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 _____	C 09/07/2023

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 and facility reported incident investigation started on 09/05/23 and concluded 09/07/23. During the report investigation, the facility was found in compliance with regulatory requirements.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, staff and resident interview, the facility failed to ensure the interdisciplinary team assessed the appropriateness to self-administer medications (SAM) for 1 of 1 supplemental resident (Resident #2) with medications observed in the room. Failure to determine whether SAM is a safe practice has the potential to limit a resident's right to SAM or result in a medication error and/or harm to a resident. Findings include: Review of the facility policy titled "Self-Administration of Medication" occurred on 09/07/23. This policy, dated 2020, stated, ". . . 1. The nursing associates will assess each resident's mental and physical abilities. . . Assessment is documented in the EHR [Electronic Health Record]. . . 3. If it is determined a resident cannot safely administer medications, the nursing associates will	F 554	F554 During the annual survey it was noted that the facility failed to remove Eye drops for the resident room and resident was not assessed for self-administration of medications. Resident #2- Completed self-administration of Medications assessment on 9/28/2023, Care plan was reviewed and update not needed. All residents who receive medications have the ability to be affected by this deficient practice. An audit of all resident rooms will be conducted to determine if they have medications in their rooms and if they are appropriate to have these medications or not. A SAMs assessment will be done on those who would like to have medications in their rooms to determine the safety of	10/12/23

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

Electronically Signed | 09/29/2023

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F 554	Continued From page 1 administer the medication. . ." Observations during medication administration on 09/05/23 at 4:11 p.m., showed a bottle of Refresh Plus (Sterile eye drops) located in Resident #2's room. When asked, Resident #2 stated, "I'm allowed to use them and do them by myself whenever I need them." Review of Resident #2's medical record occurred on 09/05/23. The record showed a SAM assessment on 06/29/21 documented in the EHR indicated Resident #2 cannot safely self-administer medications. During an interview on 09/07/23 at 8:14 a.m., an administrative staff member (#1) confirmed Resident #2 is not appropriate for SAM.	F 554	that. Education will be completed with all licensed nursing staff on or before Oct 6th, 2023 or by next scheduled shift, Training /Education will be conducted with all staff that pass medications, Staff will double checking rooms for left behind medications before leaving and reviewing the Self administration of medications policy. Audits will be conducted by DON and/or designee at random 5x a week x4 weeks and 3x a week x3 weeks, 3 months on resident capable of self-administration of medications, was there medication left in room. All audits reviewed through quality council. Audits will continue as deemed by quality council as necessary until substantial compliance has been achieved. The DON is responsible for compliance. Substantial compliance will be achieved by Oct 12th, 2023.	
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.17.1), and staff interview, the facility failed to ensure accurate coding of the Minimum Data Set (MDS) for 5 of 13 sampled residents (Resident	F 641	F641 Accuracy of Assessments 1) -Neighbor #14's MDS dated 6/20/23 was corrected to include weight gain in section K.	10/12/23

