18. Failure to complete the Death in Facility Tracking Record, also caused the facility to fail to submit the required tracking form by 03/22/18. During an interview, on 07/19/18 at 9:05 a.m., an administrative nurse (#1) confirmed the MDS for Death in Facility was not completed.	F 640		
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		8/10/18

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F 657	Continued From page 3 (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, and staff interview, the facility failed to review and revise the comprehensive care plan to reflect the current status for 1 of 13 sampled residents (Resident #25). Failure to revise the care plan limited the ability of staff to communicate care needs and ensure continuity of care for each resident. Findings include: Review of the facility policy titled "Comprehensive Assessments and Care Planning" occurred on 07/18/18. This policy, dated 2017, stated, "Purpose: To provide a comprehensive person-centered interdisciplinary care assessment of the resident's condition, in order to develop consistent quality care that will attain or maintain the highest practicable physical, mental and psychological functioning	F 657	Care plan for resident # 25 was reviewed by IDT and updated on 07/31/2018. All resident's care plans have been reviewed by IDT, no others were affected. All residents are potentially at risk for this and charts have been reviewed for the need to update care plans. No issues noted. Care plan system was reviewed and a new procedure implemented. Education was provided on 07/31/2018 to nursing, social services and culinary regarding the procedure. DON or designee will ensure and monitor compliance. Audits will be conducted 1 x week for 3 months; than 2 x month for 3 months; then monthly for 3 month. Audits will consist of the Facility activity report, changes in residents and	

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F 657	Continued From page 4 possible, a facility must make a comprehensive assessment of a resident's needs, . . .The assessment must accurately reflect the resident's status . . . A facility should use the results of the assessment to develop, review and revise the resident's person-centered comprehensive care plan. . . ." Review of Resident #25's medical record occurred on all days of survey. Diagnoses included history of transient ischemic attack [mini-stroke], history of diseases of the skin, atrial fibrillation [irregular heartbeat], and cerebral infarction [stroke]. The progress notes stated the following: * 06/06/18 at 2:21 p.m. ". . . protime [Prothrombin time (PT) is a coagulation test] is 62.10, and INR [International Normalized Ratio, is a measure of how long it takes your blood to clot] is 6.80. Provider notified we are to hold Coumadin [anticoagulant] for the next 2 days and redraw on Friday." * 06/11/18 at 10:07 a.m. "Elevated result PT-84.3, INR 9.38 . . . Advised to hold Warfarin [Coumadin] for 2 days and to repeat PT/INR. To start at 4 mg [milligrams] when result is with in normal limits." * 06/13/18 at 2:59 p.m. " INR result 3.43. Warfarin 4 mg started." * 06/14/18 at 8:30 p.m. "Resident has rash on his right upper arm, shoulder region. Resident has the same rash starting on his right abdomen. Resident's left side of his back and abdomen has urticaria [hives] present. Resident complains of itching. Resident's right antecubital [front of the elbow] region has an area approximately 18 cm [centimeter] X 10 cm that is red, raised, hard, and	F 657	the IDT care plan report. Audits will begin 08/09/2018. Analysis of the observations and facility's compliance will be presented to our Quality Assurance team beginning 08/23/2018 who will recommend changes and ongoing monitoring/auditing after analysis if needed.	

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F 657	Continued From page 5 slightly warm to touch." * 06/15/18 at 10:57 a.m. ". . . noted to have blood filled blister in between thumb and index finger on left hand measuring 1.7 cm x1.4 cm. Another fluid filled blister in between index finger and thumb on right hand measuring 1.1 cm x1 cm." * 06/21/18 at 11:14 a.m. ". . . seen on rounds today due to rash on his back and bilateral upper legs. Provider ordered Prednisone 20 mg Three tabs [tablets] for 3 days, 2 tabs for 3 days, then one tabs for 4 days, also increased ranitidine 150mg to BID [twice a day] instead of just daily. Discontinued Benadryl [antihistamine] and started Claritin [antihistamine] 10 mg BID for 7 days. . . ." * 07/07/18 at 4:38 a.m. "Red raised rashes recur again on neighbors [resident] chest arms and trunk and upper back. Does verbalize that he itches really bad. . . . advised to give Claritin 10mg tab BID PRN [as needed], Apply Benadryl anti itch cream to affected areas BID PRN. . . ." * 07/15/2018 at 12:51 a.m. "[resident name] has a rash scattered on his body tonight. Applied Benadryl cream and gave Claritin to help with this. Will monitor." * 07/18/2018 at 3:05 p.m. "Critical lab result INR 5.03. Contacted PA [Physician Assistant]. To stop Warfarin x 2 days and restart at 2 mg. To repeat INR after a month . . ." Review of Resident #25's care plan indicated the facility staff failed to address and implement interventions related to skin rash/blisters and anticoagulant use. During an interview on 07/19/18 at 10:00 a.m., an administrative nurse (#2) confirmed staff failed to review and revise Resident #25's care plan to	F 657		