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F 641	Continued From page 2 #11, #14, #21, #26, and #27) and one supplemental resident (Resident #33). Failure to accurately complete the MDS does not allow each resident's assessment to reflect their current status/needs and may affect the accurate development of a comprehensive care plan and the care provided to the residents. Findings include: SECTION K: SWALLOWING/NUTRITIONAL STATUS The Long-Term Care Facility RAI User's Manual, revised October 2019, page K-3 through K-9, stated, ". . . Coding Instructions . . . K0310: Weight Gain . . . Code 0, no or unknown: if the resident has not experienced weight gain of 5% or more in the past 30 days or 10% or more in the last 180 days or if information about prior weight is not available. . . . Code 2, yes, not on physician-prescribed weight-gain regimen: if the resident has experienced a weight gain of 5% or more in the past 30 days or 10% or more in the last 180 days, and the weight gain was not planned and prescribed by a physician. . . ." - Review of Resident #14's medical record occurred on all days of survey. Diagnoses include congestive heart failure and chronic kidney disease. A dietary progress note dated, 06/28/23 at 9:11 a.m., stated, ". . . Weight continues to increase with weight gain of 8.4# [pounds] (5.7%) in the past month and 20.8# (15.4%) in the past 6 months. . . ."	F 641	-Neighbor #27's MDS from 11/4/22 was corrected to remove the diagnoses of Schizophrenia from section I. -Neighbor #11, #21, #26 and #33's MDS's were corrected to reflect the number of anti-coagulants they received in their respective assessment reference periods. 2) -For all neighbors who have experienced a weight gain in the past 6 months, their MDS's were audited to determine if weight gain was coded correctly on the MDS. The most current inaccurate assessments were modified and MDS's resubmitted to federal and state. -For all neighbors who have a diagnosis of Schizophrenia and/or Schizoaffective disorder, their MDS's were audited to determine if Schizophrenia or Schizoaffective disorder was coded on the MDS. The most current inaccurate assessments were modified and MDS's resubmitted to federal and state. -For all neighbors who receive anticoagulant medications, their MDS's from February 1, 2023 (when training occurred that presented incorrect information to MDS coordinator) were audited to determine if anticoagulants were coded in section N. Inaccurate anti-coagulant coding was modified and MDS's resubmitted to federal and state. 3) The MDS coordinator consulted with BHS corporate clinical reimbursement nurse for education and clarification on the proper coding of anti-coagulants and	

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F 641	Continued From page 3 The quarterly MDS, dated 06/20/23, identified section K0310, coded "0," no weight gain. During an interview 09/07/23 at 9:15 a.m., the dietary manager (#8) confirmed staff incorrectly coded section K of the MDS for Resident #14. SECTION I: ACTIVE DIAGNOSES IN THE LAST 7 DAYS The Long-Term Care Facility RAI User's Manual, revised October 2019, page I-7, stated, ". . . Identify diagnoses: The disease conditions in this section require a physician-documented diagnosis . . . in the last 60 days. Medical record sources for physician diagnoses include progress notes, the most recent history and physical, transfer documents, discharge summaries, diagnosis/problem list, and other resources as available. . . Diagnostic information, including past history obtained from family members and close friends, must also be documented in the medical record by the physician to ensure validity and follow-up . . . " Review of Resident #27's medical record occurred on all days of survey. The resident's current diagnosis list identified schizoaffective disorder as of 08/18/22. The quarterly MDS assessments, dated 11/04/22, 02/04/23, and 05/04/23, identified schizoaffective disorder as an active diagnosis. Resident #27's medical record failed to show a clinical rationale for the diagnosis of schizoaffective disorder. During an interview on 09/07/23 at 11:39 a.m., an	F 641	Schizophrenia/Schizoaffective disorder on 9/8/23. The culinary manager will be educated by the DON and MDS coordinator on accuracy of assessment coding weight gain in sections K on or before 10/10/23. All staff will be educated at a mandatory training on 10/3/23. 4) This audit will be completed on two finalized MDS's weekly for 3 months. If any issues are discovered within the audit, the length of the time the audit is taking place will extend for another 2 weeks. If no issues are identified, the audit will be completed at the end of the 3 month period. Results of audits, tracking and trending will be reviewed by the Quality Improvement Team. 5) Date certain is 10/12/23	

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F 641	Continued From page 4	F 641		

administrative nurse (#1) confirmed the facility staff incorrectly coded Resident #27's MDSs for a diagnosis of schizoaffective disorder.

SECTION N: MEDICATIONS

The Long-Term Care Facility RAI User's Manual, revised October 2019, pages N-6 and N-7, stated, ". . . Coding Instructions . . . N0410E, Anticoagulant (e.g., warfarin, heparin, or low-molecular weight heparin): Record the number of days an anticoagulant medication was received by the resident at any time during the 7-day look-back period (or since admission/entry or reentry if less than 7 days). . . ."

- Review of Resident #11's medical record occurred on all days of survey. Diagnoses included cerebral vascular accident (stroke) due to thrombosis (blood clot). A physician's order, dated 11/26/19, stated, "Eliquis (apixaban) [anticoagulant] tablet; 5 mg [milligrams]; amt [amount]: 1 tab [tablet]; oral Twice A Day . . ."

The quarterly Minimum Data Set (MDS), dated 08/16/23, identified Resident #11 received an anticoagulant on "0" of 7 days. Staff failed to code the MDS accurately for anticoagulants.

- Review of Resident #21's medical record occurred on all days of survey. A physician's order, dated 03/09/23, stated, "Eliquis (apixaban) tablet; 5 mg; amt: 1 tab; oral Twice A Day. . ."

The quarterly MDS, dated 07/26/23, identified Resident #21 received an anticoagulant on "0" of 7 days. Staff failed to code the MDS accurately for anticoagulants.

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F 641	Continued From page 5 - Review of Resident #26's medical record occurred on all days of survey. A physician's order, dated 11/14/2022, stated, "Xarelto (rivaroxaban) [anticoagulant] tablet; 20 mg; amt: 1 tab; oral Once A Morning . . ." The annual MDS, dated 07/21/23, identified Resident #26 received an anticoagulant on "0" of 7 days. Staff failed to code the MDS accurately for anticoagulants. - Review of Resident #33's medical record on all days of survey. Diagnoses included embolism and thrombosis (blood clot). A physician's order, dated 12/26/22, stated, "Eliquis (apixaban) tablet; 5 mg; amt: 1 tablet; oral Twice A Day . . ." The quarterly MDSs, dated 03/26/23 and 06/23/23, identified Resident #33 received an anticoagulant on "0" of 7 days. Staff failed to code the MDS accurately for anticoagulants. During an interview on 09/07/23 at 9:20 a.m., an administrative nurse (#7) confirmed staff incorrectly coded section N of the MDS for Resident #11, #21, #26, and #33.	F 641		
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: Based on record review, review of professional	F 658	F658- During the annual survey it was	10/12/23

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F 658	Continued From page 6 reference, and staff interview, the facility failed to ensure staff followed standards of practice for 1 of 3 sampled residents (Resident #13) with an indwelling catheter. Failure to follow physician's orders for residents with indwelling catheters may result in delayed treatment, pain and/or worsening of resident's condition. Findings include: Berman, Snyder, and Frandsen's "Kozier & Erb's Fundamentals of Nursing: Concepts, Process, and Practice," 11th ed., Pearson Education, Inc., page 63, states, ". . . Carrying Out a Physician's Orders . . . If the order is neither ambiguous nor apparently erroneous, the nurse is responsible for carrying it out. . . ." Review of Resident #13's medical record occurred on all days of survey. Diagnoses included neuromuscular dysfunction of bladder and urinary retention. A physician order signed on 02/23/22, stated, "Next appointment 1 [one] year." The medical record lacked evidence of a follow up physician visit. During an interview on 09/07/23 at 10:03 a.m., an administrative staff member (#1) confirmed the facility failed to make the follow-up appointment as ordered.	F 658	noted that the facility failed to ensure staff followed standards of practice for residents with indwelling catheters, failed to follow physician's orders for residents with indwelling catheters, which may result in delayed treatment, pain and/or worsening of a resident's condition. Resident #13- has a follow up appointment scheduled for 01/19/2024 with urology. All residents that have outside appointments have the ability to be affected by this deficient practice. All resident that have had appointments in the last 30 days will be audited for any follow up appointment if indicated for month of August. Education will be completed with all licensed nursing staff on or before Oct 6, 2023 or by next scheduled shift, education on the process of returning the appointment referral forms to scheduler to make follow up appointments. Audits will be completed by DON and/or DON designee Audits will be conducted by DON and/or designee at random 2 x a week for 3 month on the appointment referral form. Audit being reviewed through quality council. Audits will continue as deemed by quality council as necessary until substantial compliance has been achieved. The DON is responsible for compliance.	