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F 657	Continued From page 6 reflect current conditions.	F 657		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to ensure the appropriate care and services to prevent complications for 1 of 1 sampled resident (Resident #19) receiving medication and nutrition by an enteral feeding tube. Failure to verify placement of the enteral tube prior to administering medications and nutrition has the potential to result in adverse events.	F 693	Resident #19 was reviewed with MD on 07/31/2018. No futher interventions needed at this time. One other resident potentially at risk. On 07/31/2018 resident was reviewed with MD no further intervention needed. Education was provided to nursing staff on 07/20 /2018 and 07/23/2018 to ensure understanding of the policy on Tube feedings/medications. Education	8/1/18

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F 693	Continued From page 7 Findings include: Review of the facility policy titled "Enteral Feeding-Intermittent Tube Feeding/Medications" occurred on 07/18/18. This policy, dated December 2002, stated, ". . . Expose gastrostomy tube, remove plug. Insert syringe. Check/measure for residual gastric contents. Return gastric contents to stomach. . . ." Review of Resident #19's medical record occurred on all days of survey. Diagnoses included cerebral vascular accident, dementia, and respiratory failure. The annual Minimum Data Set (MDS), dated 05/10/18, identified a tube feeding with 51 percent (%) or more total calories received through parenteral or tube feeding, and total dependence with feeding. Physician's orders included Jevity 1.2 calories, eight ounces every eight hours with 150 milliliters (ml) water flush. Observations identified the following: 07/17/18 at 10:45 a.m.: a staff nurse (#3) administered crushed medication and Jevity per Resident #19's enteral feeding tube without checking placement prior to the administration. 07/17/18 at 2:49 p.m.: a staff nurse (#3) administered crushed medications and Jevity per Resident #19's enteral tube without checking placement prior to the administration. During an interview on 07/18/18 2:00 p.m., an administrative nurse (#2) confirmed nursing staff should be checking placement of the enteral tube prior to use by checking for gastric contents.	F 693	consisted of the written policy and a return demonstration from the nurse. All new nurses will be observed their first 5 shifts with all tube feeding/medication administrations then will be observed weekly for 3 months. DON or designee will ensure and monitor compliance. Audits will be conducted 5 x a week for 2 weeks; then 3 x a week for 2 weeks; then weekly for 3 months; then 2 x month for 3 months; then monthly for 3 months. Audits will consist of observing nurses giving a tube feeding and/or medication. Audits began 07/26/2018. Analysis of the observations and facility's compliance will be presented to our Quality Assurance Team beginning 08/23/2018 who will recommend changes and ongoing monitoring/auditing after analysis if needed.	
F 698 SS=D	Dialysis CFR(s): 483.25(l)	F 698		7/27/18

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F 698	Continued From page 8 §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to ensure residents received the care and services consistent with professional standards of practice for 1 of 1 sampled resident (Resident #248) receiving hemodialysis outside the facility. Failure to assess/monitor hemodialysis vascular access sites (arterial-venous fistulas) on a regular basis can result in complications with access function and possible loss of the access site. Findings include: Review of the facility policy titled "Dialysis Services via Contracted Vendor" occurred on 07/18/18. This policy, dated 2017, stated, "Purpose: . . .The community ensures residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. . . . The licensed nurses and other professionals provide ongoing assessment of the residents' condition from a multidisciplinary standpoint and monitoring for complications before and after dialysis treatments received at a certified dialysis facility. . ."	F 698	Neighbor # 248 was reviewed with MD on 07/20/2018. No further interventions needed. No other residents are at risk. Education was provided on 07/20/2018 to nurses regarding assessment before and after dialysis. Treatment MAR in place for vital signs and fistula site. DON or designee will ensure and monitor compliance. Audits will be conducted 1 x week for 2 months; then 2x month for 2 months; then monthly audits for 3 months. Audits will consist of observation of residents treatment MAR to assure assessment completion. Audits began 07/27/2018. Analysis of the observations and facility's compliance will be presented to our Quality Assurance team beginning 08/ 23/2018 who will recommend changes and on-going monitoring/auditing after analysis of needed.	