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F 658	Continued From page 7	F 658	Substantial compliance will be achieved by Oct 12th, 2023.	
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, record review, and staff interview, the facility failed to provide appropriate and sufficient supervision and/or assistive devices for 1 of 4 sampled residents (Resident #13) observed during a pivot transfer. Failure to provide adequate assistance and use the assistive devices properly during transfers placed the residents at risk for accidents, falls, or injuries. Findings include: The facility failed to provide a copy of their policy addressing transfers. Review of Resident #13's medical record occurred on all days of survey and included diagnoses of multiple sclerosis and incomplete paraplegia. The current care plan stated, ". . . I do need assistance with mobility due to weakness, unsteadiness, and diagnosis of multiple sclerosis and paraplegia. . . A1 [assist of one] to stand pivot transfer with FWW [front	F 689	F689- During the annual survey it was noted that the facility failed to provide a copy of their policy addressing transfers. Failed to provide adequate assistance and use the assistive devices properly during transfers which could have resulted in injury. Resident #13- 9/28/2023 reviewed care plan to reflect appropriate transfer status. All residents that transfer have the ability to be affected by this deficient practice. All residents will be reviewed for current and appropriate transfer status as indicated in their care plan. Education provided on or before Oct 6, 2023, or by next scheduled shift to all nursing staff, on the facility policy on transfers and education on transferring a residents per their Care Plan.	10/12/23

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F 689	Continued From page 8 wheeled walker] and gait belt . . ." During an observation on 09/06/23 at 8:29 a.m., a certified nurse aide (CNA) (#5) stood at the end of Resident 13's bed while the resident slid himself to the edge of the bed, stood, swung his hips towards the wheelchair, and landed roughly and misaligned into the wheelchair. The CNA (#5) failed to assist the resident with the transfer by using the walker and applying a gait belt. During an interview on 09/07/23 at 10:01 a.m., an administrative nurse (#1) confirmed Resident #13 transferred incorrectly and stated she expected staff to follow the resident's care plan.	F 689	Audits will be completed by DON and/or DON designee Audits will be conducted by DON and/or designee at random 5 x a week x4 weeks and 3x a week x 3 months on transferring residents safely with assistive devices per their Care plan. Audits will be reviewed through quality council. Audits will continue as deemed by quality council as necessary until substantial compliance has been achieved. The DON is responsible for compliance. Substantial compliance will be achieved by Oct 12th, 2023.	
F 710 SS=D	Resident's Care Supervised by a Physician CFR(s): 483.30(a)(1)(2) §483.30 Physician Services A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. A physician, physician assistant, nurse practitioner, or clinical nurse specialist must provide orders for the resident's immediate care and needs. §483.30(a) Physician Supervision. The facility must ensure that- §483.30(a)(1) The medical care of each resident is supervised by a physician; §483.30(a)(2) Another physician supervises the medical care of residents when their attending physician is unavailable. This REQUIREMENT is not met as evidenced by:	F 710		10/12/23

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F 710	Continued From page 9 Based on facility policy, record review, and staff interview, the facility failed to ensure a physician's response to changes in resident's weight for 3 of 3 sampled residents (Resident #23, #44, and #45) with significant weight loss. Failure to ensure the physician responded in a timely manner may result in a delay of treatment and further weight loss for residents. Findings include: Review of the facility policy titled "Weight Monitoring and Documentation" occurred on 09/07/23. This policy, dated August 2019, stated, ". . . 7. Resident's weights are tracked monthly through an established monitoring system to ensure that significant changes are identified and addressed . . . 10. The physician . . . will be notified on any significant weight change. . . ." - Review of Resident #23's medical record occurred on all days of survey. Diagnoses included diabetes mellitus, diverticulosis, Parkinson's, and dementia. The current care plan stated, ". . . I'm at risk for weight changes/nutritional deficiency due to dx Dementia, Diabetes and Diverticulosis. . . . Assist me with meals. . . . " Review of dietary progress notes identified the following: 08/22/23 at 4:41 p.m., "Nutrition: Weight-119.8# [pounds] (8/22). Weight has been decreasing over the past several months with a weight loss of 11# noted from 3 months ago. Review of the physician progress notes from February 2023 through August 2023 lacked	F 710	F710-During the annual survey it was noted that the facility failed to ensure physician response to changes in residents weight in three significant weight loss in 3 of 3 residents. Resident #23-expired 9/16/2023 Resident #44-provider was notified of the weight loss on 9/28/2023 and acknowledged, will continue with current orders Resident #45- provider was notified of the weight loss on 9/28/2023 and provider acknowledged new recommendations. All residents that have the ability to be affected by this deficient practice. Policy was updated to reflect new process for monitoring of weights and notification of physician. Education was provided to all nursing staff and dietician on or before Oct 6, 2023, or by next scheduled shift in regards to the new process of notifying our provider of weight loss, and policy of weights monitoring and documentation. Education was provided to the primary provider on 09/28/2023 about new process and acknowledging weight changes. Audits will be completed by DON and/or DON designee Audits will be conducted by DON and/or designee when a weight monitoring form is used x 4 months. Audits will be reviewed through quality council. Audits will continue as deemed by quality council as necessary until	

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F 710	Continued From page 10 evidence the physician acknowledged or addressd Resident #23's significant weight loss. - Review of Resident #44's medical record occurred on all days of survey. Diagnoses included diabetes mellitus and hypothyroidism. The current care plan stated, ". . . I'm at risk for weight changes/nutritional deficiency due to dx's[diagnoses] of type II [two] diabetes mellitus, hypertension and hypothyroidism. . . I may be forgetful and confused at times . . . " A dietary progress note dated, 03/17/23 at 11:35 a.m., stated, ". . .Weights: 179.8# (3/16), 187.2# (2/19), 203#(12/14), 220.6# (9/14). Neighbor continues to lose weight with significant weight loss of 40.8# (18%) noted in the past 6 months. . . ." Review of physician progress notes from October 2022 through September 6, 2023 lacked evidence the physician acknowledged or addressed Resident #44's significant weight loss. - Review of Resident #45's medical record occurred on all days of survey. Diagnoses included dementia and macular degeneration. The current care plan stated, ". . . I'm at risk for weight changes/nutritional deficiency due to Dementia. . . ." A dietary progress note, dated 05/30/23 at 3:50 p.m., stated, ". . . Weights: 82# (5/29), 86.1# (4/30), 84.8# (3/5), 92.2# (12/1). Significant weight loss of 10.2# (11%) noted in the past 6 months. . . ." Review of physician progress notes from January	F 710	substantial compliance has been achieved. The DON is responsible for compliance. Substantial compliance will be achieved by October 12th, 2023	

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	355064	A. BUILDING _____ B. WING _____	C 09/07/2023

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 710	Continued From page 11 through July 2023 lacked evidence the physician acknowledged or addressed Resident #45's significant weight loss. During an interview on 09/07/23 at 9:25 a.m., an administrative nurse (#1) confirmed the physician progress notes lacked evidence the physician acknowledged or addressed the significant weight loss for Resident #23, #44, and #45.	F 710		
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,	F 880		10/12/23

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F 880	Continued From page 12 but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its	F 880		

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F 880	Continued From page 13 IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to follow standards of infection control for 2 of 7 sampled residents (Resident #14 and Resident #27) and 5 supplemental residents (#1, #12, #18, #39, and # 47) observed during personal cares or transfers. Failure to practice infection control standards related to hand hygiene and cleaning of mechanical lifts has the potential to spread infection throughout the facility. Findings include: HAND HYGIENE: Review of the facility policy titled "Hand Hygiene" occurred on 09/06/23. This policy, effective June 2017, stated, ". . . all associates will be trained and competent in following proper hand hygiene practices. . . Times to Perform Hand Hygiene are, but not limited to . . .Before and after direct resident contact . . . Before and after assisting a resident with personal cares . . . Before and after assisting a resident with toileting . . . After contact with a resident's mucous membranes and body fluids or excretions . . . After removing gloves or aprons . . ." - Observation on 09/05/23 at 3:53 p.m. showed two certified nurse aides (CNAs) (#2 and #3) completed perineal cares for Resident #18. The CNA (#2) cleansed the resident's perineal area, discarded the wet incontinent product, removed his gloves, donned a new pair of gloves, and placed a clean incontinent product on the	F 880	F880-During the annual survey it was noted that the facility failed to use hand hygiene and lift cleaning between residents. Resident #1, 12, 39, 47- did not have any adverse effects lift from not cleaning the lift in-between uses. Resident #14, 18, 27-did not have any adverse effects from hand hygiene not being performed. All residents have the ability to be affected by this deficient practices of hand hygiene and those who use a lift for transfers, have the ability to be affected by not lift cleaning between residents. Education provided on or before Oct 6, 2023, or by next scheduled shift to all staff, on the facility policy's on hand hygiene and cleaning medical equipment between residents. Provide education on new signage on hand hygiene and lift cleaning. Audits will be completed by DON and/or DON designee Audits will be conducted by DON and/or designee at random 10x a week x 3 months, then monthly after on hand hygiene. Audits will be completed by DON and/or DON designee Audits will be conducted by DON and/or designee at random 5 x a week x 4 week x 3 months, then monthly after on lift cleaning	