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F 698	Continued From page 9 Review of Resident #248's medical record occurred on all days of survey. The resident's current care plan stated, ". . . I am currently on Dialysis r/t [related to] ESRD [end stage renal disease] . . . Dialysis scheduled 3 times per week. . . . Monitor access site for redness, bleeding, pain and swelling. If above are noted report promptly. Monitor for signs of possible occlusion of shunt. . . . Monitor for bleeding at access site. Monitor after returning from Dialysis. . . Notify MD of weight gain and/or fluid volume excess (sudden weight gain); increased blood pressure . . ." Observation on the afternoon of 07/16/18 showed Resident #248 resting in her bed. The resident identified she goes to dialysis on Tuesday, Thursday, and Saturday and her fistula site is to her left arm. Review of the treatment administration record (TAR), the nursing progress notes, blood pressure and weight records failed to show evidence nursing staff monitored Resident #248's fistula site, weights, or blood pressure after returning from dialysis or on a regular basis. During an interview on 07/18/18 at 11:25 a.m., an administrative nurse (#2) stated she would expect the nurse to assess and document the resident condition following dialysis treatment.	F 698		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the	F 761		8/7/18

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F 761	Continued From page 10 appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, review of manufacturer's instructions, and staff interview, the facility failed to establish a system to account for all controlled/scheduled medications and failed to discard outdated medications in 1 of 1 medication storage unit. Failure to ensure controlled/scheduled medications are secured and accounted for prior to disposal may result in unauthorized access to medications and/or drug diversion, and failure to discard expired medications increased the risk of residents receiving outdated medications with reduced medication efficacy. Findings include:	F 761	No residents were affected All neighbors who have had a controlled substance could potentially be affected. Procedure for securing discontinued controlled medications has been reviewed and updated. A new locked drop box has been placed in the medication room. Upon discontinuation of a controlled substance, 2 nurses will verify they count, log the drop onto a controlled count sheet and drop the controlled substance into drop box. The DON will hold the only key until pharmacy comes and reconciles quantity prior to destruction. Education was provided to nursing staff regarding	

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F 761	Continued From page 11 Review of the facility policy titled "Discontinued Controlled Scheduled Medications" occurred on 07/18/18. This policy dated December 2007, stated, ". . . Discontinued Scheduled drugs [medications with a high potential for abuse] will be maintained in a locked box until destruction occurs. . . ." - Observation/inspection on 07/18/18, at 1:30 p.m., of the medication storage area in the nurses's station showed a locked cabinet used to store discontinued controlled medications prior to disposal. During this inspection when asked about the frequency the controlled medications are counted and/or a completed list of what medications are contained in the cabinet, the nurse (#3) stated, "There is no list of all the medications contained in the cabinet. The controlled medications are counted when discontinued, the count sheet is attached to the medication container, and stored until the medications are disposed of monthly by the pharmacist and director of nurses." Observation in the medication storage area showed each medication contained a "Narcotic Administration" form attached to it which indicated the following medication count and dates: * Hydrocodone/APAP (acetaminophen) 5/325 milligrams (mg) cassette pack with 27 tablets remaining. The attached medication count sheet indicated last counted on 05/25/18. * Lorazepam 1 mg cassette pack with 30 tablets remaining. The attached medication count sheet indicated last counted on 06/01/18. * Hydrocodone/APAP 10/325 mg cassette pack	F 761	updated procedure on 08/01/2018. DON or designee will ensure and monitor compliance. 5 audits will be conducted per week x 2 weeks; then 2 audits a week x 2 weeks; then 2 audits a month x 2 months; then monthly audit x 3 months: then quarterly x 2 months. Audits will consist of the use of the drop box and daily shift change counts until controlled medication is placed in drop box. Audits will begin 08/06/2018. Analysis of the observations and facility's compliance will be presented to our Quality Assurance team beginning 08/23/2018, who will recommend changes and ongoing monitoring/auditing after analysis if needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355064	A. BUILDING _____ B. WING _____	07/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING CENTER OF GARRISON	609 4TH AVE NE GARRISON, ND 58540

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F 761	Continued From page 12 with 27 tablets remaining. The attached medication count sheet indicated last counted on 06/02/18. * Oxycodone 5 mg cassette pack with 10 tablets remaining. The attached medication count sheet indicated last counted on 06/03/18. * Oxycodone 5 mg cassette pack with 26 tablets remaining. The attached medication count sheet indicated last counted on 06/05/18. * Fentanyl 12 micrograms (mcg) box of 9 patches remaining. The attached medication count sheet indicated last counted on 06/14/18. * Oxycodone 5 mg cassette pack with 44 tablets remaining. The attached medication count sheet indicated last counted on 06/14/18. * Oxycodone 5 mg cassette pack with 12 tablets remaining. The attached medication count sheet indicated last counted on 06/15/18. * Lorazepam 1 mg cassette pack with 13 tablets remaining. The attached medication count sheet indicated last counted on 06/15/18. * Tramadol 50 mg cassette pack with 18 tablets remaining. The attached medication count sheet indicated last counted on 06/20/18. * Morphine Sulfate (liquid) 10 mg/5 milliliter (ml) bottle with 40 ml remaining. The attached medication count sheet indicated last counted on 06/28/18. * Hydrocodone/APAP 5/325 mg cassette pack with 29 tablets remaining. The attached medication count sheet indicated last counted on 06/28/18. * Lorazepam (liquid) 2 mg/ml bottle with 26 ml remaining. The attached medication count sheet indicated last counted on 06/28/18. * Lorazepam 0.5 mg cassette pack with 28 tablets remaining. The attached medication count sheet indicated last counted on 07/03/18.	F 761		

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F 761	Continued From page 13 * Morphine Sulfate (liquid) 100 mg/5 milliliter (ml) bottle with 28.75 ml remaining. The attached medication count sheet indicated last counted on 07/03/18. * Clonazepam 1 mg cassette pack with 1 tablet remaining. The attached medication count sheet indicated last counted on 07/16/18. * Clonazepam 1 mg cassette pack with 8 tablets remaining. The attached medication count sheet indicated last counted on 07/17/18. During an interview on 07/18/18, at 2:35 p.m., an administrative nurse (#2) stated the facility does not maintain a completed list of the controlled medications stored in the cabinet and confirmed the facility does not have a good system for accountability of controlled medications waiting for disposal. The manufacturer's instructions for Tuberculin Purified Protein Derivative (Mantoux) Tubersol, dated September 2015, stated, " . . . A vial of Tubersol which has been entered and in use for 30 days should be discarded. . . ." - Observation/inspection on 07/18/18 at 1:40 p.m., of the refrigerator located in the medication storage area in the nurses's station showed: * An opened multidose vial of Tubersol/Tuberculin Purified Protein Derivative (Mantoux) dated 06/11/18. * An opened multidose vial of Influenza Quadrivalent with an expiration date of 06/16/18. During an interview on 07/18/18, at 2:35 p.m., an administrative nurse (#2) confirmed nursing staff should discard opened multidose vials after 30 days and discard medications after the expiration	F 761		

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F 761	Continued From page 14 date.	F 761		
F 908 SS=D	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure emergency equipment remained in safe operating condition for 1 of 1 suction machine. Failure to ensure the suction machine remained functional in the event of an emergency situation could delay the availability of suction use for residents and placed residents at risk for choking and aspiration. Findings include: Observation of the suction machine stored in the supply room occurred on 07/18/18 at 1:55 p.m. with a licensed nurse (#3). Observation showed the licensed nurse (#3) attempted multiple times to connect the tubing to the suction machine and the collection canister. The collection canister lid was not properly placed to create a seal and the suction machine did not produce suction. The nurse reconnected the tubing and closed the collection canister lid correctly for the suction machine to produce suction at 2:04 p.m., (nine minutes later). During an interview on 07/18/18 at 2:35 p.m. an administrative nurse (#2) stated she would expect the nurse to know how to connect and operate the suction machine in a timely manner.	F 908	No residents were affected by this. All residents are potentially at risk. Education was provided on 08/01/2018 to nurses with a return demonstration by nurses in connecting suction machine and canister. Systematically we will have the suction machine already set up and ready to be used. Training will be provided to all new nurses in their first 30 days of orientation. Continued training will be provided yearly on the set up of the suction machine. DON or designee will ensure and monitor compliance. Audits will be conducted 2x weeks for 4 weeks; then 1x week for 4weeks; then 2x month for 3 months; then 1 x month for 3 months. Audits will consist of observation of the suction machine set up and nurses ability to set it up. Audits will begin 08/06/2018. Analysis of the observations and facility's compliance will be presented to our Quality Assurance team beginning 08/ 23/2018 who will recommend changes and on-going monitoring/auditing after analysis if needed.	8/1/18