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F 880	Continued From page 14 resident. The CNA (#2) without performing hand hygiene, placed the resident's shoes on, transferred the resident with a mechanical lift, removed the lift sling and strap, emptied the garbage, combed the resident's hair and turned on the television. The CNA failed to perform hand hygiene between glove changes and before completing other tasks. - Observation on 09/05/23 at 4:08 p.m. showed two CNAs (#2 and #11) completed perineal cares for Resident #27. A CNA (#11) cleansed the resident's perineal area with a wipe and rolled the resident onto their right side. The CNA (#11) then removed her gloves and donned a new pair of gloves without performing hand hygiene. While Resident #27 was on their side, the other CNA (#2) placed a clean incontinent product under the resident, cleansed the resident's bottom with a wipe, removed his gloves and donned a new pair of gloves without performing hand hygiene. Both CNAs transferred the resident with a mechanical lift, adjusted her clothing, and removed the lift sling and strap. CNA #2 sanitized the lift, combed the resident's hair, gave the resident a drink of water, and opened the blinds before washing his hands. CNA #11 exited the room with the lift and the garbage without performing hand hygiene prior to exit. Both CNAs (#2 and #11) failed to perform hand hygiene between glove changes and before completing other tasks. - Observation on 09/06/23 at 9:07 a.m. showed a CNA (#6) donned gloves, performed perineal cares for Resident #14, removed the soiled brief, removed her gloves, adjusted her uniform top, and without performing hand hygiene, donned new gloves, applied skin barrier cream and	F 880	between residents. Audits will continue as deemed by quality council as necessary until substantial compliance has been achieved. The DON is responsible for compliance. Substantial compliance will be achieved by Oct 12th, 2023.	

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F 880	Continued From page 15	F 880		

applied a clean brief. The CNA removed her soiled gloves, tied the garbage bag, adjusted her uniform top, and without performing hand hygiene donned new gloves, washed Resident #14's underarms, dressed the resident's lower half, and assisted the resident to the wheelchair. The CNA (#6) removed her gloves, exited the room, obtained a portable oxygen concentrator, and returned to the room. The CNA failed to perform hand hygiene when he/she exited/entered the room. The CNA (#6) switched Resident #14's oxygen tubing from the room concentrator to the portable unit and touched the nasal cannulas as she applied the tubing to the resident. The CNA (#6) donned gloves, stripped the linen from the bed, put linen in a plastic bag, removed her gloves, failed to perform hand hygiene and exited the room.

DISINFECTING LIFTS

Review of the facility policy titled "Resident Care Equipment" occurred on 09/07/23. This policy, dated July 2017, stated, ". . . Associates will disinfect reusable equipment between resident uses using EPA approved disinfectant. . . ."

Observation on 09/05/23 showed staff completed resident transfers with mechanical lifts and failed to disinfect the lifts after or between each resident use as follows:
* At 12:49 p.m., Resident #1 full body transfer lift.
* At 1:15 p.m. and 4:11 p.m., Resident #12 sit-to-stand transfer lift.
* At 2:31 p.m., Resident #47 sit-to-stand transfer lift.
* At 3:03 p.m., Resident #39 sit-to-stand transfer lift.

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F 880	Continued From page 16 During an interview on 09/07/23 at 10:25 a.m., two administrative staff members (#1 and #10) stated, "Our expectation of our staff regarding hand hygiene is to follow the Hand Hygiene policy." They further stated, "Our expectation of our staff regarding disinfecting mechanical lifts is to follow the policy. Staff are to clean the lifts between and after each resident use."	F 880		